STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043024	A. BUILDING: _____ B. WING _____	C 07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

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D 000	Initial Comments A complaint investigation was conducted by the Adult Care Licensure Section on July 6, 7, 10, 11, 12, 13 and 14, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure walls and floors were kept clean and in good repair on the men's hall as evidenced by broken tiles in the common shower room; stained and rotted caulking and tile around toilets in two common bathrooms; a rotted door frame in one common bathroom; broken paper towel and toilet paper holders in two common bathrooms; a broken soap dispenser in one resident room and stains; stains, dirt and grime build up on floors and baseboards in resident rooms, four common bathrooms and the corridor. The findings are: Observations on 7/6/17 from 4:06am until 4:25am revealed: -The paper towel holder was missing from the wall leaving five areas of damaged and missing paint around the mounting board that remained	D 074		

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D 074	Continued From page 1	D 074		

attached to the wall in the first common bathroom on the right side of the men's hall.
-There were dark yellow urine stains at the base of the outside of the toilet, a brown smear and used toilet paper on the floor next to the toilet in the first common bathroom on the right side of the men's hall.
-The base of the door frame on the inside of the second common bathroom on the right side of the men's hall had rusted and rotted metal approximately two inches in length from the bottom of the frame.
-There were yellow stains at the base of the outside of the toilet in the second common bathroom on the right side of the men's hall.
-The paper towel holder was missing from the wall leaving the mounting board only in the second common bathroom on the left side of the men's hall.
-The toilet paper holder was broken leaving exposed jagged edges of the part of a plastic toilet paper holder next to the toilet in the second common bathroom on the left side of the men's hall.
-There were yellow stains at the base of the outside of the toilet in the second bathroom on the left side of the men's hall.
-The caulk and tile around the base of the toilet was cracked and loose in the first common bathroom on the left side of the men's hall.
-There were numerous broken and missing two inch square tiles on the floor in the common shower on the men's hall.
-There were loose and stained tiles around the toilet in the common shower room on the men's hall.
-There were rust stains on the wall under the sink in the common shower room on the men's hall.

Observations on the men's hall on 7/7/17 at

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10:55am revealed there was dirt and grime build up on the floors around the door jams, behind the doors and underneath sinks in 11 resident rooms and along the edge and on the baseboards in the corridor.

Interview with a Personal Care Aide (PCA) on 7/6/17 at 4:25am revealed:
-The loose tile in the common shower on the men's hall had been that way for at least a couple of months.
-The common shower was used mostly by first and second shift staff.
-He was not sure if the broken tiles in the shower and around the toilet had been reported to maintenance.

Interview with a Medication Aide (MA) on 7/6/17 at 4:00am revealed:
-Housekeepers worked during the day Monday through Friday.
-The bathrooms always had yellow urine stains around the base of the toilet.

Interview with a Housekeeper on 7/6/17 at 5:40am revealed:
-He worked part time at the facility 21 hours per week.
-He was responsible for cleaning "a little here and a little there" and was not really assigned to clean any particular area in the facility.
-He usually worked on the men's hall.
-He was responsible for cleaning the bathrooms when he was on duty.
-He did not know about the urine stains around the toilets in the common bathrooms on the men's hall because he did not work on 7/5/17.
-The tile on the shower floor and around the toilets, and the paper towel holders and toilet paper holders had been broken for "a good long

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while," definitely more than a month.
-There was a contracted maintenance group that came to the facility one day per week who was responsible for the repairs.
-He told the maintenance person when they were at the facility and the staff in the office about the broken tiles, broken paper towel holders and broken toilet paper holders.
-He did not know when he told them.

Interview with a second housekeeper on 7/7/17 at 11:00am revealed:
-He had put in a repair request for the broken tile in the common shower on the men's hall approximately one year ago (June 2016).
-Repair requests were given to the Administrator who sent the request electronically to the contracted maintenance group.
-The housekeepers used to be responsible for stripping and cleaning the floors, but approximately one year ago (June 2016), the contracted maintenance group took over responsibility for the floors.

Interview with two housekeepers on 7/7/17 at 11:00am revealed there was a contracted maintenance group that cleaned the floors, but the housekeepers did not know how often the floors were cleaned.

Interview with the contracted maintenance person on 7/10/17 at 10:33am revealed:
-He was aware of some of the repairs needed on the men's hall.
-He declined to provide specific information on when he was notified for which repairs.
-He was not responsible for stripping and cleaning the floors.

Interview with the Resident Care Coordinator

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D 074	Continued From page 4	D 074		

(RCC) on 7/7/17 at 12:08pm revealed:
-The housekeepers were responsible for cleaning the floors daily.
-The contracted maintenance group stripped and cleaned the floors, but she did not know how often they were scheduled to clean the floors.
-The contracted maintenance group was supposed to be at the facility cleaning the floors last month, but she did not know what happened and why the floors had not been cleaned.
-The contracted maintenance group had been at the facility last month and cleaned the front area lightly, but had not returned to clean the remaining floors.
-She was not aware of the stained and rotted caulking and tile around toilets in two common bathrooms; a rotted door frame in one common bathroom; broken paper towel and toilet paper holders in two common bathrooms, a broken soap dispenser in one resident room and stains, dirt and grime build up on floors and baseboards in resident rooms, four common bathrooms and the corridor.
-She was aware of the broken tile in the common shower room which had been reported to the contracted maintenance group; however she did not know when it was originally reported, so another request was submitted by the Regional Director on 7/7/17.

Interview with the Business Office Manager (BOM) on 7/7/17 at 12:18pm revealed:
-The contracted maintenance group was responsible for supervising the housekeeping staff.
-The Administrator was responsible for monitoring the environment inside and around the facility.
-Staff were expected to report any maintenance concerns/repair needs to the Administrator and the Administrator submitted the work order

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D 074	Continued From page 5 electronically to the contracted maintenance group. -In the absence of the Administrator, the BOM would text the Administrator any maintenance requests and the Administrator would put the work order in through the electronic communication system. -All of the needed repairs had not been reported by staff. -The contracted maintenance group had been at the facility approximately two weeks ago on 6/22/17 to clean the floors. Interview with the Regional Director on 7/7/17 at 12:37pm revealed: -Maintenance requests for the contracted maintenance group were put in through an electronic communication system. -He had "just put in a work order again" for concerns identified on 7/6/17 and 7/7/17.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents	D 079		

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rooms on the men's hall were kept clean and free of hazards as evidenced by a nonworking light fixture in one common bathroom, uncovered hardware for a door stop protruding from the floor next to a hand washing sink in one resident room and boxes of incontinence supplies stored behind doors and in front of hand washing sinks in two resident rooms.

The findings are:

Observations on 7/6/17 from 4:06am until 4:25am revealed:
-There were five boxes approximately two feet in length, width and height behind the door and next to the hand washing sink in resident room #7N.
-The boxes closest to the sink had yellow splash marks that were dried at the bottom of the boxes.
-One of the light florescent light fixtures was not working leaving a dim light approximately equivalent to a night light in the first common bathroom on the left side of men's hall.
-There were two boxes approximately two feet in length, width and height in front of the hand washing sink in resident room #9N.

Observations on 7/7/17 at 10:57am revealed:
-There was an uncovered door stop behind the door and next to the sink in resident room #5N which left a sharp metal object protruding from the floor.
-There was a broken soap dispenser on the wall next to the sink and above the uncovered door stop in resident room #5N which had exposed sharp plastic edges.
-The five boxes remained behind the door and next to the sink in resident room #7N.
-The two boxes remained underneath and in front of the sink in resident room #9N.

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Interview with a Personal Care Aide (PCA) on 7/6/17 at 4:25am revealed:
-The boxes of incontinence briefs were stored in residents' closets and if the closet was full, the boxes were stored in the residents' room behind the door.
-Sometimes residents would move the boxes around so he would go around to check and put the boxes away in residents' closets at the end of his shift.

Interview with a housekeeper on 7/7/17 at 11:00am revealed:
-The contracted maintenance group was responsible for the dim light in the common bathroom on the men's hall.
-He had told the Administrator about the needed repairs, but he could not remember when.
-The delivery truck brought boxes of incontinence supplies for residents and the housekeepers were responsible for setting the boxes outside the door for each resident.
-Each box was labeled with a resident's name and that was how the housekeeper knew what room to place them outside of.
-The Personal Care Aides (PCAs) were responsible for taking the incontinence supplies out of the boxes and put the supplies away in the resident's room.
-The PCAs would then let the housekeepers know when the boxes were empty and the housekeepers would take the empty boxes to the garbage.

Interview with a PCA on 7/7/17 at 11:16am revealed:
-When the incontinent supplies arrived, the PCAs would place the supplies in residents' dresser drawers and on closet shelves.
-If there was not enough room for them, the

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housekeepers were notified so they could take the boxes of incontinent supplies out to the storage shed.
-She thought the storage shed was full and that was why there were boxes in resident rooms #7N and #9N.

Observations on 7/7/17 at 11:57am revealed the storage shed in the back of the facility was filled in a disorganized manner with items including boxes of incontinent supplies, wheelchairs, bed frames, mattresses and seasonal decorations.

Interview with the Resident Care Coordinator (RCC) on 7/7/17 at 12:08pm revealed:
-Excess incontinence supplies were supposed to be stored in the shed behind the building.
-She was not aware of the disorganized overcrowded space in the storage shed, and housekeeping was responsible for keeping it cleaned and organized.
-She was not aware of urine stains around toilets in three common bathrooms, a nonworking light fixture in one common bathroom, uncovered hardware for a door stop protruding from the floor next to a hand washing sink in one resident room and boxes of incontinence supplies stored behind doors and in front of hand washing sinks in two resident rooms.

Interview with the contracted maintenance person on 7/10/17 at 10:33am revealed:
-He was aware of some of the repairs needed on the men's hall.
-He declined to provide specific information on when he was notified for which repairs.

Interview with the Business Office Manager (BOM) on 7/7/17 at 12:18pm revealed:
-She had seen the dim light in the common

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D 079	Continued From page 9 bathroom on the men's hall and reported it to the contracted maintenance group on 7/6/17. -The storage shed was supposed to be kept clean by the housekeepers who had reported cleaning the storage shed on 7/6/17 "or maybe a month ago." -The contracted maintenance group was responsible for supervising the housekeeping staff. -The Administrator was responsible for monitoring the environment inside and around the facility. -Staff were expected to report any maintenance concerns/repair needs to the Administrator and the Administrator submitted the work order electronically to the contracted maintenance group. -In the absence of the Administrator, the BOM would text the Administrator any maintenance requests and the Administrator would put the work order in through the electronic communication system. -All of the needed repairs had not been reported by staff. Interview with the Regional Director on 7/7/17 at 12:37pm revealed: -Maintenance requests for the contracted maintenance group were put in through an electronic communication system. -He had "just put in a work order again" for concerns identified on 7/6/17 and 7/7/17.	D 079		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control	D 131		

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D 131	Continued From page 10 measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 6 staff sampled (Staff F) was tested upon hire for Tuberculosis (TB) disease in compliance with TB control measures adopted by the Commission for Health Services. The findings are: Review of Staff F's personnel file revealed: -Staff F had been hired as a Personal Care Aide (PCA) on 08/12/16. -There was documentation of a TB test administered on 09/30/14 and read as negative on 10/02/14. -There was documentation of a second TB test administered on 11/17/14 and read as negative on 11/19/14. -There was no documentation of TB testing done at the time of employment. Interview with the Supervisor on 07/14/17 at 4:10pm revealed: -She was not aware that Staff F was not tested for TB at the time of employment. -The Supervisor would arrange for Staff F to receive a TB test as soon as possible.	D 131		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On	D 167		

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D 167	Continued From page 11 Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 35 shifts from 05/03/17 until 07/13/17 were staffed with at least one staff member who had completed a course on Cardiopulmonary Resuscitation (CPR) and choking management within the last 24 months. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired as a Medication Aide (MA) on 05/22/15. -There was no documentation of CPR training in Staff C's personnel file. Review of the Staff Schedule for May 2017 revealed: -Staff C worked 15 days as MA/Supervisor on 3rd shift (10:00 until 6:00am). -The MA and Personal Care Aides (PCAs) were the only staff in the facility on 3rd shift.	D 167		

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D 167	Continued From page 12 Review of the Staff Schedule for June 2017 revealed: -Staff C worked 14 days as MA/Supervisor on 3rd shift. -The MA and PCAs were the only staff in the facility on 3rd shift. Reveiw of the Staff Schedule for July 2017 revealed: -Staff C worked 6 shifts (until 07/13/17) as a MA/Supervisor on 3rd shift. -The MA and PCAs were the only staff in the facility on 3rd shift. Interview with the Resident Care Coordinator (RCC) on 07/13/17 at 5:37pm revealed: -The MA's received CPR training to assure that at least one staff member on all shifts had current CPR training. -The PCAs were not required to be certified in CPR. -The RCC was not aware that Staff C did not have current CPR certification. -The Business Office Manager maintained personnel files. -The RCC would contact Staff C to see if she had received CPR training elsewhere. Interview with the Regional Director on 07/13/17 at 5:40pm revealed: -Staff C would not work without another staff member present with current CPR certification. -CPR training classes would be scheduled as soon as possible. -All floor staff would be CPR certified in the future, which would include PCAs. _____ The facility failed to assure there was a staff on duty for 35 shifts from 05/03/17-07/13/17, who	D 167		

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D 167	Continued From page 13 had completed a course on CPR and choking management, within the previous 24 months. This failure was detrimental to the health, safety and welfare of the residents by not having adequately trained staff available in the event of cardiopulmonary arrest or choking, which constitutes a Type B Violation. _____ Review of the Plan of Protection submitted by the facility on 07/14/17 revealed: -The facility will immediately assure that each shift had a CPR certified staff member on duty. -The Manager on duty will monitor daily staff schedules to assure that a CPR certified staff member would be on duty each shift. -CPR training has been scheduled for staff on 07/21/17. -An additional CPR training will be scheduled for staff within the next 90 days, then as needed to maintain compliance. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 8/28/17.	D 167		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 269		

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D 269	Continued From page 14 Based on observations, interviews and record reviews, the facility failed to provide safety and incontinence care checks every two hours for 3 of 6 sampled residents (#1, #3 and #5) which resulted in Resident #1's death being unnoticed by staff until full rigor mortis was set, Resident #5 being hospitalized with sepsis and Resident #3 sustaining skin breakdown. The findings are: Confidential interview with a concerned citizen revealed: -She would never see staff in the halls paying any attention to the residents when visiting the facility. -All of the residents would be in the front common area and there would be no staff watching them. -The residents would sit there until after lunch and "maybe staff might push them down to their room to get changed." -That was how residents spent their day at the facility. -Staff did not check residents every two hours; they let them sit up in the front area most of the day. Observations on 7/6/17 at 3:45am revealed: -Staff A was asleep on a sheet laid on a sofa in the common area with no shoes on which was visible from the front door of the facility. -At the sound of the doorbell Staff A awoke and came to the front door of the facility. -Staff A's eyes were red when she answered the door. -After viewing identification/credentials, Staff A yelled in the direction of the men's hall and then left and went in the direction of the men's hall without opening the door. -After several minutes, Staff A returned and	D 269		

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opened the door.
-Staff A had delayed responses to standard questions of staff on duty and number of residents in the facility.
-Staff A was disoriented and had delayed physical movements with locating the key and opening the door to the activity room.
-A second Personal Care Aide (PCA) was walking from the direction of the women's hall.
-The medication room door was open and the room was dark and did not have any lights on.
-The Medication Aide (MA) and the third PCA were not immediately located after entrance to the facility.
-At approximately 3:54am the MA came from the direction of the men's hall and had red eyes.
-At approximately 4:00am Staff B, a PCA, came from the direction of the men's hall.

