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AUG - 9 2017

Division of Health Service Regulation

PRINTED: 07/25/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: ______ B. WING ______	06/23/2017

NAME OF PROVIDER OR SUPPLIER: ALZHEIMER'S RELATED CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 217 JONESBORO ROAD, DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 6/14/17 - 6/16/17 and 6/19/17 - 6/23/17.	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 and interviews, the facility failed to assure walls, ceilings and floors were kept clean and in good repair as evidenced by holes in the walls of four resident rooms, the hallway and beauty salon on the men's hall; wet marks and peeling paint on the ceilings in two common bathrooms; dirt/grime buildup and stains on the floors in three common bathrooms, two resident rooms and the beauty salon on the men's hall; and gouges and marks on the walls and dust in the vents in the resident exam room near the men's hall. The findings are: Observations of the men's hall on 6/14/17 from 9:37 a.m. until 10:46 a.m. revealed: -There were urine stains around the base of the toilet in the bathroom inside resident room #A8. -There was an unpainted patch mark over a hole in the wall by the bathroom door in resident room	D 074		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ronald [signature]

TITLE: Manager

(X6) DATE: 8/8/17

STATE FORM

8/18/17 Reviewed & accepted [initials]

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ID Prefix Tag	Plan of Correction	Complete Date
D 274	Facility maintenance will be retrained on their responsibilities. Facility has implemented a maintenance log book kept at nursing station for all staff to log necessary repairs throughout the facility (Form attached) All staff have been in serviced to the new procedure of maintenance log. The maintenance men will provide routine maintenance and document such, as well as major repairs on a daily basis. Facility will employ maintenance worker 5 days per week for 8 hours a day. All repairs will be completed and on-going. These repairs will be supervised and monitored by Resident Care Coordinator or manager or Administrator or designee.	08/04/2017
	Two housekeepers have been hired for seven days a week. Housekeepers are being rotated between halls to ensure proper cleaning is done throughout the entire building and they are familiar with all resident rooms, closets, common areas etc. Training will be conducted with housekeepers on proper cleaning techniques and use of chemicals. Administrator or manager or Resident Care Coordinator will make on-going rounds throughout the facility daily to ensure building is clean and odor free.	08/04/2017

D 079	Maintenance men will check each room daily to determine repairs needed. Administrator or manager or Resident Care Coordinator or designee will also ensure rooms are clean, uncluttered and safe. All repairs cited on survey ending on 06/23/2017 will be completed by 08/31/2017. There has been a "wind curtain" machine installed at the courtyard door and automatic fly machine over each door. There are electric fly machine in dining room and kitchen. Maintenance men or Resident Care Coordinator or Administrator or manager or designee will monitor daily to ensure all are working properly. Housekeepers will be rotated each day so they are familiar with the entire facility for cleaning and reporting repairs. All Staff will be instructed how to report any and all repairs in facility through the maintenance log book through in-service trainings will be held on August 4, August 7, August 10 2017. Log book will be reviewed daily by administrator or manager or Resident Care Coordinator or designee. Spot checks of rooms against maintenance manual will be done weekly by the administrator or manager or designee.	08/31/2017

D 105	All mechanical equipment will be repaired or replaced. This will be continuously monitored by Administrator or manager or maintenance or designee. The training of all staff to the proper procedure of reporting maintenance issues will occur on August 4, August 7, August 10, 2017. Housekeepers will be rotated daily from one hall to the other to ensure knowledge of residents, rooms, hallways and bathrooms. This rotation will be monitored by Administrator or manager or Resident Care Coordinator or designee. A daily spot check will done on reported items on maintenance log book as well as personal observations by the Administrator or manager or designee. Rounds on resident rooms, resident bathrooms, central bathroom, main living area, hallways, closets, public bathroom will be done daily on housekeeping to ensure cleanliness of the building by the Administrator or manager or Resident Care Coordinator or designee.	08/31/2017

D 112	All central air conditioning and heating units have been repaired and will be continuously maintained to ensure efficient operation. This compliance will be monitored daily for one week then three times per week for three months then once a month for twelve months then will be checked randomly. In the event a unit is under repair, fans will be provided to resident rooms to maintain comfortable and regulatory compliant temperatures. This compliance will be monitored by Administrator or manager or Resident Care Coordinator or Maintenance or designee. (See attached repair bill) (Not Invoiced Yet)	08/04/2017

D112

STATEMENT

Name: ARC of Dunn

Address: P.O. Box 923 bill to

City, St Zip: Dunn, N.C. 28334

0

Phone: 252-521-2939 Joey

217 Jonesboro Rd, Dunn, NC

B & S Air Conditioning Co., Inc.
5446 Elevation Road
Benson, NC 27504
Phone: 919-894-5151
Fax: 919-894-7091

Date	Invoice #/Description	Charges	Credits	Balance
1/1/17	Bal Forward Inv. #10731 330.93 + int	$352.04		$352.04
2/6/17	pd chk # 2419 inv # 10731		$352.04	$0.00
6/16/16	inv# 12153	$1,690.00		$1,690.00
6/28/17	inv# 12173	$287.91		$1,977.91
7/30/17	1 1/2% interest added per month if not paid within 30 days	$29.67		$2,007.58

A 1 1/2% Finance Charge Will Be Added To Accounts Not Paid Within 30 Days Of Invoice Date.

Pd 8/4 200758 Ck# 2551

[redacted] Heating and Air, Inc
[redacted]
Dunn, NC 28334

Invoice

Date	Invoice #
7/25/2017	[redacted]

Bill To
The Arc 217 Jonesboro Rd. Dunn, NC 28444

Terms	Project

Item	Description	Rate	Amount
RO	Date of Repair:07/20/17 Complaint:Waterleak Work Performed:Cleaned out drain line and replaced condensate pump. Technician:cw	0.00	0.00
SC	Service Charge	75.00	75.00
SvcLabor	Service Technician hourly labor	112.50	112.50
NPN	Condensate pump	130.00	130.00
Sales Tax	Sales Tax	22.22	22.22

Total	$339.72
Payments/Credits	$0.00
	$339.72

Phone #
910[redacted]

* TERMS: PAYMENT DUE UPON COMPLETION.
* FINANCE CHARGES: 1 1/2% WILL BE ADDED ON ACCOUNTS OVER 30 DAYS
* A $25.00 CHARGE WILL BE ADDED ON NON-SUFFICIENT FUNDS

Fax #	E-mail
910-897-0111	[redacted]

[redacted] Heating and Air, Inc
[redacted]

Invoice

Date	Invoice #
8/4/2017	24449

Bill To
The Arc 217 Jonesboro Rd. Dunn, NC 28444

Terms	Project

Item	Description	Rate	Amount
NPN	5 Solid thermostat guards. (customer installing)	350.00	350.00
Sales Tax		24.50	24.50

Total	$374.50
Payments/Credits	$0.00
	$374.50

Phone #	* TERMS: PAYMENT DUE UPON COMPLETION. * FINANCE CHARGES: 1 1/2% WILL BE ADDED ON ACCOUNTS OVER 30 DAYS * A $25.00 CHARGE WILL BE ADDED ON NON-SUFFICIENT FUNDS
[redacted]	

Fax #	E-mail
[redacted]	[redacted]

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D 273	Accepted and Approved Plan of Protection dated 06/23/17. 1. MD saw resident on 06/12/17 and ordered wound care. Home Health saw resident on 06/13/17 and treated resident with order for protective booties. Booties were delivered and placed on resident on 06/23/17. Staff received orders to dress heels daily when Home Health nurse does not visit. Resident Care Coordinator verified this was done and will continue to supervise care daily. 2. All new orders will be reviewed by the Resident Care Coordinator for disposition and clarification to ensure orders are properly implemented. In the event the Resident Care Coordinator is not present, Med Tech will be responsible and Resident Care Coordinator will review upon return. Resident Care Coordinator will monitor by follow up with home health to ensure orders were received with in a 3 day period. An audit of all residents was conducted by the Med Techs and it was determined this facility currently has no skin breakdown due to thorough skin assessments and protocol. (See attached)	08/10/2017

(D 273 contd.)	Skin assessments will be conducted weekly by Med Tech and then given to the Resident Care Coordinator to ensure that assessments are being done and to follow through with MD and Home Health for any issues. The Administrator or manager will follow up with the Resident Care Coordinator to ensure these are done weekly.	

D 310	All residents on therapeutic diets and thickened liquids will be served accordingly. A new diet sheet has been established for the residents after review of all diet orders received for residents. In-service will be conducted with all cooks and nursing staff on therapeutic diets. (See attached) Any physician diet order changes will go to the Resident Care Coordinator and be put in the Daily Communication Log Book (See attached) and the diet list will be updated at that time all therapeutic meals will be served as ordered in divided plates and goods will not be pureed together. Med Techs will be inserviced on August 4, August 7, August 10, 2017 to give any physician order change to Resident Care Coordinator. All staff will be notified of resident changes through newly established Communication Log Book. This change in policy will be monitored daily by the Administrator or manager or Resident Care Coordinator or designee. A food processor has been purchased and is currently in use in the kitchen. Kitchen staff have been inserviced on 08/02/2017 on proper operation of food processor by corporate nurse to ensure proper textures are given to residents with modified diets. This will be monitored daily by Resident Care Coordinator or manager or Administrator.	08/10/2017

D 282	The kitchen staff has either been replaced or retrained on proper techniques of cleaning of all areas of the kitchen and dining room. The kitchen will be deep cleaned on a schedule of at least once a week. Kitchen and dining room floors are mopped after each meal service. An electric fly machine has been installed in the kitchen and dining room and an air curtain at the back door. Administrator or manager will inspect kitchen and dining room to ensure the cleanliness of the kitchen and dining room daily.	08/03/2017

D310

DIETARY SHEET

	RESIDENT		MIGHTY SHAKE	DIET	TEXTURE
1				Regular	Regular
2				NAS	Chopped Meats
3				LCS	Regular
4		NO ICE		Regular	Pureed
5				Regular	Regular
6				Regular	Regular
7				NAS	Regular
8				NAS, LCS	Regular
9				Regular	Regular
10		NO ICE		NAS	Pureed
11				NAS, LCS	Regular
12				NAS	Regular
13				NAS	Regular
14			BID	NAS	Regular
15				NAS, LCS	Regular
16				NAS	Regular
17				Regular	Regular
18				NAS	Regular
19				Regular	Chopped Meats
20			w Meals & Snacks	NAS, LCS	Regular
21				LCS	Regular
22			w Meals & Snacks	Regular	Regular
23			w Meals & Snacks	NAS	Regular
24				LCS	Regular
25				NAS	Regular
26				Regular	Regular
27				Regular	Regular
28				LCS	Regular
29				Regular	Chopped Meats
30				Regular	Regular
31			Ensure 1 can TID	Regular	Regular
32					
33					

