Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036004	A. BUILDING: _____ B. WING _____	R 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted a follow-up survey on June 6 - 8, 2017 with an exit conference via telephone on June 15, 2017.	{D 000}	To be incompliance with the rule the facility will continue to have a full time housekeeper and keep the contracted Maintenace Guy to complete the repairs to assure the building is in good repair (ie.... Bathrooms, ceilings floors and walls. All the repairs will be complete by August 30, 2017	
{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 and interviews, the facility failed to assure walls, ceilings and floors were kept clean and in good repair for 4 of 4 common resident bathrooms, a shared resident bathroom (between rooms #17 and #18) and a resident bedroom (room #18). The findings are: Observation on 6/06/17 between 9:30am and 11:45am of the facility revealed: -Behind the toilet, the men's restroom between rooms #8 and #9, was a puddle of liquid approximately 12 x 12 inches in diameter that had a strong smell of urine. -A second men's restroom had a black and white checkered floor with ceramic tile with multiple cracks one was 12 inches in length by 1 inch in width and a second one 36 inches in length and 1 inch in width. -A combination restroom/shower room had two	{D 074}	The Administrator will review monthly. (JF 8/28/17)	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Blalock Jamerson — TITLE: Administrator — (X6) DATE: 7/19/2017

STATE FORM 6899 TZ8C12 If continuation sheet 1 of 50

Reviewed and accepted with revisions per telephone call with the Administrator on 8/28/17 at 10:44am.
JF 8/28/17

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{D 074}	Continued From page 1 12 x 12 inch tiles missing on the floor to the shower entrance way. -A floor in one of the women's restrooms was spongy at the doorway between the tub and toilet area when walked on and gave approximately 1/2 to 1 inch. -In the bathroom between rooms #18 and #17, the floor covering was coming up at the threshold which was only held down by one screw. -The closet door in room #18 had a broken hasp lock with sharp edges with a lock still in place. -The ceiling in room #18 had chipped paint in one corner approximately 12 x 12 inches in size. Interviews with 5 residents on 6/14/17 revealed: -The bathroom between rooms #8 and #9 always smelled of urine. -The floor in the bathroom / shower room had been "soft for a few months probably from leaking water". -The missing tiles in front of the shower room had been gone for "a while", but could not remember how long. -The housekeeping could be better, "bathrooms could be cleaned better". -"The bathrooms sometimes had bad smells". Interview on 6/08/17 at 2:30pm with a Personal Care Aide (PCA) revealed: -The resident who was previously in room #18 had lost his key and had broken the lock on the closet door to get his belongings out. -She had noticed the missing tiles in the shower room, and had told the administrator but could not give a specific time. Interview on 6/08/17 at 3:00pm with the Administrator revealed: -All floors in the facility were going to be replaced soon, but she could not give an exact date.	{D 074}		

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D 269	Continued From page 3 traumatic brain injury and hyperlipidemia. -Resident #7 was discharged from the hospital 5/31/17. Review of the Resident #7's Resident Register revealed an admission date of 5/31/17. Review of Resident #7's Care Plan dated 5/31/17 revealed: -He required limited assistance with eating, toileting and grooming. -He required extensive assistance with ambulation, bathing and dressing. Observation during walk through on 6/6/17 of Resident #7 at 9:50am revealed: -He was sitting in the living room in a chair and was wearing green hospital scrub bottoms and a blue scrub top. -His teeth were brown and broken off in the front (top and bottom). -He got up and walked down hall using his walker. -He had a strong urine odor and the entire seat of his scrub bottoms was stained and wet. -He was wearing yellow non-skid "fall" socks from the hospital and no shoes. -The bottoms of the socks were black from wearing them without shoes. -He met with the Resident Care Director (RCD) and was taken to see the doctor waiting in the medication room. Interview on 6/7/17 with RCD at 9:55am revealed: -Resident #7 was admitted on 5/31/17. -Resident #7's room was at the end of the hall. -Resident #7 needed to be cleaned and changed. -"I will get someone in a minute to check on him". Observation on 6/6/17 of Resident #7 at 11:44am	D 269	The Facility will make sure that when a new resident is admitted, they will receive care and services which are adequate for each individual. The admin. will document on each Resident during the initial assessment, and that assessment. Each Resident will get a copy of the Residents Rights along with a contact number, if they feel their rights are being violated The PCA will continue do a round change every 2 hours, and check on each	

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{D 074}	Continued From page 2 -The loose floor coverings in the restroom was caused by the threshold not being completely secured down. -The facility did not have a full time maintenance man. -"The facility contracted with a man to do repairs when needed and he came when he could get around to it."	{D 074}	The facility will do an assessment upon entry of the home to schedule bath days and continue to do hourly checks and if a resident is in need of assistance the PCA will assist them immediately. The PCA will continue to document in the PCA log and the RCD will check each log weekly to assure the facility is incompliance. The Log will be kept in the nurses station for Review. This will start as of 7/13/17.	
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 10 sampled residents (Resident #7) who required assistance with bathing and who was wearing the same soiled clothing for 10 days, in accordance with the resident's assessed needs and current symptoms. The findings are: A. Review of Resident #7's FL2 dated 5/31/17 revealed: -Diagnoses included dementia, depression, asthma, diabetes mellitus, hypertension,	D 269		

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D 269	Continued From page 4 revealed: -He was sitting in the living room in a chair. -He was in the same green scrub bottoms and blue scrub top. -The seat of his scrub bottoms was still soiled and wet and still had a strong urine odor. -He was wearing a white hospital bracelet with an admission date of 5/1/17. -His hair was greasy and not combed. -His fingernails were long and had a brown substance under them. -He was wearing broken eye glasses with silk tape securing both arms to the frame. Interview on 6/6/17 with Resident #7 at 11:44am revealed: -He was discharged from the hospital on 5/31/17. -He came here to live instead of going home. -"I have been wearing these (clothes) since I got here". -"I have no clothes to wear" -He had let one of the Personal Care Aides (PCAs) know that he did not have any clothes to wear and had not received anymore. -His glasses have been broken "about a year". -"I can't live on my own" and "I need to be taken care of". -"My brother won't let me live at home". Observation on 6/6/17 of Resident #7's room at 12:00pm revealed: -There were 5 twin beds in the room and only Resident #7's bed was made. -There were 3 armoires in the room and all of them were empty. -There was one dresser in the room and it was empty. -There was a night stand and it was empty. -Under Resident #7's bed was a pair of slip on shoes.	D 269	Resident every hour. If any Resident is found to be aggressive the will be put on the aggressive list, and they will continue to be checked on every 15 min. All the check logs will be kept in the nursing station for Review. The RCD will check all logs weekly to assure they are being completed and sign off to assure the building is incompliance with the Rule. Correction date: 7/13/17 (JF 8/28/17)	

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D 269	Continued From page 5 -There were 2 white hospital bags with Resident #7's papers in them with no clothes observed in the bags. -There was a pair of blue jeans on the floor beside the shoes. -The twin bed belonging to Resident #7 was made with a fitted sheet, blanket and a pillow. Interview on 6/6/17 with Administrator at 12:05pm revealed: -She checked Resident #7. -Resident #7 "is not wet". -"It is grease on his bottom and he has an order for it". Review of Resident #7's physician's orders revealed: -There was no order documented on the FL2 dated 5/31/17 for any type of grease, oil, or ointment. -There was no subsequent order documented in the record for any type of grease, oil, or ointment. Review of Resident #7's June 2017 electronic Medication Administration Record revealed there was no entry for any type of grease, oil, ointment or lotion. Observation on 6/6/17 of Resident #7 at 2:30pm revealed: -He was sitting in the living room in a chair and was still in the same clothes. -He had a strong urine odor. -His appearance remained the same. -The seat of his green scrub bottoms was now covered in a "large brown ring" of what looked to be dried urine. -The right side of his glasses were hanging off of his face and the tape was no longer there.	D 269		