Observation on 7/7/17 at 10:50am revealed there were 10 residents in wheelchairs lined up along the wall outside of the dining room.

Interview with a PCA on 7/7/17 at 10:50am revealed she was trained to keep residents in wheelchairs lined up outside the dining room and they usually sat there from after the 10:00am snack until lunch time at 12:00pm, and then again after lunch.

Confidential interview with a staff revealed:
-Residents "pretty much hung out there (in the hall outside the dining room) all day except for meals, snacks, showers and incontinence care every two hours."
-Some residents lay down after lunch.

Observation on 7/10/17 at 6:55pm revealed:
-There were 23 residents in the common area with one PCA sitting and using her cell phone on

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the side of the common area enclosed by a brick partitioning wall approximately three feet in height.
-The PCA could not see all of the residents sitting in the hallway in front of the dining room or the resident sitting in the common area on the men's hall side that also had the brick partitioning wall.
-Only ten residents were visible to the PCA's location.

Observations on 7/11/17 at 12:34pm revealed:
-There was a resident hunched over to the side and leaning forward in her wheelchair in the hallway outside the dining room.
-There was a second resident leaned over the back of her wheelchair sleeping in the hallway outside the dining room.

Interview with a second PCA on 7/11/17 at 12:34pm revealed the residents would sit in the hallway after lunch for approximately 15 minutes to get medications before they were taken to their room to lie down for a nap.

Observations on 7/11/17 at 1:08pm revealed the resident who was hunched over her chair was no longer in the hallway and the resident who was sleeping leaned back was awake and sitting up.

Interview with a third PCA on 7/6/17 at 4:17am revealed 3rd shift staff performed rounds every two hours which meant changing residents that were incontinent and checking the residents to make sure they were in their bed.

Interview with Staff A on 7/6/17 at 4:54am revealed:
-Third shift staff were responsible to check all residents every two hours and change residents who were incontinent.

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-Staff documented completed activities of daily living on the computer.
-Residents were bathed on 1st and 2nd shift.
-There were five residents on the women's hall that needed to be turned and repositioned every two hours.
-There were three residents that were hard to change because they were stiff and contracted so she would have to grab and pull the resident's legs and "rock" the resident back and forth to turn the resident side to side, to clean them and change their incontinent brief.

Interview with a Medication Aide (MA) on 7/6/17 at 5:50am revealed:
-The 3rd shift staff did their first rounds on residents at 10:00pm by checking and making sure the residents were where they were supposed to be.
-Then staff would check residents for incontinence and safety at midnight.
-The staff did not really do any rounds at 2:00am, but waited until about 3:00-3:30am to check and change residents.
-Staff would check the residents every 30 minutes after incontinence care because once staff woke the residents up they would be up and try to get up on their own.

Telephone interview with a second MA on 7/8/17 at 12:20am revealed:
-The 3rd shift staff rounded on residents when they first arrived (10:00pm), again at 12:00am, 2:00am and 4:00am.
-The 3rd shift staff would check residents one last time at 5:00am before the end of the shift at 6:00am to make sure they were in their beds and clean and dry.
-The women had to be checked more frequently because they were "heavy wetters."

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-The MAs were responsible for writing care notes for residents whenever a resident was on antibiotics or for anything that needed to be passed on to the next shift like illness, accidents, incidents or a resident being sent to the hospital.

Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed:
-She was aware of shift to shift complaints where the oncoming shift would complain the outgoing shift left work like laundry and wet residents unattended.
-She would go and talk to the involved staff and they would swear the residents were changed.
-She would review staff expectations in providing care to residents with whatever staff was involved whenever she got a complaint.

1. Review of Resident #1's current FL-2 dated 12/21/16 revealed diagnoses included Alzheimer's Dementia, Depression and Hypertension.

Review of Resident #1's current care plan dated 3/23/17 revealed Resident #1 was ambulatory, needed limited assistance with bathing, dressing and toileting and required supervision with meals.

Review of a Licensed Health Professional Support (LHPS) Evaluation dated 5/4/17 for Resident #1 revealed there was documentation Resident #1 was previously ambulatory, had suffered a Cerebral Vascular Accident, was sent out 4/5/17, was no longer ambulatory and required two staff to assist with transfers.

Telephone interviews with Resident #1's Power of Attorney (POA) on 7/6/17 at 10:10am and 7/7/17 at 4:50pm revealed:
-She visited with Resident #1 at the facility to

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assist with feeding her either lunch or dinner every day.
-Staff at the facility had called her on the morning of 5/7/17 at 8:02am to notify her that Resident #1 had "passed away" and instructed her to go to the morgue at the local hospital to identify her body.
-The local hospital contacted her at 10:24am, but she could not remember what was said.
-She went immediately to the local hospital and was told she did not need to identify Resident #1, so she requested to see Resident #1's body.
-Resident #1 had gauze over eyes, her body was stiff and cold, and her hand was raised to her mouth.
-She was still "horrified" by seeing Resident #1 in "full rigor mortis" and felt "no one should have to see a family member that way."
-Resident #1 died with "absolutely no dignity."

Telephone interview with a Deputy Sheriff on 7/7/17 at 9:44am revealed:
-The dispatch center received a call from the facility at 7:16am on 5/7/17 for the death of a resident.
-It was standard practice for Emergency Medical Services (EMS) and the Sheriff to respond to cardiac arrest calls at an assisted living facility.
-Staff reported finding Resident #1 dead while doing routine checks of residents.
-EMS was at the facility and confirmed Resident #1 was dead on arrival at 7:30am on 5/7/17.
-Staff reported Resident #1 was last seen alive at 9:30pm on 5/6/17 and were unable to give exact answers of when Resident #1 was checked between 9:30pm on 5/6/17 and 7:00am on 5/7/17.
-It was concerning that the last time Resident #1 was checked was at 9:30pm on 5/6/17.
-"Ten hours was a long time for someone not to be checked on."

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D 269	Continued From page 20 Interview with a Personal Care Aide (PCA) on 7/10/17 at 12:57pm revealed: -She found Resident #1 deceased on the morning of 5/7/17. -She started her shift at 6:00am and the facility was short staffed that morning leaving one PCA on the right side when there were usually two. -It took at least an hour to work her way to Resident #1. -Resident #1's bed was by the door and her roommate was by the window. -She started with the roommate and was talking to Resident #1 trying to arouse her while she was providing care for the roommate, but Resident #1 did not respond. -She took the roommate up the hall to the common area and returned to care for Resident #1. -Resident #1 was lying in bed with the covers pulled up to her nose and when she pulled the covers back she was shocked at how Resident #1 looked. -Resident #1's body was all purple, the lower half of her body was hanging off the bed, her eyes were open looking up toward the ceiling and her arms and hands were raised above her chest but not resting on her chest. -She was unable to provide adequate post mortem care because Resident #1 was really cold and stiff making it difficult to move her body to undress and dress her. -She was soaking wet with urine and had a larger yellow ring around where she was wet that came from urine that had been there long enough to dry. -The Medication Aide (MA) and the Resident Care Coordinator (RCC) saw Resident #1's body before she left the facility. -Staff D was working the night before (5/6/17 -	D 269		

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5/7/17).
-Staff D worked as a dietary aide in the kitchen during the day and also worked 3rd shift as a PCA.

Confidential interview with a staff revealed:
-On the morning that Resident #1 died (5/7/17), she was wearing the same shirt that the PCA had put on her the day before.
-Resident #1 was incontinent and should have been checked and changed through the night on 5/6/17.
-There were many times the PCA had come to work and found residents "soaked head to toe."
-There were "multiple times residents were found with diarrhea all over."
-Residents were found in the worst condition when Staff A and Staff D had worked the previous shift.
-She had reported this many times over the last couple of months to the Supervisors and the Supervisors had reported it to the Administrator, "but nothing ever happened which was very discouraging."
-Staff had reported finding clean incontinence pads laid over urine soaked sheets to the Administrator and nothing was done about it.
-Staff could not remember when it was reported to the Administrator.

Telephone interview with a MA on 7/8/17 at 12:20am revealed:
-She was on duty the night Resident #1 died.
-Resident #1 was quiet and stayed to herself most of the time on 3rd shift.
-She had gone into Resident #1's room at approximately 2:00am to give Resident #1's roommate medication.
-She had to turn the light on in the room and thought she remembered Resident #1 pulling up

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the blanket to block the light.
-She was almost certain the PCA who was assigned to Resident #1 that night was Staff D.
-Staff D was at work and "as far as she knew she was on the hall," but could not say if Staff D checked on Resident #1 for rounds every two hours.
-She knew from working on the floor previously that Resident #1's roommate was a "heavy wetter" and usually needed pain medication; that was how she knew to go and check on her at 2:00am.
-She had worked with Staff D before, she did not have any problems with Staff D and she was not aware of any concerns related to Staff D performing personal care and safety checks on residents.

Interview with a second MA on 7/6/17 at 12:15pm revealed:
-She was on duty the morning Resident #1 died.
-The PCA reported to her that Resident #1 had died at about 6:30am.
-She went down to Resident #1's room with the PCA and checked Resident #1.
-She did pull back the covers and saw that Resident #1's "eyes were up and she was kind of cool."
-The staff that were on duty for 3rd shift on 7/5/17-7/6/17 (Staff A and Staff B) were the same staff on duty the night Resident #1 died.
-She was not aware of concerns about 3rd shift staff sleeping while on duty, but had heard that Staff A was found sleeping at 3:00am on 7/6/17.

Interview with Staff D on 7/12/17 at 1:04pm revealed:
-She had called the facility on 5/6/17 and told "the girls" she had just worked 6:00am to 6:00pm in the kitchen and she was going to take a nap.

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D 269	Continued From page 23 -She overslept and did not make it to work until 4:30am, but she thought there were four other staff working. -When she arrived, she checked with the other staff on duty to see if the rounds had been done and staff told her the residents had all been checked and changed. -She went into Resident #1's room around 5:00am and it was like Resident #1 "literally" looked at her so she pulled the covers up and turned off the light. -Resident #1 looked like someone who was just waking up would look at you. -She did not check on Resident #1 anymore after 5:00am because she did not want to agitate her and wake her up. -She did not check to see if Resident #1 was wet, "I know I should have." Review of "Care Notes" for Resident #1 dated 5/6/17 and 5/7/17 revealed: -On 5/6/17 staff documented Resident #1 was doing well until approximately 5:30pm when she became agitated, declined pain medication, was again agitated at 9:20pm and again declined pain medication telling staff she wanted to see her [family member] before she left. -On 5/7/17 staff documented checking Resident #1 at 6:30am and she was already deceased. Review of an Emergency Medical Services (EMS) report dated 5/7/17 for Resident #1 revealed: -There was documentation EMS received the call at 7:13am and arrived at the facility at 7:31am on 5/7/17. -There was documentation Resident #1 was lying in her bed not conscious with rigor and staff reported she was last seen alive at 9:00pm on 5/6/17.	D 269		

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D 269	Continued From page 24 Based on observations, interviews and record review, Resident #1's reported roommate on 5/6/17, was not interviewable Review of Resident #1's reported roommate's May 2017 electronic Medication Administration Record (eMAR) revealed the roommate was given an as needed medication at 2:26am on 5/7/17. Interview with the RCC on 7/10/17 at 4:57pm revealed: -She had arrived at the facility at approximately 8:00am on 5/7/17 and Resident #1 was dead. -"It looked like she had been dead for a long time" because she was already stiff and blue around the mouth. -She had talked to staff and all staff reported Resident #1 was alive when they last saw her. -She did not know which PCA was assigned to care for Resident #1 for 3rd shift on 5/6/17. -She did know that Staff A, Staff B, Staff C and Staff D were working for 3rd shift on 5/6/17. -Staff D notified the RCC on 5/7/17, that she did not arrive to work until 3:00am because she had worked from 6:00am until 6:00pm on 5/6/17 in the kitchen, went home to take a nap and overslept. -She was not notified that Staff D was not present for work at 10:00pm on 5/6/17. Interview with the Administrator on 7/11/17 at 1:34pm revealed: -She was out of the facility on medical leave when Resident #1 passed. -The RCC called her and told her Resident #1 was found by 1st shift. -She did not have any further information about the circumstances before Resident #1's death on 5/7/17.	D 269		

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2. Review of Resident #5's current FL-2 dated 11/21/16 revealed diagnoses included Vascular Dementia, Vertigo, Seizures, Degenerative Disk Muscle Weakness, Osteoarthritis, Chronic Obstructive Pulmonary Disease, Cerebral Vascular Accident and Palpitations.

Review of Resident #5's current quarterly assessment dated 3/21/17 revealed Resident #5 was ambulatory with a walker; required limited assistance with eating, toiling and transfers; and required extensive assistance with bathing and dressing.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 3/13/17 revealed Resident #5 had left sided weakness, used a walker for short distances and otherwise used a wheelchair, wore a brace on his left leg and required one staff to assist with transfers.

Telephone Interviews with Resident #5's family member on 7/10/17 at 12:25pm and 7/13/17 at 4:27pm revealed:
-She had visited Resident #5 on the Monday before he went to the hospital (5/22/17), and he "wasn't doing so well," was sluggish and felt hot, so she asked staff to check his temperature.
-She did not know if staff checked the resident or not because she had to leave the facility.
-She was going to make Resident #5 an appointment with his Primary Care Provider (PCP), but on Wednesday (5/24/17) the Medication Aide (MA) contacted the family member sometime in the afternoon and told her Resident #5 was being sent to the hospital.
-She told the MA she would take Resident #5 to the hospital herself which she did the evening of 5/24/17.
-When she got to the facility, Resident #5 was

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"really out of it and pale as a ghost."
-Resident #5 had a really bad urinary tract infection (UTI) because he was left lying in urine all the time.
-He had been wet so much the bacteria got into his urethra and went up into his bladder and then into his blood.
-Resident #5 had E coli (Escherichia coli) in his blood and was in the hospital for ten days. (Escherichia coli is a bacteria commonly found in feces.)
-The infection was so bad it made his heart work too hard and he had a heart attack.
-Resident #5 was able to use the bathroom himself, but would pee on himself if he took a nap.
-Sometimes Resident #5 would get "raw down there" but the family member took care of that by putting ointment on the area that was raw.
-Sometimes she would arrive in the parking lot to visit the resident and would see all the staff outside smoking cigarettes.
-Staff would see her and get up and go in the building to change Resident #5, and they would be just coming out of his room by the time she made it down there.
-There were times staff would come to the room and ask Resident #5 "Are you wet?" He would say "No" and they would say "OK" and leave.
-Staff can't ask a memory care resident if they were wet because they wouldn't know half the time; staff needed to check him and they did not do that.
-The family member would visit Resident #5 and change his incontinent brief which was usually saturated with urine.
-Each time the family member would show the saturated brief to the staff and the Administrator.
-The Administrator would type something on the computer and that was it.