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D 312	Meal times have been changed to: Breakfast at 7:30 am, lunch at 12:30 pm and dinner at 5:30 pm. (See attached) These times will be inserviced on August 4, August 7, August 10, 2017 with all staff and posted at nursing station and on dining room door. This change will be added to the communication log for staff notification. There will be adequate table and chairs for residents and those assisting residents. Staff have been inserviced on proper way to feed residents on August 4, August 7, August 10, 2017 and will be monitored daily by administrator or manager or Resident Care Coordinator or designee. A Resident Right's Inservice was held on July 26, 2017 by the ombudsman to all staff. Facility will continue to have Resident Right's inservices at least quarterly. The facility Administrator or Resident Care Coordinator or manager or designee will monitor that the Resident Rights inservices are held quarterly.	08/10/2017

D 338	Staff was inserviced on Resident Right's, specifically including preventing, identifying and reporting suspected abuse and neglect by ombudsman on July 26, 2017. Our plan of Protection states, Facility will have staff do 30-minute round checks on all residents on all shifts. (See attached). All staff will monitor for verbal and physical abuse and report to supervisors immediately. Administrative staff will be in constant communication with all staff and residents to question incidents of abuse. If behaviors are noted by staff, there will be a note book for potential issues.- (See attached) All employees under investigation for verbal and physical abuse were immediately suspended and subsequently terminated. The nurse aide registry was notified of our decision to terminate and outcome of investigation. Random unannounced visits will be conducted on each shift routinely by administrator or Resident Care Coordinator or manager or designee. (Form enclosed) A Confidential Concern box will be placed at the front entrance of facility for confidential concerns of staff, residents, family members and visitors. The box will be checked daily by Resident Care Coordinator or Administrator. All concerns will	07/26/2017

D338

SPECIAL OBSERVATION RECORD
SAFETY ATTENDANT TO COMPLETE EVERY 30 MINUTES

__1st Shift__2nd Shift__3rd Shift Date:_____Resident_____

Time	Procedural Code(s)	Behavioral Code(s)	Initials	Time	Procedural Code(s)	Behavioral Code(s)	Initials
06:00:00 AM				03:00:00 PM			
06:30:00 AM				03:30:00 PM			
07:00:00 AM				04:00:00 PM			
07:30:00 AM				04:30:00 PM			
08:00:00 AM				05:00:00 PM			
08:30:00 AM				05:30:00 PM			
09:00:00 AM				06:00:00 PM			
09:30:00 AM				06:30:00 PM			
10:00:00 AM				07:00:00 PM			
10:30:00 AM				07:30:00 PM			
11:00:00 AM				08:00:00 PM			
11:30:00 AM				08:30:00 PM			
12:00:00 PM				09:00:00 PM			
12:30:00 PM				09:30:00 PM			
01:00:00 PM				10:00:00 PM			
01:30:00 PM				10:30:00 PM			
02:00:00 PM				11:00:00 PM			
02:30:00 PM				11:30:00 PM			
				12:00:00 AM			

Printed Name	Signature	Initial	Printed Name	Signature	Initial

Procedual Codes	Behavioral Codes		
1=1:1 With Staff	8=Calm	15=Threatening	22=Quiet
2=Direct Observation	9=Cooperative	16=Combative	23=Watching TV
3=Eating	10=Appears Sleeping	17=Yelling	
4=Fluids Served	11=Agitated	18=Restless	
5=Toileted/Hygiene	12=Confused when awake	19=Aggressive	
6=Bath/Linen Changed	13=Pulling Clothes	20=Talking	
7=Hemodialysis	14=Attempts out of bed/chair	21=Crying	

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D310

The A.R.C. Of : ______________________________

Daily Communication Log

Please list anything pertinent to the resident in the space provided. If there are no issues with a resident, place a check mark beside their name.

Day: ____________________ Date: ____________________

Name	7-3 shift	3-11 shift	11-7 shift

D338

SPECIAL OBSERVATION RECORD
SAFETY ATTENDANT TO COMPLETE EVERY 30 MINUTES

__1st Shift__2nd Shift__3rd Shift Date:_____Resident_____

Time	Procedural Code(s)	Behavioral Code(s)	Initials	Time	Procedural Code(s)	Behavioral Code(s)	Initials
06:00:00 AM				03:00:00 PM			
06:30:00 AM				03:30:00 PM			
07:00:00 AM				04:00:00 PM			
07:30:00 AM				04:30:00 PM			
08:00:00 AM				05:00:00 PM			
08:30:00 AM				05:30:00 PM			
09:00:00 AM				06:00:00 PM			
09:30:00 AM				06:30:00 PM			
10:00:00 AM				07:00:00 PM			
10:30:00 AM				07:30:00 PM			
11:00:00 AM				08:00:00 PM			
11:30:00 AM				08:30:00 PM			
12:00:00 PM				09:00:00 PM			
12:30:00 PM				09:30:00 PM			
01:00:00 PM				10:00:00 PM			
01:30:00 PM				10:30:00 PM			
02:00:00 PM				11:00:00 PM			
02:30:00 PM				11:30:00 PM			
				12:00:00 AM			

Printed Name	Signature	Initial	Printed Name	Signature	Initial

Procedual Codes	Behavioral Codes		
1=1:1 With Staff 2=Direct Observation 3=Eating 4=Fluids Served 5=Toileted/Hygiene 6=Bath/Linen Changed 7=Hemodialysis	8=Calm 9=Cooperative 10=Appears Sleeping 11=Agitated 12=Confused when awake 13=Pulling Clothes 14=Attempts out of bed/chair	15=Threatening 16=Combative 17=Yelling 18=Restless 19=Aggressive 20=Talking 21=Crying	22=Quiet 23=Watching TV

Unannounced Facility Visit

Administrative Staff: _____

Date of visit: _____

Staff is awake and working.	
Residents are asleep/awake.	
Residents are investigated.	
Facility is locked and secured.	

Additional comments/information:

_____

_____

_____

_____

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D 338

Alzheimer's Related Care
The A.R.C. of Dunn
217 Jonesboro Rd, PO Box 923
Dunn, NC 28334
910.892.1711 P
910.892.5343 F

Incident/Accident Report

[ ] Resident [ ] Visitor [ ] Employee

Name: _____ Room Number: _____

Address & Phone Number if a Visitor or Employee: _____

Date of Incident/Accident: _____ Time: _____ [ ] A.M. [ ] P.M.

Description of Event:

_____

_____

_____

_____

Vital Signs: Temperature _____ Pulse _____ Respirations _____ Blood Pressure _____

Description of Injury:

_____

_____

_____

Staff Action Taken:

_____

_____

_____

Family/ RP/Guardian Notified:

Name: _____ Date: _____ Time: _____ [ ] A.M. [ ] P.M.

Primary Care Provider Notified:

Name: _____ Date: _____ Time: _____ [ ] A.M. [ ] P.M.

Follow Up Notes on Person Involved in Incident/Accident:

_____

_____

Signature and Title of Person Filing Report: _____

Signature of Administrator/Executive Director: _____

D338

Disposition of Incident Report

Resident _____ Date _____

Assesed

_____

_____

_____

_____

Plan

_____

_____

_____

_____

Follow - Up _____

_____

_____

Unit Coordinator _____

Med Tech _____

MD _____

Safety Committee Meeting 07/20/2017

We had one fall in the last 60 days. Resident 6 rolled off of her bed onto her mat. When she fell, the bed rail fell and landed on her arm. She received a bruise on her right forearm. She was sent to the ER. No broken bones. She returned and was closely monitored for 24 hours. Bed rails were changed to a more secure bed rail. No other incidents in nursing.

Housekeeping now has a ladder to make it more safe for them to do cleaning of high areas. We will now purchase more wet floor signs. All housekeepers will continue to concentrate on all rooms to ensure they are safe and free of hazards.

Dietary knows to always lock the kitchen doors at any time they leave the kitchen. Kitchen will also get a wet floor sign for when they are mopping floor. We will put all residents that are physically

able to sit in regular dining room chairs giving them more respect and dignity. When they are removed from their wheel chair, walker or geri chair it will be removed from dining room to prevent fall hazards and clutter.

Maintenance has no issues.

(D 338 contd.)	be addressed daily by Resident Care Coordinator or Administrator. Plan on protection states: Facility Med Techs have been trained on July 1, July 3, August 4, August 7 and August 10, 2017 on how to report incidents and all bruising that is found. All reports will be signed by the administrator and Resident Care Coordinator or designee. Reports will be sent to DSS and any reports of bruising of unknown origin will be reported to the health care registry. The Resident Care Coordinator will monitor all reports and follow up on all reports with the administrator. The facility has established the Disposition of Incident Report form to ensure each incident report addresses that the resident was... 1. assessed 2. there is a plan in place based upon assessment 3. Follow-up to the plan. This form is signed by the Unit Coordinator, Administrator, Med Tech and the physician. (Form attached) Weekly skin assessments will be done on all residents. This assessment will be recorded on the skin assessment form. The skin assessment form will be reviewed by Resident Care Coordinator for disposition and follow up. Plan of protection on falls states: The facility has trained	

(D 338 contd.)	all staff on fall risks on July 1, July 3, August 4, August 7 and August 10, 2017. The Administrator or manager or Resident Care Coordinator will do a safety meeting and address all concerns with the MD. The facility will review MAR for medication changes and address all concerns with the safety committee on admission quarterly or after a fall or any significant change in a resident. Safety committee met on July 20, 2017 to discuss issues regarding falls, residents safety, facility hazards and improving environment. (see attached) The facility has established reporting of inappropriate behaviors of residents to incident reports and Disposition of incident report form and/or reference to the Behavior Guidelines. (Previously attached) The Plan of Protection states: Resident currently being followed by psych. Facility will follow all psych recommendations. Facility will seek more appropriate placement for this resident. Until this time, resident will have constant supervision. (Previously attached) Update of Plan of Protection on 06/16/2017: Employees with allegations were suspended and subsequently terminated. The 24 hour and 5 day report was sent to health care registry. Confidential Concern box for staff, residents, families and	

(D 338 contd.)	visitors have been placed in front entrance of facility. The facility has 30 minute checks on residents. (Previously attached) All staff have been trained and instructed to report verbal or physical abuse. Resident Rights Inservice was held on July 26, 2017. (See attached) See sensitive file for staff training names/ku	

D 358	The staff member that misinformed the surveyor is no longer employed by the ARC of Dunn. All Med Techs have been retrained on medication administration and medication errors. The Resident Care Coordinator or designee will review resident MARs daily to ensure all medications are dispensed appropriately. A cart audit will be conducted weekly by third shift Med Tech or Resident Care Coordinator. At that time, any discrepancies will be recorded and given to the Resident Care Coordinator or Administrator or manager to report to MD and complete a medication error report form. (see attached)	07/06/2017

D358

MEDICATION ERROR REPORT

Resident's Name: _____ Record #: _____

Date/Time Error Occurred: _____ Date Report Completed: _____

Type of Error:

_____ **Wrong Resident**

_____ **Wrong Medication**

_____ **Wrong Dose**

_____ **Wrong Time**

_____ **Wrong Recording**

_____ **Wrong Route**

_____ **Control Drug Count Incorrect**

Description of Events: _____

Reasons for error occurring: _____

Physician's Order: _____

Supervisor Notification (Date/Time): _____

Physician Notification (Date/Time): _____

Comments: _____

Action Taken and Precautions to prevent a similar error: _____

Staff Submitting Report _____ Date _____

Staff Making Error _____ Date _____

Supervisor _____ Date _____

Physician Signature (if Required) _____ Date _____

Blank.