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D 269	Continued From page 6 Observation on 6/6/17 of Resident #7 at 3:50pm revealed: -He was sitting in the living room in a different chair. -His appearance and clothing remained the same. Observation on 6/7/17 of Resident #7 at 8:45am revealed: -He was sitting in the living room. -He was wearing the same clothes as on 6/6/17 for the exception of boxer underwear over the top of the green scrubs. -He was unable to tell me where the underwear came from. -He smelled of urine. -His glasses were taped on both sides. -His hair was greasy and not combed. Interview on 6/7/17 with RCD at 8:50am revealed: -Resident #7 "is having his shower today". -"All of his (Resident #7) clothes are downstairs". -Resident #7's clothes were in the laundry. Interview on 6/7/17 with Resident #7 at 9:00am revealed: -A PCA was going to give him a shower this morning. -The clothes he was wearing were the only clothes he had. -A PCA told him she would get him some more clothes. Interview on 6/7/17 with a PCA at 9:15am revealed: -Resident #7 "came here without clothes". -The facility had extra clothes in the basement and if there were not any that fit a resident they would get some from a "clothes closet" at a church.	D 269		

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D 269	Continued From page 7 -Clothing was also donated. -"I am giving him his shower now". -She was unable to tell me why Resident #7 had not had a shower since admission to the facility. Observation on 6/7/17 of resident #7's bottom and groin at 9:18am revealed bottom was red and both groin areas red without any open areas. Interview on 6/7/17 with the Administrator at 9:20am revealed: -She notified Resident #7's family to bring more clothes. -The facility would get clothes from the clothes closet at a local church. -The clothes closet was open on Tuesdays. -Resident #7 only had a yellow outfit from the hospital. -Resident #7's brother was supposed to bring him clothes. -Resident #7's glasses were broken and Resident #7 needed to be on a list to see an optometrist. -The doctor would see him and assess the need for incontinent supplies. -It was her expectation that all residents that come to the facility without clothes would be provided some until other arrangements were made. -She was unable to answer why extra clothes were not provided for Resident #7. Observation on 6/7/17 of Resident #7 at 10:05am revealed: -He was walking down the hallway and was wearing a different set of clothes. -His hair was combed. -He was wearing blue pair of non-skid socks and no shoes. Interview on 6/7/17 with another PCA at 10:20am	D 269		

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D 269	Continued From page 8 revealed: -She gave the baths on first shift. -Resident #7 "has not had a bath since he has been here". -"I just ask the residents if they want a bath." -She was not aware of a bathing log or schedule that kept track of who gets a bath and when. -Resident #7 "does not have clothes, we put them (scrubs) back on everyday". Telephone Interview on 6/9/17 with Resident #7's family member at 10:20am revealed: -Resident #7 was admitted to the facility on 5/31/17 from the hospital. -The facility did not notify him of Resident #7 not having clothes. -It was his expectation the facility provide the daily care for Resident #7 such as food, showers, medications and any assistance needed in getting dressed. -He expected the facility to notify him when Resident #7 needed clothes and personal care supplies. -He was unaware Resident #7 was being neglected. -Resident #7 needed someone to watch after him and help take care of him. -In his opinion, Resident #7 needed to be in a place that was capable of dealing with residents with mental illness. _____ The facility failed to provide personal care to 1 of 10 sampled residents (Resident #7), who had a documented assessed need and history of requiring assistance with toileting, grooming, bathing and dressing. The facility's failure to assist Resident #7 with toileting, grooming, bathing and dressing, resulted in impaired skin integrity and neglect. This noncompliance	D 269		

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D 269	Continued From page 9 constitutes a TYPE A2 Violation. ~~The facility failed to provide a plan of protection.~~ Amended A plan of protection was requested from facility on July 14th CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 15, 2017.	D 269	The facility will continue to monitor all residents and if any Resident is a threat to themselves or others, or states self harm the facility will follow the policy and procedure of the facility. (Refer to Plan of Protection pg 20 of SOD)	
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 10 sampled residents (Resident #9), who was having suicidal thoughts, in accordance with the resident's assessed needs and current symptoms. The findings are: A. Review of Resident #9's current FL2 dated 1/24/17 revealed diagnoses included type 2 diabetes, hypertension, hyperlipidemia, obesity and hypokalemia. Review of Resident #9's care plan dated 1/31/17 revealed she required minimal assistance with	{D 270}	The facility will monitor daily and correction date: 7/13/17 (JF 8/28/17)	

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{D 270}	Continued From page 10 eating, toileting, ambulation and dressing, and extensive assistance with bathing and grooming. Interview on 6/6/17 with Resident #9 at 9:45am revealed: -"I need to go to the ER, I don't feel good". -She told the Medication Aide (MA), "just a little while ago". Observation on 6/6/17 of Resident #9 at 9:45am revealed: -She was lying at the foot of the bed under the covers. -Her room was cluttered with clothes. -She was fully dressed. Interview on 6/6/17 with the Resident Care Director (RCD) at 9:45am revealed: -Resident #9 says she wants to go to the emergency room (ER) all the time. -"She doesn't feel good" all of the time. -Resident #9 "misses her kids". -"I will get to her later". Observation on 6/6/17 of Resident #9 at 12:00pm revealed she was in pajamas, bedroom shoes, hair not combed, bags under her eyes, not smiling and a flat affect. Interview on 6/6/17 with Resident #9 at 12:00pm revealed: -She was going to "hurt herself". -She "had to go to the hospital". -She had a plan to hurt herself but would not give specifics. -Surveyor reported Resident #9's suicidal threats to the RCD and the Administrator at 12:00pm. Interview on 6/6/17 with the RCD at 12:00pm revealed:	{D 270}		

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{D 270}	Continued From page 11 -Resident #9 always threatened suicide when new people were in the building. -Resident #9 saw the doctor this morning and did not report suicidal thoughts. -She would tend to Resident #9. Interview on 6/6/17 with the Administrator at 12:00pm revealed Resident #9 always presented with complaints of suicide. Interview with Resident #9 on 6/6/17 at 12:55pm revealed: -She continued her complaints of suicidal thoughts. -She stated, "I'm going to hurt myself, I'm suicidal." Interview with the Administrator on 6/6/17 at 12:56pm revealed: -Surveyor reported Resident #9's suicidal threats to the Administrator at 12:56pm. -She stated Resident #9 verbalized self-harm and had suicidal thoughts when new people were there. -Resident #9 was seen by the psychologist this morning. -She was informed by the psychologist that Resident #9 was not having any issues and was "ok". Interview with the RCD on 6/6/17 at 2:15pm revealed: -She checked on Resident #9 after she was notified Resident #9 had verbalized self-harm and suicidal thoughts. -"That's how all these 911 calls happen." -She did not think Resident #9 had any "as needed" medications for anxiety. Interview with the Administrator on 6/6/17 at	{D 270}		

