STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 1/24/17 through 1/27/17.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#3 and #6) with known diagnoses of Dementia and behaviors which were harmful to themselves and other residents; resulting in Resident #6 wandering unsupervised into other residents' rooms and ingesting rubbing alcohol; and Resident #3 wandering unsupervised and hitting other residents. The findings are: 1. Review of Resident #6's current FL-2 dated 09/26/16 revealed: -Diagnoses included dementia and hypertension. -Resident #6 was ambulatory and intermittently disoriented. Observation of Resident #6 on 01/27/17 at 12:39pm revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 1	D 270		

-Resident #6 was lying on his bed in his room with his eyes closed.
-Resident #6's room was located on the left side of 100 hall towards the end of the hall, away from the dining rooms, medication room, and staff offices.

Attempted interview of Resident #6 on 01/27/17 at 1:45pm revealed Resident #6 was alert and only oriented to self.

Observation of Resident #6 on 01/27/16 at 2:42pm-2:45pm revealed:
-Resident #6 walked into room #218 (not his room) and sat down in the bedside chair.
-After sitting briefly in the chair, Resident #6 walked to the doorway of room #218; a Personal Care Aide (PCA) who was walking down the hall saw Resident #6 in the doorway of room #218.
-The PCA told Resident #6 he couldn't be in that room; "this is not your room."
-The PCA guided Resident #6 down the hallway and into his own room.

Observation of Resident #6 on 01/27/17 from 3:08pm-3:27pm revealed:
-Resident #6 was walking in the hallway towards 300/400 hall.
-Resident #6 went into the Business Office Manager's (BOM) office at 3:10pm and sat down in a chair in that office.
-Resident #6 left the BOM's office at 3:12pm and walked toward 300/400 hall; he entered room #430 (not his room).
-The female resident in room #430 told Resident #6 this was not his room. Resident #6 left the room and walked across the hall and knocked on a bathroom door, then continued to walk down the 300/400 hall.
-At 3:14pm, Resident #6 entered room #435 (not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 2	D 270		

his room).The female resident in room #435 told Resident #6 to "get out of here" in a loud, stern voice; Resident #6 left room #435.
-At 3:17pm, Resident #6 attempted to enter room #439 but was met by a male resident at the doorway. The resident told Resident #6 "you can't come in here."
-Resident #6 stopped in the hall outside room #439 and another resident approached him and told him "come on I will take you to your room."
-At 3:19pm, when Resident #6 and the other resident were near the BOM's office, the resident assisting Resident #6 saw a PCA and told the PCA that Resident #6 needed help.
-The PCA redirected Resident #6 to sit down in the chair in the hallway outside of the BOM's office; the PCA left Resident #6 sitting in the chair outside the BOM's office.
-At 3:22pm, Resident #6 got out of the chair and began to walk around the area near the front entrance between 100/200 and 300/400 halls.
-At 3:27pm, the same resident who had assisted Resident #6 earlier guided Resident #6 down 100/200 hall and into his room. The resident assisted Resident #6 to get in bed and sat down in the chair in the room with Resident #6.
-The onlt time staff intervened to redirect Resident #6 was when the resident told the PCA Resident #6 needed help and the PCA assisted Resident #6 to sit in the chair outside BOM's office.
-At no time did staff intervene to prevent Resident #6 from entering the other residents' rooms or remove Resident #6 from the other residents' rooms.

Observation of Resident #6 on 01/27/17 at 4:50pm revealed he was being escorted out of room #107 (not his room) by a PCA;
the PCA guided Resident #6 out of room #107,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 3 down the hallway, and into the small dining room. Interview with a PCA on 01/27/16 at 4:50om revealed: -When staff went to get Resident #6 for dinner he was not in his room, the hallway, or the television common room. -The PCA went looking for Resident #6 and found him asleep on the bed in room #107 (not his room). Interview with a second PCA on 01/26/17 at 3:05pm revealed: -Resident #6 wandered but was easily redirected by staff. -Resident #6 "goes in other residents'rooms and gets in their bed." -It was facility procedure for staff to check on each resident every two hours. -Staff were always mindful to keep tract of residents who wandered. -Interventions implemented for residents who wandered included re-orienting the resident and using the wander guard system. Interview with a third PCA on 01/26/17 at 3:35pm revealed: -Resident #6 wandered but it was to be expected due to his diagnosis of dementia. -Staff checked on residents every two hours or more often when the residents were walking in the halls. Review of the Nurses Notes for Resident #6 dated 09/14/16 at 8:45pm revealed: -Staff reported to the Registered Nurse (RN) that Resident #6 "wanders/paces hall." -Staff reported to the RN that Resident #6 put "things in his mouth i.e.: soap, hand sanitizer, shampoo. Will eat anything."	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 4	D 270		

-"Needs frequent monitoring and redirection."
-The Nurse Note was signed by the home health RN.

Review of the Nurses Notes for Resident #6 dated 12/15/16 revealed:
-Resident #6 was oriented to "person only, walks up and down halls days and night with sundowning ...attempts to open doors and leave during night."
-"Frequently puts non food items in his mouth i.e.: soap, hand sanitizer", and would take food off of residents' plates.
-The Nurse Note was signed by the home health RN.

Interview with a PCA on 01/26/17 at 6:46pm revealed Resident #6 was "bad to put stuff in his mouth;" staff had to "watch him real close."

Interview with a Medicaiton Aide (MA) on 01/26/17 at 6:55pm revealed:
-Resident #6 was "forgetful" and "wanders."
-Resident #6 "will go into other residents' rooms" unless staff stopped him.
-Staff redirected Resident #6 as needed.
-The MA was not aware of any special interventions or monitoring for Resident #6; "he has a wander guard."

Interview with a second MA on 01/27/17 at 09:18am revealed:
-Resident #6 was the "typical dementia patient"; he walked the halls and went in to other residents' rooms, but was easily redirected.
-Resident #6 would "sometimes" put stuff in his mouth "that he is not supposed to" so staff monitored him closely.

Review of Resident #6's Assessment and Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 5	D 270		

Plan dated 08/01/16 revealed:
-Resident #6 was "forgetful" and "sometimes disoriented."
-There was no documentation on the Assessment and Care Plan of Resident #6's behaviors of wandering or putting non-food and potentially harmful items in his mouth or interventions to address those behaviors.

Review of the Nurse Notes for Resident #6 dated 11/19/16 revealed:
-At 1:10pm: "Resident was noted by his room mate (sic) drinking rubbing alcohol, room mate (sic) took it from him. 911 called."
-At 8:30pm: Resident #6 returned back to the facility from the ED."Dx (diagnosis) ETOH (alcohol) poisoning. Will continue to monitor."

Interview with the Administrator on 01/26/17 at 6:07pm revealed the staff member that wrote the Nurses Note on 11/19/16 at 1:10pm was a MA who no longer worked at the facility.

Review of the hospital Emergency Department (ED) instructions for Resident #6 dated 11/19/16 revealed:
-Resident #6 was evaluated and discharged on 11/19/16.
-The diagnosis was "ingestion of nontoxic substance, accidental or unintentional."

Interview with a MA on 01/27/17 at 09:18am revealed:
-The MA was not on duty the day Resident #6 drank the rubbing alcohol (11/19/16).
-After Resident #6 ingested the rubbing alcohol, it was "reiterated" to watch the medication carts and supplies; no extra monitoring or interventions were put in place for Resident #6's safety.
-The MA could not recall where Resident #6 got

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 6	D 270		

the rubbing alcohol.

Interview with a second MA on 01/27/16 at 3:41pm revealed:
-Resident #6 wandered and went in to other residents' rooms.
-Safety interventions used for Resident #6 included checking on him every 2 hours, use of a wander guard, redirecting him when he went in to other residents' rooms, and reminding him of his room number.
-The MA came to work on second shift the day Resident #6 ingested the rubbing alcohol (on first shift on 11/19/16).
-The MA "heard" from other staff that Resident #6 had gone into another resident's room and drank the alcohol and was "trying to eat deodorant."
-Resident #6 was sent to the hospital and poison control was contacted.
-"[Resident #6's name] will eat anything."
-Interventions implemented after the incident on 11/19/16 to monitor and keep Resident #6 safe included "we tried to keep a closer eye on him" to prevent Resident #6 into going into other residents' rooms and staff "made sure" foreign items Resident #6 could ingest were removed from "his room and surrounding rooms."