0392

CONTROLLED SUBSTANCE DAILY COUNT

Date	Shift	On-coming Shift Signature	Off-going Shift Signature	Outcome	Pager/Keys Initial	

Blank

D 392	Plan of Protection on 06/21/2017 included that Resident Care Coordinator will do random cart audits to ensure all medications are delivered, counted and placed on med cart with proper medication counts. The Resident Care Coordinator will do the cart audits weekly. The cart audit reports will be given to the administrator or manager weekly. (Previously attached) Any identified diversion of medication will be reported to pharmacy and investigated and suspects will be immediately suspended and reported to the Health Care Registry and to the Harnett county Sheriff's Department. All narcotics are counted at the change of each shift with the oncoming and off-going Med Techs. Med Techs have been instructed that if a discrepancy is found during count, the oncoming Med Tech is not to assume the responsibility of the med cart and the Administrator or manager or Resident Care Coordinator will be notified immediately. (See attached)	07/06/2017

D 438	This event will be reported to the Health Care Registry. Any and all complaints and concerns of resident abuse either physical or verbal immediately will be reported by the Administrator or manager or Resident Care Coordinator. Cart audits have been inserviced and put in place to ensure such events do not happen in facility and will be monitored consistently by Administrator or manager or Resident Care Coordinator. This event has been reported to the Health Care Registry any and all discrepancies of medications or medication diversion immediately upon discovery the Resident Care Coordinator or Administrator or manager. Measure of monitoring have been inserviced and put in place to ensure such events do not happen in facility and will be monitored by Administrator or manager or Resident Care Coordinator. Any bruising of unknown origin or any injuries of unknown origin will immediately be reported to the Health Care Registry. Complete body assessments have been put in place and inserviced to prevent incidents such as this in the future. This will be reported by the Resident Care Coordinator with follow up by the Administrator or manager. Skin assessments will be done weekly by Med Techs then given to Resident Care	06/24/2017

(D 438 contd)	Coordinator to review and follow up for disposition.	

D 465	Alzheimer's Related Care of Dunn is currently and will remain staffed according to the needs of the residents and the state required regulation. Med Techs have been instructed by postings at the nursing station that the facility will not work short. Plan of Protection on 06/23/2017 is: The Administrator or designee will review all schedules daily to ensure adequate required staffing. He also will calculate time cards daily and check hours for all shifts. The Administrator or designee will be responsible for all staffing. The Administration or designee will ensure that the facility is staffed at a minimum of ratio 1:8 for first shift, 1:8 for second shift and 1:10 for third shift. The Administrator or designee will ensure facility is never below these levels. Residents needs will be assessed to determine due to the enhanced level of care of our residents, more staff will be made available for the care of all residents. The facility has hired and checked off a PRN PCA that is available 24/7 to fill in as a call in might occur.	06/24/2017

D 477	All current and new staff have been trained according to all regulations related to special care units. Current staff files will be reviewed and all will be in compliance. The facility will not purge employee files but maintain the integrity of such file. The Administrator or manager or Resident Care Coordinator or designee will review personnel files quarterly to ensure compliance with this rule.	08/10/2017

D 912	The Administrator, Resident Care Coordinator or manager will assure that all Residents Rights will be protected and all prescribed medications will be given as ordered at all times. Medications will be available for residents as ordered. This will be monitored by Administrator or Resident Care Coordinator or manager. Resident Care Coordinator will do random cart audits to ensure all medications are delivered, counted and placed on med cart with proper medication counts. The Resident Care Coordinator will do the cart audits weekly. The audit reports will be given to the administrator or manager. See prior corrective steps outlines in this Plan of Correction.	07/06/2017

D 914	The Administrator or Resident Care Coordinator or manager will ensure that all residents will be free of mental and physical abuse and neglect related to health care Resident Rights, Special Care Unit staffing and health care personnel registry reports. Systems and training have been put in place to prevent such infractions in the future. Prior corrective steps contained in this Plan of Correction states that all staff will monitor for verbal and physical abuse and report to supervisors immediately. Administrative staff will be in constant communication with all staff and residents to question incidents of abuse. If behaviors are noted by staff, there will be a note book for potential issues. See prior corrective steps outlined in this Plan of Protection.	06/24/2017

D 980	Plan of Protection of 06/23/2017 update. The corporate office has replaced the Administrator in the facility. Also, the Executive Director has been replaced with a manager. The Resident Care Coordinator has been replaced. The Administrator, manager, Resident Care Coordinator ensures all residents will receive proper care 24 hours per day 7 days per week. Each resident will be treated with dignity and respect by all staff members assigned by the Administrator, manager or Resident Care Coordinator. The Administrator, Manager, Resident Care Coordinator will follow all rules that govern the facility. The Administrator, manager and Resident Care Coordinator will ensure adequate numbers of staff will be hired and trained to care for each resident 24 hours per day 7 days per week. The Administrator, manager, Resident Care Coordinator will ensure compliance by daily supervision of staff and review staffing schedule and labor hours.	06/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 6/14/17 - 6/16/17 and 6/19/17 - 6/23/17.	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 and interviews, the facility failed to assure walls, ceilings and floors were kept clean and in good repair as evidenced by holes in the walls of four resident rooms, the hallway and beauty salon on the men's hall; wet marks and peeling paint on the ceilings in two common bathrooms; dirt/grime buildup and stains on the floors in three common bathrooms, two resident rooms and the beauty salon on the men's hall; and gouges and marks on the walls and dust in the vents in the resident exam room near the men's hall. The findings are: Observations of the men's hall on 6/14/17 from 9:37 a.m. until 10:46 a.m. revealed: -There were urine stains around the base of the toilet in the bathroom inside resident room #A8. -There was an unpainted patch mark over a hole in the wall by the bathroom door in resident room	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 074	Continued From page 1 #A8. -There was a large irregularly shaped wet mark in the ceiling of the common shower room above the slide hanger for the shower curtain. -There was a door knob sized hole in the wall behind the entrance door in resident room #A4. -There were water marks and peeling paint on the ceiling around the two vents in the common bathroom. -There were yellow stains on the floor around the toilet and under the sink in the common bathroom. -The emergency light in the hallway did not cover the original hole made to install the fixture, leaving a hole approximately the size of half a golf ball above the fixture. -There was dirt build up and used paper towels on the floor in the beauty salon and the bathroom inside the beauty salon. -There was a large cut hole approximately eight inches by one foot revealing insulation under the sink in the bathroom inside the beauty salon. -There were brown drip marks on the wall behind the first chair and next to the garbage can in the beauty salon. -There were yellow stains on the floor under the sink in the beauty salon. -There were dark yellow/brownish stains on the floor by the second bed in resident room #A1. -There was grime build up on the tile floor and tile baseboard around the toilet in the common bathing room. -There was no toilet paper holder in the bathroom inside resident room #A5, leaving four small holes in the wall next to the toilet. Interview with a Housekeeper on 6/14/17 at 10:32 a.m. revealed: -She did not usually work on the men's hall. -She had not noticed the holes in the walls, wet	D 074		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 074	Continued From page 2	D 074		

marks and peeling paint on the ceilings or build up on the floors.
-The Maintenance Man recently (within a week) started working on general repairs on the men's hall.
-She reported any repair concerns she noticed to the Maintenance Man.

Interview with the Maintenance Man on 6/14/17 at 10:39 a.m. revealed:
-He was not aware of all of the needed repairs identified on the men's hall.
-He did know about most of the holes in the walls and was in the process of repairing them.
-He was at the facility two to three days per week for maintenance and repairs.
-He did not routinely walk through the building to identify any needed repairs.
-Sometimes staff would tell him about repairs and sometimes they would write it down.
-Staff would write down repairs concerns in a book kept at the nurse's station.

Interview with the Maintenance Man on 6/14/17 at 2:07 p.m. and 2:22 p.m. revealed:
-He had made repairs to the hole in the wall in room #A4 three to four times and would have to get some type of plate to keep the door from going all the way over.
-The sheet for staff to document repair concerns was a suggestion and did not yet exist.
-He would come in and fix what he could and report to the Executive Director (ED).

Interview with the ED on 6/14/17 at 2:30 p.m. revealed:
-The Housekeeper working the men's hall on 6/14/17 did not usually work on that hall.
-Housekeepers reported any repair concerns to the Maintenance Man or to the ED.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 074	Continued From page 3 -There was also a book that staff were supposed to write repair concerns in. -The rooms were checked daily for any need repairs by the housekeepers. -The Maintenance Man worked in the building three days per week and was responsible for maintenance tasks such as stripping the floors and changing air filters in addition to any needed repairs. -They were also in the process of painting the dining room which took time away from other maintenance jobs.	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 and interviews, the facility failed to assure the facility was kept clean and free of obstructions and hazards as evidenced by damaged door handles to two rooms and a closet on the men's hall, one set of folding closet doors off the tracks in one resident room on the men's hall, broken toilet paper and towel holders in two resident bathrooms on the men's hall, six broken electrical outlets on the men's hall, a loose light fixture from the ceiling of one resident room on	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 4	D 079		

the men's hall, an improperly fitting toilet tank cover in one resident bathroom on the men's hall and the presence of numerous flies in resident rooms, common bathrooms, corridors and common areas.

The findings are:

Observations on 6/14/17 from 9:37 a.m. until 10:46 a.m. revealed:
-There were two hanging brackets and a screw left protruding from the wall next to the bathroom in resident room #A8.
-The toilet paper and towel holders were missing leaving just brackets protruding from the wall in the bathroom of resident room #A8 where a towel hung on one bracket while the toilet paper was on the floor.
-The top to the toilet tank was too small leaving a gap of approximately one inch where the tank was not covered.
-In the bathroom inside resident room #A8, the electrical outlet in the bathroom on the wall next to the sink was loose and not flush with the wall leaving a gap of approximately ¼ inch.
-The electrical outlet on the wall next to the bed in resident room #A8 was loose and not flush with the wall leaving a gap of approximately ½ inch and did not fully cover the opening for the outlet in the wall.
-The light fixture on the ceiling, in resident room #A2, was loose and hanging by wires leaving a gap of approximately one inch.
-In resident room #A2, the dresser next to the second bed was approximately six to eight inches out from the wall revealing an electrical outlet that was loose and not flush with the wall leaving a gap of approximately ¼ inch.
-There were two folding doors to the closet in resident room #A10 that were not attached to the

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 6	D 079		

p.m. revealed:
-There were live flies in resident room #B5.
-There were live flies in the Special Care Director's (SCD) office and the SCD of a sister facility was swatting at flies with a fly swatter.