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-Once Resident #5 went to the hospital, "I knew he wasn't going back there (to the facility) even if I had to bring him home because it was getting dangerous there."
-It was dangerous because the staff did not watch the residents or take care of them.

Review of "Care Notes" dated 5/5/17 through 6/2/17 for Resident #5 revealed:
-On 5/22/17 staff documented Resident #5 "slept well with no problems."
-The next entry was on 5/25/17 where staff documented, "hospital."
-The last entry was on 6/2/17 where staff documented, "hospital."

Interview with two Personal Care Aides (PCAs) on 7/12/17 at 11:12am revealed:
-They had not noticed anything different about Resident #5 for the few days before he left the facility.
-Resident #5 was quiet, stayed to himself and only came out of his room to eat.

Interview with a third PCA on 7/12/17 at 4:33pm revealed:
-Resident #5's family member would bring him snacks so he would stay in his room a lot.
-Some days he would come out of his room and some days he would not.
-The last few days he was at the facility he did not come out of his room.
-One of the MAs went down there and said Resident #5 wasn't acting right; that was the same day he was sent out (5/24/17).

Interview with a fourth PCA on 7/13/17 at 9:22am revealed:
-Resident #5 liked to stay in the bed and sometimes had a problem getting up in the

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morning.
-He was able to get up and shave himself and dress himself; he might need some assistance like help with tying his shoes.
-Resident #5 used the bathroom and a urinal, mostly the bathroom.
-Resident #5 was occasionally incontinent, "not like every day."
-He was the same the last few days he was at the facility except he did not want to get up; he did not seem sick.
-She reported Resident #5 not wanting to get up to the MA on duty.
-She could not remember which day it was, but it was the day before or the day he was sent out (5/24/17).

Interview with a fifth PCA on 7/13/17 at 9:39am revealed:
-Resident #5 was paralyzed on one side and needed assistance with showering.
-He used a urinal but still needed to be changed.
-He stayed in his room a lot.

Interview with a MA on 7/11/17 at 5:52pm revealed:
-Resident #5 was pale and was not acting like himself on the day his family member took him to the hospital (5/24/17).
-Resident #5 normally answered questions, but the day he was sent out he was not responding.
-She checked Resident #5's vital signs and they were normal.
-She called the family member because she was concerned about the resident and the family member decided to take Resident #5 to the hospital.
-Resident #5 had been "Okay" before the day he got sick (5/24/17).
-His family member had come to her before with

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concerns about the resident being wet and she would "just take care of it."
-The Resident Care Coordinator (RCC), Business Office Manager and Administrator knew about the family member's complaints that Resident #5 was found with a saturated incontinence brief on because the family member would call and tell them.

Telephone interview with a second MA on 7/8/17 at 12:20am revealed:
-Resident #5 was quiet and "pretty much stayed to himself."
-He used a urinal and did not require much assistance on 3rd shift.
-"It was a shocker" to hear Resident #5 had been sent out on 2nd shift and was not returning to the facility.

Review of hospital records dated 5/24/17 through 6/2/17 for Resident #5 revealed:
-There was documentation Resident #5 presented to the Emergency Room (ER) with shortness of breath, productive cough, weakness and a fever of 100.3 degrees Fahrenheit.
-There was documentation Resident #5 was admitted to the hospital with sepsis, having Escherichia Coli in his urine and blood.
-There was documentation Resident #5 had elevated cardiac enzymes showing a Myocardial Infarction "felt to be secondary to overwhelming sepsis, demand ischemia."

Telephone interview with Resident #5's Primary Care Provider's (PCP) Nurse on 7/12/17 at 11:49am revealed:
-Resident #5 was last seen in the PCP's office on 5/1/17 for a routine follow up visit.
-There was no notations of Resident #5 being ill or going to the hospital.

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-The next notation after 5/1/17 was that the resident was going to [name of another facility] following a hospitalization from 5/24/17 through 6/2/17.
-There were no concerns documented by the PCP at the 5/1/17 visit.

Telephone interview with a hospital Physician on 7/12/17 at 4:12pm revealed:
-She was familiar with Resident #5 and had overseen his care for the last four days he was hospitalized.
-Resident #5 had an extensive UTI and the same strain of E. coli bacteria that was in his urine was also in his blood.
-It would be hard to say, but she would expect at least generalized weakness and malaise to have been present for a few days.
-Resident #5's admitting complaint was that he was weaker than normal.
-There was a definite increased risk of UTI with urinary incontinence especially if urinary hygiene was inadequate.

Attempted telephone interview with the admitting hospital Physician on 7/12/17 at 10:46pm was unsuccessful.

Review of a discharge notice for Resident #5 dated 6/2/17 revealed the resident was discharged to a higher level of care and the notice was signed by Resident #5's POA and the Administrator's name was signed.

Interview with the RCC on 7/10/17 at 4:57pm revealed:
-She only knew that Resident #5's family member told her she took the resident to the hospital and he had pneumonia and a heart attack.
-The family member came back and said she

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was moving the resident to a higher level of care.
-She did not know anything else about Resident #5.

3. Review of Resident #3's current FL-2 dated 09/01/16 revealed diagnoses included Alzheimer's Dementia, diabetes (unspecified), rectal pain, anemia and hypertension.

Review of Resident #3's Service Plan dated 02/16/16 revealed:
-The resident was disoriented at times.
-The resident was incontinent of bowel and bladder.
-The resident was fully dependent during toileting.

Interview with a Personal Care Aide (PCA) on 07/10/17 at 10:20am revealed:
-It was routine to come in on first shift and find all the bedbound residents wet.
-Residents would be "soaked with urine or muddy [soiled with feces] all up their back".
-First shift PCAs "would have to do a complete bed change along with cleaning and drying resident first thing".

Interview with a 2nd PCA on 07/12/17 at 11:20am revealed:
-The PCA would "always" find Resident # 3 "soaked" (with urine) in the mornings.
-If the resident had been left in her recliner all night, she and the chair would be soaked.
-If the resident was in her bed, both the bed and resident would be soaked.
-The PCA had reported this to her supervisor or the Administrator many times but nothing was done.

Interview with a 3rd PCA on 07/12/17 at 10:35am revealed:

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D 269	Continued From page 32 -Resident #3 was always "wet" in the morning. -Four out of five days, she would be in her recliner with her bed made [as if she had spent the night in the recliner]. -"Sometimes they (previous shift staff) would not put a chuck in the recliner and it (recliner) would really be soaked". -The recliner was fabric and it began to "stink really bad". -Resident #3's family member had to replace the recliner because it smelled so bad. -The PCA recalled the resident having one pressure sore on her coccyx area when the resident left the facility. Interview with the Resident Care Coordinator (RCC) on 07/11/17 at 4:58pm revealed: -Every shift complained about what the other 2 shifts were not doing. -She was not aware of any specific complaints about Resident #3. -The RCC and Business Manager had discussed doing shift rounds about 2 weeks ago. Interview with Resident #3's family member on 07/10/17 revealed: -On approximately 05/15/17, she had spoken with the Manager about continuously finding Resident #3 in soiled clothing and in a wet bed. -The family member complained about the resident's bottom not being cleaned properly. -The family member provided bed linens, a dirty clothes hamper and did the resident's laundry. -The clothing and linens that were placed in the hamper were frequently soaked with urine. -The family member repeatedly found that disposable pads were placed over urine soaked linens on the resident's bed. -On approximately 05/25/17, she removed wet linens from the resident's bed and found dried	D 269		

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urine stains on the mattress.
-The family member voiced her complaints to "anyone who would listen" but the lack of care continued.

Interview with the Administrator on 07/11/17 at 1:23pm revealed:
-Resident #3's family member had complained about the resident being wet and wet sheets being in the laundry hamper.
-The complaint was made "a week or so before she (Resident #3) went to the hospital the last time".
-The Administrator had sent out a memo to all staff reminding them that residents were to be checked every 2 hours.

Review of Primary Care Provider's (PCP) chart note dated 03/31/17 revealed:
-Resident #3 had a pressure wound on the left buttock "¾ inch with scabbed area".
-Resident #3 had a pressure wound on the right buttock "1/2 inch round".
-The PCP ordered wounds to be cleaned every 5 days with wound cleaner and cover with Duoderm, replace Duoderm as needed for soilage or loose tape.

Review of PCP chart note dated 04/20/17 revealed:
-"Staff tell me her ulcerations look unchanged".
-There was an order to continue current plan of care for wounds.

Review of PCP chart note dated 05/19/17 revealed:
-Resident #3 had "pressure ulceration stage 2 on sacral area 1/3 inch round".
-There was an order to continue current plan of care for the wound.

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D 269	Continued From page 34 [Refer to Tag D0465 10A NCAC 13F .1308(a) Special Care Unit Staffing] The facility's failure to provide safety checks and incontinence care every two hours resulted in Resident #1's death going unnoticed by staff until full rigor mortis was set accompanied by urine saturated bed linen; Resident #5 being hospitalized with sepsis; and Resident #3 sustaining skin breakdown. This failure to provide incontinence care and personal care in accordance with the resident's assessed needs resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. Review of a Plan of Protection dated 07/13/17 revealed: -Staff will be assigned specific residents on every shift to provide the care needed according to the residents current Plan of Care. -Residents will be checked every 2 hours. -An Incontinent Care Log will be implemented for documentation of 2 hour checks. -The Manager/Supervisor will make rounds on every shift to assure the assessed needs of the residents are being met. -The Incontinent Log will be monitored by the Manager or designee. -Staff will receive training on the Incontinent Care Log. -A training will be conducted for staff on personal care, respect and dignity THE DATE OF CORRECTION FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 13, 2017.	D 269		

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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 provided supervision for 2 of 6 sampled residents (#1 and #3) according to the needs of the residents which resulted in Resident #1 and #3 sustaining bruises secondary to falls; and failed to provide supervision of up to 23 residents at a time kept throughout the day in the common area. The findings are: Observation on 07/07/17 at 3:30pm revealed: -Approximately 20 residents were sitting in the common area unattended. -A resident in a wheelchair was attempting to pull the sound system off of a table. -There were no staff supervising the residents. Observation on 07/12/17 at 9:00am revealed: -Twenty three residents were sitting in the common area. -Two staff members were present. -A resident had a wooden board game with a 5 inch plastic wand attached by a rubber/plastic cord; the resident had the wand in his mouth and was chewing on the cord.	D 270		

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-Neither staff intervened.

1. Review of Resident #3's current FL-2 dated 09/01/16 revealed diagnoses included Alzheimer's Dementia, diabetes (unspecified), rectal pain, anemia and hypertension.

Interview with Resident #3's family member on 07/07/17 at 4:44pm revealed:
-The family member did not think that the resident was supervised properly.
-The resident had fallen on "01/13/17, 02/16/17, 03/20/17, 04/11/17, 05/20/17 and 05/25/17".
-The resident had both bed and chair alarms but family member often found they were not applied by staff.
-The resident had a fall mat but the family member had found it leaning against the wall several times.
-The resident had sustained a severe skin tear to the back of her right hand and a bruise to her forehead on 03/23/17 without an explanation from staff.
-The resident had sustained a bruised forehead on 06/05/17 without explanation.

Review of Accident/Injury Reports for Resident #3 revealed:
-The resident was found lying on the floor on 01/13/17 at 1:15am with swelling on her left forehead; she was not sent to a local hospital's Emergency Room (ER) for evaluation.
-The resident was found on the floor on 03/05/17 at 8:30pm with a "knot" on her forehead; she was sent to a local ER for evaluation.
-The resident fell while trying to get out of wheelchair on 04/11/17 at 7:05pm; no injury was noted but she was sent to a local ER for evaluation.
-The resident fell while "trying to walk to the front"

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on 05/20/17 at 6:45pm; bruises were on the resident's upper right arm, back and right hand.

Interview with a Personal Care Aide (PCA) on 07/12/17 at 10:20am revealed:
-The PCA worked first shift.
-The PCA would "always" find Resident #3 in her recliner with the foot elevated.
-The chair alarm would be on the resident's wheelchair not on the recliner.

Interview with a 2nd PCA on 07/12/17 at 11:20am revealed:
-The PCA worked first shift.
-Resident #3 was in her recliner "most mornings".
-The chair alarm was "never" on the recliner.
-The fall mat was down sometimes.

Interview with a 3rd PCA on 07/12/17 at 11:35am revealed:
-The chair alarm was never on the recliner in the morings [when she worked first shift].
-The bed alarm "got real weak [wouldn't sound loudly] for a while-at least a week or two".
-Resident #3 finally got a new bed alarm before she left.
-The PCA reported the "way she found the resident in the morning many times to the Supervisor and to the Administrator".

Interview with a 4th PCA on 07/12/17 at 4:45pm revealed she could not understand how the resident could be left in the recliner all night because she was constantly calling out to use the bathroom.

Interview with Resident #3's Primary Care Provider (PCP) on 07/06/17 at 11:02am revealed:
-The resident had fallen several times but the PCP could not remember specifics.

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-The PCP did not "keep track" of telephone calls she received from the facility.

Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed:
-She was not aware of any residents with bruises over the last two to three months.
-Staff were expected to check on each resident every two hours and any resident that needed an eye kept on them was kept up front most of the time.

Interview with the Administrator on 7/11/17 at 1:34pm revealed:
-She had been out on medical leave since May 2017.
-The RCC and Business Office Manager (BOM) were in charge in her absence.
-Staff were expected to check on residents every two hours minimum.
-The facility also used chair alarms, bed alarms and fall mats to prevent falls.

2. Review of Resident #1's current FL-2 dated 12/21/16 revealed diagnoses included Alzheimer's Dementia, Depression and Hypertension.

Review of an "Accident/Injury Report" for Resident #1 dated 4/22/17 at 7:20am revealed:
-Resident #1 was found sitting on the edge of her bed and had a bruise on her right hip.
-There were check marks indicating the incident was reported and the resident was alone.
-Resident #1 had an abrasion and staff did not administer first aide.
-There was a check mark indicating Resident #1 was alert and oriented.
-Resident #1 "had bruising on her right hip and returned back to the facility with a diagnosis of

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Osteoarthritis."
-There was a check mark indicating the resident was sent to the emergency room on 4/22/17 at 7:40am by Emergency Medical Services (EMS).
-There was documentation a message was left for the Power of Attorney (POA) on 4/22/17 at 7:30am.
-Under "Name of private physician notified" there was documentation of "EMS" on 4/22/17 at 7:35am.
-The report was signed by a Medication Aide (MA) and the Administrator.

Review of "Care Notes" for Resident #1 dated 3/1/17 through 4/23/17 revealed there was no documentation of a suspected fall or bruise for Resident #1 on or about 4/22/17.

Review of an EMS report for Resident #1 dated 4/21/17 revealed:
-Facility staff reported Resident #1 fell and had right hip pain and bruising.
-The resident was transported to the emergency room (ER).