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{D 270}	Continued From page 12 2:15pm revealed after she was notified at 12:55pm that Resident #9 had verbalized self-harm and suicidal thoughts, Resident #9 told the Administrator that she (Resident #9) was not suicidal. Interview with the RCD on 6/6/17 at 3:50pm revealed: -Resident #9 was seen by the psychologist that morning. -Resident #9 did not feel well, so the psychologist obtained orders for labs from the mental health Physician's Assistant (PA). -The facility called 911 "around 1:00pm" after she was notified Resident #9 had verbalized self-harm and suicidal thoughts at 12:00pm and 12:55pm on 6/6/17. Interview on 6/7/17 with the RCD at 8:50am revealed: -Resident was taken to the ER yesterday for a suicide attempt. -Resident #9 "is not on any frequent checks" before or after returning from the hospital. -The facility "used to use the hotbox (frequent checks every 30 minutes for 24 hours, then every 1 hour for 48 hours) but we haven't in awhile." Interview on 6/7/17 with RCD at 10:14am revealed: -Resident #9 "won't be back from the hospital until tomorrow". -No further details were given by the RCD about Resident #9. Telephone interview on 6/7/17 with Resident #9's psychologist's office, medical office assistant (MOA) at 2:30pm revealed: -It was documented Resident #9 verbalized wanting to go to the hospital frequently.	{D 270}		

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{D 270}	Continued From page 13 -There was no documentation of Resident #9 complaining of self-harm or suicidal ideation. -The "first line of defense is to send out" with any complaint of self-harm or suicidal ideation. -It was the expectation to follow any orders to prevent a decline in status, hospitalizations, or possible suicide attempts. -There was no documentation of Resident #9 being sent to the hospital on 6/7/17. Telephone interview on 6/7/17 with Resident #9's Psychologist at 2:40pm revealed: -She was seen on 6/6/17 at 9:40am. -Her complaints were to see her children, she didn't feel good, and did not want to be at the facility. -It was his expectation when resident complained of self-harm, suicidal ideations or homicidal ideations, 911 was to be called and someone was to stay with the resident until Emergency Medical Services (EMS) arrived. -The resident was to be protected until EMS arrived. -"Supervision should be increased and the resident should be watched closely until EMS gets there". -It was the expectation to be sent out for repetitive complaints of depression, increased agitation and crying, and with any thoughts of suicide or homicide. -He was not notified by the facility of Resident #9's self-harm or suicidal ideations. Interview on 6/7/17 with RCD at 2:55pm revealed: -She did not have training related to residents with mental illness. -For suicidal ideations "we must send out immediately" for evaluation. -Resident #9 frequently complained about, "hurting herself, or that she doesn't feel good, and	{D 270}		

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{D 270}	Continued From page 14 she misses her kids all the time". Interview on 6/7/17 with Resident #9 at 3:00pm revealed: -She just returned from the hospital. -She "cut" herself yesterday with a "knife" that she "got from the kitchen" and "no one was in there". -She stated she "wanted to hurt herself" because she "missed her kids". -She gave the knife to the Administrator and the RCD. -The RCD called 911. -"I have had thoughts before of hurting myself". -She had told the staff before of her thoughts of hurting herself and was not sent to the hospital in the past 3 months. -She had called 911 twice recently. -She missed her children and worried about them a lot. -She did not know if her children "are safe or not". -She stated "no one checks on me", and the staff "doesn't care". -She was not aware the staff checked on her more than usual. Observation on 6/7/17 of Resident #9 at 3:00pm revealed: -She pointed to a 2 inch break in the skin on her left forearm that she identified as her "cut" mark. -The wound to the left forearm was closed and healing. -No signs of bleeding, redness or swelling noted. Interview on 6/7/17 with Administrator at 3:30pm revealed: -Resident #9 "wanted to go to the hospital". -She was not aware Resident #9 "cut herself". -She was unaware Resident #9 had a knife. -Resident #9 "was known for saying she needs to	{D 270}		

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{D 270}	Continued From page 15 go to the ER". -Resident #9 "was known for saying, I want to see my kids". -Resident #9 was sent to the ER for suicidal thoughts at least twice in the past, but was not sure how many times total. -The facility sent Resident #9 to the hospital and the hospital would send Resident #9 right back. -Facility policy was to call 911 if the resident communicated suicidal thoughts or homicidal ideation. -The staff was to stay with the resident until EMS arrived. -She was not sure why a staff member did not stay with Resident #9. -The staff was to notify the family and/or responsible person, the physician and the Administrator. -An incident report was to be filled out and a copy was to be sent to the County Department of Social Services. Interview on 6/8/17 with the RCD at 9:00am revealed: -Resident #9 was seen by her psychotherapist on 6/06/17 around 9:00 am. -The dictated notes were printed off by the psychotherapist and put in the med room to be filed. -She did "not read" the notes or talk to the psychotherapist. Interview on 6/8/17 with Dietary Supervisor at 9:50am revealed: -She had worked at the facility for more than 10 years. -She worked from 5:00 am until 2:30 pm on 6/06/17. -There were no knives turned in by anyone on 6/06/17.	{D 270}		

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{D 270}	Continued From page 16 -All knives were visible and available. -The entrance from the dining room to the kitchen was kept open at all times. -"A resident could come into the kitchen and get a knife easily at any time". -Staff were not in the kitchen at all times. Observation on 6/8/17 of the kitchen at 9:50am revealed: -There was an entrance from the dining room that was kept open all day and was not locked. -An assortment of knives were visible and available. Interview on 6/8/17 with a Personal Care Aide (PCA) at 10:00am revealed: -She helped Resident #9 with her shower and her hair. -Resident #9 "gets around by herself". -She was not aware of Resident #9 having suicidal thoughts. -She had not increased supervision on Resident #9 after returning from the hospital. -She checked on all residents every 2 hours. Interview on 6/8/17 with another PCA at 10:00am revealed: -She was not aware of Resident #9 having suicidal thoughts. -She had not increased supervision on Resident #9 after returning from the hospital. -She checked on all residents every 2 hours. Interview on 6/8/17 with Administrator at 4:20pm revealed: -Resident #9 was not on any increased supervision after returning from the hospital. -Resident #9 has not been on any increased supervision at all. -"We used to use the hotbox" (where the	{D 270}		

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{D 270}	Continued From page 17 residents record would sit in a special "hotbox" and frequent checks were every 30 minutes for 24 hours then every 1 hour for 48 hours). -The only policy for a resident that came back from the hospital and or needing increased supervision was to use the "hotbox" method. -"I guess we will go back to using the hotbox". Review of Resident #9's hospital admission notes dated 6/6/17 to 6/7/17 revealed: -Resident #9 arrived to the ER via ambulance on 6/6/17 at 2:12pm. -The documented chief complaint was worsening suicidal ideations that began the morning of 6/6/17. -The facility staff had reported Resident #9 was trying to cut herself. -Psychiatric/Behavioral documented by the ER physician, as positive for suicidal ideas and negative for confusion. -A physical exam documented Resident #9 as being oriented to person, place and time and no rash noted. -A diagnosis documented as moderate episode of recurrent major depressive disorder. -Management of diagnosis documented as "admission for psychiatric floor". -She was admitted to the psychiatric unit on 6/7/17 at 11:47am. -Resident #9's diagnosis upon admission to the psychiatric floor was documented as "depression with a chief complaint of suicidal ideations". -A past psychiatric history documented as, "bipolar disorder, previous suicide attempts, and previous psychiatric admissions". -A psychiatric evaluation documented as completed on Resident #9, with an "outcome of stable, a prognoses as guarded, and recommendations to follow up with psychiatrist within 7 days and to return to the nearest ER if	{D 270}		