Interview with a Housekeeper on 6/14/17 at 10:32 a.m. revealed:
-She did not usually work on the men's hall.
-She had not noticed the holes around door handles, loose and broken electrical outlets and broken toilet paper and towel holders.
-The Maintenance Man recently (within a week) started working on general repairs on the men's hall.
-She reported any repair concerns she noticed to the Maintenance Man.
-The flies came in from the exit doors when staff and residents went outside to smoke cigarettes.

Interview with the Maintenance Man on 6/14/17 at 10:39 a.m. revealed:
-He was not aware of all of the needed repairs identified on the men's hall.
-He did not know about the electrical outlets.
-He was at the facility two to three days per week for maintenance and repairs.
-He did not routinely walk through the building to identify any needed repairs.
-Sometimes staff would tell him about repairs and sometimes they would write it down.
-Staff would write down repairs concerns in a book kept at the nurse's station.
-The flies came in from the exit doors when staff and residents went outside to smoke cigarettes.
-There were usually fly strips hanging at the exit doors to catch the flies.

Interview with the Maintenance Man on 6/14/17 at 2:07 p.m. and 2:22 p.m. revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 7 -He did not know about the loose light fixture in room #A2. -The flies came in all the time from residents going out to the enclosed area to smoke cigarettes. -When the residents went out to smoke, they would hold the door open for a long time and the flies came in. -There were usually fly strips kept in front of the door. -He could replace the rusted toilet paper holder in room #A10. -The closet in room #A10 would need new pieces (which he had) on the top to attach the doors to the track. -The sheet for staff to document repair concerns was a suggestion and did not yet exist. -He would come in and fix what he could and report to the Executive Director (ED). Interview with the ED on 6/14/17 at 2:30 p.m. revealed: -The Housekeeper working the men's hall on 6/14/17 did not usually work on that hall. -Housekeepers reported any repair concerns to the Maintenance Man or to the ED. -There was also a book that staff were supposed to write repair concerns in. -The rooms were checked daily for any need repairs by the housekeepers. -The Maintenance Man worked in the building three days per week and was responsible for maintenance tasks such as stripping the floors and changing air filters in addition to any needed repairs. -They were also in the process of painting the dining room which took time away from other maintenance jobs. Observations on 6/21/17 at 6:00 p.m. revealed:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 8 -A fan had been installed over the door inside the facility to the enclosed smoking area. -The light fixture was secure to the ceiling in resident room #A2.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the ventilation was maintained in working condition in two common bath and shower rooms with no windows on the men's hall. The findings are: Observations on 6/14/17 at 9:45 a.m. and 10:32 a.m. revealed: -The ventilation fans did not turn on when the switches were turned on in the common shower room and common bathroom with the tub on the men's hall. -The common shower room and common bathing room did not have windows and were humid. Interview with a Housekeeper on 6/14/17 at 10:32 a.m. revealed: -The ventilation fans in the common shower and bathing rooms had not been working for a while. -She had reported it to maintenance, but could not remember when. -The Maintenance Man recently (within a week) started working on general repairs on the men's	D 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 105	Continued From page 9	D 105		

hall.
-She reported any needed repairs she noticed to the Maintenance Man.

Interview with the Maintenance Man on 6/14/17 at 10:39 a.m. revealed:
-He was not aware the ventilation fans in the common shower and bathing rooms were not working.
-He was at the facility two to three days per week for maintenance and repairs.
-He did not routinely walk through the building to identify any needed repairs.
-Sometimes staff would tell him about repairs and sometimes they would write it down.
-Staff would write down any needed repairs in a book kept at the nurse's station.

Observation on 6/14/17 at 2:07 p.m. revealed the Maintenance Man was taking apart the ventilation fan in the common shower room.

Interview with the Maintenance Man on 6/14/17 at 2:07 p.m. and 2:22 p.m. revealed:
-He would have to order a part for the ventilation fans.
-The sheet for staff to document repair concerns was a suggestion and did not yet exist.
-He would come in and fix what he could and report to the Executive Director (ED).

Interview with the ED on 6/14/17 at 2:30 p.m. revealed:
-The Housekeeper working the men's hall on 6/14/17 did not usually work on that hall.
-Housekeepers reported any repair concerns to the Maintenance Man or to the ED.
-There was also a book that staff were supposed to write repair concerns in.
-The rooms were checked daily for any needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 105	Continued From page 10 repairs by the housekeepers. -The Maintenance Man worked in the building three days per week and was responsible for maintenance tasks such as stripping the floors and changing air filters in addition to any needed repairs. -They were also in the process of painting the dining room which took time away from other maintenance jobs. Upon request 6/14/17, 6/15/17 and 6/16/17, the maintenance request book was not available for review. Observation on 6/21/17 at 6:00 p.m. revealed the ventilation fan had been removed in the common shower room on the men's hall.	D 105		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements (c) Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C). This rule apply to new and existing facilities This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide an adequate number of fans for residents when air conditioning units in the facility were not working and the temperature in the main corridor was 82 degrees Fahrenheit (F). The findings are:	D 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 112	Continued From page 11 Confidential interview with a staff revealed: -The air conditioner had not been working since approximately 5/25/17. -Resident room #A10 was the hottest room on the men's hall. -There was only one fan in the facility for all of the residents. -Staff would have to share the one fan between residents' rooms to try to keep residents cool when the air conditioner was not working. Confidential interview with a second staff revealed: -The air conditioning in the facility had not been working for a couple of weeks. -The only fans available were the ceiling fans in the hallway of the men's hall. Confidential interview with a third staff revealed: -The air conditioning at the facility had been out for a couple of weeks. -The resident in room #A10 kept saying it was hot. -There was only one fan in the facility. -Staff put the fan in resident room #A10. Confidential interview with a fourth staff revealed: -The staff thought the air conditioning had been out for a couple of weeks (end of May). -There was only one fan in the building. -The resident in room #A10 complained it was hot, so staff put the fan in that room. Review of AccuWeather temperature records for the local area from 6/1/17 through 6/14/17 revealed: -The high temperatures averaged 87 degrees F . -There were ten days where the outside temperature was greater than 85 degrees F.	D 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 112	Continued From page 12 -There were five days where the outside temperature was 90 degrees F or higher. Observation on 6/14/17 at 10:22 a.m. revealed the temperature in resident room #A12 was 82 degrees F and there was no fan in the room. Interview with the Executive Director on 6/14/17 at 2:30 p.m. revealed: -The air conditioning unit on the men's hall had stopped working on 6/13/17. -He called the repair company on 6/13/17. -The repair company was at the facility to fix it on 6/14/17. Observation on 6/15/17 at 4:35pm revealed the temperature in the front hall was 81 degrees F. Observation on 6/15/17 at 5:35 p.m. revealed: -The thermostat in the main corridor near the men's hall showed a temperature of 82 degrees F. -There was one fan in use on the men's hall set up in the entrance area of the hallway. Observation on 6/15/17 at 5:42 p.m. revealed: -There were 12 residents sitting in the common area. -The room temperature in the common area was 85.2 degrees F. -There was only one fan in the common room. Interview with the air conditioning repair person on 6/15/17 at 5:35 p.m. revealed: -He was at the facility on 6/14/17 to repair an air conditioning unit. -He came back to fix a different air conditioning unit on 6/15/17. -The company was called for the first repair last week (6/8/17) and came out for to repair the first	D 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 112	Continued From page 13 unit on 6/14/17. -The company received a call on 6/15/17 regarding air conditioner not working at the facility so he came back out to the facility on 6/15/17 to repair a second air conditioning unit. -The repair delay for the first unit may have been related to getting a part shipped, he was not sure. Telephone interview with the air conditioning repair company Receptionist on 6/16/17 at 11:58 a.m. and 6/21/17 at 2:12 p.m. revealed: -The facility contacted the company for the first repair on 6/8/17. -The facility contacted the company for the second repair on 6/15/17. -There was no record of any calls prior to 6/8/17. -There was a delay in getting the first repair done from 6/8/17 to 6/14/17 because the company technicians were backed up on prior calls for service. Interview with the Manager on 6/19/17 at 9:10 a.m. revealed: -The compressor for the air conditioner went out for the initial repair done on 6/14/17. -He did not think the air conditioner was out for more than a few days. -Facility staff were "pretty timely with building and mechanical issues." -There were five or six air conditioning units in the building and it seemed that when one got fixed another stopped working at this time of year.	D 112		
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.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 14	D 273		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to contact the Primary Care Provider for wound care orders for more than 30 days for 1 of 7 sampled residents (#8), who returned from a rehabilitation center with a stage II ulcer on her left heel.

The findings are:

Review of Resident #8's current FL-2 dated 6/12/17 revealed diagnoses included Dementia, Chronic Atrial Fibrillation, Idiopathic Peripheral Neuropathy, Muscle Weakness and Age Related Physical Debility.

Observations on 6/19/17 at 10:58 a.m. revealed:
-Resident #8 had a wound approximately half dollar sized on her left heel that was brownish/black surrounded by redness.
-Resident #8 had a wound approximately half dollar sized on her right heel that had a dark purplish bruise and mushy appearance.
-Resident #8 had a wound approximately the size of a quarter on the inner side of her right ankle that was pink and red with a scabbed center.
-Resident #8 had a wound approximately pea sized on the outer side of her left ankle that was scabbed with redness around it.
-There were no dressings removed or placed on the resident's wounds.
-There were no heel protectors on the residents feet or in the resident's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 15 Based on observations, interviews and record reviews, Resident #8 was not interviewable. Interview with a Personal Care Aide (PCA) on 6/19/17 at 10:58 a.m. revealed: -The wounds on Resident #8's heels had been there for a few days. -The Medication Aide (MA) knew about it. -She thought the resident had Home Health Nurses coming to the facility to do wound care. Interview with a second PCA on 6/20/17 at 3:55 p.m. revealed: -The sores on Resident #8's heels had been there for more than a month. -She did not know what was being done for them. Interview with a third PCA on 6/21/17 at 2:26 p.m. revealed: -She had first noticed the sores on Resident #8's heels three days ago. -The Medication Aide (MA) said she had "put a note in" for the PCP already. -The sores on Resident #8's heels looked like they were getting worse and getting deep. -She did not think a Home Health Nurse (HHN) was seeing the resident for her heels. Telephone interview with a former MA on 6/21/17 at 10:58 a.m. revealed: -She had worked at the facility from March 2017 until the end of May or early June 2017 and now worked at a sister facility. -When Resident #8 returned to the facility from the rehab (nursing rehabilitation), the MA would have to wrap her heel with gauze each day. -The Special Care Director (SCD) told her that the resident was supposed to have Home Health according to the paperwork that came from the rehab.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 16	D 273		

Review of Nursing Rehabilitation Center discharge orders dated 5/11/17 for Resident #8 revealed the resident was admitted to the Rehabilitation Center on 4/1/17 and discharged to the facility on 5/11/17.