Review of ER records dated 4/22/17 for Resident #1 revealed:
-Resident #1 was seen for a chief complaint of a fall.
-EMS reported the facility stated that Resident #1 fell and staff noted bruising on her right hip.
-EMS and hospital staff did not note any bruising.
-Resident #1 did have pain with palpation and movement of the right hip.
-The discharge diagnoses included Right Hip Pain and Osteoarthritis.

Resident #1 was deceased on 5/7/17.

Telephone interview with Resident #1's POA on

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D 270	Continued From page 40 7/10/17 at 9:10am revealed: -Staff had contacted her at 8:00am or 9:00am on 4/22/17, and told her they had found Resident #1 on the floor in her room; she had a bruise on her hip and they were sending her to the emergency room (ER). -She visited Resident #1 at the facility later that day (4/22/17) and did not see any bruising. Interview with a MA on 7/13/17 at 9:37am revealed: -The PCA reported the bruise on Resident #1's right hip the morning of 4/22/17. -She went down and checked Resident #1 and she was sitting on the bed with a bruise on her right hip. -She did not know if the resident fell or not. Interview with a Personal Care Aide (PCA) on 7/13/17 at 9:49am revealed: -She found the bruise on Resident #1 on 4/22/17 and reported it to the MA. -She was taking care of Resident #1 on 4/21/17 and the resident did not have any bruises. -On 4/22/17 she was getting the resident up and saw the bruise and it seemed like it was from a fall. -The previous shift did not report anything. Interview with a second PCA on 7/12/17 at 4:33pm revealed: -Resident #6 was Resident #1's roommate for a little while. -Resident #6 tried to help Resident #1 out of the bed to go to the bathroom and Resident #1 fell and that was how she got the bruise on her right hip. -The first shift MA found it (Resident #6 trying to assist Resident #1), so it had to have happened the night before (4/21/17).	D 270		

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D 270	Continued From page 41 Based on observations, interviews and record review, Resident #6 was not interviewable. Confidential interview with a staff revealed: -Resident #6 liked to help other residents get up from their wheelchairs and their beds and would become aggressive with staff when they tried to redirect her. -Resident #6 was Resident #1's roommate for a short while during the last two weeks of April 2017. Review of "Care Notes" dated 4/23/17 through 6/30/17 for Resident #6 revealed on 4/26/17 staff documented Resident #6 was aggressive after being told not to transfer Resident #1. Interview with Resident #1's Primary Care Provider (PCP) on 7/6/17 at 11:06am revealed: -She had not seen the resident since 4/13/17. -She was not aware of a suspected fall or staff finding a bruise on Resident #1 on 4/22/17. -All of her visit notes were kept in the residents' records. Interview with a third PCA on 7/6/17 at 4:17am revealed: -Third shift staff performed rounds every two hours, checking on all of the residents to make sure they were in their beds. -In between rounds, staff would walk the halls to try and "keep an eye on" the residents. -He was not aware of any residents at high risk for falls on the men's hall. -He was not sure about the women's hall because he did not work on the women's hall. -He did not know what the "number six" indicated when written next to the name of some residents outside the door.	D 270		

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D 270	Continued From page 42 -He was going to ask the MA what the "number six" indicated. Second interview with the third PCA on 7/6/17 at 4:20am revealed the "number six" indicated the room number. Third interview with the third PCA on 7/6/17 at 4:25am revealed the "number six" indicated the resident was at high risk for falls. Interview with a fourth PCA on 7/6/17 at 4:54am revealed: -Third shift staff were responsible to check all residents every two hours. -There weren't any residents on the women's hall who had fallen in the last three months. -There was one resident who had fallen on the men's hall a few weeks ago. -Some residents had fall mats placed on the floor next to their beds when they were in the bed. -She would place the fall mat with approximately ¼ of the mat under the bed and ¾ out from the edge of the bed. Interview with a second MA on 7/6/17 at 5:50am revealed: -The 3rd shift staff did their first rounds on residents at 10:00pm by checking and making sure the residents were where they were supposed to be. -Then staff would check residents for incontinence and safety at midnight. -The staff did not really do any rounds at 2:00am, but waited until about 3:00-3:30am to check and change residents. -Staff would check the residents every 30 minutes after incontinence care because once staff woke the residents up, they would be up, and try to get up on their own.	D 270		

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D 270	Continued From page 43 -Staff placed mats on the floor and folded up wheel chairs to help prevent falls and injuries. -Most residents fell on the 2nd shift because that's when the residents were awake and moving around. A second confidential staff interview revealed: -Staff would come in and find residents with new bruises on their eye, face and forearms and ask the previous shift what happened. -Previous shift staff would say the resident fell and that was it. Nothing was done about it. -She had reported this many times to the Supervisors and the Supervisors had reported it to the Administrator, "but nothing ever happened which was very discouraging." -Residents were found in the worst condition after Staff A had worked the previous shift. Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed: -She was not aware of any residents with bruises over the last two to three months. -She did not know any of the details about the bruise found on Resident #1 on 4/22/17, except that staff found a bruise and sent the resident to the ER. -Staff were expected to check on each resident every two hours and any resident that needed an eye kept on them was kept up front most of the time. Interview with the Administrator on 7/11/17 at 1:34pm revealed: -She had been out on medical leave since May 2017. -The RCC and Business Office Manager (BOM) were in charge in her absence. -Staff were expected to check on residents every two hours minimum.	D 270		

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D 270	Continued From page 44 -The facility also used chair alarms, bed alarms and fall mats to prevent falls. [Refer to Tag D0465 10ANCAC 13F Special Care Unit Staffing]. The facility failed to provide supervision according to the needs of the residents which resulted in Resident #3 having bruises of unknown origin and six falls over five months that also resulted in multiple bruises; and Resident #1 having a "suspected fall" with bruising on her hip which resulted in pain and required transportation to the emergency room. The facility's lack of supervision of the residents resulted in physical harm and serious neglect which constitutes a Type A2 Violation. Review of a Plan of Protection date 07/10/17 revealed: -Immediately staff will be assigned to supervise the common areas when residents are present. -Schedules will be reviewed daily by the Manager or designee to assure required staff are on duty. -Department Heads will make monthly monitoring checks to 2nd and 3rd shifts to assure duties are being performed. -Immediately a training will be held for all staff on job duties, responsibilities and the chain of command. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 13, 2017.	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	D 273		

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D 273	Continued From page 45 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for the acute needs of 4 of 6 sampled residents (#1, #2, #3, and #6) resulting in Resident #1 not having medical treatment for three days following an assault by another resident and being hospitalized; Resident #2 and #6 having aggressive behaviors toward staff and other residents which were not communicated to the Primary Care Physician or Mental Health Provider by staff; and Resident #3 not having a referral to a urologist for symptoms of a urinary tract infection. The findings are: 1. Review of Resident #1's current FL-2 dated 12/21/16 revealed diagnoses included Alzheimer's Dementia, Depression and Hypertension. Interview with a Medication Aide (MA) on 7/6/17 at 5:50am revealed: -"It scared me the way they [other staff] say [name of Resident #2] jumped on [name of Resident #1]. They [other staff] said it was pitiful." -She was told Resident #1 had a stroke or a seizure following the attack. -Resident #1 was hospitalized, returned to the facility, declined and passed away.	D 273		

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D 273	Continued From page 46 Telephone interview with Resident #1's Power of Attorney (POA) on 7/6/17 at 10:10am and 7/7/17 at 4:50pm revealed: -Resident #1 was attacked by another resident on 4/1/17 and was not taken to the hospital for three days. -Staff contacted her at 8:56am on 4/1/17 and informed her there had been an incident involving Resident #1 and another resident. -She immediately went to the facility and found Resident #1 in her room and there were four Personal Care Aides (PCAs) in the room with her. -Resident #1 was "so scared, shaking and did not recognize family members" when the POA saw her within 15 minutes of being contacted by staff. -She was told by staff that Resident #1 was sitting on the sofa in the common area by herself when another resident came and sat down near her which made a third resident, Resident #2, angry. -Staff told her Resident #2 went to Resident #1 and grabbed her by her shoulders and blouse, ripping the buttons off of her blouse and yanking her up off of the sofa. -Staff told her Resident #1 was heard screaming and by the time two PCAs came to get Resident #2 off of Resident #1, Resident #1's blouse was up over her head and her right shoe had been "stomped off." -Staff told her that it was a struggle for them to get Resident #2 off of Resident #1. -She could not find Resident #1's right shoe after the incident. -Staff told her that Resident #2's family member had already picked her up from the facility which lead her to believe that family member had been contacted prior to staff contacting her since she was at the facility within 15 minutes of staff contacting her. -She spoke with the Administrator on 4/1/17 who told her that Resident #1 was not hurt in the	D 273		

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incident with Resident #2. She was just scared and did not need to go to the hospital.
-She told staff on 4/1/17 and 4/2/17 that she was worried that Resident #1 was not herself, did not recognize family members, and was no longer able to walk, feed dress herself.
-She could not remember if it was 4/2/17 or 4/3/17 when the Resident Care Coordinator (RCC) and the Administrator told her they were going to take Resident #1 to the local urgent care to be evaluated for a urinary tract infection (UTI).
-The Administrator had said she thought that Resident #1's confusion may have been caused by a UTI.
-She was waiting at the facility when the Administrator returned from urgent care with Resident #1.
-The Administrator told her Resident #1 did not have a UTI, but they were going to treat her for a cough with Mucinex. (Mucinex is an over the counter decongestant.)
-She told the RCC and the Administrator she was concerned that something else had to be wrong with Resident #1 that was causing her confusion and making it so she could not function.
-The Administrator said they were going to watch Resident #1 for a day on the Mucinex and see if Resident #1 got better before doing anything else.
-She had also told the PCAs there was something wrong with Resident #1 on 4/1/17, 4/2/17 and 4/3/17 and they agreed.
-On 4/4/17, after she visited Resident #1 in the morning, the RCC contacted her later that afternoon with concerns about Resident #1 having right leg pain and they had called Emergency Medical Services (EMS).
-She arrived at the facility before EMS and Resident #1 was sitting in a wheelchair in the RCC's office.
-She followed EMS and Resident #1 to the local

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hospital where Resident #1 had x-rays that showed no broken bones of her right leg.
-While in the Emergency Room (ER), she told the doctor she was concerned about Resident #1's confusion and about the attack by Resident #2 on 4/1/17.
-A CT (Computed Tomography) scan or MRI (Magnetic Resonance Imaging) was done and the doctor came back and said Resident #1 had, had a stroke three to four days prior to coming to the ER, and that it was possible that the attack caused the stroke.
-Resident #1 was admitted to the hospital and was also diagnosed with Pneumonia and treated with antibiotics.
-Resident #1 was "never the same (after the incident); she never walked again, all but stopped eating, could not feed herself and did not know who her family was."

Review of an "Accident/Injury Report" for Resident #1 dated 4/1/17 at 8:30am revealed:
-Resident #1 was sitting on the couch with another resident and the resident scratched her on the right side of her nose.
-There were check marks indicating the incident was reported and the resident was not alone.
-Resident #1 had an abrasion and staff applied a cool wash cloth to the scratch.
-There was a check mark indicating Resident #1 was alert and oriented.
-"Resident [#1] was scared at the time it happened, kept her monitored. [POA] did come and visit with her. [POA] stated not to send her to the hospital because she thought she was just scared because of the incident."
-There was a check mark indicating the resident was not sent to the emergency room.
-The POA was notified on 4/1/17 at 8:45am and a message was left for the Primary Care Provider

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on 4/3/17 at 3:00pm.
-The report was signed by a PCA and the Administrator.

Interview with a PCA on 7/10/17 at 10:37am revealed:
-She was in the dining room assisting with feeding another resident when she heard a scream the morning of 4/1/17.
-She came out to the common area and found Resident #2 grabbing Resident #1 by her shirt hard enough to rip the buttons off of her shirt.
-Resident #1 was very upset and Resident #2 was agitated, belligerent and aggressive.
-There were four or five staff that came to help including PCAs and the MA.
-Staff took Resident #1 to the medication room to clean the blood off of her face.
-Resident #1 was never the same after the incident; she was fearful, out of it, clammy and sweaty.
-The MA called for an ambulance and by then Resident #1's POA was at the facility and initially told the MA to do whatever needed to be done.
-She did not know what happened, but the POA then said not to send Resident #1 to the hospital so the MA sent the ambulance away.
-Resident #1's POA stayed with her that day.
-The next day (4/2/17), Resident #1 was still "very out of it" and could not stand.
-The Administrator instructed staff to keep Resident #1 "up front" because she "kept hollering."
-She was concerned about Resident #1's wellbeing, but the POA did not want the resident sent to the hospital.

Interview with a second PCA on 7/10/17 at 12:57pm revealed:
-She was working the day Resident #2 hit

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Resident #1 on 4/1/17.
-She was in the kitchen and heard a scream; two other PCAs were already there by the time she got to Resident #1.
-Resident #1 was shaky, and scared "like she was in shock" and had a big scratch on her face after the incident.
-On 4/2/17, she was concerned that Resident #1 was "not acting right" and reported it to the Administrator the same day.
-Resident #1 was no longer able to walk, feed herself or dress herself and needed to be changed for incontinence.

Interview with a second MA on 7/10/17 at 1:53pm revealed:
-The morning of 4/1/17, at breakfast time, Resident #1 walked by the medication room and said she had an upset stomach and did not want to eat breakfast.
-She sat Resident #1 on a sofa in the common area closest to the women's hall and went back to the medication room.
-When she came out of the medication room, she saw Resident #2 had sat down next to Resident #1 on the sofa and had grabbed Resident #1 by her shirt with one hand and was punching Resident #1 repeatedly in the face and head.
-She went to the residents yelling for help and at Resident #2 to stop.
-PCAs came from the women's hall and the dining room to help get Resident #2 off of Resident #1.
-She notified both residents' family members and was preparing to send Resident #1 to the hospital.
-Resident #2's family member said she would come and get Resident #2 and was texting the Administrator.
-In the meantime, Resident #1's POA had arrived

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to the facility and spoke with the Administrator on the phone.
-She had already called for an ambulance when the Administrator told her on the phone not to send Resident #1 to the hospital.
-A day or two later, the Administrator took Resident #1 to urgent care because she said Resident #1 might have a UTI.
-It was not common practice for the Administrator to take residents to the doctors and residents did not usually go to urgent care; they went to the hospital or their doctor.
-There was no paperwork or instructions brought back from urgent care for Resident #1 and there were no medications; "there was nothing."

Review of "Care Notes" for Resident #1 dated 3/1/17 through 4/23/17 revealed:
-There was no documentation from 3/1/17 through 4/10/17 of Resident #1 having right foot pain.
-On 4/11/17, staff documented Resident #1 returned from the hospital and was complaining of her right foot hurting.
-On 4/15/17, staff documented Resident #1's feet were "really hurting."
-On 4/17/17, staff documented Resident reported her right foot was hurting.

Review of an urgent care visit note dated 4/3/17 for Resident #1 revealed:
-Resident #1 was seen as a new patient for new confusion and not being familiar with surroundings.
-A resident scratched Resident #1's right cheek on Saturday 4/1/17; she had not acted normal since then and had not been walking normally due to weakness in legs and knees.
-Resident #1 was not recognizing family as of 4/3/17.