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{D 270}	Continued From page 18 symptoms worsen, and a discharge back to facility". Review of a psychologist progress visit notes for Resident #9 dated 6/6/17, 5/30/17, 4/21/17, 4/10/17, and 3/14/17, revealed: -A diagnosis of bipolar disorder. -The chief complaints were documented as "I want to go the hospital", "I want to see my kids", "I got in a fight" "I want to see my babies", "I called the police on my roommate, I am afraid of her", "sadness and anxiety". -Current symptoms on all visits of depression documented as; "sadness, worthlessness and helplessness". -Current symptoms on all visits of anxiety documented as "worry". -Goals were documented as follows; "Staff should report any concerns to the physician, self-soothing techniques, redirect negative cognition's, managing and reducing agitation and stress, improving rapport, and reducing sadness and depressive mood". Review of the Mental Health Physician's Assistant (PA) visit notes for Resident #9 dated 5/10/17, 4/12/17, and 3/15/17, revealed: -A diagnosis of bipolar disorder. -The non-pharmacological management documented as to "redirect (Resident #9) early when signs of aggression and agitation start. Early intervention may help avoid escalation and continue psychotherapy". Review of the facility's Medical Emergency Policy revealed: -When an emergency arises the MA shall evaluate the resident in question. -If the resident was in any type of distress, call 911 before doing anything else.	{D 270}		

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{D 270}	Continued From page 19 -Never leave the resident alone. -An aide may stay with the resident while you go call 911. -Always notify the resident's responsible party about the incident after which the incident/accident report must be filled out and faxed to the Department of Social Services. The facility failed to provide supervision for 1 of 10 sampled residents in accordance with their assessed needs and current symptoms. Resident #9 was having suicidal thoughts and required hospitalization. The failure of the facility to provide supervision in accordance with Resident #9's assessed needs and current symptoms resulted in suicidal ideations, a suicide attempt, and transport to the ER. These failures resulted in substantial risk of serious injury or death of residents and constitutes a Type A2 Violation. The Plan of Protection provided by the facility on 6/6/17 revealed: -Any resident that threatens to hurt themselves or others the facility will contact their mental health provider and send them out for evaluation if needed. -The facility will contact both mental health and medical doctor and follow-up as needed. -The facility will provide supervision for aggressive behaviors when needed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 15, 2017.	{D 270}		

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D 273	Continued From page 20	D 273	At anytime a Doctor schedules a referral order the facility will immediately schedule the appt. If@ anytime the referral can not be made the RCD will contact the Referring doctor and Document the Reasoning to why the appt can not be made. The Documentation Will be kept in each Residents Chart in the nursing station for Review the Administrator Will check each Referral and document in the Residents Chart to assure each	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (Resident #3, and #9). Resident #3 with a referral to psychotherapy and Resident #9 with a referral for Physical therapy (PT) and Occupational therapy (OT). The findings are: A. Review of Resident #3's current FL2 dated 1/6/17 revealed: -A diagnosis of schizophrenia, unspecified. -Medications included Invega 6mg extended release twice daily for 5 days (used to treat schizophrenia), Invega Sustenna 156 mg/ml intramuscular injection for a one time dose on 1/14/17 (used to treat schizophrenia), Invega Sustenna 234 mg/ml intramuscular injection every 3 weeks to begin on 2/4/17, trazodone 100mg at bedtime (used to treat major depression and insomnia), and hydroxyzine 50mg twice daily (used to treat anxiety and insomnia). Review of the Mental Health Provider's Assisted Living Service Request form for Resident #3 dated 12/6/16 revealed:	D 273		

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D 273	Continued From page 21 -Services requested included psychiatry and psychotherapy services. -Reason for requested services included evaluation and management of emotional and behavioral problems and psychotropic medication use. Review of a Primary Care Provider (PCP) visit note dated 12/7/16 revealed an order for Resident #3 to be evaluated by mental health "ASAP." Review of Resident #3's Mental Health Physician's Assistant (PA) visit note dated 12/13/16 revealed a referral to psychotherapy. Interview with the Resident Care Director (RCD) on 6/7/17 at 4:10pm revealed: -Resident #3 had refused psychotherapy services. -There was no documentation of psychotherapy services or documentation of refusals in Resident #3's record. Interview with the Administrator and RCD on 6/8/17 at 10:47am revealed: -Resident #3 had attended Psychosocial Rehabilitation (PSR) day program. -Resident #3 had also participated in Assertive Community Treatment (ACT). -They could not confirm the dates of attendance for PSR or ACT. -They were unable to find documentation of psychotherapy visit notes or documentation of refusal by the resident. Review of emergency services detailed call service reports revealed Resident #3's behaviors were as follows: -On 1/03/17 at 11:49am he was abusive to staff	D 273	referral has been made at the attempt. This will start on 7/13/17 to assure the facility is incompliance. The Administrator will monitor monthly and correction date: 7/13/17 (JF 8/28/17)	

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D 273	Continued From page 22 and other residents and smoked in the facility. -On 1/03/17 at 14:25pm he was to be involuntarily committed due to possible violent behaviors. Review of facility charting notes revealed Resident #3 had the following behaviors from12/31/16 to 1/3/17: -He was loud, very angry, and screamed in his room and in the hallway. -He had delusions, was rude to staff, and continued to smoke in his room. Review of hospital records for Resident #3 dated 1/10/17 revealed: -He was involuntarily committed and admitted to the psychiatric floor from 1/3/17 to 1/10/17. -He was admitted for psychiatric stabilization and medication management. -He had been aggressive and violent towards other residents and staff in the facility. -He had threatened to harm others in the facility. -Resident #3 had a discharge diagnosis of paranoid schizophrenia. -He was to follow-up with Psychiatrist in 7 days and continue outpatient treatment. Review of Resident #3's Mental Health PA visit note dated 1/10/17 revealed: -He had returned to the facility on 1/10/17 from the hospital. -Documentation to continue psychotherapy and supportive care. Review of emergency services detailed call service reports revealed Resident #3's behaviors were as follows: -On 1/21/17 at 9:48pm he was unruly, loud and not listening to staff. -On 1/24/17 at 7:04am he was "causing problems."	D 273		

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D 273	Continued From page 23 -On 1/28/17 at 1:56am he was "causing problems." -On 1/30/17 at 11:35pm he was out of control, ran up and down the halls, yelled, and acted violent. -On 2/03/17 at 9:00pm he was "not leaving other residents alone." -On 2/04/17 at 1:21pm and 3:09pm he was to be picked up for involuntary commitment. Review of facility charting notes revealed Resident #3 had the following behaviors from 1/11/17 to 2/4/17: -He was disrespectful to staff, continued to smoke in his room, had loud outbursts, and bothered other residents. -He cursed and walked into other residents" rooms after being told to stop. -He had gone into other residents' rooms and stolen their belongings. -He threatened to harm another resident and was disruptive and disrespectful to other residents. -He was out of control and was agressive to staff and other residents. Review of hospital records for Resident #3 dated 2/24/17 revealed: -He was involuntarily committed and admitted to the psychiatric floor from 2/4/17 to 2/24/17. -He was admitted for worsening behaviors, psychiatric stabilization and medication management. -He had discharge diagnoses of schizophrenia and acute psychosis. Review of Resident #3's record revealed: -There were no psychotherapy visit notes from 12/13/16 until 2/4/17. -There was no documentation that Resident #3 had refused psychotherapy. -There was no order to discontinue	D 273		