Observation of the 100/200 hall on 01/26/17 from 6:42pm-7:00pm revealed:
-The entrance door to the storage room identified by staff as the oxygen storage room was unlocked and open.
-There were multiple residents on the 100/200 hall between 6:42pm-7:00pm.
-Items such as mouthwash, "liquid skin cleanser", lotion, "surface cleaner", caulk, and "floor cleaner" were observed in the oxygen storage room on the counters and floor.
-There were no staff present in the oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 7	D 270		

storage room or on the hall to monitor the storage room.

Observation of the room identified as the oxygen storage room located on 100/200 hall on 01/26/17 at 7:04pm revealed the entrance door to the room was closed and locked.

Interview with the Administrator on 01/27/17 at 5:22pm revealed the storage room on 100/200 hall was supposed to be locked at all times unless staff were in the room.

Interview with the home health RN from the contracted home health provider on 01/26/17 at 6:15pm revealed:
-The home health/mental health RN was providing home health services to Resident #6 for his history of sexually inappropriate behaviors.
-Resident #6 walked the halls and would go in to other residents' rooms.
-Facility staff had reported to the RN that Resident #6 had a history of placing "non-food items" and "hand sanitizer" in his mouth (the RN was not sure of the dates of the staff reports but she had documented it her charting notes).
-Resident #6 had not had any recent incidents of behavior problems or putting items in his mouth.
-Staff had not notified the home health RN that Resident #6 drank rubbing alcohol and the RN had no knowledge of the incident on 11/19/16 when Resident #6 drank the alcohol.

Review of the Nurses Notes for Resident #6 dated 01/24/17 revealed "No recent sexually inappropriate behaviors. No longer putting nonfood items in his mouth."

Multiple requests for the Accident/Incident Report for Resident #6 for 11/19/16 revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 8 Accident/Incident Report was not provided. Based on observations, record reviews, and interviews, Resident #6 was not interviewable. Telephone interview with Resident #6's Power of Attorney (POA) on 01/27/16 at 10:45am revealed: -Staff called the POA in "November (2016) or early December" (2016) to report Resident #6 went into another residents' room, got a bottle of rubbing alcohol, and drank it. -Staff did not know how much rubbing alcohol Resident #6 drank so he was sent to the hospital. -Hospital staff told the POA that Resident #6 did not drink enough of the rubbing alcohol to "harm him." -The POA could not understand how the rubbing alcohol could be accessible to Resident #6. -The POA wondered why staff did not see Resident #6 with the alcohol or know how he got it. -The POA asked the facility staff "how this could be allowed" and was told they did not know how he got the alcohol. -The POA was unaware of any "precautions" taken by the facility to prevent further incidents. -Facility staff had not ever mentioned Resident #6's wandering behaviors to the POA. -The POA was concerned with the level of monitoring and supervision Resident #6 received at the facility. -The POA had "never" walked into the building and "saw staff" or had staff greet her. -The POA moved out of state and could not visit as frequently as before but had received reports from other visitors of Resident #6 (to include another family member who visited Resident #6 "a few weeks ago", friends, and pastor) that staff were never "visable", were hard to locate, and were never out in the halls.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 9 Interview with the Resident Care Director (RCD) on 01/27/17 at 3:00pm revealed: -Resident #6 was "constantly redirected by staff" and was "checked on every two hours and as needed." -The RCD was aware Resident #6 ingested rubbing alcohol but did not have "many details" about the incident because staff "went straight to [Administrator's name.]" -After the incident on 11/19/16, the D thought "maybe 15 minute checks were done" for Resident #6, but "you'll have to ask [Admininstrator's name]." -The RCD did not know where Resident #6 got the rubbing alcohol or where Resident #6 was found with the alcohol. Interview with the Administrator on 01/26/17 at 6:07pm revealed: -First shift staff called the Administrator to report Resident #6 was found by staff with an empty bottle of rubbing alcohol (11/19/16). -Staff could not smell alcohol on Resident #6's breath and did not know if he drank the rubbing alcohol. -The Administrator told staff to send Resident #6 to the hospital emergency department (ED). -Resident #6 was sent to the ED and returned back to the facility the same day. Interview with the Administrator on 01/27/17 at 5:22pm revealed: -Resident #6 wore a wander guard to address his wandering behaviors. -Staff had "no idea where he got the alcohol." -Resident #6 had been found walking down the hall with an empty rubbing alcohol bottle (11/19/16). -Staff had searched all residents' rooms to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 10	D 270		

remove anything Resident #6 could ingest and Resident #6 was on two hour checks, but other than that, there were no other monitoring or safety interventions implemented for Resident #6 after he ingested the alcohol on 11/19/16.
-Staff had not implemented any additional monitoring or safety interventions for Resident #6 prior to or after 11/19/16.
-The Administrator was aware that Resident #6 liked to wander the halls and open doors but was not aware Resident #6 was entering other residents' rooms.
-The Administrator expected all staff to know where residents were and to redirect them as needed.
-All staff were responsible for monitoring and redirecting residents.
-When staff observed residents going in rooms that did not belong to them, the Administrator expected staff to document the incidents on an Accident/Incident Report and notify her.
-Anything "out of the ordinary" was supposed to be documented on an Accident/Incident Report.
-The Administrator "was not really aware" Resident #6 was wandering into other residents' rooms and had not seen any Accident/Incident Reports about it.
-If the Administrator had been aware Resident #6 was entering other residents' rooms, she would have assessed the situation and assured the RN and physician were notified to address the situation.
-An incident report should have been completed for the incident that occurred on 11/19/16.

Telephone interview with Resident #6's physician on 01/27/17 at 4:25pm revealed:
-The physician recalled being notified by the facility "maybe a few months ago" of a resident drinking rubbing alcohol but did not recall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 11	D 270		

specifically if it was Resident #6.
-The physician would expect a resident who wandered into other residents' rooms, put harmful objects in their mouth, or ingested a potentially harmful substance to be monitored "more often" and expected the resident to be moved to a location where the resident could be monitored "more often."
-The physician did not recall being notified by the facility of Resident #6's wandering into other residents' rooms and did not have access to Resident #6's medical records at that time.

2. Review of Resident #3's current FL-2 dated 10/4/16 revealed:
-Diagnoses included Dementia, Coronary Artery Disease, Hyperlipidemia, Chronic Obstructive Pulmonary Disease and Benign Prostate Hypertrophy.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #3's current care plan dated 8/1/16 and signed by the Primary Care Provider (PCP) revealed the resident was referred to mental health on 8/1/16 for dementia; no specific behaviors were documented.

Confidential interview with a resident revealed:
-Resident #3 had hit other residents and staff.
-"There are people [other residents] who [were] scared of him."
-"They [staff] don't do nothing about it."

Confidential interview with a second resident revealed:
-Resident #3 had hit the resident two times in the past; once in August 2016 and the second time about a month later.
-On 1/25/17, Resident #3 was at the kitchen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 12	D 270		

when Resident #11 tapped Resident #3 on the shoulder and said he needed to get by; as soon as Resident #11 passed by Resident #3, Resident #3 "punched him and nailed him in the neck."
-Resident #3 "hits everybody and nothing [was] done about it. He's allowed to walk around; walks around all night; [goes] in your room at night and we [residents] have to get him out; staff [did] absolutely nothing."
-Residents had to yell for staff to come or go down to the medication room to get the staff; the staff did not routinely check on residents.
-Resident #3 was "really going to hurt somebody one of these days."

Confidential interview with a third resident revealed:
-The resident got along with Resident #3 and had never been hit by Resident #3.
-Resident #3 had hit a couple of other residents; the last time he hit a resident was two days ago (1/24/17).
-Resident #3 "had good days and bad days, sometimes he might be in a bad mood - you can never tell."

Confidential interview with a fourth resident revealed the resident said "You gotta be careful of [Resident #3], his mind [was] not right, he's hit people that work here and live here."

Observation on 1/24/17 at 10:38am revealed Resident #3 was walking in the 100 hall with a wander guard bracelet on his wrist and did not respond to greeting; there was no staff observed on the 100 hall.