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-Resident #1 was unable to answer any questions.
-There was documentation under "Plan Notes" that no urinary tract infection was noted. Due to acute delirium would advise [resident] to go to the ER (Emergency Room). Caregivers state they will take her to the ER themselves, do not want EMS transport and needs bloodwork and further testing to rule out other cause.

Interview with the Administrator on 7/11/17 at 6:04pm revealed:
-She had read the visit note from the urgent care for Resident #1 dated 4/3/17.
-She was the person who took Resident #1 to the urgent care on 4/3/17, because she was concerned that Resident #1 was not herself and may have had a urinary tract infection.
-The urgent care provider did tell her to take Resident #1 to the ER.
-She called Resident #1's POA on the way back to the facility after leaving the urgent care provider's office, who told her not to take Resident #1 to the ER.
-The POA was at the facility when she returned from urgent care with Resident #1.
-She did not contact Resident #1's Primary Care Provider (PCP) on 4/1/17, 4/2/17 or 4/3/17 because she was just concerned with getting the urine sample and getting Resident #1 to urgent care to see if the resident had a UTI..
-The MAs were responsible for notifying the PCP.

Interview with Resident #1's POA on 7/10/17 at 1:30pm revealed:
-She did not tell the Administrator not to take Resident #1 to the hospital on 4/1/17.
-The Administrator had said Resident #1 was just scared and the POA "just went along with it."
-She did not tell the Administrator not to take

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Resident #1 to the ER after leaving urgent care on 4/3/17.
-The Administrator had never said anything about the ER, only that Resident #1 had an upper respitary infection.

Interview with a third MA on 7/10/17 at 7:10pm revealed:
-She did not remember what day it was, but she was the one who sent Resident #1 to the hospital (4/4/17).
-The resident was agitated which was unusual for her and kept asking to see her family member.
-Resident #1 was different after the attack, but this day, she was the worst she had been and she kept complaining her right side hurt.
-She called the ambulance and sent Resident #1 to the hospital around dinner time that day (4/4/17).
-The nurse at the hospital said Resident #1 had a massive stroke on the day of the attack and another mini stroke the day she was sent to the hospital.

Review of an Emergency Medical Services (EMS) report dated 4/4/17 for Resident #1 revealed:
-EMS was at the facility at 6:30pm on 4/4/17 for Resident #1 having leg pain for four days.
-Staff and family reported Resident #1 was assaulted on 4/1/17 and received an injury to her right foot.
-Family reported that Resident #1 was seen at urgent care after the incident.
-Resident #1 still had pain and there was no obvious sign of injury, no bruising or swelling.

Review of hospital admission records dated 4/4/17 through 4/11/17 for Resident #1 revealed:
-Resident #1 presented with a three day history of right lower extremity pain following an incident

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where she was "picked up roughly by another agitated resident and put back down roughly."
-Resident #1 was ambulatory prior to the incident, but has since needed a wheelchair to get around.
-The family member noted that Resident #1 had "not been acting herself for the last couple of days, which has also been concerning."
-Resident #1 was seen at urgent care on 4/3/17 for evaluation of a cough and was diagnosed with a viral syndrome.
-The x-rays done in the ER of Resident #1's right lower extremity were negative.
-A chest x-ray done in the ER showed pneumonia and blood test showed an elevated white blood cell count.
-A CT scan done in the ER showed an acute verses subacute stroke in the left occipital lobe and a follow up MRI showed a large acute verses subacute stroke in the left hemisphere and a small acute stroke in the right MCA distribution.
-Resident #1's "altered mental status was likely secondary to acute Cerebral Vascular Accident" and her knee pain "seems to be secondary to arthritis."
-Resident #1's bacteriuria and pyuria was treated with intravenous antibiotics which resolved her elevated white blood cell count.
-Resident #1's overall "prognosis was poor given her advanced dementia, depression, stroke and poor oral intake."

Interview with Resident #1's Primary Care Provider (PCP) on 7/6/17 at 11:06am and 7/12/17 at 10:09am revealed:
-She was not notified that Resident #1 was confused and not herself on 4/1/17, 4/2/17, 4/3/17 or 4/4/17.
-She was made aware of the incident involving Resident #1 and Resident #2 when she saw Resident #1 on 4/13/17, for a follow up visit to the

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hospitalization.
-Staff told her Resident #1 was pushed or something was done to make her fall to the floor and she was sent to the hospital.
-She had not seen the resident since 4/13/17.
-All of her visit notes were kept in the residents' records.
-Facility staff reporting concerns about residents to her could be a better process.
-It was hard because she did not see all of the residents when she came to the facility each week and she would not know if she wasn't told by staff.
-She was usually at the facility every week and was available during the day by phone.
-She would see residents each week based on her own follow up schedule and staff were able to add residents to the list based on concerns or if someone had been in the hospital.

Review of a PCP visit note dated 4/13/17 for Resident #1 revealed:
-Resident #1 was seen by the PCP for a follow up from the hospital.
-There was documentation that, "She was in the hospital on 4/4/17 because of right lower extremity pain that was caused by another resident. After multiple x-rays of her right foot it was found to not have any fractures, however before being discharged she was found to be slumped to one side and was treated for ischemic stroke. She was also treated for pneumonia. She was admitted on 4/4/17 and discharged 4/11/17."

Interview with the Administrator on 7/11/17 at 1:23pm revealed:
-Staff reported what happened between Resident #1 and Resident #2 the morning of 4/1/17.
-She came to the facility to check on the resident the next day which was a Sunday (4/2/17), got

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her up and walked her around and even took her out on the front porch.
-Resident #1 kept complaining her feet were hurting so she clipped her toe nails and put lotion on her feet (on 4/2/17).
-The next day (4/3/17), Resident #1's POA came to visit and the resident did not recognize the POA.
-She did not notice Resident #1 having any other problems, so she thought Resident #1 might have a UTI.
-The POA said she thought the resident was just scared.
-She thought Resident #1 had a UTI and needed to go to urgent care so she took her on 4/3/17.
-The resident did not have a UTI and no medications were prescribed.
-She stopped and called the POA to ask if she wanted Resident #1 to go the emergency room (ER) since she was right there and the POA said not to take her.
-The next day staff sent Resident #1 to the ER, EMS did not want to take her, but they did.
-She could not remember which staff, but staff texted or called to say that Resident #1 was admitted with pneumonia.
-She did not contact Resident #1's Primary Care Provider (PCP) on 4/1/17, 4/2/17, 4/3/17 or 4/4/17 because she knew the PCP would not be in the facility until Thursday 4/6/17.
-It was the facility protocol for staff to contact the PCP for any change in the resident's status and document the contact in the care notes.

2. Review of Resident #2's current FL-2 dated 6/7/16 revealed diagnoses included Alzheimer's Dementia, Hypertension and Hyperlipidemia.

Telephone interview with a Medication Aide (MA) on 7/8/17 at 12:20am revealed:

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-Resident #2 was aggressive with staff and would fuss and pull away when redirected by staff.
-Resident #2 was intimidating.
-"You definitely want another staff with you; you don't want to be with her by yourself."

Review of Resident #2's current care plan dated 2/22/17 revealed:
-Resident #2 wandered and was verbally and physically abusive.
-There were check marks indicating the resident was not receiving medications for behaviors, was not seeing a Mental Health Provider (MHP) and was not referred to a MHP.

Based on observations, interviews and record reviews, Resident #2 was not interviewable due to diagnosis of Dementia.

Telephone interview with Resident #2's Power of Attorney (POA) on 7/12/17 at 11:24am revealed:
-She felt that overall the facility did a good job but there were some "glitches."
-Glitches meant the staff did not always call when something was going on with the resident, for example if the resident did not feel well staff did not let the POA know about it.
-She would only find out by going to visit the resident which she or another family member did at least every other day.
-When Resident #2 needed to see the doctor, the staff would call the POA and she would make the appointment and take the resident.
-When Resident #2 got violent and hit people (staff/residents), staff would call the POA and tell her Resident #2 needed to see someone (licensed provider) and get some medications.
-Resident #2 was seeing a Mental Health Provider (MHP) at the facility and she also saw a neurologist for her dementia.

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D 273	Continued From page 58 -The facility staff set the appointments for the MHP, but the POA contacted the neurologist because the medications weren't working. -The neurologist was the one that added the Seroquel which had to be increased several times before it started working. (Seroquel is an anti-psychotic used to treat psychiatric disorders including schizophrenia, bipolar disorder and major depression.) -She could not remember the dates Resident #2 was seen by the MHP and the neurologist. -Resident #2 had pills available for an extra dose in case she was having a bad day. -She could not remember any incidents of Resident #2 attacking another resident since that night (4/1/17) and she felt terrible for what happened. Review of "Care Notes" dated 2/19/17 through 7/7/17 for Resident #2 revealed: -On 2/19/17 staff documented, "very fussy, hitting and kicking." -On 2/20/17 staff documented, "fussing and fighting this morning." -On 3/11/17 staff documented, "slapped the [explicit] out of the aide this morning; her [POA] was called." -On 3/11/17 staff documented Resident #2's POA came and took Resident #2 out of the facility because the resident attacked an aide. -On 3/13/17 staff documented Resident #2 was trying to fight the aides. -On 3/25/17 staff documented Resident #2 was "very agitated." -On 4/1/17 staff documented Resident #2 was "fighting staff and other residents; [POA] was called." -On 4/2/17 staff documented Resident #2 was out of the facility with family. -On 4/1/4/17 staff documented Resident #2 was	D 273		

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very agitated during her shower.
-On 5/18/17 staff documented Resident #2 was walking without her walker and became agitated when staff asked the resident to use her walker.

Interview with a Personal Care Aide (PCA) on 7/10/17 at 10:37am revealed:
-Resident #2 "was something else." She would try to hit staff for any "little thing."
-She was close to a particular resident and when that resident was moved to another room, Resident #2 would go into that room all the time and was aggressive with a family member in that room.
-Staff had to "fight with her (Resident #2) to get her out of the room."
-Resident #2's medications were changed after the incident with Resident #1 on 4/1/17 and she was better for a while.
-For the last several weeks, Resident #2 had been aggressive with staff and verbally abusive with other residents like before.
-Resident #2 would tell other residents to "just shut up" in the common area because she was watching television.

Interview with a second PCA on 7/10/17 at 12:57pm revealed:
-Resident #2 was violent, fought with staff, would not let staff assist her with anything and called staff names.
-She had not seen her aggressive with other residents since 4/1/17, but Resident #2 had slapped a PCA since then.
-No one had given her any instructions for what to do when Resident #2 was being aggressive.
-She would just walk away and let Resident #2 calm down.

Review of an "Examination or Contact by

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Physician" sheet for Resident #2 revealed:
-On 4/27/17 the Mental Health Provider (MHP) wrote for Resident #2 to continue her current regimen which included Seroquel 50mg at bedtime, Depakote 750mg at bedtime, Prozac 20mg daily and Seroquel 25mg every four to six hours as needed for agitation/aggression not to exceed 200mg per day; and to contact the MHP if symptoms worsened or if side effects developed.
-On 5/1/17 the MHP wrote a clarification order for Seroquel 25mg every four hours as needed for acute agitation, 200mg maximum per day and to continue Seroquel 50mg at bedtime.

Review of a prescription order dated 5/1/17 for Resident #2 revealed there was an order for Seroquel 25mg every six hours as needed for agitation signed by Resident #2's Neurologist.

Review of Resident #2's electronic Medication Administration Record (eMAR) for April 2017 revealed there was no entry for Seroquel 25mg every four to six hours as needed.

Review of Resident #2's May, June and July 2017 eMAR revealed:
-There was an entry for Seroquel 25mg every six hours as needed for agitation.
-There were no doses administered in May, June or July 2017.

Telephone interview with Resident #2's Primary Care Provider's (PCP) Nurse on 7/12/17 at 12:30pm revealed:
-The majority of contacts came from Resident #2's POA.
-It was either the POA or another family member that brought the resident to appointments.
-There was no documentation of any incidents on 4/1/17, 5/31/17 or 6/10/17, but they did have a

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note about a fall on 5/15/17.
-Resident #2 was last seen on 7/11/17 and there were no concerns.

Telephone interview with Resident #2's Neurologist's Office Assistant on 7/13/17 at 10:40am revealed:
-The neurologist had not had any contact from the facility staff, only the POA three times about Resident #2's behaviors.
-It would be nice if the facility staff contacted the neurologist with concerns.

Review of a Therapist's visit note for Resident #2 dated 4/4/17 revealed there was documentation that staff told the Therapist they were concerned Resident #2 "unexpectedly hit another resident while in the television room."

Telephone interview with Resident #2's Mental Health Provider (MHP) on 7/13/17 at 11:26am revealed:
-She visited Resident #2 for the first time at the facility on 3/22/17.
-The Therapist had informed her Resident #2 was having issues with aggression on 4/4/17, but she was on vacation and did not receive the message until she returned.
-She was not able to see Resident #2 until 4/17/17.
-She did not think the facility called the MHP, but rather let the Therapist know about the incident when they came on 4/4/17.

Interview with the Resident Care Coordinator (RCC) on 7/13/17 at 10:00am revealed:
-She had just been made aware of Resident #2 not getting Seroquel when she was agitated.
-The MAs said that the Seroquel helped some, so she did not understand why it had not been given.

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D 273	Continued From page 62 -At the time of the incident with Resident #1 on 4/1/17, she was in the process of getting psychiatric services for Resident #2. -Resident #2 had a lot of medication changes since then and it seemed to be helping because the PCAs could give her a shower now. -The RCC would contact Resident #2's PCP when there was a concern about the resident. Interview with the Administrator on 7/11/17 at 1:34pm revealed: -Resident #2's POA took her to all of her appointments. -Staff were expected to contact the MHP for behavior concerns and if it was to the point of involuntary commitment, staff were expected to contact the Administrator. -She would have to check Resident #2's record regarding contact with the MHP. -Resident #2 had as needed medication available for agitation. 3. Review of Resident #6's current FL-2 dated 5/18/17 revealed diagnoses included Alzheimer's Dementia, Hypertension, Hypothyroidism and history of a Cerebral Vascular Accident. Review of a Psychiatric Hospital discharge summary dated 4/19/17 for Resident #6 revealed: -The admission diagnosis was Dementia with Behavior Disturbance. -Resident #6 was discharged to the facility with instructions for caregivers to "call the unit for any questions or concerns 24 hours per day/seven days per week. There will be access to an MD or licensed provider. The caregiver/[resident] advised to call 911 or go to the nearest Emergency Room (ER) for acute decompensation."	D 273		

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Interview with a Medication Aide (MA) on 7/6/17 at 5:50am revealed Resident #6 was violent and would "come at staff." She would "just turn on you" out of nowhere.

Confidential interview with a staff revealed:
-Resident #6 liked to help other residents get up from their wheelchairs and their beds and would become aggressive with staff when they tried to redirect her.
-The resident refused to get up until after 3:00pm and would yell at staff, "get out of my room and turn the light off."
-Resident #6 was "even worse" being aggressive and attacking staff when it was time for her shower.
-The Supervisor and Resident Care Coordinator (RCC) knew "how she (Resident #6) was" and that she would fight staff the "whole time" she being assisted to shower.
-"Everyone in this building was aware of her (Resident #6) behavior."
-Staff felt they did not have a say in how things went at the facility.
-Staff had reported concerns about Resident #6's behavior to the RCC and Business Office Manager just the other day.