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D 273	Continued From page 24 psychotherapy services. -He had a guardian. Interview with the Administrator on 6/8/17 at 3:25pm revealed Resident #3 told her "he didn't need it (psychotherapy), he wanted to go to Florida." Telephone interview with the Psychologist on 6/9/17 at 10:06am revealed: -"He (Resident #3) was never my client." -He never had psychotherapy visits with Resident #3. Telephone interview with Resident #3's Guardian on 6/9/17 at 3:07pm revealed: -Resident #3 had participated in ACT or PSR from December to February 2017, and at some point had both programs at the same time. -Resident #3 originally had ACT and he refused to see them, then he began going to PSR, and participated in PSR better than ACT. Telephone interview with the Administrator on 6/12/17 at 12:44pm revealed Resident #3: -Had been evaluated by the Mental Health Provider's PA on 12/06/16. -Had also started the "day program" in December 2016. -Could not participate in the ACT team and the day program at the same time. -"Did not do ACT after 12/06/16." Telephone interview with the PSR day program owner on 6/12/17 at 1:20pm and 6/13/17 at 10:23am revealed Resident #3: -Had started PSR around the last week of November 2016. -Had attended PSR again on 12/04/16 and then refused from 12/11/16 to 12/13/16.	D 273		

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D 273	Continued From page 25 -Was discharged from PSR after the 3 refusals and was not their client after 12/13/16. Telephone interview with the Mental Health provider's medical office assistant on 6/13/17 at 12:17pm revealed: -"Refer to psychotherapy" meant the Mental Health provider's Psychologist would evaluate Resident #3 for therapy. -There was no documentation of psychotherapy visits from 12/13/16 to 2/4/17. -There was no documentation that Resident #3 had refused psychotherapy. -The Psychologist would "sometimes" notify the Mental Health PA about psychotherapy refusals, but "he did not always do that." Telephone interview with the Mental Health PA on 6/13/17 at 1:12pm revealed: -The psychotherapy referral was entered as a note for the Psychologist to see Resident #3 for therapy. -She was unaware that there were no psychotherapy visits done from 12/13/16 to 2/4/17. -"If he (Psychologist) said he did not see him (Resident #3), then it wasn't done." -She did not feel the lack of psychotherapy contributed to Resident #3 being involuntarily committed on 1/03/17 and 2/04/17. Refer to interview on 6/08/17 with the Administrator at 9:00am and 10:41am. Refer to interview on 6/8/17 with the RCD at 9:00am and 10:25am. B. Review of Resident #9's current FL2 dated 1/24/17 revealed: -Diagnoses included type 2 diabetes,	D 273		

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D 273	Continued From page 26 hypertension, hyperlipidemia, obesity and hypokalemia. -An order for Physical Therapy (PT) 6 times a week, Range of Motion (ROM) by Occupational therapy (OT) 5 times a week, and Speech Therapy 5 times a week. -Resident #9 documented as semi-ambulatory. -Resident #9 documented as a fall risk. Review of the Resident #9's Resident Register revealed an admission date of 7/29/16. Review of Resident #9's record revealed a signed physician's order dated 2/03/17 for PT/OT evaluate and treat/weakness. Review of Resident #9's Licensed Health Professional Support (LHPS) dated 3/31/17 revealed: -Resident #9 required assistance with transfers. -Resident #9 is semi-ambulatory and considered a fall risk. -Resident #9 required assistance with bathing, dressing and other personal care needs. -LHPS tasks provided for Resident #9 were documented as, PT 6 times a week, ROM 5 times a week, and speech therapy. Review of Mental Health Physician's Assistant (PA) visit notes dated 5/10/17, 4/12/17, and 3/15/17, revealed: -A diagnosis of bipolar disorder. -The non-pharmacological management documented as Resident #9 "is to "participate in physical activity to help with mood, physical-health, and cognitive function. Review of a Psychologist visit notes dated 6/06/17, 5/30/17, 4/21/17, 4/10/17, and 3/14/17, revealed:	D 273		

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D 273	Continued From page 27 -A diagnoses of bipolar disorder. -Goals documented as follows; "Staff should report any concerns to the physician, self-soothing techniques, redirect negative cognitions, managing and reducing agitation and stress, improving rapport, and reducing sadness and depressive mood". Observation on 6/8/17 of Resident #9 walking down hall at 8:45am revealed her walking slow while "scooting" feet as she walked. Interview on 6/8/17 with Resident #9 at 8:45am revealed: -She was not taking PT/OT or speech therapy at this facility. -She took PT/OT and speech therapy at the last facility for stroke and falls. -She was not aware she was supposed to. -She "stumbles a lot". -She complained about being "very weak". -"I sleep a lot because there's nothing to do." -The only exercise she got "is walking up and down the halls" by herself without being prompted. -She would like to go on walks, play games, and watch movies. Interview on 6/8/17 with the Administrator at 9:00am and 10:41am revealed: -She was not aware of the order for PT/OT evaluation and treatment dated 2/03/17. -She was not sure why Resident #9 did not get the PT/OT evaluation and treatment as ordered on 2/03/17. Interview on 6/08/17 with the RCD at 9:00am and 10:25am revealed: -She was not aware Resident #9 was not getting PT/OT or speech therapy.	D 273		

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D 273	Continued From page 28 -She was not aware of the order for PT/OT evaluation and treatment dated 2/3/17. -She "must have missed the order" dated 2/3/17. Telephone Interview on 6/08/17 with the pharmacy at 11:00am revealed: -The pharmacy was given the order dated 2/3/17 for PT/OT evaluation and treatment. -On the order dated 2/03/17, were also medication orders that were processed and placed on the Electronic Medical Record (eMAR). -The pharmacy did not initiate any referral orders for PT/OT to evaluate and treat. -The pharmacy did not put referral orders on the eMAR. Telephone interview on 6/07/17 with Resident #9's Primary Care provider's (PCP) office at 2:30pm revealed: -The order for PT/OT was to re-evaluate Resident #9's weakness and the need for more PT/OT. -Resident #9 was still considered a fall risk as documented on her FL2 dated 1/24/17. -The PCP expected the facility staff to follow the orders to prevent a decline in Resident #9's status and hospitalizations and with the depression. Telephone interview on 6/08/17 with Home Health at 10:05am revealed: -Resident #9 was admitted to home health on 2/19/17 for medication injections. -She was not aware of the PT/OT order to evaluate and treat dated 2/13/17. -She had a copy of the FL2 dated 1/24/17 but asked facility for the order to be faxed over from the physician with a reason or diagnose attached to complete the order and she made the facility aware. -Any orders were to be faxed over to home health	D 273		