Review of an untitled document from the Rehabilitation Center dated 5/11/17 revealed:
-There was documentation addressed to the facility to "Please address the following issues: [Name of Resident #8; please continue the following treatment: clean left heel with normal saline, paint with Betadine, apply foam and wrap with Kerlex daily."

Review of Resident #8's current care plan dated 5/15/17 revealed:
-There was no documentation of wounds, wound care or pressure ulcer prevention.
-There was an "X" marked next to normal under "Skin."
-The Primary Care Provider (PCP) signed the care plan electronically.

Review of "Nurse's Notes" dated 3/7/17 through 6/13/17 for Resident #8 revealed there was no documentation of wounds, wound care or pressure ulcer prevention.

Review of electronic notes dated 2/9/17 through 5/22/17 for Resident #8 revealed there was no documentation of wounds, wound care or pressure ulcer prevention.

Review of Resident #8's May and June 2017 electronic Medication Administration Record revealed there was no entry for wound care.

Review of an "Incident/Accident Report" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 17 5/30/17 at 12:15 a.m. for Resident #8 revealed: -Staff documented noticing a skin tear on Resident #8's right heel. -Staff documented the wound was cleaned and wrapped. -Staff documented attempted contact with the family, but there was no answer. -Staff documented contacting the PCP. Review of "Skin Assessment Charts" for Resident #8 revealed: -On 5/17/17, staff documented, "Left heel wrapped Home Health Care." -On 5/24/17, staff documented next to heels, "clear." -On 6/7/17, staff documented next to heels, "healing abrasion." Attempted interview with the family member on 6/23/17 at 2:16 p.m. was unsuccessful. Telephone interview with a MA on 6/21/17 at 9:57 a.m. revealed: -He had noticed the wounds on Resident #8's heels when the resident came back from the hospital. -Another MA was doing wound care when she worked and then he would do it on the days he worked. -There were no wound care orders. -He would clean the wound and wrap it because "it looked good." -The other MA said she had reported the heel wounds to the PCP. -The PCP came to facility every Friday. -If a resident had a wound or a bruise he would fill out a skin assessment sheet and an incident report and slide the forms under the door to the Special Care Director's (SCDs) office.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 18	D 273		

Interview with a second MA on 6/22/17 at 6:02 p.m. revealed:
-The first time she saw the wounds on Resident #8's feet, the wounds were "fresh" and she cleaned them and reported them to the SCD.
-She also documented the wounds on an incident report (5/30/17) which was given to the SCD.

Review of a PCP visit note dated 6/12/17 for Resident #8 revealed:
-There was an order for Keflex 500mg three times daily for ten days. (Keflex is an antibiotic commonly used to treat skin infections.)
-There was an order for a Home Health (HH) referral for wound care for bilateral feet.

Telephone interview with the PCP on 6/21/17 at 4:59 p.m. revealed:
-She had ordered wound care for Resident #8 at her last visit with the resident which was about 3-4 weeks ago.
-She could not remember the date, but the order was in the resident's record.
-She also ordered staff to do wound care until HH was seeing the resident for wound care.
-She also ordered antibiotics for possible wound infection.

Review of "Nurse's Notes" for Resident #8 revealed:
-There was documentation by the HHN that Resident #8 was admitted to HH on 6/13/17.
-The HHN documented the PCP would be contacted for further wound care orders.
-The HHN documented she would consult with the HH wound specialist for recommendations.

Telephone interview with the HHN on 6/23/17 at 10:13 a.m. and 11:33 a.m. revealed:
-Resident #8 had an unstageable wound on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 19	D 273		

left heel and a stage I pressure ulcer on her right heel on admission to HH June 2017.
-The left heel wound was unstageable because there was slough on the top of the wound.
-The left heel measured 2.5cm length, 3cm width and 0.2cm depth.
-The right heel measured one centimeter diameter.
-The left foot wound had to be developing for some time, at least a week if not longer.
-HH would be seeing the resident three days per week and staff would be responsible for basic dressing changes between HHN visits.
-On the day she saw the resident at the facility, she had discussed the importance of staff completing wound care daily with the SCD and did extensive teaching on wound care.

Telephone interview with the Assistant Director of the Rehabilitation Center on 6/23/17 at 11:30 a.m. revealed:
-The treatment orders for wound care were faxed to the facility on 5/11/17.
-Resident #8 was discharged to the facility on 5/11/17.
-On 5/10/17, Resident #8's had a stage II pressure ulcer on her left heel.
-The left heel wound measured 0.8cm length by 1.2cm width.
-The resident did not have any other wounds.

Review of a PCP visit note dated 6/22/17 for Resident #8 revealed there was an order for heel protectors for wound prevention/pressure reduction and there were no specific wound care orders.

Interview with the SCD of a sister facility on 6/23/17 at 12:05 p.m. revealed:
-She had worked at the facility previously as the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 20 SCD and was helping with administrative responsibilities at the facility during the survey. -HH would have been responsible for the wound care orders included with the discharge orders from the rehab. -When residents returned from the hospital or a rehab, the discharge orders were faxed to pharmacy, reviewed and sent to HH if HH services were ordered. -The SCD was responsible for any needed follow up with HH to make services were being provided as ordered. Interview with the Manager on 6/23/17 at 12:10 p.m. revealed he planned to be at the facility daily to assure residents were receiving the proper care. _____ The delay in the facility contacting the Primary Care Provider for treatment orders for pressure sore on Resident #8's left heel, resulted worsened and new pressure sores over the course of a month with no intervention. The facility's delay in follow up on the wound care needs for Resident #8 demonstrates serious neglect and harm, which constitutes a Type A2 Violation. _____ Review of the Plan of Protection submitted by the facility on 6/23/17 revealed: -Resident #8 was seen by the PCP on 6/12/17 and a HH referral for wound care was ordered. -Resident #8 was seen by HH on 6/13/17. -Protective booties [for her feet] were ordered, delivered and placed on the resident's feet 6/23/17. -Staff received orders to change dressings daily when the HHN does not visit the resident.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 21 -The (SCD) verified this was done and will continue to supervise [Resident #8's wound] care daily. -All new orders will be reviewed by the (SCD) for disposition and clarification to ensure orders are properly implemented. -In the event the (SCD) is not present, the MA [on duty] will be responsible [for the disposition and clarification of orders] and the (SCD) will review upon return. -When a resident is admitted/returned with HH orders or any orders, the orders will be clarified with the PCP by the (SCD) or MA. -The (SCD) will monitor by follow up with HH to ensure orders were received within a three day period. -The (SCD) will follow up with [the PCP for] any orders according to the residents' needs. -The (SCD) will conduct weekly skin assessments. -The Administrator will review the weekly skin assessments completed by the (SCD) to assure the proper care for any area of concern. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 7/23/17.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 282	Continued From page 22	D 282		

reviews, the facility failed to assure the kitchen, dining and food storage areas were kept clean, orderly and free from contamination as evidenced by a heavy amount of spilled dry foods, crumbs and wrappers under the storage shelves in the dry pantry; dirt and grease build up on the floors in the pantry, under kitchen work areas and along kitchen baseboards; a heavy concentration of a black substance resembling mold on the floor around and on the cover to the sink drain in the kitchen; and flies in the kitchen and dining area.

The findings are:

Observations on 6/14/17 from 10:46am until 10:59am revealed:
-There was a heavy buildup of dirt and food crumbs on the floor behind the door and underneath the shelving in the dry pantry.
-There were empty food wrappers underneath the shelving in the dry pantry.
-There was heavy dirt and grime build up on the tile floor and tile baseboards in the kitchen and heavy buildup of grease and dirt on the tile floor in front of the stove.
-There was a heavy buildup of dirt, grime and a black substance resembling mold around the catch basin under the sink in the kitchen.
-There were several flies in the kitchen and the dining room.

Interview with the Cook on 6/14/17 at 10:59am revealed:
-The cook was responsible for cleaning the floors in the kitchen and pantry at the end of each day.
-He would be cleaning the floors after dinner on 6/14/17.

Review of the "Food Establishment Environment Inspection Report" for the facility dated 3/27/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 282	Continued From page 23 revealed the facility was given two deductions for physical facilities with comments including residue present on floors under shelving in storage room and general cleaning needed on floors in kitchen. Interview with the Executive Director (ED) on 6/14/17 at 2:30pm revealed: -It was not mold around the catch basin under the sink in the kitchen, it was "like a scum." -He had had a plumber evaluate the drain and the plumber recommended replacing the material around the drain with concrete. -The facility was in the process of considering projects like that. -The kitchen staff was supposed to clean the catch basin at least every other day and clean the floors in the kitchen and pantry daily. -He was responsible for supervising the kitchen staff. Observations on 6/14/17 at 4:52pm revealed: -The catch basin and tile floors in the kitchen were clean. -There was a heavy buildup of dirt and food crumbs on the floor behind the door and underneath the shelving in the dry pantry unchanged from 6/14/17 at 10:59am. -There were empty food wrappers underneath the shelving in the dry pantry unchanged from 6/14/17 at 10:59am. -There were several flies in the kitchen and dining room.	D 282		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 24 (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve a pureed meal as ordered by the Primary Care Provider and listed on the diet sheet for two meal observations (lunch and dinner) for 1 of 2 residents (#3). The findings are: Review of Resident #3's current FL-2 dated 6/12/17 revealed: -Diagnoses included Alzheimer's Dementia, Hypertension, Osteoporosis and Gastroesophageal Reflux Disease. -There was on order for Pureed, No Added Salt diet (NAS). Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 4/5/17 revealed: -There was a mark next the personal assistance task for feeding techniques for residents with swallowing problems. -There was documentation the resident was on a NAS, pureed diet and required assistance with eating. Review of the facility's undated diet list revealed Resident #3 was on a no added salt pureed diet. Interview with the Cook on 6/14/17 at 4:57pm revealed most residents were on a regular diet with a few on mechanical soft and two residents on a pureed diet.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 25 Observations of the dinner meal on 6/14/17 from 5:24pm until 6:10pm revealed: -The Cook placed pulled chicken in gravy, mashed potatoes, marinated cucumbers with onions and brownies on the serving cart which he then took to the dining room where the residents were seated. -The pureed food was not prepared prior to the start of residents being served their meals. -The Cook and Personal Care Aides (PCAs) began serving residents the dinner meal at 5:34pm. -Resident #3 was served mashed potatoes and gravy with chocolate pudding at 5:52pm. -Resident #3 did not have any chicken or marinated cucumbers with onions on her plate. -Resident #3 was picking up food with her fingers, used the spoon at times and had some assistance and prompting by a PCA. -Resident #3 drank all of her milk and half of her tea; ate all of her pudding and one third of the mashed potatoes and gravy. -Resident #3 finished her dinner at 6:02pm. Interview with the Cook on 6/14/17 at 5:58pm revealed: -He had ground up chicken in the mashed potatoes and gravy for Resident #3. -He did not have a response for where were the marinated cucumbers and onions for Resident #3. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Observations of the lunch meal on 6/15/17 from 11:41am until 12:15pm revealed: -At 11:57am Resident #3 was served the lunch meal including finely chopped spaghetti with meat	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 26	D 310		

sauce, pureed squash and pudding.
-Resident #3 ate 80% of her meal and drank sips of milk and tea without any coughing, gagging or difficulty swallowing.