Based on observations, interviews and record reviews, Resident #6 was not interviewable due to diagnosis of Dementia.

Telephone interviews with Resident #6's Power of Attorney (POA) on 7/12/17 at 9:36am and 7/13/17 at 5:30pm revealed:
-There was an incident where Resident #6 got into a confrontation with one of the Personal Care Aides (PCAs) and ended up on the floor and having to go the emergency room (ER).
-She knew Resident #6 could be difficult, but also

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D 273	Continued From page 64 knew that some of the staff did not know how to talk to the residents or work with them to get them to be cooperative. -She had not been told at any time that Resident #6 would not take her medications which were supposed to help her. Review of an "Examination or Contact by Physician" sheet for Resident #6 revealed on 6/6/17 the Mental Health Provider (MHP) documented the resident "does have Seroquel as needed if needed, follow up in six to eight weeks unless needed sooner." (Seroquel is an anti-psychotic used to treat psychiatric disorders including schizophrenia, bipolar disorder and major depression.) Review of an "Accident/Injury Report" dated 5/19/17 at 5:30pm for Resident #6 revealed: -Resident #6 was aggressive with staff that were trying to redirect her, and stumbled and fell striking her head on the floor. -There were check marks indicating the incident was witnessed and the resident was not alone. -Resident #6 had a laceration and Resident #6 refused first aid. -There was a check mark indicating Resident #6 was alert and oriented. -Resident #6 had an abrasion of her scalp, a minor head injury without loss of consciousness and needed routine follow up with her Primary Care Provider (PCP). -There was a check mark indicating the resident was not sent to the emergency room. -The POA was notified on 5/19/17 at 5:30pm and a message was left for the PCP on 5/19/17 at 5:45pm. -The report was signed by a PCA and the Administrator.	D 273		

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D 273	Continued From page 65 Review of ER discharge instructions dated 5/19/17 for Resident #6 revealed the resident was seen and treated for an abrasion of the scalp and minor head injury without loss of consciousness. Interview with a second MA on 7/12/17 at 10:55am revealed: -On 5/19/17, Resident #6 had attacked a staff from behind and both the staff and the resident fell backwards with the resident hitting the floor still fighting with staff. -Resident #6 hit her head and was bleeding so staff cleaned the blood off of her head and called 911. -The incident started because Resident #6 was trying to assist another resident and staff tried to redirect her. -Staff notified Resident #6's POA, but did not call the PCP or MHP. -The PCP and MHP were not contacted because the incident happened on a weekend. Review of "Care Notes" dated 4/23/17 through 6/30/17 for Resident #6 revealed: -On 4/23/17 staff documented Resident #6 was very aggressive, attacked an aide with her fist and was kicking and punching staff. -On 4/26/17 staff documented Resident #6 was aggressive after being told not to transfer Resident #1. -On 5/18/17 staff documented Resident #6 was a little aggressive after dinner. -On 5/21/17 staff documented Resident #6 was aggressive later in the evening. -On 5/31/17 staff documented Resident #6 was agitated after dinner and was given an as needed medication. -On 6/9/17 staff documented Resident #6 was very aggressive in the evening. -On 6/12/17 staff documented Resident #6 was	D 273		

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D 273	Continued From page 66 sent to the ER due to abnormal lab results. Review of ER discharge instructions dated 6/12/17 for Resident #6 revealed: -Resident #6 was seen and treated for Dementia and a Urinary Tract Infection (UTI). -There was documentation under additional instructions, "Discussed with [POA] that she must take the patient to follow up with a psychiatrist to begin further weaning off of Depakote." Review of an "Addendum to Orders" dated 6/16/17 for Resident #6 revealed: -The MHP documented that Resident #6 would require updated labs to ensure her UTI had resolved in addition to checking other indices that were abnormal last week (to include ammonia). -There was documentation from the MHP to "ensure if [name of Resident #6] becomes agitated/aggressive, she is given Seroquel 25mg one tab; this can be repeated every four hours in addition to the two tabs at bedtime for sleep. Please report to our office if [name of Resident #6] mood/behaviors and meal consumption decreases." Review of Resident #6's electronic Medication Administration Record (eMAR) for April 2017 revealed there was no entry for Seroquel 25mg every four to six hours as needed. Review of Resident #6's May 2017 eMAR revealed: -There was an entry for Seroquel 25mg every six hours as needed for agitation. -There was documentation Seroquel had been administered on 5/25/17 at 5:33pm and 5/31/17 at 5:34pm. Review of Resident #6's June 2017 eMAR	D 273		

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revealed:
-There was an entry for Seroquel 25mg every six hours as needed for agitation.
-There was documentation Seroquel had been administered on 6/12/17 at 3:38pm and 6/14/17 at 5:33pm.

Review of Resident #6's July 2017 eMAR revealed:
-There was an entry for Seroquel 25mg every six hours as needed for agitation.
-There was documentation Seroquel had been administered on 7/11/17 at 7:44pm.

Interview with a third MA on 7/10/17 at 7:10pm revealed:
-Resident #6 would tend to physically harm staff but not residents.
-Resident #6 had grabbed one resident the other day, but did not hurt her.
-Resident #6 would get an as needed medication when she was agitated, but it did not work. "It was like candy to her."
-She would contact Resident #6's family member and tell her to make sure she talked to the doctor about the right medication to calm Resident #6 down.
-The family member would tell her they knew, they were working on it and to give Resident #6 her Seroquel.

Interviews with the RCC on 7/10/17 at 4:57pm and 7/13/17 at 10:00am revealed:
-Resident #6 was seen by a local MHP that the resident's family member brought her to.
-The family member decided when to bring Resident #6 to the MHP.
-If Resident #6 was having aggression and/or agitation, staff would give her an as needed medication.

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D 273	Continued From page 68 -If the medication did not work then the MA or the RCC would contact the MHP. -She thought she had documented once in the care notes that she had contacted the MHP for Resident #6's behavior. -She had just been made aware of Resident #6 not getting Seroquel when she was agitated. -The MAs said that the Seroquel helped some, so she did not understand why it had not been given. Interview with Resident #6's PCP on 7/6/17 at 11:06am revealed the resident's family member had reported Resident #6's aggressive behaviors and a mental health referral should have been made, but she could not see in her notes where that had been done. Telephone interview with Resident #6's MHP on 7/12/17 at 5:22pm revealed: -The facility had never contacted the MHP about Resident #6. -The resident's POA was the only person who contacted the MHP and brought the resident to all of her appointments. Interview with a PCA on 7/10/17 at 10:37am revealed: -When PCAs were concerned that a resident was not themselves or feeling ill, they were supposed to report it to the Supervisor on duty. -The Supervisor would then check the resident and maybe have the resident see the house doctor on Thursdays or send the resident out to the hospital. Interview with a fourth MA on 7/13/17 at 9:37am revealed: -When there was concern about a resident being sick or not acting right, the MAs called the family not the doctor.	D 273		

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-If a resident was really sick, then the MA sent the resident to the hospital.
-Anytime a resident was sent out they had a follow up visit with their PCP.

Telephone interview with a fifth MA on 7/8/17 at 12:20am revealed:
-The MAs were responsible for writing care notes for residents whenever a resident was on antibiotics or for anything that needed to be passed on to the next shift like illness, accidents, incidents or a resident being sent to the hospital.
-Staff had just been instructed on 7/7/17 to contact the PCP for incidents, accidents and illness.

Interview with the RCC on 7/13/17 at 10:00am revealed:
-If a resident was not feeling well or was not acting like themselves the MAs were expected to contact the PCP.
-The RCC would also assist with contacting the PCP.
-The MA or the RCC would then document what happened in the resident care notes.

4. Review of Resident #3's current FL-2 dated 09/01/16 revealed diagnoses included Alzheimer's Dementia, diabetes (unspecified), rectal pain, anemia and hypertension.

Telephone interview with Resident #3's family member on 07/10/17 at 10:56am revealed:
-The family member was concerned about the resident's constant need to urinate beginning in April 2017.
-The family member had asked the Resident Care Coordinator (RCC), at least once every 2 weeks beginning in April 2017, if the resident had been checked for a urinary tract infection (UTI)

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and was told that the resident had been checked and results were negative.
-The family member asked the RCC for an urologist referral approximately 05/04/17 for the resident.
-The RCC told the family member that she would ask the Primary Care Provider (PCP) when she next was in the facility.
-The family member was told by the RCC one week later that the PCP had changed the resident's medication.
-The family member again asked about the urologist referral and the RCC stated that she ask the PCP during the next visit.
-The family member reminded the RCC to speak with the PCP about the referral during the week of 05/21/17.
-The family member also asked to be notified when the PCP was in the facility so she could meet and discuss the resident's condition.
-The RCC stated that she would telephone the family member when the PCP was in the facility.
-When asked about the urologist referral, the RCC told the family member that she (family member) could discuss it with the PCP when they met.
-The family member was not notified when the PCP was in the facility on 05/19/17.
-The family member again asked the RCC about meeting with the PCP and was told that the PCP was going to call the family member after she had discussed the resident's condition with the facility's psychiatric provider.
-The family member asked the RCC about the urologist referral and was told again that she (family member) could discuss it with the PCP when called [after the week of 05/19/17 visit].
-The family member did not receive a telephone call from the PCP.
-The family member called the RCC on the

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morning of 06/01/17 and again asked to be notified when the PCP was at the facility.
-The RCC told the family member that she would telephone with a time that she could meet with the PCP that day.
-The family member did not receive notification that the PCP was at the facility on 06/01/17.
-The family member went to the facility at 4:00pm on 06/01/17 and was told that the RCC had left for the day.

Interview with the RCC on 07/10/17 at 4:58pm revealed that she was working on getting a referral for Resident #3 before she was sent to the hospital "the last time".

Review of the PCP chart note dated 05/19/17 revealed:
-Resident #3 was being seen for diabetes, wound care and blood pressure control.
-Resident #3 would be seen in "1 month" (06/19/17) for follow-up.

Interview with the PCP on 07/06/17 at 11:02am revealed:
-Resident #3 had a history of diabetes, pneumonia, and UTI.
-The PCP had treated the resident in the past for pneumonia and UTI.
-The resident also had pressure sores, and on 05/19/17, when the PCP last saw the resident, she had two pressure sores on the sacral area.
-The PCP did not recall being contacted regarding any issues with Resident #3.
-The PCP did not remember anything about Resident #3 other than what she had treated the resident for in the past.

Review of a Care Note dated 06/06/17 revealed Resident #3 was sent to a local Emergency

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D 273	Continued From page 72 Room and admitted to hospital care on 06/06/17 at 6:30am with nausea and vomiting. Review of a Death Certificate for Resident #3 revealed: -The resident died on 06/08/17. -The cause of death was listed as sepsis, acute renal failure and atrial fibrillation. The facility's failure to contact the primary care provider or mental health provider for the acute health care needs of 4 of 6 residents resulted in Resident #1 not recieving medical treatment for three days following an assault by another resident and was hospitalized for cerebral vascular accident; Resident #3 not having a referral to a urologist for symptoms of a urinary tract infection as requested by a family member; and Resident #2 and #6 not receiving care from the primary care provider or mental health provider following agressive behaviors toward other residents. This failure resulted in serious physical harm and neglect to the residents and constitutes a Type A2 Violation. Review of a Plan of Protection dated 07/10/17 revealed: -Starting immediately, all staff will be instructed on the procedure to follow if a resident has an injury requiring more than first aid or significant change in condition. -Staff will be instructed to first call 911, the resident's doctor and then family or responsible party. -A Behavior Mood form will be implemented to track residents with aggressive behaviors and a 24 hour Communication Log for significant changes. -The Care Manager will monitor the Behavior Mood forms and 24 hour Communication Log	D 273		

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D 273	Continued From page 73 daily. -All staff will receive training on Resident Right's. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 13, 2017.	D 273		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to report one incident of a resident (#2) assaulting another resident (#1) to the Mental Health Provider in a timely manner for	D 456		

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D 456	Continued From page 74 Resident #2 who had aggressive behaviors; and seek emergency medical treatment for Resident #1 who was injured. The findings are: Interview with a Medication Aide (MA) on 7/10/17 at 1:53pm revealed: -The morning of 4/1/17 at breakfast time, Resident #1 walked by the medication room and said she had an upset stomach and did not want to eat breakfast. -She sat Resident #1 on a sofa in the common area closest to the women's hall and went back to the medication room. -When she came out of the medication room she saw Resident #2 had sat down next to Resident #1 on the sofa and had grabbed her by her shirt with one hand and was punching her repeatedly in her face and on her head. -She went to the residents yelling for help and for Resident #2 to stop. -Personal Care Aides (PCAs) came from the women's hall and the dining room to help get Resident #2 off of Resident #1. -Resident #2 had been known to attack staff before the incident with Resident #1, but not other residents. -The Mental Health Provider (MHP) changed Resident #2's medications after the incident with Resident #1 on 4/1/17. -Normally staff completed the incident report, but the Administrator completed the incident report for Resident #1 and had a PCA to sign it. -The Administrator had asked the MA to sign the incident report, but she refused because what was written on the report was not what happened. -There was no incident report completed for Resident #2.	D 456		

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Based on observations, interviews and record reviews, Resident #2 was not interviewable due to a diagnosis of Dementia.

Telephone interview with Resident #1's Power of Attorney (POA) on 7/6/17 at 10:10am revealed:
-Resident #1 was attacked by another resident 4/1/17 and was not taken to the hospital for three days.
-Resident #2 was a "big woman" and grabbed Resident #1 by her shirt, yanked her and stomped her foot.

Review of an "Accident/Injury Report" for Resident #1 dated 4/1/17 at 8:30am revealed:
-Resident #1 was sitting on the couch with another resident and the resident scratched her on the right side of her nose.
-There were check marks indicating the incident was reported and the resident was not alone.
-Resident #1 had an abrasion and staff applied a cool wash cloth to the scratch.
-There was a check mark indicating Resident #1 was alert and oriented.
-"Resident [#1] was scared at the time it happened, kept her monitored. [POA] did come and visit with her. [POA] stated not to send her to the hospital because she thought she was just scared because of the incident."
-There was a check mark indicating the resident was not sent to the emergency room.
-The POA was notified on 4/1/17 at 8:45am and a message was left for the Primary Care Provider (PCP)on 4/3/17 at 3:00pm.
-The report was signed by a PCA and the Administrator.

Telephone interview with Resident #2's POA on 7/13/17 at 4:57pm revealed:
-She picked Resident #2 up from the facility on

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4/1/17 after she attacked Resident #1 because she wanted to try and help her and get her calm.
-The staff at the facility did not tell her what to do either way.
-She contacted the resident's PCP to get some medication changes to try and help Resident #2.
-Resident #2 saw a psychiatrist after seeing her PCP, but she was still irritable and not being nice to staff so she contacted Resident #2's neurologist because they help people with Alzheimer's.
-She had to help Resident #2 because she was not herself.
-She did not think the staff knew Resident #2 had a neurologist.
-She kept Resident #2 with her for two nights so the other resident could calm down and not be so traumatized.