Observation on 1/25/16 at 11:22am revealed Resident #3 was walking in the hall after lunch; there was no staff observed on the 100 hall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 13 Observation on 1/26/17 at 11:01am revealed: -A woman's voice yelled "help" coming from the bathroom on the 200 hall. -Resident #12 was in the bathroom standing at the sink and stated "He's [Resident #3] harassing me again." -The Maintenance Man was escorting Resident #3 from the bathroom. Interview with the Maintenance Man on 1/26/17 at 11:01am revealed Resident #3 had "just walked in there [bathroom]; he's a wanderer; nothing happened." Interview with Resident #12 on 1/26/17 at 11:31am revealed: -Resident #3 had just walked into the bathroom when she was in there and was "harassing" her again. -He had walked into her room on 1/22/17 and she was asking him to leave when he "hit me with his fist just as hard as he could on my neck." -Resident #12 "tried" to report the incident to the Medication Aide (MA) but was interrupted and told she did not handle the situation correctly; she should have went to staff to get Resident #3 out of her room. -The resident reported the incident to the Administrator the morning of 1/23/17 and she said she would talk to the MA. -She did not have any bruising on her neck, but it still hurt. -Other residents were aware of Resident #3 "harassing" her and would assist in redirecting Resident #3; staff did not watch Resident #3. -Resident #3 hit Resident #11 on 1/22/17 near the kitchen; punched him in the back of the head when he walked by.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 14 Interview with Resident #11 on 1/26/17 at 5:40pm revealed: -He had been hit by Resident #3 "just the other day" when he was trying to get into the dining room at lunch time. -"As soon as I walked by [Resident #3] he punched me good and hard in the back of the head." -He was "shook up, but okay" after sitting down in the dining room. -There was a housekeeping staff present in the dining room who witnessed Resident #3 punch him. -Everyone has seen Resident #3 hit residents and did not do anything about it; all the staff "cared about was making sure [name of Resident #3] was okay." -He could not remember the names of other residents that Resident #3 had hit. Second confidential interview with a resident revealed: -Resident #3 had gotten into a "fist fight" with Resident #7 who lived on the 400 hall. -The "fist fight" happened last week (week of 1/15/17) at lunchtime near the common area and front entrance, and was witnessed by MAs and Personal Care Aides (PCAs). -Resident #3 had hit Resident #11 outside the dining room a few days ago (1/22/17 - 1/24/17). -Resident #3 "used to be real bad, just walk into other residents' room and punch them." -"Every now and then, [Resident #3] would get in his moods, you could see it on his face and he would just hit people." -Staff did not do anything, just tell one resident to go one way and tell the other to go the other way. Interview with Resident #7 on 1/27/17 at 2:40pm revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 15	D 270		

-He had been at the facility "a good long time, don't rightly know how long."
-He had never gotten into a "fist fight" or been hit by another resident.

Interview with a PCA on 1/27/17 at 3:15pm revealed:
-Resident #7 could be confrontational and argumentative; would tell Resident #3 not to go down the 300 and 400 hall.
-The PCA said, "You gotta keep an eye on them [Resident #7 and Resident #3] to stop it before it starts."
-The PCA had never seen Resident #3 hit anyone.

Based on observations, interviews and record reviews, Resident #3 was not interviewable.

Telephone interview on 1/25/17 at 4:32pm with Resident #3's Power of Attorney (POA) revealed:
-The staff at the facility worked with the resident so he wasn't "all drugged up" like he had been at a previous facility.
-"For some reason he got aggressive" until the staff "got his medications right" then there was no more aggression.
-The resident had not been aggressive since he first got to the facility (June 2016).
-"He's never hurt anyone, they surely would have called me if he had."

Confidential interview with a staff revealed:
-The staff had never seen Resident #3 actually hit another resident, the staff had seen him "draw his fists."
-"I'm sure there [were] a few [residents] who wanted to hit [Resident #3]; it's a natural reaction when somebody hits you."
-The residents would normally report any abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 16	D 270		

to the MA; if the staff had witnessed the abuse, it would be reported to the Supervisor on duty.
-The staff did not have any specific concerns but was concerned about residents "wellbeing" because there were "a lot of new staff and a lot of new residents."

Review of "Nurse Notes" for Resident #3 revealed:
-There were 15 entries from 5/29/16 through 9/6/16 where staff documented Resident #3 having aggressive behavior including five incidents of hitting other residents and four incidents of hitting staff.
-On 9/22/16 at 9:50am "Resident in shower raised fist to hit [PCA] and hit shower stall with left arm; obtained skin tear to left arm below elbow ...transported to [name of local hospital], family and PCP (Primary Care Provider) notified."
-On 9/22/16 (no time)"(Late entry) It was reported that resident had entered another resident's room, told him [other resident] to get out of his chair, [the other] resident told him [Resident #3] to leave; resident scratched resident on his right arm."
-On 9/23/16 at 6:00am "Resident grabbed an aide's face and hit her in the stomach. Please continue to monitor."
-On 9/26/16 at 2:00pm "Resident showing signs of aggression, PRN (as needed medication) given, will monitor."
-On 9/28/16 at 9:15am "Resident showing signs of aggression, PRN given, will continue to monitor."
-On 10/3/16 at 6:15am "Resident was standing in hallway blocking entrance to another resident's room, the second resident then asked resident to move so he could get in his room. This agitated Resident [#3] he became angry and hit the second resident striking him on the neck and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 17	D 270		

chin. Resident [#3] was redirected and scheduled PRN [medications] were given."
-On 10/5/16 at 11:15am "Spoke with Guardian, explained resident fell trying to put his leg on another resident's wheelchair ...Administrator and MD notified."
-On 10/30/16 at 10:20am "Showing signs of aggression, PRN given."
-On 11/2/16 at 1:30pm "Resident balled fist and swung at another resident while walking by. Not provoked, did not make contact and was redirected."
-On 11/3/16 at 9:20am "Resident showing signs of aggression. Resident swung at one of the aides. PRN [medication] given at 9:24am. PRN effective."
-On 11/4/16 at 3:00pm "Resident was not acting himself, walking with back sunk in. RCD [Resident Care Director] notified, POA notified, 911 called, sent to [name of local hospital] via EMS [Emergency Medical Services]. At 7:00pm "Resident arrived at facility via EMS with no new orders or [medication] changes."
-On 12/22/16 at 10:50am "Resident still showing signs of aggression, PRN administered, will monitor."
-There was no documentation of interventions or increased supervision for Resident #3 following documented entries of aggressive behaviors from 9/22/16 through 12/22/16.
-There were no further entries 12/23/16 through 1/26/17.

Review of a psychiatric visit note for Resident #3 dated 10/27/16 revealed:
-Resident was seen for a new patient referral; admitted to the facility with a history of dementia.
-"Staff voiced no new issues or concerns today."
-Resident #3 was "irritable" and had "no thoughts to harm others or recent assaultive behaviors."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 18 Review of a psychiatric visit note for Resident #3 dated 1/12/17 revealed: -Diagnoses included Dementia, Anxiety and Insomnia. -There were no medication changes. -"Patient seems stable without reports of aggression toward staff recently. Will see patient at the usual interval unless crisis or emergency occurs. Staff monitor and report changes in mood/behavioral and medication side effects." Interview with a MA/Supervisor on 1/27/17 at 3:50pm revealed: -Resident #12 had reported being hit by Resident #3, but no staff had witnessed him hitting her. -She had never seen Resident #3 hit Resident #7. -The last time Resident #3 attempted to hit another resident was a "few weeks ago" on 1st shift where Resident #3 swung at Resident #11 and Resident #11 "swung back and made contact." -The 1st shift MA reported what happened at change of shift; "I'm sure she would have documented something ...there was some concern for his [Resident #3's] safety" -Resident #3 "was not the same as was when he first came to the facility; he had been better since they changed his medications." -Regarding the "Nurse Note" dated 10/3/16, she could not remember who the resident was that Resident #3 hit. -It "had been a while" since Resident #3 hit anyone; he was occasionally agitated with staff and she had seen him make an aggressive stance with his fists balled, which was "common behavior" for Resident #3. -Residents were checked every two hours; there were no residents being checked more	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 19	D 270		

frequently.
-When staff made their "rounds" every two hours, staff would make sure the "wanderers" were in their own beds.
-If staff noticed one of the wandering residents in another resident's room, they would redirect the wandering resident back to their own room.
-Residents with behaviors were usually redirected and given a PRN and "usually forgot about the whole thing."
-The MA did not have any further response for any interventions or increased monitoring when Resident #3 had aggressive behavior.
-Resident #3's Power of Attorney (POA) had been notified when he hit someone.