Interview with the Cook on 6/15/17 at 5:20pm revealed:
-His process for puree was to add some bread to the vegetables and blend until puree and the same process for the meat.
-The blender he had would not chop up things like spaghetti noodle to puree, but the blender would make it "real soft."

Observation on 6/16/17 at 11:55am revealed:
-The lunch meal had been pureed already for two residents.
-There was green beans the consistency of thick soup and turkey with stuffing resembling oatmeal.

Review of Primary Care Provider (PCP) visit notes for Resident #3 revealed:
-On 4/3/17 there was an order for aspiration precautions with a pureed diet.
-On 5/29/17 there was an order for aspiration precautions.
-On 6/15/17 there was a note documenting, "Aspiration precautions is a standard notification to staff to monitor a patient while eating due to dementia. There is no specific action needed."

Interview with the Executive Director (ED) on 6/16/17 at 10:39am revealed:
-He was responsible for supervising the kitchen staff.
-A new cook trained for three to seven days and had a safe serve certificate.
-The cooks had been trained on preparing pureed food.
-He could not remember when it was, but there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 310	Continued From page 27 had been a pureed class for the facility and the sister facility staff. -He was going to get [name of food supply company] to come back and repeat training on therapeutic diets.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 3 of 5 sampled residents (#3, #6 and #8) with a diagnosis of dementia and in a special care unit, who needed assistance in the dining room during two meal observations. The findings are: Interview with the Special Care Director (SCD) on 6/14/17 at 9:15am revealed breakfast was served at 7:00am, lunch was served at 12:00pm and dinner was served at 5:00pm. Interview with the Cook on 6/14/17 at 4:57 p.m. revealed there were four residents who needed assistance with feeding; Resident #6, #8, #11 and a fourth resident.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(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 312	Continued From page 28 Observations of the dinner meal on 6/14/17 from 5:24pm until 6:10pm revealed: -The Cook placed food for the dinner meal on the serving cart and began pouring some of the drinks including tea, milk and water in cups that were on a separate serving cart at 5:24pm -The cook did not fill all of the cups before taking the food serving cart and the drink cart to the dining room where residents were already seated. -The Cook and Personal Care Aides (PCAs) started serving residents drinks and the dinner meal at 5:34pm. -At 5:40pm, the Medication Aide (MA) added crushed medications to the mashed potatoes and gravy for Resident #6 and walked away. -Resident #6 was fussing with Resident #10 while attempting to feed herself. -Resident #10 attempted three times to eat food from Resident #6's meal tray. -The cook removed Resident #6's tray from in front of her and placed it on top of the serving cart uncovered at 5:43pm. -At 5:47pm, a PCA returned Resident #6's dinner tray and stood next to her to provide feeding assistance until 5:53pm. -At 5:52pm, Resident #8 was given a dinner roll and had not yet received her dinner tray. -At 5:56pm, Resident #8 was given her dinner tray and a Housekeeper/PCA stood next to her and provided feeding assistance until 6:02pm. -Resident #8 was fidgety and distracted during the dinner meal and ate only one third of the meal and drank sips of water, milk and tea with encouragement before the Housekeeper/PCA said, "You must not be too hungry." -A PCA stood next to and in front of Resident #3 who was in a Geri chair with a tray, to provide feeding assistance from 5:58pm until 6:02pm. -Resident #8 was assisted out of the dining room at 6:02pm.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 312	Continued From page 29 -There were no chairs available in the dining room for staff to sit next to and feed residents who needed assistance. Interview with a PCA on 6/15/17 at 4:05pm revealed: -The meal time was not usually the "way it was" on 6/14/17. -The Cook normally had the drinks and silverware on the table before the residents were seated in the dining room. -The Cook had told staff he was running behind for the dinner meal on 6/14/17. -She would sit down to the feed the residents at each meal. -The residents needed staff to pull up a chair and sit down with so they would eat. Observations of the lunch meal on 6/15/17 from 11:41am until 12:15pm revealed: -At 11:41am there was tea, milk and water at each place setting at each table in the dining room. -At 11:45am the door was opened for residents to enter the dining room. -At 11:48am Resident #6 was served and a PCA squatted next to the resident to provide feeding assistance. -At 11:51am the PCA was standing next to Resident #6 providing feeding assistance. -At 11:54am the Housekeeper brought a chair for the PCA to sit down while feeding Resident #6. -At 11:57am Resident #3 was served a lunch tray and the Housekeeper/PCA stood next to the resident to provide feeding assistance. -There were two other staff, plus one staff in training, standing next to two additional residents providing feeding assistance. Interview with the Housekeeper/PCA on 6/15/17	D 312		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 312	Continued From page 30 at 5:22pm revealed: -Providing feeding assistance meant make sure each resident had water, juice and milk. -Staff were supposed to sit down and feed the residents and talk to them. -In response to observations of the dinner meal on 6/14/17 and the lunch meal on 6/15/17, the Housekeeper/PCA said, "Some people sit, some stand and I am not a sitter." -Staff should always sit down with residents to provide feeding assistance out of respect and to encourage the residents to eat. 1. Review of Resident #6's current FL-2 dated 7/12/16 revealed diagnoses included Vascular Dementia and Metabolic Encephalopathy. Review of Resident #6's current care plan dated 1/19/17 revealed there was documentation the resident required extensive assistance with eating including supervision and prompting. Review of Resident #6's current Special Care Unit quarterly profile dated 4/17/17 revealed there was a mark next to dependent for eating for Resident #6. Review of Resident #6's May 2017 Personal Care Record revealed: -There was documentation Resident #6 required extensive assistance (EA) with eating. -Staff documented 62 of 93 opportunities as EA, leaving 31 entries blank for May 2017. Review of Resident #6's June 2017 Personal Care Record revealed: -There was documentation Resident #6 required Supervision (S) with eating. -Staff documented 8 of 45 opportunities as EA, one as totally dependent (TD) and the remaining	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 312	Continued From page 31 36 opportunities as S for May 2017. Interview with a Medication Aide (MA) on 6/16/17 at 11:19am revealed: -The Personal Care Records were not completed properly for Resident #6. -Resident #6 needed feeding assistance not just supervision. Based on observations, interviews and record reviews, Resident #6 was not interviewable. 2. Review of Resident #8's current FL-2 dated 6/12/17 revealed diagnoses included Dementia, Idiopathic Peripheral Neuropathy, Muscle Weakness and Age Related Physical Debility. Review of Resident #8's current care plan dated 5/15/17 revealed the resident required extensive assistance including prompting and supervision. Review of Resident #8's June 2017 Personal Care Record revealed: -There was documentation Resident #6 required extensive assistance (EA) with eating. -Staff documented 66 of 66 opportunities as EA for June 2017. Upon request on 6/21/17, 6/22/17 and 6/23/17, there was no May 2017 Personal Care Record available for review for Resident #8. Based on observations, interviews and record reviews, Resident #8 was not interviewable. 3. Review of Resident #3's current FL-2 dated 6/12/17 revealed: -Diagnoses included Alzheimer's Dementia, Osteoporosis and Gastroesophageal Reflux Disease.	D 312		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 312	Continued From page 32 -Diet order included a no added salt diet was to be pureed. Interview on 6/22/17 at 3pm with the Special Care Director revealed the resident had a pureed diet because she did not have any teeth. Review of Resident #3's current care plan dated 1/19/17 revealed there was documentation the resident required extensive assistance with eating including prompting at all meals and being fed sometimes. Based on observations, interviews and record reviews, Resident #3 was not interviewable. Interview with the Executive Director (ED) on 6/16/17 at 10:39am revealed: -He was responsible for supervising the kitchen staff. -There was a kitchen manager and a cook; the PCAs helped serve plates. -A new cook trained for three to seven days and had a safe serve certificate. -All staff were trained on feeding residents at hire. -He expected staff to assure drinks were on the table and to sit while feeding residents. -He was going to get [name of food supply company] to come back and repeat training on feeding assistance.	D 312		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 33	D 338		

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure residents were protected from abuse as evidenced by alleged physical abuse by Staff D toward three residents (#6, #10 and #11); alleged verbal abuse by two staff (D and E) toward four residents (#6, #10, #11 and #12); four residents having bruises of unknown origin (#6, #8, #10 and #11); and Resident #7, who had a diagnosis of Dementia and was known to have sexually aggressive behaviors towards other residents, being placed in Resident #13's room on admission to the facility when a private room was available.

The findings are:

1. Based on observations, interviews and record reviews, alleged verbal and physical abuse towards residents by two staff, Staff E and Staff D were as follows:

Confidential interview with a staff member revealed:
-Staff E was "just rude" toward residents.
-Staff E would yell at residents and say things like, "Get your black (expletive) in the room."
-Staff had witnessed Staff E pulling Resident #7 down to his room because he wasn't moving fast enough.
-Staff felt like it was useless to report the Special Care Director (SCD) and staff did not interact with the Executive Director (ED) "like that."
-The ED might be at the facility three days per week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 338	Continued From page 34 -That was why there was no point in reporting anything to the SCD, because nothing happens. Confidential interview on another staff member revealed: -Staff E was rude and cussed at residents. -"She yanks and pulls on their arms..." with no apparent injuries. -She had said something about it to Staff E but it did not help. -It had not been reported to the SCD or the ED since nothing was ever done about such things. -Never saw her "pop" any residents. Confidential interview with a third staff member revealed: -Staff E, PCA yelled at a resident and took a resident by the arm and dragged him out of a room. -She told the resident, "Don't come out of this room." and said things like, "Go to your (expletive) room." and "Stay in your (expletive) (expletive) room." Confidential interview with a fourth staff member revealed: -She had witnessed Staff E curse at Resident #14. -Staff E said, "I'm not taking your (explicit) out to smoke, you can take your own (expletive) out to smoke." -Staff E cursed at Resident #7 saying, "Get your mother (expletive) up and go to your room," on 6/14/17. -A lot of staff reported what Staff E said to resident #7 to the SCD the next day (6/15/17). Confidential interview with a resident revealed: -The resident was not afraid of any staff. -The resident had not known of any sexual	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 338	Continued From page 35	D 338		

abuse, but had seen some rough handling given to residents and had heard verbal abuse such as yelling at residents on the women's hall and the men from Staff D and Staff E.
-Staff E, who worked the late evening and through the night shift was very loud and disrespectful to residents.
-She made the resident feel like a child the way she spoke to the resident.
-She yelled out at residents in the hallway and in the day room using bad language.
-One time she "picked at a resident" over and over again during a television program by "tapping" him on his leg until he had to leave the room.
-Staff E had taunted a resident with a walker to chase her over and over again and the resident appeared distressed and concerned.
-She kept running around up and down the hall yelling at the resident to chase her.
-The resident was not stable on her feet and might have fallen with the PCA running at her and around her.
- She was very loud in the hallway even with the door shut and it was very disturbing to hear her and the way she spoke to the residents.
-The resident did not like the way Staff D and Staff E pulled on the residents' arms.
-Staff E was observed to jerk on a residents' arms and pull then down the hallway.
-The resident said Staff E was "bossy" and did not care about the residents.
-On one occasion, she made the resident go out to smoke on the front porch and not the smoking area in the back of the facility.
-The rule was only to use the front porch when it was raining. This time it was not raining.
-She explained to her that she preferred to follow the rules and go out to the back to smoke, but she made her go to the front porch to smoke with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 338	Continued From page 36	D 338		

her.
-She said ,"If you want to smoke you will go out front!"
-Another time she cursed as she did frequently when just talking, and she said, "I"m going to do whatever the hell I want!"
-She used "F(expletive) every other word "
-She was not suited to care for the elderly.
-"She was smart mouthed." and very disrespectful.
-The resident told management about some of the resident's concerns related to Staff E, but she was still working in the facility.