Confidential interview with a staff revealed:
-The incident report available for the incident that occurred on 4/1/17 with Resident #1 and Resident #2 was not the original incident report.
-The Administrator rewrote the incident report, told the MA to sign it and the MA said no because that was not what happened.
-The PCA that signed the report said she was just doing what she was told to do.

Interview with a PCA on 7/10/17 at 12:57pm revealed:
-PCAs were responsible for reporting incidents and accidents to the MAs.
-PCAs did not fill out incident reports at the facility.
-Only the MAs filled out the incident reports.

Interview with a second MA on 7/10/17 at 7:10pm revealed she only completed incident reports when she sent a resident out to the hospital.

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SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

(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 456	Continued From page 77 Telephone interview with Resident #2's Mental Health Provider (MHP) on 7/13/17 at 11:26am revealed: -She visited Resident #2 for the first at the facility on 3/22/17. -The Therapist had informed her Resident #2 was having issues with aggression on 4/4/17, but she was on vacation and did not receive the message until she returned. -She was not able to see Resident #2 until 4/17/17. -She did not think the facility called the MHP, but rather let the Therapist know about the incident when they came on 4/4/17. Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed: -She communicated this change to all other staff verbally when they came to work and it continued from MA to MA via shift to shift report. -There had not been a formal staff meeting to communicate changes in policy and procedure to staff for approximately six months. -Completed incident reports were faxed to the Department of Social Services. -There was no process of review for incident reports to ensure all information was complete and all notifications were made. Interview with the Administrator on 7/11/17 at 1:34pm revealed: -Staff were expected to complete incident reports after there was an incident or accident involving a resident like a fall. -She did not think an incident report had been completed for Resident #2 attacking Resident #1 on 4/1/17, and she did not know why. -She did not rewrite incident reports; she or the MA on duty may assist staff in completing an	D 456		

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incident report.
-The staff who witnessed the incident or accident was responsible for completing the incident report.
-Once the incident report was completed, it was placed under her door or given to her if she was there.
-Either she or the Business Office Manager signed off on the incident report and then faxed the report to DSS.
-Staff were expected to contact the MHP for behavior concerns and if it was to the point of involuntary commitment, staff were expected to contact the Administrator.
-She would have to check Resident #2's record regarding contact with the MHP.

_____

The facility's failure to report resident to resident assault to the Mental Health Provider in a timely manner for Resident #2 resulted in a delay of treatment for aggressive behaviors which was detrimental to the safety and welfare of the residents which constitutes a Type B Violation.

_____

Review of the Plan of Protection submitted by the facility on 7/14/17 revealed:
-Training will be provided on procedure for accident and incident reporting to responsible staff to include: completion of accident and incident reports, notification of responsible party and/or family member, notification of Primary Care Provider by fax and notification of reportable incidents to the Department of Social Services within 48 hours.
-The resident's Mental Health Provider will be contacted in the event the incident involves assaultive and/or aggressive behaviors.
-The Executive Director will review all accident/incident reports for required

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D 456	Continued From page 79 documentation and notification. -An in-service was conducted on 7/11/17 for staff on accident/incident reporting and in-service will be conducted again on 7/21/17 for staff. -Training will be conducted on accident/incident reporting monthly for three months and new staff will be in-serviced upon hire. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 8/28/17.	D 456		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of residents on 18 of 48 shifts resulting in staff not providing every two hour incontinence care and safety checks for residents and lack of intervention for injuries sustained from a resident to resident assault, illness and falls for 3 of 6 sampled residents (#1, #3 and #5) on 10 of the shifts.	D 465		

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D 465	Continued From page 80 The findings are: Observations on 7/6/17 at 3:45am revealed: -Staff A was asleep on a sheet laid on a sofa in the common area with no shoes on which was visible from the front door of the facility. -At the sound of the doorbell Staff A awoke and came to the front door of the facility. -Staff A's eyes were red when she answered the door. -After viewing identification/credentials, Staff A yelled in the direction of the men's hall and then left and went in the direction of the men's hall without opening the door. -After several minutes, Staff A returned and opened the door. -Staff A had delayed responses to standard questions of staff on duty and number of residents in the facility. -Staff A was disoriented and had delayed physical movements with locating the key and opening the door to the activity room. -A second Personal Care Aide (PCA) was walking from the direction of the women's hall. -The medication room door was open and the room was dark and did not have any lights on. -The Medication Aide (MA) and the third PCA were not immediately located after entrance to the facility. -At approximately 3:54am the MA came from the direction of the men's hall and had red eyes. -At approximately 4:00am Staff B, a PCA, came from the direction of the men's hall. Interview with the MA on 7/6/17 at 4:00am and 5:50am revealed: -She did not know Staff A was asleep on the sofa in the common area. -Staff A was on medications that made her feel tired and she would doze off sometimes.	D 465		

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-She did not have a response for the actions of placing a sheet on the sofa and removing shoes appearing as a plan to take a nap.
-The Administrator was aware that Staff A would doze off "every now and then" at work and "was on her [Staff A]" about that.
-The 3rd shift had been short staffed for a while.

Interview with the PCA on 7/6/17 at 4:45am revealed:
-At 3:45am on 7/6/17, the MA was in the medication room, Staff B was on the men's hall and the PCA was on the women's hall.
-She did not know what the MA or Staff B was doing, or that Staff A was asleep on the sofa in the common area.
-She had started working in the facility on 6/21/17 so she did not really know if Staff A had slept while at work before.
-She did not know how long the MA was in the medication room.

Interview with Staff A on 7/6/17 at 4:54am revealed:
-She had worked at the facility for six years as a PCA with the last year on 3rd shift.
-She worked 3rd shift because it was less strenouous.
-She worked as a home health aide during the day.
-She had health issues that made her feel drowsy at times and sometimes she would doze off at work.
-She denied sleeping heavily on the sofa on 7/6/17 at 3:45am.
-The MA was aware that Staff A would feel sick sometimes which made Staff A sleepy.
-The other PCA usually woke her up if she dozed off.
-There had been a night before 6/21/17, when

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she worked with just herself and the MA because the second PCA did not come in.
-She had worked in the facility with just two staff on duty several times in the last few months.

Interview with Staff B on 7/6/17 at 5:18am revealed:
-He worked at the facility for approximately one year.
-He had a full time day job as a custodian.
-The 3rd shift staff were prone to getting drowsy.
-"I'm like a zombie."
-It was not easy to stay awake all night so he would catch himself dozing off and get up and walk around.
-He had not noticed any staff putting sheets down, "kicking off" their shoes and going to sleep.
-He stayed on the men's hall so he was not aware of what the other staff on duty were doing.

Confidential interview with a staff revealed:
-Two different PCAs reported Staff D was sleeping while on duty on 3rd shift.
-Staff D was a PCA and worked as a dietary aide during the day.
-A third PCA complained the medication room door would always be locked and the MA would be in the medication room "probably sleeping."
-The Administrator knew about the complaints because staff told her three to four weeks ago.
-No one was ever spoken to about sleeping on 3rd shift while on duty by the Administrator.
-The Administrator was afraid to lose staff, so she never said anything to them about sleeping while on duty, coming late for work and calling out at the last minute.

Observation on 7/10/17 at 6:55pm revealed:
-There were 23 residents in the common area with one PCA sitting and using her cell phone on

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the side of the common area enclosed by a brick partitioning wall approximately three feet in height.
-The PCA could not see all of the residents sitting in the hallway in front of the dining room or the resident sitting in the common area on the men's hall side that also had the brick partitioning wall.
-Only ten residents were visible to the PCA's location.

Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed:
-She had not been in the practice of spot checking staff performing their duties on 3rd shift.
-She and the Business Office Manager (BOM) had been planning to start doing shift rounds to check on staff.

Interview with the Business Office Manager (BOM) on 7/7/17 at 12:37pm revealed:
-She was not aware of any previous concerns about Staff A or 3rd shift staff in general sleeping while on duty for 3rd shift.
-She was aware of all shifts reporting late for work.
-Staff was expected to remain on duty until the next shift arrived to work.
-She was not aware of health issues that would make Staff A tired at work.
-The MA on duty was responsible for supervising staff on duty and to report any concerns about staff performance to the RCC.
-There RCC did not routinely observe 3rd shift staff perform duties.
-The RCC reported staff concerns to the Administrator or the BOM in the absence of the Administrator.
-The BOM reported issues and concerns to the Regional Director in the absence of the Administrator.

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D 465	Continued From page 84 Interview with Clinical Specialist on 7/7/17 at 12:37pm revealed Staff A was no longer working at the facility as of 7/7/17. Interview with the Administrator on 7/11/17 at 1:34pm revealed she was not aware staff had been sleeping on 3rd shift or any previous reports of Staff A specifically sleeping on 3rd shift. Confidential interview with a staff revealed the facility was short staffed frequently because there were a lot of call ins and there was not always coverage to replace the staff that called in. Review of staff time cards and the facility census for 4/1/17, 4/2/17 and 4/11/17 revealed: -The census documented there were 44 residents in the facility on 4/1/17, 4/2/17 and 4/11/17 which required 44 aide hours for 1st and 2nd shift, and 35.2 aide hours for 3rd shift. -The staff time cards documented 36 aide hours for 2nd shift on 4/1/17 leaving the facility short 8 aide hours. -The staff time cards documented 36.67 aide hours for 1st shift on 4/2/17 leaving the facility short 7.33 aide hours. -The staff time cards documented 30 aide hours for 2nd shift on 4/2/17 leaving the facility short 14 aide hours. -The staff time cards documented 27.98 aide hours for 3rd shift on 4/2/17 leaving the facility short 7.22 aide hours. Review of staff time cards and the facility census for 4/21/17 and 4/22/17 revealed: -The census documented there were 45 residents in the facility on 4/21/17 and 4/22/17 which required 45 aide hours for 1st and 2nd shift, and 36 aide hours for 3rd shift.	D 465		

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D 465	Continued From page 85 -The staff time cards documented 36.13 aide hours for 3rd shift on 4/21/17 which included 7.38 hours belonging to Staff A, 7.5 hours belonging to Staff B, 7.5 hours belonging to Staff D and a fourth staff arriving one hour late. -The staff time cards documented 39 aide hours for 1st shift on 4/22/17 leaving the facility short 6 aide hours. -The staff time cards documented 39.75 aide hours for 2nd shift on 4/22/17 leaving the facility short 5.25 aide hours. -The staff time cards documented 37.87 aide hours for 3rd shift on 4/22/17 which included 7.37 hours belonging to Staff A and 7.75 hours belonging to Staff B. Interview with the Business Office Manager on 7/14/17 at 9:20am revealed: -Staff D worked in the kitchen from 6:00am until 6:00pm and then on the floor from 6pm until 8pm on 4/2/17. -She also worked 3rd shift from 10:00pm until 6:00am on 4/21/17. -Staff D actually clocked in at 10:06pm on 4/22/17, but had trouble with clocking out 6:00am. Review of staff time cards and the facility census for 5/6/17 revealed: -The census documented there were 45 residents in the facility on 5/6/17 which required 45 aide hours for 1st and 2nd shift, and 36 aide hours for 3rd shift. -The staff time cards documented 35.75 aide hours for 2nd shift on 5/6/17 leaving the facility short 9.25 aide hours. -The staff time cards documented 38 aide hours for 3rd shift on 5/6/17 which included 7.5 hours belonging to Staff A, 7.5 hours belonging to Staff B and 7.5 hours belonging to Staff D.	D 465		

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D 465	Continued From page 86 Interview with Staff D on 7/12/17 at 1:04pm revealed: -She had called the facility on 5/6/17 and told "the girls" she had just worked 6am to 6pm in the kitchen and she was going to take a nap. -She overslept and did not make it to work until 4:30am, but she thought there were four other staff working. -She could not answer how she was clocked in on the time record for 10:00pm on 5/6/17 because staff clock in using their finger print and she was not at the facility to clock in. -There were times the clock did not accept her finger print and she would have fill out paperwork to account for her hours. Interview with the Resident Care Coordinator (RCC) on 7/10/17 at 4:57pm revealed: -She had arrived at the facility at approximately 8am on 5/7/17 and Resident #1 was dead. -"It looked like she had been dead for a long time" because she was already stiff and blue around the mouth. -She had talked to staff and all staff reported Resident #1 was alive when they last saw her. -She did not know which PCA was assigned to care for Resident #1 for 3rd shift on 5/6/17. -She did know that Staff A, Staff B, Staff C and Staff D were working for 3rd shift on 5/6/17. -Staff D did not arrive to work until 3am because she had worked from 6:00am until 6:00pm on 5/6/17 in the kitchen, went home to take a nap and overslept. -She was not notified that Staff D was not present for work at 10:00pm on 5/6/17. -The BOM was responsible for the time card records. Interview with the Business Office Manager on 7/14/17 at 9:20am revealed:	D 465		

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D 465	Continued From page 87 -There was a note in the time clock system that Staff D forgot to clock in for 3rd shift on 5/6/17. -When an employee could not clock in using their fingertip or forgot, they were supposed to fill out a form and then a note was put in the computerized time clock system. Review of staff time cards and the facility census for 5/20/17 through 5/24/17 revealed: -The census documented there were 44 residents in the facility on 5/20/17 through 5/22/17 which required 44 aide hours for 1st and 2nd shift, and 35.2 aide hours for 3rd shift. -The staff time cards documented 38.75 aide hours for 2nd shift on 5/20/17 leaving the facility short 5.25 aide hours. -The staff time cards documented 28.48 aide hours for 3rd shift on 5/20/17 leaving the facility short 6.72 aide hours. -Staff hours for 3rd shift on 5/20/17 included 5.25 hours for Staff A, who was one hour and 40 minutes late and 7.5 hours for Staff B. -The staff time cards documented 29.18 aide hours for 3rd shift on 5/21/17 leaving the facility 6.02 aide hours short. -Staff hours for 3rd shift on 5/21/17 included 8 hours belonging to Staff A and 7.23 hours belonging to Staff B. -Staff time cards for 5/21/17 documented Staff D punched in at 10:27pm and punched out at 11:21pm. -The staff time cards documented 30.37 aide hours for 3rd shift on 5/22/17 leaving the facility short 4.83 aide hours. -The staff time cards documented 29.25 aide hours for 3rd shift on 5/23/17 leaving the facility short 5.95 aide hours. -The staff time cards documented 37.23 aide hours for 1st shift on 5/24/17 leaving the facility short 6.77 aide hours.	D 465		

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D 465	Continued From page 88 Review of staff time cards and the facility census for 6/1/17, 6/2/17, 6/5/17, 6/11/17 and 6/12/17 revealed: -The census documented there were 44 residents in the facility on 6/1/17 which required 44 aide hours for 1st and 2nd shift, and 35.2 aide hours for 3rd shift. -The staff time cards documented 31.73 aide hours for 2nd shift on 6/1/17 leaving the facility short 12.27 aide hours. -The census documented there were 42 residents in the facility on 6/11/17 and 6/12/17 which required 42 aide hours for 1st and 2nd shift, and 33.6 aide hours for 3rd shift. -The staff time cards documented 19.25 aide hours for 3rd shift on 6/11/17 leaving the facility short 15.15 aide hours. -The staff time cards documented 39.23 aide hours for 2nd shift on 6/12/17 leaving the facility short 2.77 aide hours. -The staff time cards documented 22.6 aide hours for 3rd shift on 6/12/17 leaving the facility short 11 aide hours. The facility's failure to assure adequate staffing for 18 shifts resulted in staff failing to respond immediately to a residents death, resident to resident assault with injuries, illness and falls. This failure resulted in serious harm and neglect to Resident #1, Resident #3 and Resident #5 which constitutes a Type A1 Violation. Review of the Plan of Protection submitted by the facility on 7/14/17 revealed: -The facility would immediately review staffing for all shifts to ensure that shifts are staffed according to state guidelines. -The Manager on duty will ensure compliance of policy and procedure are upheld as outlined in the	D 465		

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D 465	Continued From page 89 employee handbook regarding [staff] being present in the community during scheduled shifts. -The Care Manager and Business Office Manager will [be responsible] for reviewing daily schedules for adequate [staff] coverage. -Staff scheduled are not permitted to leave at the end of their shift until their relief has arrived or a Manager has relieved staff of their duties. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 8/13/17.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in	D 468		

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Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure 6 of 6 sampled staff assigned to perform duties in a special care unit (SCU) received 6 hours of orientation training (Staff A, D, E and F) within the first week of employment and 20 hours of training within six months of employment (Staff A, B, C, D, E and F). The findings are:

Review of the facility's license history revealed teh facility has been licensed as a SCU since 03/19/12.