Interview with a second MA/Supervisor on 1/26/17 at 6:15pm revealed:
-"Every now and then, out of the blue [Resident #3] might get mad and start cussing."
-"It had been a while since [Resident #3] hit someone."
-Staff was "always on the hall, so we try to keep an eye the ones that wander. Plus [name of Resident #3] had a bracelet, so if he got out staff would know."
-Resident #3 did wander into other resident's rooms, but staff "was always in the hall so they kept an eye on him."
-The MA did not have any further response for any specific interventions or increased supervision of Resident #3.

Interview with a third MA/Supervisor on 1/27/17 at 11:36am revealed:
-Resident #3 showing signs of aggression documented in "Nurse Notes on 9/26/16, 9/28/16 and 12/22/16," usually meant Resident #3 would swing towards people, but did not connect."
-The MA was not aware of Resident #3 hitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 20	D 270		

[Resident #11] within the last week near the dining room; and Resident #12 had not reported to the MA that Resident #3 punched her [Resident #12] in the neck in her room.
-The MA had not seen Resident #3 hit anyone or harass any resident, nor had anyone reported anything.
-Resident #3 would just walk up and down the halls all day; he did "swing at the air, he did it to me, I just tell him you can't do that and he'll say okay and keep walking down the hall."
-There were no residents who had reported being afraid of Resident #3.
-If Resident #3 did hit another resident, staff would give him a PRN and notify the Administrator.

Second interview with Resident #12 on 1/27/17 at 3:20pm revealed:
-She reported to the MA/Supervisor interviewed on 1/26/17 that Resident #3 had punched her the neck on 1/22/17.
-"Like I said she [MA] kept arguing with me that I should have come to get her [MA] and that I did it wrong."
-She had also reported the incident to the Administrator on 1/23/17 who said she would talk to the MA/Supervisor.
-Resident #3 punched in the neck in the afternoon on 1st shift; there was a PCA that came when she yelled.
-The PCA pulled Resident #3 out of her room and asked him if he was okay; she did not ask Resident #12 if she was okay.
-The right front part of her neck still hurt from where Resident #3 punched her.
-Since 1/26/17, Resident #3 had come up to her twice whispering and making her feel uncomfortable.
-Other residents redirected Resident #3 away

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 21	D 270		

from her on both occasions.

Staff was not available for interview regarding "Nurses Notes" entries dated 9/22/16, 9/23/16, 11/2/16 and 11/3/16.

Observation on 1/27/17 at 4:37pm revealed:
-Resident #3 was walking out of room 323 [not his room].
-A male resident was lying in the bed closest to the window and yelled, "He doesn't belong in here."
-Another resident said to Resident #3, "Come on [name of Resident #3] let's go watch TV" while lightly holding Resident #3's arm and guiding him toward the common area.
-There were no staff observed near room 323.

Observation on 1/27/17 at 5:15pm revealed:
-A resident was walking with Resident #3 down the hall, lightly holding his arm.
-The resident said he was "keeping an eye on him" while they stopped in front of the medication cart where there were staff and other residents.

Telephone interview with the Mental Health Provider (MHP) on 1/26/17 at 12:42pm revealed:
-Resident #3 was usually calm and "just walked the halls."
-The resident was diagnosed with Dementia with behavior disturbance.
-She was not aware of any recent aggressive behaviors by Resident #3; he had those behaviors in the past where he resisted care and was aggressive with staff.
-She had not received any reports from staff that the resident was displaying aggressive behaviors.
-She had not known Resident #3 to have been aggressive with other residents.
-She would expect staff to report any aggressive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 22	D 270		

behaviors because that would be a safety concern, there could have been a problem with the resident's medications and/or the resident may have "had something physical going on."
-She would be concerned for the safety of other residents as well as the safety of Resident #3 if another resident were to hit him back.
-Had she been notified, interventions such as medication evaluation, every 15 minute checks on the resident and possible re-evaluation of the level of care, could have been initiated.
-She was at the facility weekly on Thursdays but not on 1/26/17; she contacted the Resident Care Director (RCD) on 1/26/17; he did not report any behavior concerns for Resident #3.

Telephone interview with the Primary Care Provider (PCP) on 1/27/17 at 4:20pm revealed:
-He had seen Resident #3 at the facility, but could not remember all the details and did not have the resident's information available.
-If Resident #3 were assaulting other residents, there would be a safety concern for him and other residents.

Interview with the Administrator on 1/26/17 at 12:30pm revealed Resident #3's medications were changed in October 2016 following a hospital admission because staff and providers were "trying to figure out why he wasn't our [name of Resident #3]."

Interview with the Administrator on 1/26/17 at 5:57pm revealed:
-There was no policy or procedure on supervision of residents with high risk behaviors or concerns.
-Every 15 minute checks were done on a person to person basis.
-There were no residents on every 15 minute checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 23 Interview with the Administrator on 1/27/17 at 5:20pm revealed: -If residents abusing other residents was seen or reported: staff was expected to assess both residents and notify the PCP, MHP and the family. -If the abuse was a one-time incident, the resident would have been put on a two hour watch and staff would get the HHN to assess the resident for possible infection or medication issues. -She was not aware of Resident #3 hitting another resident since October 2016 when his medications were changed. -A two hour watch meant that every two hours staff saw the resident and documented that they laid eyes on the resident. -Resident #12 had not reported anything to her about Resident #3 punching her. -If Resident #12 had reported an incident of Resident #3 punching her to the MA/Supervisor, the MA would have texted the Administrator about the incident. -When Resident #3 walked into other resident's rooms, any staff on duty redirect him. -She would not tolerate any resident taunting or abusing another resident. -The Administrator would address any concerns of resident abuse with the PCP, MHP, DSS and family; all the staff had to do was notify her by text and completing an accident/incident report. -She was not aware of Resident #3 allegedly hitting Resident #7, Resident #11 and Resident #12. _____ The facility failed to supervise 2 of 3 residents (#3 and #6) who required increased supervision	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 24 related to diagnoses of Dementia with behaviors which were harmful to self and others. The facility's failure to supervise Resident #6 who was known to wander and had a history of ingesting rubbing alcohol, resulted in the resident having access to harmful substances in other residents' rooms; and the failure to supervise Resident #3 who had a history of aggressive behaviors, resulted in the resident hitting other residents. This failure to supervise Resident #3 and Resident #6 resulted in substantial risk for serious physical harm which constitutes a Type A2 Violation. _____ Review of the facility's Plan of Protection dated 1/26/17 and 1/27/17 revealed: -Resident #3 and Resident #6 will be placed on 30 minute checks; this will be documented. -Resident #3 and Resident #6 will be moved closer to the nurses' station to protect the rights of other residents. -When a resident wanders into another residents' room, an incident and accident form will be completed immediately. -The Administrator, Owner, Physician, Power of Attorney/Guardian will be notified immediately; each resident will be assessed on an individual basis and follow through on what is best for residents on an as needed basis. -The Administrator will identify all residents with behaviors and meet with staff. -Staff will document resident identified behaviors every two hours. -Any resident identified at high risk, will be checked on every 30 minutes. -Residents identified will be moved closer to the nurses' station for more supervision. -The Administrator will walk through the facility	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 270	Continued From page 25 daily to make sure all residents are safe and all paperwork is completed. -Any reports will be addressed to the Administrator immediately; the Administrator will take action depending on the incident. -The Administrator will follow up daily to make sure 30 minute checks are being completed by staff. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 2/26/17.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider and Mental Health Provider for 1 of 5 sampled residents (#3) who had a diagnosis of Dementia with behaviors and a history of hitting other residents and staff, resulting in continued aggressive behaviors without interventions. The findings are: Review of Resident #3's current FL-2 dated 10/4/16 revealed: -Diagnoses included Dementia, Coronary Artery Disease, Hyperlipidemia, Chronic Obstructive Pulmonary Disease and Benign Prostate	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 26	D 273		

Hypertrophy.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #3's current care plan dated 8/1/16 and signed by the Primary Care Provider (PCP) revealed the resident was referred to mental health on 8/1/16 for dementia; no specific behaviors were documented.

Confidential interview with a resident revealed:
-Resident #3 had hit other residents and staff.
-"They [staff] don't do nothing about it."