Interview on 6/16/17 at 5:40 p.m. with the ED and the SCD revealed:
-They were not aware of any type of abuse with any of the employees.
-There had never been a complaint investigation on any of the employees.
-No staff or residents had never reported to either the ED or the SCD any incidents of abuse of any kind.

Interview on 6/19/17 at 2:40 p.m. with the Special Care Director (SCD) revealed:
-She had not been aware of Staff E and any verbal abuse allegations.
-No residents or staff had told her about these allegations.
-No investigation had been completed related to these allegations.

A. Review of Resident #11's current FL-2 dated 4/25/17 revealed diagnoses included Alzheimer's disease, Type 2 Diabetes, Hypertension, Hyperlipidemia, Anxiety, and Mood disorder.

Confidential interview with a staff revealed:
-Staff frequently found bruises on residents after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 37 Staff D worked. -Staff would fill out incident reports about Staff D and the Special Care Director (SCD) would change the incident report or get rid of them. -Resident #11 was afraid of Staff D. -Resident #11 would not talk or sleep whenever Staff D worked. -Residents were neglected because staff did not do their job. -There were residents who had repeated falls and residents who had wounds that nothing was done about. Confidential interview with another staff revealed: -Staff D was abusive toward residents on the women's hall. -Staff could not report Staff D to the SCD or the Executive Director (ED) or they would get fired. -These allegations had been reported to the SCD and the ED and that staff was fired. Confidential interview with a resident: -The resident had witnessed Staff D speaking harshly to Resident #11. -Staff D often yells at Resident #11 ordering her around. -She had asked Staff D to stop speaking to Resident #11 that way several times. -The resident denied seeing Staff D hit Resident #11. Confidential interview with a third staff revealed: -The PCA had noticed some bruises on Resident #11 in the past but she was not certain of the date. -The PCA was told by other staff that Resident #11 had fallen. -The PCA noted that she had heard that Staff D had hit Resident #11. -She had not witnessed Staff D hitting Resident	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 38 #11. -She had seen Staff D handle Resident #11 & Resident #6 roughly as he was helping them with dressing and other activities of daily living. -The PCA knew other staff persons had reported Staff D to administration and nothing was ever done. Confidential telephone interview with fourth staff revealed: -The staff had noticed bruises on Resident #11's arm. -The staff reported he had heard from other staff that Staff D had caused the bruise. -The staff did not write an incident report regarding the bruises because another staff person had already done so. Interview with the Resident #11 on 6/19/17 at 10:30 a.m. revealed: -The resident was lying in bed grinding her teeth. -Resident did not respond verbally to questions but would shake her head in agreement or disagreement. -When asked if the resident had ever fallen, Resident #11 shook her head yes. -When asked if she had any bruises now, the resident shook her head no. -The resident shook her head yes when asked about being afraid of staff. -The resident also shook her head yes when asked specifically about Staff D. -When asked if Staff D had ever hit her, the resident shook her head yes. No bruises were observed on Resident #11 on 6/19/17. Interview with Resident # 11's Guardian revealed: -He had no concerns with her care.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 39	D 338		

-He comes to the facility every month to visit.
-He noted that the resident was now more agreeable to showering and had refused a lot in the past.
-Resident #11 used to walk the halls a lot but her mobility recently declined.
-Resident #11 now drags her feet and had two falls last month.
-He recalled that the last bruises he observed were consistent with a fall the resident had the day prior.

Review of incident reports for Resident #11 revealed:
-Resident #11 fell while walking on 5/11/17. There were no open wounds, cuts, or instant bruising.
-Resident #11 was found lying on the floor on 5/17/17. No injury was noted.

Review of skin and shower assessments for Resident #11 revealed:
-A bruise to the left forearm and wrist on 6/7/17.
-On 5/10/17 small bruising was observed to the inner right forearm and an area above the right elbow. A third bruise is noted on the upper part of the inner, left forearm.
-Bruising to the left shoulder was noted on a shower assessment sheet for 4/13/17.
-A clear skin assessment was noted on 3/9/17.

Telephone interview with Staff D on 6/16/17 at 7:02 p.m. revealed:
-He was not abusive toward any resident.
-He had not spoken harshly to Resident #11.
-He felt the allegations were out of spite and jealousy because he came to work to his job and did not sleep or use drugs.

Interview with the SCD on 6/22/17 at 4:08 p.m. revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 40 -She was not aware of any allegations of Staff D speaking harshly to or rough handling any residents. -Staff may have reported that Staff D was loud or that he did not make a resident's bed before he left at the end of his shift, but that was it. -If staff had reported a bruise and said that the bruise did not look related to a fall then an investigation would be done. -There were no investigations done because staff did not report that bruise appeared to be from rough handling or like finger prints. Interview on 6/16/17 at 5:40 p.m. with the ED and the SCD revealed: -They were not aware of any type of abuse with any of the employees. -There had never been a complaint investigation on any of the employees. -No staff or residents had never reported to either the ED or the SCD any incidents of abuse of any kind. -Staff D was a loud, tall, big man and it may have been concerning to residents because of his size and loud voice. -One resident complained he was "boisterous", but the resident does not understand. Interview with the ED on 6/16/17 at 7:40 p.m. revealed: -He was not aware of the allegations of verbal and physical abuse by Staff D. -He would only hear of stuff like this when he terminated an employee which he had recently done. -The SCD was not aware either. -No staff had reported these allegations to either of us. Interview with the Manager on 6/19/17 at 9:10	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 41	D 338		

a.m. revealed:
-He was at the facility one day per week.
-The Administrator would come to the facility "sporadically" due to health issues.
-The ED was at the facility every day.
-He had not been aware of the allegations of abuse involving Staff D.
-The ED had interviewed all of the Medication Aides (MAs) on 6/16/17 about the allegations.
-He had brought the Corporate Nurse with him to the facility on 6/19/17 and planned to interview all staff about the allegations.

Refer to interview on 6/22/17 at 4:08 p.m. with the SCU.

B. Review of resident #12's current FL-2 dated 4/25/17 revealed diagnoses included Vascular Dementia and Seizure disorder. Resident #12 was intermittently disoriented, required bathing assistance, was incontinent of bladder but continent of bowel, and semi-ambulatory with the use of a rollator.

Confidential telephone interview with staff revealed:
-Resident #12 was possibly abused by Staff D.
-There was an incident where Staff D yelled at Resident #12.
-Another staff person possibly witnessed him pushing Resident #12 while yelling at her.

Confidential telephone interview with a second staff person revealed:
-Staff D was abusive toward residents on the women's hall.
-Resident #12 had an accident and wet herself. Staff D would talk mean to Resident #12, saying things like, "You're nasty. You too grown for stuff like this."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 42 -Staff D's hand on the back of Resident #12's shoulder. -Staff reported that she was unsure of what type of contact occurred. -Staff could not report Staff D to the Special Care Director (SCD) or the Executive Director (ED) or they would get fired. -These allegations had been reported to the SCD and the ED and that staff was fired. Interview with Resident #12 on 6/16/17 at 6:00 p.m. revealed: -Resident #12 reported that she accidentally urinated on the floor while trying to make it to the restroom. -Staff D yelled, "Who peed on this floor?" -Resident #12 responded that she had done so by accident. -Resident #12 was embarrassed and Staff D hurt her feelings by yelling at her. -Staff D had never hit or pushed her. -When asked how she usually interacted with Staff D, Resident #12 shrugged her shoulders. -When asked if she was afraid of Staff D, Resident #12 said "maybe that's a yes." -Resident #12 did not feel comfortable discussing her concerns with administration. Telephone interview with Staff D on 6/20/17 at 10:11 a.m. revealed: -He was going down the women's hall and every time he went down there was pee on the floor. -He asked who was peeing on the floor. -Resident #12 said she had peed on the floor. Refer to interview on 6/22/17 at 4:08 p.m. with the SCU. C. Review of Resident #10's current FL-2 dated 11/17/16 revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 43 -The resident's diagnoses included vascular dementia, cerebral vascular accident with residual weakness, hypertension, diabetes mellitus, Crohn's Disease and chronic obstructive respiratory disease. -The resident was intermittently disoriented and a wanderer. -The resident was semi ambulatory. -The resident required assistance with bathing, dressing. -A medication order included Aggrenox capsule 200-25mg twice daily. (Anti-platelet agents used to prevent excessive blood clotting and thus prevent strokes.). Review of a medication order dated 1/23/17 revealed Aggrenox 200-25mg twice daily was reordered. Review of a psychotherapy note for Resident #10 dated 9/20/16 revealed the resident had vascular dementia with behavioral disturbances, anxiety and major depression. Review of Resident #10's assessment and care plan dated 1/19/17 revealed: -The resident required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming, and supervision with transfers. -The resident was always disoriented and a wanderer. Observations on 6/16/17 at 5:20 p.m., on 6/17/17 at 10:00 a.m. and on 6/22/17 at 10:00 a.m. of Resident #10 revealed there were no bruises or injuries to the arms wrists or hands. Observation on 6/19/17 at 11:15 a.m. revealed there were no marks or bruises on Resident #10's abdomen, forearms, back or legs.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 44 Review of Skin Assessment forms for Resident #10 signed by the medication aide (MA) revealed: -On 5/10/17 Small bruises and cut wrist on left hand was documented. -On 6/07/17 Light bruising on the left shoulder blade was documented. Review of Resident #10's "Charting Notes" for Resident #10 revealed there were no notes for the dates of the bruising on 5/10/17 and 6/07/17. Review of the facility's accident/incident reports revealed there was no documentation of a any accident/incident reports for the dates of the bruising, 5/10/17 and 6/07/17, documented by the medication aide for Resident #10. Review of the resident's primary care physician (PCP) visits revealed on 3/30/17, 4/04/17, 4/17/17 and 5/29/17 revealed there was no documentation related to bruising. Confidential interview with a staff member revealed: -Staff D "abused residents.", including Resident #10 with bruises on her arms. -The staff member saw Staff D, "grab her arms" (Resident #10) and left a mark on her wrist. -The staff member had heard Resident #10 say, "Stop hurting me." -The staff member completed skin assessments after Staff D worked because of resident treatment received from him. - The staff member was not comfortable reporting the incident to management for fear of being fired. Confidential interview from another staff member revealed Staff D was "abusive" to residents on	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 45	D 338		

the women's hall.