1. Review of Staff A's personnel file revealed:
-Staff A was hired as a Personal Care Aide (PCA) on 04/12/12.
-There was no documentation of SCU training during Staff A's first 6 months of employment.

2. Review of Staff B's personnel file revealed:
-Staff B was hired as a PCA on 07/07/16.
-There was documentation of 11 hours of SCU training dated 07/11/16.
-There was no additional documentation of SCU training.

3. Review of Staff C's personnel file revealed:
-Staff C was hired as a Medication Aide (MA) on

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05/22/15.
-There was 7 hours of SCU training dated 05/23/15.
-There was no additional documentation of SCU training during Staff C's first 6 months of employment.

4. Review of Staff D's personnel file revealed:
-Staff D was hired as a PCA/Dietary staff on 08/28/14.
-There was no documentation of SCU training during Staff D's first 6 months of employment.

5. Review of Staff E's personnel file revealed:
-Staff E was hired as a PCA on 04/14/14.
-There was no documentation of SCU training during Staff E's first 6 months of employment.

6. Review of Staff F's personnel file revealed:
-Staff F was hired as a PCA on 08/12/16.
-There was no documentation of SCU training during Staff F's first 6 months of employment.

Interview with the facility's Supervisor on 07/14/17 revealed:
-She was not aware that Staff A, D, E and F had not received at least 6 hours of SCU orientation training during their first week of employment.
-She was not aware that Staff A, B, C, D, E and F had not completed the required 20 hours of SCU training during their first 6 months of employment.
-The Administrator arranged for new employee training.

Interview with the Regional Director on 07/14/17 at 05:30pm revealed:
-New hires should have completed the required SCU training within their first 6 months of employment.
-All staff files will be audited by the Business

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D 468	Continued From page 92 Office Manager as soon as possible to determine training needs. -Required training for all staff will be scheduled as soon as possible. The facility's failure to assure 4 of 6 staff assigned to perform duties in a SCU received 6 hours of orientation training within the first week of employment and and 6 of 6 staff received 20 hours of training within 6 months of employment resulted in staff who were inadequately trained to provide care and assistance to residents with diagnoses which included dementia and aggressive behaviors. This failure was detrimental to the safety and welfare of all residents, which constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility on 07/17/17 revealed: -All staff will complete at least 6 hours of SCU specific training upon hire. -The remainder of the training hours up to 20 hours, but not limited to 20 hours will be completed within 90 days of employment. -Failure to complete the training will result in being removed from the schedule. -The Executive Director and Business Office Manager will monitor and track for compliance. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 8/28/17.	D 468		
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	D912		

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D912	Continued From page 93 regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to cardio-pulmonary resuscitation training and special care unit orientation and training. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure 35 shifts from 05/03/17 until 07/13/17 were staffed with at least one staff member who had completed a course on Cardiopulmonary Resuscitation (CPR) and choking management within the last 24 months. [Refer to Tag D0167 10A NCAC 13F .0507 Training on Cardiopulmonary Resuscitation (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure 6 of 6 sampled staff assigned to perform duties in a special care unit (SCU) received 6 hours of orientation training (Staff A, D, E and F) within the first week of employment and 20 hours of training within six months of employment (Staff A, B, C, D, E and F). [Refer to Tag D0468 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D914		

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D914	Continued From page 94	D914		

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 personal care, supervision, health care, incident and accident reporting and special care unit staffing.

The findings are:

1. Based on observations, interviews and record reviews, the facility failed to provide safety and incontinence care checks every two hours for 3 of 6 sampled residents (#1, #3 and #5) which resulted in Resident #1's death being unnoticed by staff until full mortis was set, Resident #5 being hospitalized with sepsis and Resident #3 sustaining skin breakdown. [Refer to Tag D0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to provided supervision for 2 of 6 sampled residents (#1 and #3) according to the needs of the residents which resulted in Resident #1 and #3 sustaining bruises secondary to falls; and failed to provide supervision of up to 23 residents at a time kept throughout the day in the common area. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].

3. Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for the acute needs of 4 of 6 sampled residents (#1, #2, #3, and #6) resulting in Resident #1 not having medical treatment for

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D914	Continued From page 95 three days following an assault by another resident and being hospitalized; Resident #2 and #6 having aggressive behaviors toward staff and other residents which were not communicated to the Primary Care Physician or Mental Health Provider by staff; and Resident #3 not having a referral to a urologist for symptoms of a urinary tract infection. [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type A2 Vilolation)]. 4. Based on observations, interviews and record reviews, the facility failed to report one incident of a resident (#2) assaulting another resident (#1) to the Mental Health Provider in a timely manner for Resident #2 who had aggressive behaviors; and seek emergency medical treatment for Resident #1 who was injured. [Refer to Tag D0456 10A NCAC 13F .1212(g) Reporting of Accidents and Incidents (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of residents on 18 of 48 shifts resulting in staff not providing every two hour incontinence care and safety checks for residents and lack of intervention for injuries sustained from a resident to resident assault, illness and falls for 3 of 6 sampled residents (#1, #3 and #5) on 10 of the shifts. [Refer to Tag D0465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate	D980		

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D980	Continued From page 96 training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure consistent responsibility for the operation, administration, management and supervision of the facility under the implementation of all residents' rights which resulted in significant noncompliance with state rules and regulations related to personal care, supervision, health care, reporting accidents and incidents, special care unit staffing, housekeeping and furnishings, test for tuberculosis, training on cardiopulmonary resuscitation and special care unit staff orientation and training. The findings are: Interview with a Medication Aide (MA) on 7/6/17 at 4:40am revealed: -She was unable to reach the Administrator who had only been at the facility two days a week related to health issues for two to three months. -She was able to contact the Resident Care Coordinator (RCC) and the Business Office Manager (BOM). -The facility had announced there would be a new Administrator last week (6/29/17). Interview with a Personal Care Aide (PCA) on 7/6/17 at 5:18am revealed he reported any concerns to the Supervisor on duty or the BOM. Interview with the BOM on 7/7/17 at 12:37pm revealed: -The MA on duty was responsible for supervising staff on duty and to report any concerns about	D980		

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staff performance to the RCC.
-The RCC reported staff concerns to the Administrator or the BOM in the absence of the Administrator.
-The BOM reported issues and concerns to the Regional Director in the absence of the Administrator.

Confidential interview with a concerned citizen revealed:
-The Administrator had not been to the facility in more than a month (since approximately May 2017).
-The staff would sit and text on their phones while assisting residents with eating their meals. She would ask the Supervisors to address this issue with the PCAs, and the Supervisors would say they did not want to make the PCAs mad.
-The Supervisor should make the PCAs do their jobs because that was what they were supposed to be doing.
-The PCAs just "run over them."

Interview with the RCC on 7/10/17 at 4:57pm revealed:
-The BOM had been filling in for the Administrator since May 2017.
-The week of 6/22/17, the Administrator was in the facility for three days because the BOM was on vacation.
-Other than the week of 6/22/17, the Administrator would call, text or "pop up every now and then."

Interview with the BOM on 7/10/17 at 5:55pm revealed:
-She would try to take care of the Administrator's responsibilities the "best she could" when the Administrator was not there.
-If there was something she could not take care

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D980	Continued From page 98	D980		

of, she would text or call the Administrator.
-The Administrator had been on leave since the middle of April 2017, and was only at the facility for approximately half a day once or twice a week.

Interview with the Administrator on 7/11/17 at 1:23pm revealed:
-She had been on medical leave for three months.
-The RCC was in charge and the BOM was under her.
-She was "in and out (of the facility)" for half days a few times each week.
-The RCC and BOM also had the Regional Director if they needed anything.
-The RCC and BOM were responsible for writing up or suspending any staff for any problems.
-If one shift was complaining about the previous shift, she would talk to that staff and write the staff up.
-She was not aware of any recent complaints about previous shifts not doing their work and leaving residents wet.

Interview with the Regional Director on 7/7/17 at 12:37pm revealed:
-He was not aware the Administrator had only been available in the facility for one to two half days per week for two to three months as reported by staff.
-He normally visited facilities he was responsible for every month, but 7/7/17 was actually his first visit to the facility since he became responsible for the facility in April 2017.
-He was not previously aware of the concerns identified 7/6/17 and 7/7/17 related to staff being available and present for work, personal care for residents and housekeeping.

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D980	Continued From page 99 Noncompliance in the following rule areas was identified during the survey. 1. Based on observations, interviews and record reviews, the facility failed to provide safety and incontinence care checks every two hours for 3 of 6 sampled residents (#1, #3 and #5) which resulted in Resident #1's death being unnoticed by staff until full mortis was set, Resident #5 being hospitalized with sepsis and Resident #3 sustaining skin breakdown. [Refer to Tag D 0269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provided supervision for 2 of 6 sampled residents (#1 and #3) according to the needs of the residents which resulted in Resident #1 and #3 sustaining bruises secondary to falls; and failed to provide supervision of up to 23 residents at a time kept throughout the day in the common area. [Refer to Tag D 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for the acute needs of 4 of 6 sampled residents (#1, #2, #3, and #6) resulting in Resident #1 not having medical treatment for three days following an assault by another resident and being hospitalized; Resident #2 and #6 having aggressive behaviors toward staff and other residents which were not communicated to the Primary Care Physician or Mental Health Provider by staff; and Resident #3 not having a referral to a urologist for symptoms of a urinary tract infection. [Refer to Tag D 0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D980		

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D980	Continued From page 100 4. Based on observations, interviews and record reviews, the facility failed to assure adequate staffing to meet the needs of residents on 18 of 48 shifts resulting in staff not providing every two hour incontinence care and safety checks for residents and lack of intervention for injuries sustained from a resident to resident assault, illness and falls for 3 of 6 sampled residents (#1, #3 and #5) on 10 of the shifts. [Refer to Tag D 0465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A1 Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to report one incident of a resident (#2) assaulting another resident (#1) to the Mental Health Provider in a timely manner for Resident #2 who had aggressive behaviors; and seek emergency medical treatment for Resident #1 who was injured. [Refer to Tag D 0456 10A NCAC 13F .1212(g) Reporting Accidents and Incidents (Type B Violation)]. 6. Based on observations, interviews and record reviews, the facility failed to assure 35 shifts from 05/03/17 until 07/13/17 were staffed with at least one staff member who had completed a course on Cardiopulmonary Resuscitation (CPR) and choking management within the last 24 months. [Refer to Tag D 0167 10A NCAC 13F .0507 Training on Cardiopulmonary Resuscitation (Type B Violation)]. 7. Based on observations, interviews and record reviews, the facility failed to assure 6 of 6 sampled staff assigned to perform duties in a special care unit (SCU) received 6 hours of orientation training (Staff A, D, E and F) within the first week of employment and 20 hours of training within six months of employment (Staff A, B, C, D, E and F). [Refer to Tag D 0477 10A NCAC 13F	D980		

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D980	Continued From page 101 .1309 Special Care Unit Staff Orientation and Training (Type B Violation)]. 8. Based on observations, interviews and record reviews, the facility failed to assure walls and floors were kept clean and in good repair on the men's hall as evidenced by broken tiles in the common shower room; stained and rotted caulking and tile around toilets in two common bathrooms; a rotted door frame in one common bathroom; broken paper towel and toilet paper holders in two common bathrooms; a broken soap dispenser in one resident room and stains; stains, dirt and grime build up on floors and baseboards in resident rooms, four common bathrooms and the corridor. [Refer to Tag D 0074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings]. 9. Based on observations, interviews and record reviews, the facility failed to assure residents rooms on the men's hall were kept clean and free of hazards as evidenced by a nonworking light fixture in one common bathroom, uncovered hardware for a door stop protruding from the floor next to a hand washing sink in one resident room and boxes of incontinence supplies stored behind doors and in front of hand washing sinks in two resident rooms. [Refer to Tag D 0079 10A NCAC 13F .0306(a) (5) Housekeeping and Furnishings]. 10. Based on record reviews and interviews, the facility failed to assure 1 of 6 staff sampled (Staff F) was tested upon hire for Tuberculosis (TB) disease in compliance with TB control measures adopted by the Commission for Health Services. [Refer to Tag D 0131 10A NCAC 13F .0406(a) Test for Tuberculosis]. The Administrator failed to ensure that the	D980		

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D980	Continued From page 102 management, operations, and policies of the facility were implemented to ensure the services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the Administrator. The Administrator's failure to ensure residents were free of neglect resulted in a resident not receiving medical attention for three days following an assault by another resident, having bruises and being found in full rigor mortis; a second resident having skin breakdown, bruises and multiple falls due to personal care not being provided; a third resident being hospitalized for sepsis despite repeated requests for a urology consult by the family member; and insufficient staffing for multiple shifts when significant incidents occurrred, such as lack of health care referral and follow up, falls and death unnoticed until full rigor mortis was set. Noncompliance was also identified in housekeeping and furnishings, accident and incident reporting, testing for tuberculosis, special unit staff orientation and training, and training on cardio-pulmonary resuscitation. This failure resulted in serious physical harm and serious neglect to Residents #1, #3, #5, and #6, and constitutes a Type A1 Violation. Review of a Plan of Protection dated 07/14/17 revealed: -The current Administrator has resigned. -A veteran Administrator will assume duties of the facility no later than 07/31/17. -A Manager on Dusty assignment will be implemented effective immediately under the direction of the Regional Director of Operations. -The Administrator will assure compliance with all rule areas cited in the Plan of Protections, within	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043024	A. BUILDING: _____ B. WING _____	C 07/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTER'S REST HOME	40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526

(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
D980	Continued From page 103 30 days from 07/14/17. THE DATE OF CORRECTION FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 13, 2017.	D980		