Confidential interview with a second resident revealed:
-Resident #3 had hit the resident two times in the past; once in August 2016 and the second time about a month later.
-On 1/25/17, Resident #3 was at the kitchen when Resident #11 tapped Resident #3 on the shoulder and said he needed to get by; as soon as Resident #11 passed by Resident #3, Resident #3 "punched him and nailed him in the neck."
-Resident #3 was "really going to hurt somebody one of these days."

Confidential interview with a third resident revealed:
-The resident got along with Resident #3 and had never been hit by Resident #3.
-Resident #3 had hit a couple of other residents; the last time he hit a resident was two days ago (1/24/17).
-Resident #3 "had good days and bad days, sometimes he might be in a bad mood - you can never tell."

Confidential interview with a fourth resident revealed the resident said "You gotta be careful of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 27	D 273		

[Resident #3], his mind [was] not right, he's hit people that work here and live here."

Observation on 1/26/17 at 11:01am revealed:
-A woman's voice yelled "help" coming from the bathroom on the 200 hall.
-Resident #12 was in the bathroom standing at the sink and stated "He's [Resident #3] harassing me again."
-The Maintenance Man was escorting Resident #3 from the bathroom.

Interview with the Maintenance Man on 1/26/17 at 11:01am revealed Resident #3 had "just walked in there [bathroom]; he's a wanderer; nothing happened."

Interview with Resident #12 on 1/26/17 at 11:31am revealed:
-Resident #3 had just walked into the bathroom when she was in there and was "harassing" her again.
-He had walked into her room on 1/22/17 and she was asking him to leave when he "hit me with his fist just as hard as he could on my neck."
-Resident #12 "tried" to report the incident to the Medication Aide (MA) but was interrupted and told she did not handle the situation correctly; she should have went to staff to get Resident #3 out of her room.
-The resident reported the incident to the Administrator the morning of 1/23/17 and she said she would talk to the MA.
-She did not have any bruising on her neck, but it still hurt.
-Resident #3 hit Resident #11 on 1/22/17 near the kitchen; punched him in the back of the head when he walked by.

Interview with Resident #11 on 1/26/17 at 5:40pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 28	D 273		

revealed:
-He had been hit by Resident #3 "just the other day" when he was trying to get into the dining room at lunch time.
-"As soon as I walked by [Resident #3] he punched me good and hard in the back of the head."
-He was "shook up, but okay" after sitting down in the dining room.
-There was a housekeeping staff present in the dining room who witnessed Resident #3 punch him.
-Everyone has seen Resident #3 hit residents and did not do anything about it; all the staff "cared about was making sure [name of Resident #3] was okay."
-He could not remember the names of other residents that Resident #3 had hit.

Second confidential interview with a resident revealed:
-Resident #3 had gotten into a "fist fight" with Resident #7 who lived on the 400 hall.
-The "fist fight" happened last week (week of 1/15/17) at lunchtime near the common area and front entrance, and was witnessed by MAs and Personal Care Aides (PCAs).
-Resident #3 had hit Resident #11 outside the dining room a few days ago (1/22/17 - 1/24/17).
-Resident #3 "used to be real bad, just walk into other residents' room and punch them."
-"Every now and then, [Resident #3] would get in his moods, you could see it on his face and he would just hit people."

Interview with Resident #7 on 1/27/17 at 2:40pm revealed:
-He had been at the facility "a good long time, don't rightly know how long."
-He had never gotten into a "fist fight" or been hit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 29	D 273		

by another resident.

Interview with a PCA on 1/27/17 at 3:15pm revealed:
-Resident #7 could be confrontational and argumentative; would tell Resident #3 not to go down the 300 and 400 hall.
-The PCA said, "You gotta keep an eye on them [Resident #7 and Resident #3] to stop it before it starts."
-The PCA had never seen Resident #3 hit anyone.

Based on observations, interviews and record reviews, Resident #3 was not interviewable.

Telephone interview on 1/25/17 at 4:32pm with Resident #3's Power of Attorney (POA) revealed:
-The staff at the facility worked with the resident so he wasn't "all drugged up" like he had been at a previous facility.
-"For some reason he got aggressive" until the staff "got his medications right" then there was no more aggression.
-The resident had not been aggressive since he first got to the facility (June 2016).
-"He's never hurt anyone, they surely would have called me if he had."

Confidential interview with a staff revealed:
-The staff had never seen Resident #3 actually hit another resident, the staff had seen him "draw his fists."
-"I'm sure there [were] a few [residents] who wanted to hit [Resident #3]; it's a natural reaction when somebody hits you."
-The residents would normally report any abuse to the MA; if the staff had witnessed the abuse, it would be reported to the Supervisor on duty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 30 Review of "Nurse Notes" for Resident #3 revealed: -There were 15 entries from 5/29/16 through 9/6/16 where staff documented Resident #3 having aggressive behavior including five incidents of hitting other residents and four incidents of hitting staff. -On 9/22/16 at 9:50am "Resident in shower raised fist to hit [PCA] and hit shower stall with left arm; obtained skin tear to left arm below elbow ...transported to [name of local hospital], family and PCP notified." -On 9/22/16 (no time)"(Late entry) It was reported that resident had entered another resident's room, told him [other resident] to get out of his chair, [the other] resident told him [Resident #3] to leave; resident scratched resident on his right arm." -On 9/23/16 at 6:00am "Resident grabbed an aide's face and hit her in the stomach. Please continue to monitor." -On 9/26/16 at 2:00pm "Resident showing signs of aggression, PRN given, will monitor." -On 9/28/16 at 9:15am "Resident showing signs of aggression, PRN given, will continue to monitor." -On 10/3/16 at 6:15am "Resident was standing in hallway blocking entrance to another resident's room, the second resident then asked resident to move so he could get in his room. This agitated Resident [#3] he became angry and hit the second resident striking him on the neck and chin. Resident [#3] was redirected and scheduled PRN [medications] were given." -On 10/5/16 at 11:15am "Spoke with Guardian, explained resident fell trying to put his leg on another resident's wheelchair ...Administrator and MD notified." -On 10/30/16 at 10:20am "Showing signs of aggression, PRN given."	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 31	D 273		

-On 11/2/16 at 1:30pm "Resident balled fist and swung at another resident while walking by. Not provoked, did not make contact and was redirected."
-On 11/3/16 at 9:20am "Resident showing signs of aggression. Resident swung at one of the aides. PRN [medication] given at 9:24am. PRN effective."
-On 11/4/16 at 3:00pm "Resident was not acting himself, walking with back sunk in. RCD [Resident Care Director] notified, POA notified, 911 called, sent to [name of local hospital] via EMS [Emergency Medical Services]. At 7:00pm "Resident arrived at facility via EMS with no new orders or [medication] changes."
-On 12/22/16 at 10:50am "Resident still showing signs of aggression, PRN administered, will monitor."
-There was no documentation that the PCP or Mental Health Provider (MHP) was notified of Resident #3's aggressive behaviors 9/23/16 through 12/22/16.
-There were no further entries 12/23/16 through 1/26/17.

Review of a psychiatric visit note for Resident #3 dated 10/27/16 revealed:
-Resident was seen for a new patient referral; admitted to the facility with a history of dementia.
-"Staff voiced no new issues or concerns today."
-Resident #3 was "irritable" and had "no thoughts to harm others or recent assaultive behaviors."
-The note was electronically signed by the MHP.

Review of a psychiatric visit note for Resident #3 dated 1/12/17 revealed:
-Diagnoses included Dementia, Anxiety and Insomnia.
-There were no medication changes.
-"Patient seems stable without reports of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 32	D 273		

aggression toward staff recently. Will see patient at the usual interval unless crisis or emergency occurs. Staff monitor and report changes in mood/behavioral and medication side effects."
-The note was electronically signed by the MHP.

Review of "Nurse Notes" and "Accident/Incident Reports" for Resident #3 revealed there was no documentation of incidents involving Resident #3 hitting or punching Resident #7, Resident #11 or Resident #12 in January 2017.