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D 273	Continued From page 29 to be carried out and an order for PT/OT dated 2/13/17 was never faxed over. -She did not receive a call from the facility inquiring about an order for PT/OT dated 2/03/17. -She gave Resident #9 a medication injection once a month and while she was at the facility there were no inquiries about the PT/OT order dated 2/03/17. Refer to interview on 6/08/17 with the Administrator at 9:00am and 10:41am. Refer to interview on 6/08/17 with the RCD at 9:00am and 10:25am. Interview on 6/08/17 with the Administrator at 9:00am and 10:41am revealed: -All orders received, regardless of what's on them, were faxed to the pharmacy by the Resident Care Director (RCD). -The RCD was responsible for contacting all referrals needed, (ie.home health or psychotherapy) and should have contacted the appropriate agency. -The RCD was responsible for any and all clarifications on the orders, and should have contacted the physician for the clarification. Interview on 6/08/17 with the RCD at 9:00am and 10:25am revealed: -She received all new orders and per policy all orders must be faxed to the pharmacy regardless of what's on them. -She was responsible for faxing all orders to the pharmacy. -She was responsible for contacting home health and any other agency needed for any and all referrals on the orders.	D 273		

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D 273	Continued From page 30 The facility failed to assure referral and follow-up to meet the acute health care needs of Resident #3 with a diagnosis of schizophrenia, unspecified with a referral for psychotherapy services and Resident #9 with diagnoses of type 2 diabetes, hypertension, hyperlipidemia, obesity and hypokalemia with an order for PT/OT/ST. The failure to ensure psychotherapy visits were done resulted in the risk of continued behaviors for Resident #3. The failure to ensure physical therapy and occupational therapy orders were initiated resulted in high risk of falls, and risk for continued weakness for Resident #9. These failures were detrimental to the health and safety of the affected residents and constitutes a Type B Violation. --- The Plan of Protection provided by the facility on 6/08/17 revealed: -The facility will make sure that when a resident is seen by the doctor or returns from the hospital the RCD will read over the chart for any referrals or needed appointments, and the RCD will schedule. -This will be done every time someone is seen by the Doctor or therapist. -The RCD will audit each shift to make sure no one has been sent out or seen by a doctor. -All orders will not be filed until they are complete. -The Director (Administrator) will keep a census of all hospital and doctor appointments and follow-up with the RCD at the end of each week to assure no referrals or orders have been missed. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 30, 2017.	D 273		

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D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility. The findings are: Review of the facility's resident roster revealed a current census of 28. Observation on 6/06/17 at 9:45am revealed there was not an activity calendar posted.	D 317	The Activities Director will continue to schedule activities in accordance with the needs of each Resident, it will continue to be @ least 14 hrs a week. The director will continue document on each participant in the activity book, the Admin will continue to do a 1x month review for ideas from the Residents, and the book will be kept in the nursing station for Review. The RCD will check the Book weekly to assure the rule is met and the building is in compliance	

Correction date: 7/13/17 (JF 8/28/17)

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D 317	Continued From page 32 Observations on 6/06/17, 6/7/17 and 6/8/17 between 9:00am and 4:30pm revealed no activities being done. Observation on 6/7/17 at 10:30am revealed a June activity calendar posted in the facility. Review of the June 2017 activity calendar posted in the hallway of the facility for the week of 6/5/17 revealed: -The activities scheduled for 6/5/17 were exercise 3-5pm and front porch sitting 6-8pm. -The activities scheduled for 6/6/17 were checkers 6-7pm and movie 7-9pm. -The activities scheduled for 6/7/17 were exercise 4-5pm and checkers 6-7pm. -The activities scheduled for 6/8/17 were nails 4-5pm and arts / crafts 6-8pm. -The activities scheduled for 6/9/17 were exercise 4-5pm and Wal-Mart 1-3pm. -The activity scheduled for 6/10/17 was Church Service 10-11am. Interviews with 9 residents on 6/9/17 revealed: -"We don't do many activities". -"It would be nice to have things to do other than just sit around". -"We used to play bingo once a week, but it has been a while since we played bingo". -"The staff will set out a checker board but not all the pieces are there". -"I just sit around and read, because there is nothing else to do". -"We do go out to the dollar store once a month, but if you don't have money you can't go". -"The only activities people do here is smoke and watch television". -"The television used to watch movies is broken". -"We will watch movies on the regular TV." -"There is a resident who leads the exercises in	D 317		

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D 317	Continued From page 33 the dayroom sometimes." -"There is a church service on Saturday's". Observation on 6/8/17 of the living room at 4:20pm revealed: -There were 2 televisions in the living room. -One television was not working and was connected to a VCR/DVD player. -The other television was working and connected to cable TV. Interview on 6/08/17 with the Administrator at 4:20pm revealed: -"All of our activities are posted on the calendar". -Activities are scheduled later in the day so the residents that go to the day program can participate. -The residents went to the store when they got paid. -She was a certified activity director. -Most of the residents got paid once a month. -Some residents did not get paid. -The residents watched TV, played games and sat outside. -She was not aware that one TV in the living room was not working. -A staff member led the residents in an exercise class in the dayroom every day. -The staff did nails 1-2 times a week. -Some of the residents went to church on Sunday. -A Personal Care Aide (PCA) on 2nd shift made the activity calendar. -The Resident Care Coordinator (RCD) was responsible for initiating the activities. -The Administrator did a 6 month assessment for all activities on each resident. -She was not able to provide the 6 month assessments. -"We do birthday parties with food".	D 317		

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D 317	Continued From page 34 -They had a pizza party on Memorial Day. -She stated that it was difficult for her to get the residents to participate. A. Review of Resident #9's current FL2 dated 1/24/17 revealed diagnoses included type 2 diabetes, hypertension, hyperlipidemia, obesity and hypokalemia. Review of the Resident #9's Resident Register revealed an admission date of 7/29/16. Observation on 6/6/17 of Resident #9 at 9:45am revealed: -Resident #9 was lying at the foot of the bed under the covers. -The room was cluttered with clothes. -Resident #9 was fully dressed. Observation on 6/6/17 of Resident #9 at 12:00pm revealed she was in pajamas, bedroom shoes, hair not combed, bags under her eyes, not smiling and a flat affect. Review of a Psychologist psychotherapy progress visit notes for Resident #9 dated 6/06/17, 5/30/17, 4/21/17, 4/10/17, and 3/14/17 revealed: -A diagnosis of bipolar disorder. -Current symptoms on all visits of depression documented as; "sadness, worthlessness and helplessness". -Current symptoms on all visits of anxiety documented as "worry". -Goals were documented as follows; "Staff should report any concerns to the physician, self-soothing techniques, redirect negative cognitions, managing and reducing agitation and stress, improving rapport, and reducing sadness and depressive mood".	D 317		

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D 317	Continued From page 35 Review of physician visit notes for Resident #9 dated 5/10/17, 4/12/17, and 3/15/17 revealed: -A diagnosis of bipolar disorder. -The non-pharmacological management documented as follows: Resident #9 is to "participate in physical activity to help with mood, physical health, and cognitive function, participation in cognitive leisure activities (i.e. reading, crossword puzzles etc.), which have been shown to help psychiatric symptoms and maintain mental capacity, increasing social interaction to help mood/anxiety and cognition. Review of Resident #9's care plan dated 1/31/17 revealed she requested to be a part of the day program. Interview on 6/08/17 with Resident #9 at 8:45am revealed: -"I sleep a lot" because of nothing to do. -The only exercise she gets "is walking up and down the halls". -She would like to go on walks, play games, and watch movies. -The TV in the living room was "broken a long time ago". Interview on 6/08/17 with the Administrator at 4:20pm revealed: -Resident #9 used to go to the day program when she first got here. -In January 2017 Resident #9 stopped going because she did not "qualify". -Resident #9 "could benefit" by going back on the day program and going out more. -She would see "what she could do" to get her back on that program. -Resident #9 does go to church to eat some Sundays. -Resident #9 "stays in her room mostly.	D 317		

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D 317	Continued From page 36 B. Review of Resident #3's current FL2 dated 1/6/17 revealed: -A diagnosis of schizophrenia, unspecified. -An admission date of 6/17/16. Review of the Mental Health Physician's Assistant (PA) visit notes for Resident #3 dated 12/13/16 and 1/10/17 revealed the non-pharmacological management was documented as follows: -"I encourage this patient to participate in physical activity to help with mood, physical health, and cognitive function". -"I recommend the patient participate in cognitive leisure activities (i.e. reading, crosswords, etc), which have been shown to help psychiatric symptoms and maintain mental capacity." -"I recommend increasing social interaction to help mood/anxiety and cognition. -"Please redirect early when signs of aggression and agitation start. Early intervention may help avoid escalation." -"This will help reduce need for medications." Review of Resident #3's record revealed: -He was involuntarily committed on 1/3/17 to the behavioral health unit. -He was involuntarily committed on 2/4/17 to the behavioral health unit. -His behaviors included communicating threats to staff and residents, smoking in his room, cursing staff and residents, being "out of control", arguing with residents, sneaking into other residents' rooms in the middle of the night, abusive to staff and residents, harassing residents, yelling, running up and down the halls, being "unruly and loud", and failure to follow house rules. -A facility discharge date of 3/2/17. Telephone interview with Resident #3's Guardian	D 317		

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D 317	Continued From page 37 on 6/09/17 at 3:07pm revealed Resident #3 "did not really participate in activities much." Telephone interview with the Mental Health Provider's PA on 6/13/17 at 1:12pm revealed: -The facility "did not provide a lot of activities." -Resident #3 "kept more to himself, he didn't want to participate." The facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility. This resulted in Resident #9 and Resident #3 with physician visit notes which recommended participation in cognitive leisure activities and increased social interactions, to be without the required activities and social interactions. These failures were detrimental to the health, safety and well being of the residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 6/14/17 revealed: -The facility will plan scheduled activities for 14 hours per week and complete a common review every 6 months to incorporate ideas from each resident. -The facility will post a calendar of all scheduled activities on the wall so that all residents can see what is posted with dates and times. -Each 6 months the facility will speak with the current residents and see what ideas they have and incorporate them on the activity board to assure all residents have an input and are participating.	D 317		

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D 317	Continued From page 38 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 30, 2017.	D 317	If @ anytime a Resident or staff call 911 and someone is sent out for evaluation the SIC on the shift will Continue to Document each incident But for All Reports to DSS. the RCD will look over each incident Report and notify the Admin of all the incidents will sign @ the bottom of each Report to Show it was seen and faxed. The Reports will be Kept in the nursing station in the incident/accident book for Review to assure the facility is incompliance.	
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the county department of social services of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 4 of 10 sampled residents (Resident #1, #6, #9 and #10). The findings are: A. Review of Resident #1's current FL2 dated 7/8/16 revealed: -Diagnoses included acute cystitis with hematuria. -Resident #1 was not physically abusive, was not a wanderer, and was not verbally abusive or dangerous to self or others. Review of Resident #1's care plan dated 12/8/16	D 451		

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	HAL036004	A. BUILDING: _____ B. WING _____	R 06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ASSISTED LIVING	721 NORTH MARIETTA STREET GASTONIA, NC 28052

(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 451	Continued From page 39 revealed: -He required limited assistance with eating, toileting, bathing, dressing and grooming. -He required minimal assistance with ambulation. Review of the county emergency services detailed call service reports revealed: -A report dated 10/13/16 at 8:59am related to Resident #1 being assaulted by another resident. -A report dated 10/13/16 9:30am related to Resident #1 needing to go to hospital with a head injury. Further review of Resident #1's record revealed: -He was treated in the emergency room (ER) on 10/13/16 for a minor head injury. Review of the incident and accident reports received by the county department of social services on Resident #9 revealed no incident and accident reports dated 10/13/16. Interview on 6/8/17 with Resident Care Director (RCD) at 2:30pm revealed she was able to locate only 1 incident report for Resident #1 dated 3/18/17 for chest pain. Refer to interview on 6/8/17 with the Administrator at 2:15pm. Refer to interview on 6/8/17 with the RCD at 2:30pm. Refer to the facility's policy on incident reporting. B. Review of Resident #9's current FL2 dated 1/24/17 revealed diagnoses included type 2 diabetes, hypertension, hyperlipidemia, obesity and hypokalemia.	D 451	This will start as of 7/13/17 *(continued) The Administrator will monitor daily and correction date of 7/13/17. (JF 8/28/17)	

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D 451	Continued From page 40 Review of Resident #9's care plan dated 1/31/17 revealed: -She required minimal assistance with eating, toileting, ambulation and dressing. -She required extensive assistance with bathing and grooming. Review of the county emergency services detailed call service reports for Resident #9 revealed a report dated 6/7/17 at 1:00pm related to suicidal ideation. Further review of Resident #9's record revealed she was admitted to the hospital on 6/6/17 to the behavioral health unit. Review of the incident and accident reports received by the county department of social services on Resident #9 revealed no incident and accident report dated 6/7/17. Interview on 6/8/17 with RCD at 2:30pm revealed she was able to locate only 1 incident report for Resident #9 dated 3/13/17 for argument with roommate. Refer to interview on 6/8/17 with the Administrator at 2:15pm. Refer to interview on 6/8/17 with the RCD at 2:30pm. Refer to the facility's policy on incident reporting. C. Review of resident #6's current FL2 dated 1/24/17 revealed diagnoses included bipolar, hypertension, hyperlipidemia and chronic obstruction pulmonary disease. Review of Resident #6's care plan dated 2/20/17	D 451		

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D 451	Continued From page 41 revealed she was independent with ambulation and transfers. She required limited assist with eating, toileting, bathing, dressing and grooming. Review of the county emergency services detailed call service report revealed a report dated 1/31/17 at 4:23pm related to suicide attempt. Continued review of Resident #6's record revealed she went to the emergency room (ER) but was not admitted to the hospital related to the 1/31/17 incident. Review of the incident and accident reports received by the county department of social services on Resident #6 revealed no incident and accident report dated for 1/31/17 at 4:23pm. Refer to interview on 6/8/17 with the Administrator at 2:15pm. Refer to interview on 6/8/17 with the RCD at 2:30pm. Refer to the facility's policy on incident reporting. D. Review of Resident #10's current FL2 dated 4/25/17 revealed diagnoses included anemia, cerebral infraction, chronic kidney disease, diabetes and dry eye syndrome. Review of the county emergency services detailed call service report revealed a report dated 5/17/17 at 10:13 related to a fall. Continued review of resident #10's record revealed she went to the ER on 5/17/17, due to a fall, but was not admitted.	D 451		