Interview with a MA/Supervisor on 1/27/17 at 3:50pm revealed:
-Resident #12 had reported being hit by Resident #3, but no staff had witnessed him hitting her.
-She had never seen Resident #3 hit Resident #7.
-The last time Resident #3 attempted to hit another resident was a "few weeks ago" on 1st shift where Resident #3 swung at Resident #11 and Resident #11 "swung back and made contact."
-The 1st shift MA reported what happened at change of shift; "I'm sure she would have documented something ...there was some concern for his [Resident #3's] safety"
-Resident #3 "was not the same as was when he first came to the facility; he had been better since they changed his medications."
-Regarding the "Nurse Note" dated 10/3/16, she could not remember who the resident was that Resident #3 hit.
-It "had been a while" since Resident #3 hit anyone; he was occasionally agitated with staff and she had seen him make an aggressive stance with his fists balled, which was "common behavior" for Resident #3.
-If a resident had a change in their condition or a fall, staff filled out an accident/incident report,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 33	D 273		

called or texted the Administrator, faxed the report to the Department of Social Services (DSS) and the Primary Care Provider (PCP), placed the report and fax confirmations in the Administrator's box in the medication room, notified the family and documented in the record.
-Residents with behaviors were usually redirected and given a PRN and "usually forgot about the whole thing."
-When a resident hits another resident, an accident/incident report should have always been done, the Administrator was notified and the Psychiatric Home Health Nurse (HHN) was notified.
-Resident #3's Power of Attorney (POA) had been notified when he hit someone.

Interview with a second MA/Supervisor on 1/26/17 at 6:15pm revealed:
-"Every now and then, out of the blue [Resident #3] might get mad and start cussing."
-"It had been a while since [Resident #3] hit someone."

Interview with a third MA/Supervisor on 1/27/17 at 11:36am revealed:
-Resident #3 showing signs of aggression documented in "Nurse Notes on 9/26/16, 9/28/16 and 12/22/16," usually meant Resident #3 would swing towards people, but did not connect."
-The MA was not aware of Resident #3 hitting [Resident #11] within the last week near the dining room; and Resident #12 had not reported to the MA that Resident #3 punched her [Resident #12] in the neck in her room.
-The MA had not seen Resident #3 hit anyone or harass any resident, nor had anyone reported anything.
-Resident #3 would just walk up and down the halls all day; he did "swing at the air, he did it to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 34	D 273		

me, I just tell him you can't do that and he'll say okay and keep walking down the hall."
-If Resident #3 did hit another resident, staff would give him a PRN and notify the Administrator.

Second interview with Resident #12 on 1/27/17 at 3:20pm revealed:
-She reported to the MA/Supervisor interviewed on 1/26/17 that Resident #3 had punched her the neck on 1/22/17.
-"Like I said she [MA] kept arguing with me that I should have come to get her [MA] and that I did it wrong."
-She also reported the incident to the Administrator on 1/23/17 who said she would talk to the MA/Supervisor.
-Resident #3 punched in the neck in the afternoon on 1st shift; there was a PCA that came when she yelled.
-The right front part of her neck still hurt from where Resident #3 punched her.

Staff was not available for interview regarding "Nurses Notes" entries dated 9/22/16, 9/23/16, 11/2/16 and 11/3/16.

Interview with the Resident Care Director (RCD) on 1/27/17 at 11:10am revealed:
-He was not aware of any further documentation available for Resident #3 but the Administrator might have more information.
-In the case of a resident hitting another resident, staff was to complete and accident/incident report, write a note in the chart, notify the Administrator or Supervisor on duty.
-That was the complete process staff was expected to follow.

Telephone interview with the Mental Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 35 Provider (MHP) on 1/26/17 at 12:42pm revealed: -Resident #3 was usually calm and "just walked the halls." -The resident was diagnosed with Dementia with behavior disturbance. -She was not aware of any recent aggressive behaviors by Resident #3; he had those behaviors in the past where he resisted care and was aggressive with staff. -She had not received any reports from staff that the resident was displaying aggressive behaviors. -She had not known Resident #3 to have been aggressive with other residents. -She would expect staff to report any aggressive behaviors because that would be a safety concern, there could have been a problem with the resident's medications and/or the resident may have "had something physical going on." -She would be concerned for the safety of other residents as well as the safety of Resident #3 if another resident were to hit him back. -Had she been notified, interventions such as medication evaluation, every 15 minute checks on the resident and possible re-evaluation of the level of care, could have been initiated. -Staff contacted the MHP by calling a a pager system that would send a notification to the Nurse Practitioner, Psychiatrist and Psychotherapist. -There was also a visit list sent to the facility by the MHP each week which listed the residents who were going to be seen so that staff could provide input and report any concerns. -The Psychiatric HHN was not part of the same agency and did not routinely contact the MHP. -The MHP was at the facility weekly on Thursdays but not on 1/26/17; she contacted the Resident Care Director (RCD) on 1/26/17; he did not report any behavior concerns for Resident #3. Telephone interview with the Primary Care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 36	D 273		

Provider (PCP) on 1/27/17 at 4:20pm revealed:
-He had seen Resident #3 at the facility, but could not remember all the details and did not have the resident's information available.
-The facility notified him by fax and sent "stuff all the time."
-There were also forms for review and signing waiting in the office at the facility for when he was there.
-He did not know where the facility filed the signed documents he reviewed.
-If Resident #3 were assaulting other residents, there would be a safety concern for him and other residents.

Review of "Faxed Communication" forms and "Accident/Incident Report" forms for Resident #3 revealed there was no documentation the PCP was notified of any incidents of Resident #3 hitting Resident #7, Resident #11, Resident #12 or of Resident #3 having aggressive behaviors during December 2016 and January 2017.

Interview with the Administrator on 1/27/17 at 5:20pm revealed:
-If residents abusing other residents was seen or reported: staff was expected to assess both residents and notify the PCP, MHP and the family.
-She was not aware of Resident #3 hitting another resident since October 2016 when his medications were changed.
-Resident #12 had not reported anything to her about Resident #3 punching her.
-If Resident #12 had reported an incident of Resident #3 punching her to the MA/Supervisor, the MA would have texted the Administrator about the incident.
-Staff had not reported any instances of Resident #3 hitting other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 37 -When Resident #3 walked into other resident's rooms, any staff on duty redirect him. -The Administrator would address any concerns of resident abuse with the PCP, MHP, DSS and family; all the staff had to do was notify her by text and completing an accident/incident report. -She was not aware of Resident #3 allegedly hitting Resident #7, Resident #11 and Resident #12. The facility failed to communicate the aggressive behaviors of Resident #3 who had a diagnosis of Dementia and a history of hitting other residents and staff, to the Primary Care Provider and Mental Health Provider. The facility's failure to communicate Resident #3's ongoing aggressive behaviors to providers resulted in continued aggressive behaviors without intervention. This failure to notify medical and mental health providers was detrimental to the safety and wellbeing of residents, which constitutes a Type B Violation. Review of the facility's Plan of Protection dated 1/27/17 revealed: -The Administrator will in-service staff on the process of health care referral and follow up. -The Administrator will make sure the physician and family is notified of all incidents/accidents immediately. -Any behaviors, injuries or other areas of concern are considered incidents/accidents. -All incident/accident reports will be reviewed within 72 hours by the Administrator. -The Administrator will make sure all areas of documentation are completed on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 273	Continued From page 38 incident/accident reports and that the appropriate agencies, physician and family have been notified. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 3/13/17.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all meals were served using non-disposable tableware as evidenced by serving water using disposable cups for 3 of 3 meals observed and serving dessert in disposable cups and bowls for 2 of 3 meals observed. The findings are: Observation of the lunch meal on 01/24/17 between 11:10am -12:45pm revealed: -During the second seating of the lunch meal in the large dining room 14 of 15 residents were served water in disposable cups. -During the second seating of the lunch meal in	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 287	Continued From page 39	D 287		

the small and large dining rooms, all residents were served dessert (sliced mandarin oranges) using disposable cups and bowls.

Observation of the dinner meal on 01/24/17 from 4:56pm-5:30pm revealed:
-During the first seating of the dinner meal in the small dining room, water was served to 16 of 17 residents using disposable cups.
-During the first seating of the dinner meal in the small dining room, dessert (sliced peaches) was served to 14 of 17 residents using disposable tableware.
-During the second seating of the dinner meal in the large dining room, water was served to 15 of 16 residents using disposable cups.
-During the second seating of the dinner meal in the large dining room, dessert (sliced peaches) was served to 16 of 16 residents using disposable cups and bowls.

Observation of the lunch meal on 01/25/17 11:10am -12:46pm revealed:
-During the second seating of lunch in the small dining room, 13 of 13 residents were served water using disposable cups.
-During the second seating of lunch in the large dining room, 21 of 22 residents were served water using disposable cups.
-Dessert (cake) was served on non-disposable plates on 01/25/17.

Interview with a resident on 01/25/17 at 11:35am revealed:
-Water was "sometimes" served in plastic cups for meals.
-The resident did not know how often water was served in disposable cups.
-The resident "preferred" having water served in disposable cups because the resident could take

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 287	Continued From page 40	D 287		

the water with them when exiting the dining room after eating.
-The resident did not know if disposable tableware was used to serve food such as dessert.

Interview with a second resident on 01/26/17 at 8:50am revealed:
-Water was not routinely served at meals but was served if the resident requested it.
-"Sometimes" water and food were served in disposable tableware.

Interview with a Personal Care Aide (PCA) on 0`/24/17 at 5:05pm revealed water was normally served in non-disposable cups at meals, but the dishwasher "runs a little behind sometimes"; therefore, water was "sometimes" served in "plastic cups" at meals.

Interview with a Dietary Aide on 01/25/17 at 12:00pm revealed:
-Water was served at all meals; "it's mandatory."
-Water was usually served in disposable cups at lunch and dinner because there were not enough non-disposbale water cups.
-Dessert was "sometimes" served in disposable cups or bowls because there were not enough bowls.

Interview with a Cook on 01/25/17 at 12:50pm revealed:
-Dessert was served using disposable tableware "sometimes" because there was not enough non-disposable tableware.
-The cook did not know how often water was served in disposable cups; "ask the aide."
-There were not enough cups for all residents to get water served using non-disposable cups.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 287	Continued From page 41 Observation of the kitchen on 01/25/17 at 3:02pm revealed: -There were 85 non-disposable 6 ounce glasses identified by the Administrator as water glasses on hand. -There were more than 50 non-disposable dessert bowls on hand. -The Administrator started the dishwasher and the cycle started and was completed after approximately one minute. Interview with the Administrator on 01/25/17 at 3:05pm revealed: -About one to two weeks ago, kitchen staff notified her of a shortage in non-disposable water cups/glasses. -The Administrator placed an order for 48 non-disposable water glasses one to two weeks ago after being notified by staff of the shortage. -A total of 24 non-disposable water glasses were delivered to the facility the previous day (01/24/17) and 24 more non-disposable water glasses were expected "any day." -There were enough bowls to serve dessert at all meals, -The Administrator expected kitchen staff to run the dishwasher between each meal service and serve all meals in non-disposable tableware. -The Administrator would assure non-disposable tableware was used to serve all meals.	D 287		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 309	Continued From page 42	D 309		

staff.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure a therapeutic diet list was maintained for the guidance of dietary staff for 3 of 3 residents sampled (#2, #7, #8) who had orders for a therapeutic diets.

The findings are:

Observation of the kitchen on 01/24/16 at 11:10am revealed:
-There was a list posted on the door that had the names of the residents who received dietary supplemental shakes.
-There was not a therapeutic diet list posted.

Review of Resident #2's current FL-2 dated 10/11/16 revealed:
-Diagnoses included dysphagia and Parkinson's disease.
-There was an order for a pureed diet.

Review of the diet orders for Resident #2 dated 12/01/16 revealed Resident #2 was ordered a regular pureed diet.

Review of Resident #9's current FL-2 dated 01/19/17 revealed:
-Diagnoses included dementia, coronary artery disease (CAD), and hypertension.
-There was an order for a pureed diet.

Review of Resident #9's diet order dated 12/01/16 revealed:
-Resident #9 was ordered a pureed regular diet.
-Resident #9 required feeding assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 309	Continued From page 43	D 309		

Review of Resident #10's current FL-2 dated 10/04/16 revealed:
-Diagnoses included dementia, anorexia, and hypertension.
-There was an order for a pureed diet.

Review of Resident #10's diet order dated 12/01/16 revealed:
-Resident #10 was ordered a pureed regular diet.
-Resident #10 required feeding assistance.

Interview with two dietary staff members on 01/24/17 at 11:10am revealed:
-Residents #2, #9, and #10 were ordered a regular diet with pureed texture.
-There was not a list posted with the names of the residents who received the pureed diets.
-All kitchen staff "know who gets pureed."
-All kitchen staff were trained upon hire by the Resident Care Director (RCD) on who received a pureed diet.
-If a diet changed, the RCD would let kitchen staff know.

Interview with a dietary staff member on 01/24/17 at 11:30am revealed there used to be a diet list posted in the kitchen (staff was not sure when it was posted), but staff did not know what happened to the list.

Observation of the lunch meal in the small dining room on 01/24/16 from 11:10am -11:40am revealed Residents #2, #9, and #10 were all served a regular pureed diet consisting of pureed meatballs and noodles, pureed carrots and applesauce.

Interview with the RCD on 01/24/17 at 3:40pm revealed:
-There were only three residents who resided in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 309	Continued From page 44 the facility on therapeutic diets. -When the RCD began working in the facility (in September 2016), there was a therapeutic diet list posted in the kitchen but it was "torn up." -The RCD removed the damaged diet list and was going to make a new diet list. -The RCD had not replaced the theraoeutic diet list yet. -There was not a therapeutic diet list posted in the kitchen at that time (01/24/17 at 3:40pm). Interview with the Administrator on 01/24/17 at 4:00pm revealed: -A therapeutic diet list was supposed to be posted in the kitchen. -The Administrator was not aware a diet list was not posted in the kitchen. Interviews with the Administrator on 01/24/17 at 4:30pm revealed: -The Administrator was responsible for assuring the therapeutic diet list was posted for guidance for kitchen staff. -The Administrator would assure a therapeutic diet list was made and posted in the kitchen that day (01/24/17). Observation on 01/24/17 at 5:10pm revealed: -A therapeutic diet list was posted on the door in the kitchen. -Resident #2's, Resident #9's, and Resident #10's names and diet orders were documented on the therapeutic diet list.	D 309		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 45	D 358		

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:
Based on observations, interviews and record reviews, the facility failed to administer medications as ordered by a Physician for 2 of 8 residents with orders for Proscar (Resident #8) and for Levemir insulin (Resident #7).

The findings are:

1. Review of Resident #8's FL-2 dated 10/04/16 revealed diagnoses included mental retardation and adenocarcinoma.

Review of Resident #8's record revealed a multi paged physician's order dated 10/26/16 for Proscar (used to decrease the urge to urinate and decrease nighttime urination), 5mg once daily.

Observation during the medication pass on 01/25/17 at 8:25am revealed that Proscar was not listed on the Medication Administration Record (MAR).

Interview with the Medication Aide (MA) on 01/25/17 at 11:15am revealed:
-She did not remember administering Proscar to Resident #8.
-She did not realize that Proscar had been ordered for Resident #8.

Telephone interview with the facility's providing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 46	D 358		

pharmacy on 01/25/17 at 3:40pm revealed that an order for Proscar for Resident #8 was never received.

Telephone interview with the prescribing physician's nurse on 01/26/17am at 9:00am revealed:
-Resident #8 had cancer of the bladder.
-The Proscar had been ordered on 10/26/16 to reduce lower urinary tract symptoms including nocturia (excessive urination at night) and urinary urgency during the day.
-The peak effect of the medication would occur 3 to 6 months after medication was started.
-The physician expected that medication would be started within 48-72 hours after the order was written.
-The possible effects of not starting the medication included urinary retention (the inability to urinate) and continuation or worsening of nocturia and urinary urgency.
-Resident #8's follow-up appointment had been scheduled 6 months after the Proscar had been ordered (04/24/17) so the effectiveness of the medication could be accessed.

Based on observation, interviews and record review, Resident #8 was not interviewable.

Interview with the facility Administrator on 01/27/17 at 11:00am revealed:
-All new medication orders are given to the Supervisor.
-The Supervisor faxes the order to the pharmacy.
-Once the medication has arrived, the Supervisor transcribes the order on the MAR and puts the medication in the medication cart.
-The top page of the multi paged physician's order form is then placed in the resident's record.
-One of the remaining pages of the multi paged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 47	D 358		

order form is sent to the providing pharmacy.
-The Administrator could not explain why this process was not followed for Resident #8's ordered medication.
-The Administrator could not explain how the complete multi paged order was placed in the resident's record without being ordered.
-The Administrator sent the pharmacy a photograph of the medication order and gave the hard copy of the order to the SIC for processing.

The Supervisor referred all questions to the Administrator.