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D 451	Continued From page 42 Review of the incident and accident reports received by the county department of social services on Resident #10 revealed no incident and accident report dated 5/7/17. Interview with Resident #10 was attempted on 6/7/17 at 11:10am, but Resident #10 refused to discuss anything. Refer to interview on 6/8/17 with the Administrator at 2:15pm. Refer to interview on 6/8/17 with the RCD at 2:30pm. Refer to the facility's policy on incident reporting. Interview on 6/8/17 with the Administrator at 2:15pm revealed: -Incident report were to be filled out on any resident being sent out of the facility for any reason. -A copy of the incident report filled out is also sent to the county. -The Medication Aide was responsible for filling out any incident reports. -The RCD was responsible for sending a copy to the county. -The RCD was responsible to ensure all incident report were done and complete. -She was responsible for looking at the incident reports once a month to look for trends. Interview on 6/8/17 with the RCD at 2:30pm revealed: -She was responsible for making sure incident reports are done on all resident sent out of the facility. -She made sure the county gets a copy of every	D 451		

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D 451	Continued From page 43 incident report. -The incident reports were filled in the resident's individual record and a copy sent to the county is placed in a notebook in the medication room. She was unable to locate the notebook that contained all of the copies of incident reports sent to the county. The facility's policy on Incident Reporting revealed "in the effort to maintain a safe work environment, incidents/accidents that occur on (name of facility) property must be reported. It is the intent of (name of facility) to minimize accidents injuries and illnesses by correcting identified causes when appropriate and feasible. An accident is an event that causes injury or illness to a person, even minor injuries such as cuts or sprains are considered accidents. If in doubt treat the situation as if it were an accident. An incident is an event that have the potential of causing personal injury. The incident/accident reporting policy requirements apply to all accidents and incidents involving residents living in this facility. The MT/SIC must report all accidents or incidents resulting in injury or illness regardless of severity, occurring during their shift. This needs to be done by filling out an incident/accident report."	D 451		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	{D912}		

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{D912}	Continued From page 44 This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, health care referral and follow-up, activities and implementation. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 10 sampled residents (Resident #9), who was having suicidal thoughts, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (Resident #3, and #9). Resident #3 with a referral to psychotherapy and Resident #9 with a referral for Physical therapy (PT) and Occupational therapy (OT). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care [Type B Violation)]. C. Based on observations, interviews and record reviews, that facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility. [Refer to Tag 315, 10A NCAC 13F .0905 Activities Program (Type B Violation)].	{D912}		

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{D912}	Continued From page 45 D. Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, personal care and supervision, health care, activities, reporting accidents and incidents and neglect. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A2 Violation)].	{D912}	The Admin will make sure that All Residents that are in the facility will Receive the care and services which are adequate for the needs of each Resident (ie.... personal care and supervision, healthcare, activities, total operations of the facility). The management will maintain adequate living arrangements, appropriate supervision and support with the ADL's. The management will oversee all operations in the facility and continue to Report to the Owner of any needed changes to assure the	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation: This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure that all residents were free of neglect related to Personal Care and Supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 10 sampled residents (Resident #7) who required assistance with bathing and who was wearing the same soiled clothing for 10 days, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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D980	Continued From page 46 Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate 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 A2 VIOLATION Based on observations, interviews, and record reviews, the administrator failed to assure the total operation of the facility met and maintained rules related to housekeeping and furnishings, personal care and supervision, health care, activities, reporting accidents and incidents and neglect. Non-compliance identified during the survey included: A. Based on observations and interviews, the facility failed to assure walls, ceilings and floors were kept clean and in good repair for 4 of 4 common resident bathrooms, a shared resident bathroom (between rooms #17 and #18) and a resident bedroom (room #18). [Refer to Tag 74, 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings]. B. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 10 sampled residents (Resident #9), who was having suicidal thoughts, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. C. Based on observations, interviews, and record	D980	The facility is incompliance. any changes or Sanctions will be documented and kept in the Admin office and completed in a timely matter. Correction date: 7/13/17 (JF 8/28/17)	

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D980	Continued From page 47 reviews, the facility failed to assure referral and follow up to meet the routine and acute healthcare needs for 2 of 5 sampled residents (Resident #3, and #9). Resident #3 with a referral to psychotherapy and Resident #9 with a referral for Physical therapy (PT) and Occupational therapy (OT). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care [Type B Violation)]. D. Based on observations, interviews and record reviews, that facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility. [Refer to Tag 315, 10A NCAC 13F .0905 Activities Program (Type B Violation)]. E. Based on interviews and record reviews the facility failed to notify the county department of social services of any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 4 of 10 sampled residents (Resident #1, #6, #9 and #10). [Refer to Tag 451, 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents]. F. Based on observations, interviews, and record review, the facility failed to provide personal care for 1 of 10 sampled residents (Resident #7) who required assistance with bathing and who was wearing the same soiled clothing for 10 days, in accordance with the resident's assessed needs and current symptoms. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)]. Interview on 6/8/17 with the Administrator at 9:00am and 10:41am revealed:	D980		

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D980	Continued From page 48 -All orders received, regardless of what's on them, were faxed to the pharmacy by the Resident Care Director (RCD). -The RCD was responsible for contacting all referrals needed (home health or psychotherapy), and should have contacted the appropriate agency. -The RCD was responsible for any and all clarifications on the orders, and should have contacted the physician for the clarification. Interview on 6/8/17 with the Administrator at 2:15pm revealed: -The RCD was responsible to ensure all incident reports were done and complete. -The RCD was responsible for sending a copy of the incident reports to the county. -She was responsible for looking at the incident reports once a month to look for trends. Interview on 6/8/17 with the Administrator at 4:20pm revealed: -She stated she was the Director of Nursing at the facility. -She was responsible for the total operations of the facility. -When asked if she was also the Administrator she replied, "I am not the Administrator" and requested to see the license. -When shown the license, with her name listed as the Administrator, she replied "I will have to talk to the owner about that". -She was not aware that she was listed as the facility Administrator and also held responsible. -She was a certified activity director. -The RCD was responsible for initiating the activities. _____ Failure of management to provide oversight and	D980		

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D980	Continued From page 49 monitor the facility for all licensure rule areas resulted in failure to assure walls, ceilings and floors were kept clean and in good repair for 4 of 4 common resident bathrooms, 1 shared resident bathroom, and 1 resident bedroom; failure to provide supervision for 1 of 10 sampled residents in accordance with the resident's assessed needs and current symptoms; failure to ensure referral and follow up for 2 of 5 sampled residents, failure to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility; failure to notify the county department of social services of any accident or incident resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 4 of 10 sampled residents; and failure to provide personal care for 1 of 10 sampled residents in accordance with the resident's assessed needs and current symptoms. The failure of management to provide oversight in these areas constitutes a Type A2 Violation. The facility failed to provide a Plan of Protection. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 15, 2017.	D980		

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D980	Continued From page 49 activities. Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in failure to assure walls, ceilings and floors were kept clean and in good repair for 4 of 4 common resident bathrooms, 1 shared resident bathroom, and 1 resident bedroom; failure to provide supervision for 1 of 10 sampled residents in accordance with the resident's assessed needs and current symptoms; failure to ensure referral and follow up for 2 of 5 sampled residents, failure to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility; failure to notify the county department of social services of any accident or incident resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid for 4 of 10 sampled residents; and failure to provide personal care for 1 of 10 sampled residents in accordance with the resident's assessed needs and current symptoms. The failure of management to provide oversight in these areas constitutes a Type A2 Violation. The facility failed to provide a plan of protection as of the mailing of the initial Statement of Deficiencies on July 7, 2017. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 15, 2017.	D980		