2. Review of Resident #7's FI-2 dated 01/10/17 revealed:
-Diagnoses included diabetes mellitus (unspecified) and dementia.
-An order for Levemir insulin, 24 units injected subcutaneously (SQ) twice a day with meals.

Observation during the 4:00pm medication pass on 01/25/17 revealed:
-An entry on the Medication Administration Record (MAR) for Resident #7 to receive Levemir insulin, 24 units SQ twice a day with meals.
-The Medication Aide (MA) injected the ordered amount of insulin.
-The MA depressed the insulin pen plunger and held it in place for 2-3 seconds and then withdrew the needle.

Review of the manufacturer's recommendations revealed:
-Once the medication is injected, the insulin pen plunger should be held in place for at least 6 seconds before withdrawing the needle.
-If the insulin pen is not held in place with the plunger depressed for at least 6 seconds, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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 48 total dosage of insulin may not be administered. Interview with the MA on 01/25/17 at 4:37pm revealed: -The MA explained the steps of preparing the Levemir insulin pen for injection correctly. -The MA could not state the correct number of seconds the insulin pen must be held in place after the injection. Interview with the Administrator on 01/26/17 at 9:27am revealed: -She was not aware that the MA was not using proper technique when injecting Levemir insulin via the pen delivery system. -The Administrator will review proper insulin administration with all MA's as soon as possible.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure each residents' right to privacy was maintained as evidenced by the failure to supervise Resident #6, who was a known wanderer and had a history of entering other residents' rooms, repeatedly entering other residents' rooms and getting into their beds. The findings are: Review of Resident #6's current FL-2 dated	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHALLOTTE ASSISTED LIVING	520 MULBERRY STREET SHALLOTTE, NC 28459

(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
D911	Continued From page 49	D911		

09/26/16 revealed:
-Diagnoses included dementia and hypertension.
-Resident #6 was ambulatory and intermittently disoriented.

Interview with resident on 01/26/17 at 8:50am revealed:
-Resident #6 wandered the hall "constantly."
-Resident #6 walked the halls at night and came into the resident's room and got in his bed "last night" (01/25/16).
-Resident #6 woke of the resident by entering his room; the resident was not able to go back to sleep
-Staff "don't do nothing to stop him."

Interview with a second resident on 01/26/17 at 11:08am revealed:
-Resident #6 would "wander around" and "walk everywhere."
-Resident #6 "came in my room four times yesterday (01/25/16) and I yelled to get him out."
-Resident #6 "bothered" and would get on the resident's "nerves" by entering the resident's room.
-Staff didn't "watch" Resident #6 or do anything to keep him from coming into her room.

Interview with a third resident on 01/27/17 at 2:20pm revealed:
-Resident #6 came into her room and tried to get in her bed; the last incident occurred three weeks ago.
-It was an invasion of the resident's privacy, but Resident #6 "don't know what he's doing. He's pitiful. I feel sorry for him."
-Staff "really don't do anything" to keep Resident #6 out of her room.

Interview with a fourth resident on 01/27/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D911	Continued From page 50 3:13pm revealed: -Resident #6 "goes in everyone's room and gets in their bed." -Resident #6 bothered her "sometimes." -The resident did not know why staff did not keep Resident #6 in his own room. -Other residents would tell Resident #6 to go back to his own room. Interview with a fifth resident on 01/27/17 at 3:15pm revealed: -Resident #6 went into the resident's room "every time he's out in the hall." -"It bothers me." -Staff "don't do nothing to keep him out." Observation of Resident #6 on 01/27/16 at 2:42-2:45pm revealed: -Resident #6 walked into room #218 (not his room) and sit down in the bedside chair. -After sitting briefly in the chair, Resident #6 walked to the doorway of room #218; a Personal Care Aide (PCA) who was walking down the hall saw Resident #6 in the doorway. -The PCA told Resident #6 "this is not your room." -The PCA guided Resident #6 down the hallway into his room. Observation of Resident #6 on 01/27/17 from 3:08pm-3:27pm revealed he entered two different residents' rooms (Room #430 and Room #435) on the 300/400 that were not his room and attempted to enter a third resident's room (Romm #439) on the 300/400 but was met at the door by that resident and re-directed by another resident to his own room. Observation of Resident #6 on 01/27/17 at 4:50pm revealed he was being escorted out of room #107 (not his room) by a PCA.	D911		

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	HAL010008	A. BUILDING: _____ B. WING _____	R 01/27/2017

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D911	Continued From page 51 Interview with a PCA on 01/27/16 at 4:50om revealed: -When staff went to get Resident #6 to come eat dinner he was not in his room, the hallway, or the television common room. -The PCA went looking for Resident #6 and found him asleep on the bed in room #107 (not his room). -The PCA guided Resident #6 out of room #107 and into the small dining room. Interview with a second PCA on 01/26/17 at 3:05pm revealed: -Resident #6 wandered but was easily redirected by staff. -Resident #6 "goes in other residents' rooms and gets in their bed." -It was facility procedure for staff check on every resident every two hours. -Interventions implemented for any resident who wandered included re-orienting the resident and using the wander guard system. Interview with a Medication Aide (MA) on 01/26/17 at 6:55pm revealed: -Resident #6 was "forgetful" and "wanders." -Resident #6 "will go into other residents' rooms unless staff stop him." -Staff redirected Resident #6 as needed. -The MA was not aware of any special interventions or monitoring for Resident #6; "he has a wander guard." Interview with a second MA on 01/27/17 at 09:18am revealed Resident #6 was the "typical dementia patient"; he walked the halls and went in to other residents' rooms, but was easily redirected.	D911		

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D911	Continued From page 52 Interview with a third MA on 01/27/16 at 3:41pm revealed: -Resident #6 wandered and went in to other residents' rooms. -Other residents had complained to the MA about Resident #6 coming in to their room and getting in to their bed. -Intervention implemented by staff for Resident #6 included checking on him every 2 hours, redirected him when he went in to other residents' rooms, and reminded him of his room number. Review of the Nurses Notes for Resident #6 documented by the contracted home health Registered Nurse (RN) revealed: -On 09/14/16: "Staff reports patient wanders/paces hall ...needs frequent monitoring and redirection." -On 12/15/16: Resident #6 was oriented to "person only, walks up and down halls days and night with sundowning ...attempts to open doors and leave during night." -On 12/26/16: "Staff reports patient continues to wander halls at night. Re-directable during the day but not at night." -On 01/02/17: "Staff report patient continues to wander halls at night" -On 01/17/17: "Patient has a habit of lying around on other patients' beds, floor, wheelchair-reminded him if he's tired he needs to lie in his bed or on sofa. Staff will monitor." Based on observations, record reviews, and interviews, Resident #6 was not interviewable. Interview with the Administrator on 01/27/17 at 5:22pm revealed: -Resident #6 wore a wander guard to address his wandering behaviors. -The Administrator was aware that Resident #6	D911		

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D911	Continued From page 53 liked to wander the halls and open doors but was not aware Resident #6 was entering other residents' rooms. -The Administrator expected all staff to know where residents were and to redirect them as needed. -All staff were responsible for monitoring and redirecting residents. -Anything "out of the ordinary" was supposed to be documented on an Accident/Incident Report. -When staff observed residents going in to rooms that did not belong to them, the Administrator expected staff to document the incidents on an Accident/Incident Report and notify her. -An Accident/Incident report should have been completed any time Resident #6 was found in other residents' rooms. -The Administrator "was not really aware" Resident #6 was wandering into other residents' rooms and had not seen any Accident/Incident Reports about it. Review of the Accident/incident Reports for Resident #6 revealed there were not any Accident/incident Reports documenting Resident #6 going into other residents' rooms.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	D912		

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D912	Continued From page 54 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 health care referral and follow up. The findings are: Based on observations, interviews and record reviews, the facility failed to notify the Primary Care Provider and Mental Health Provider for 1 of 5 sampled residents (#3) who had a diagnosis of Dementia with behaviors and a history of hitting other residents and staff, resulting in continued aggressive behaviors without interventions. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]	D912		
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 neglect related to supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#3 and #6) with known diagnoses of Dementia and behaviors which were harmful to themselves and other residents; resulting in Resident #6 wandering	D914		

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D914	Continued From page 55 unsupervised into other residents' rooms and ingesting rubbing alcohol; and Resident #3 wandering unsupervised and hitting other residents. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)]	D914		