Confidential interview with a resident revealed:
-The resident did not like the way Staff D and Staff E pulled on the residents' arms.
-Staff E was observed to jerk on a residents' arms and pull then down the hallway.
-She was not suited to care for the elderly.

Review of facility time cards of Staff D, Nursing Assistant (NA) revealed:
-The times listed on the time card revealed he was on duty on 5/09/17 at approximatelt 9:45 p.m. and out on 5/10/17 at Approximatly 6:00 a.m. on the night shift.
-Time cards for 6/07/17 were requested and were not provided.

Based on observations interview and record review, Resident #10 was not interviewable.

Telephone interview on 6/22/17 at 12:56 p.m. with a family member of Resident #10 revealed:
-The resident was happy and doing well in the facility.
-Over the last few years there had been decline but she had adjusted and seemed well.
-He had no concerns about staff at the facility and was not aware of any concerns with the resident.
-The facility called when there were any changes.

Telephone interview on 6/20/17 at 10:15 a.m. with Staff D revealed:
-He worked on the men's hall mostly but had worked with the women's hall on the night shift sometimes.
-He worked some shiftson the women's hall in May 2017.
-On his shifts, he had assisted Resident #10 to get out of bed in the morning, dress and change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 46	D 338		

the resident before his shift ended when he had worked on the women's hall.
-He never saw bruises on Resident #10.
-He never grabbed Resident #10 by the wrist or arms and had not bruised the resident.
-He had not observed any staff injuring Resident #10 causing bruises.

Interview on 6/20/17 at 10:27 a.m. with a Medication Aide revealed:
-There had been no bruises observed on Resident #10.
-Staff were to fill out the bath Body Forms and the Skin Assessment forms if they saw sores, lesions and bruises and inform the MA and or the Special Care Director (SCD).
-She was not aware of any investigations into the reasons for cuts and bruises.
-The Executive Director (ED) and the SCD would complete any investigations.

Interview on 6/16/17 at 5:40 p.m. with the ED and the SCD revealed:
-They were not aware of any type of abuse with any of the employees.
-There had never been a complaint investigation on any of the employees.
-No staff or residents had never reported to either the ED or the SCD any incidents of abuse of any kind.
-Staff D was a loud, tall, big man and it may have been concerning to residents because of his size and loud voice.
-One resident complained he was "boisterous", but the resident does not understand.

Interview on 6/20/17 at 1:15 p.m. with the SCD revealed:
-She was not aware of any HCPR investigation by the facility for resident bruises of unknown origin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 47	D 338		

or verbal abuse by Staff E.
-A report would be completed by the ED.
-She was not aware of any residents with bruises at this time.
-When a resident was seen to have bruises during baths or on routine observations, the care staff were to write on the Skin Assessment sheets and give them to the medication aide to review and pass onto the SCD.
-When aides were bathing a resident, the Body Assessment was to be completed on the sheets for personal care sheets daily. and put in the personal care log notebook.
-There was not a system to ensure a review of the skin and bath reports and HCPR reports were completed when the injuries were of unknown origin.

Interview on 6/21/17 at 4:46 p.m. with the ED revealed:
-He was just been made aware of the bruises on some residents.
-He was not aware an investigation was to be completed and sent to the HCPR.
-He had not investigated all of the bruises with unknown injuries
-He had not completed a HCPR report for any bruises of unknown origin.

Interview on 6/22/17 at 4:10 p.m. with the SCD revealed:
-The process for report of bruises and injuries was for each PCA and NA and MA to document it and report it to the SCD.
-Document on the Bath Body form and/or the Skin Assessment form and report it to the MA and or the SCD for further follow-up and investigation as necessary.
-MA were to review the reports weekly.
-There was no system of review of all reports for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 48	D 338		

the SCD to assess needs and for reporting of injuries and bruising.

Refer to Interview with the SCD on 6/22/17 at 4:08 p.m.

D. Review of the current FL-2 dated 7/12/16 for Resident #6 revealed:
-The resident's diagnoses included vascular dementia, metabolic encephalopathy, hypertension, hypothyroid, atrial fibrillation, and chronic obstructive pulmonary disease.
-The resident was constantly disoriented and a wanderer.
-The resident required assistance with bathing and dressing.

Review of the assessment and care plan dated 1/19/17 for Resident #6 revealed:
-The resident required extensive assistance with eating, bathing, toileting, ambulation, dressing, grooming and transfers.
-The resident used a wheelchair.
-The resident was always disoriented with significant memory loss that required reminders.

Observations on 6/19/17 at 10:33 a.m., 6/20/17 at 8:45 a.m. and 6/23/17 at 11:45 a.m. of Resident #6 revealed there were no bruises or injuries observed on the resident's arms hands and wrists.

Review of an accident/incident form dated 4/16/17 at 1:30 p.m. was signed by the medication aide (MA) revealed:
-The aide was changing the resident's shirt and found bruising on the left and right arm and the MA would let the next shift know of the concern.
-Under the follow-up notes area, there was documentation the resident had small bruise on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 49	D 338		

each arm the same color as the one on her head. "It looked like where someone picked her up _?_. " (unable to read the last word). It was signed by the Executive Director (ED) with no date of the follow-up note documented.
- There was no other investigation information documented.

Review of Skin Assessment forms dated 5/10/17 by a MA revealed:
-There was documentation of arm and leg bruising.
-There was no documentation of a review by the SCD or ED.
-There was no documentation of an investigation having been completed.
-The MA contacted the physician and X-rays were ordered.

Review of facility time cards for Staff D for the night shift revealed:
-The time card had documentation he was in the facility on 5/09/17 at approximately 9:45 p.m. and out on 5/10/17 at approximately 6 a.m.
-Time cards for 4/16/17 were requested but not provided by the end of the survey.

Interview with a Medication Aide (MA) on 6/19/17 at 10:35 a.m. revealed:
-She had seen bruises on Resident #6's arm on 4/16/17.
-The bruises had been reported to her by the Personal Care Aides (PCAs) on duty.
-She asked the PCAs if the bruises were there the day before and the PCAs said no.
-She filled out an incident report and gave it to the Special Care Director (SCD).

Confidential interview with a staff revealed:
-Staff was abusive toward Resident #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 50 -He left bruises on Resident #6 with bruises on her arms. -Staff frequently found bruises on residents after Staff D worked. -The MA heard Resident #6 say, "Stop hurting me!" when Staff D is trying to assist the resident to dress. -His approach make that happen and he is not gentle. -He continues with the way he spoke to the residentsuch as harshly and loudly and then the resident would become even more agitated. -The MA completed skin assessments and incident reports for Resident #6 after Staff D worked because of the documentation of bruises after Staff D worked the night before. -"Staff would fill out incident reports about Staff D and give them to the SCD and after the SCD reviewed them she would change the reports or get rid of them." Confidential interview with a second staff member revealed: -Staff D was abusive toward residents on the women's hall. - He would be loud and was observed to be rough with his hands while assisting them to change clothes and other activites of daily living assistance. -The resident could be heard saying "You are hurting me." when Staff D was in the room with the resident. -Staff would document any bruising on Skin Assessment Forms and Bath Forms that would be reviewed by the SCD -Staff could not report Staff D to the SCD or the ED because they were afraid they would get fired. -These allegations had been reported before to the SCD and the ED by a different staff member and then that staff was fired.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 51 Confidential interview with a previous employee revealed: -Staff D, hurt resident when assisting them. -Staff D put his hands on Resident #6's shoulders and the resident said, "You are hurting me." -This was a routine thing and could not give a specific date for the incident. Confidential interview on a third staff member revealed: -The staff member had seen a bruise on Resident #6's left arm in April 2017. -The staff member had informed the MA who evaluated the resident's skin. -The procedure if bruises or injuries were found was to document it in the Bath Log on the body form or on the Skin Assessment Log if noticed not during bath time. -Then the staff members were to tell the MA or SCD. Interview on 6/16/17 at 5:25 p.m. with Resident #6 revealed: -She liked it at the facility and had no problems. -Food medication administration and getting to physician checks were no problem. -Personal care staff helped with her bath, cooked her food and gave her medications. -Staff were nice to the residents and she had not been aware of any resident abuse by staff either verbal or physical. -She did not think she had ever had any bruises or injuries. Attempted telephone interview with Resident #6's family member revealed they were not available. Confidential interview with a resident revealed: -The resident had seen some rough handling	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 52	D 338		

given to residents.
-The resident did not like the way Staff D and Staff E pulled on the residents' arms.
-Staff E was observed to jerk on a residents' arms and pull then down the hallway.
-She was not suited to care for the elderly.
-She had told management about some of her concerns related to Staff E, but she was still working in the facility.

Review of facility time cards of Staff D, Nursing Assistant (NA) revealed:
-He was on duty on 5/09/17 at "21:42" and out on 5/10/17 at "5:98" on the night shift.
-Time cards for 6/07/17 were requested and were not provided.

Telephone interview with Staff D on 6/16/17 at 7:02 p.m. revealed:
-He was not abusive toward any resident.
-He had not rough-handled Resident #6.
-He felt the allegations were out of spite and jealousy because he came to work to his job and not sleep on the job or use drugs.

Confidential interview with a fourth staff member revealed:
-She saw Staff D had worked the night of 4/15/17 when she came in at 6 a.m. on 4/16/17 and this was the night before the resident was discovered to have arm bruises on 4/16/17.
-She went to check on the resident that morning because of this and the resident was found to have arm bruises.
-Staff D was big and might have caused the marks on the resident.

Confidential interview with a fifth staff member revealed:
-The staff member had seen bruises on Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 53 #6's arms after the third shift at night. -She had bruises on both of her upper arms. -Staff was concerned Resident #6 "was getting beaten because the bruises were not fall bruises, the bruises were on her upper arms and looked like finger prints like someone grabbed her." -Staff D, Nursing Assistant (NA) had worked that night. -He was alright with working with some residents and others he was not. -He and Resident #6 did not get along well. He was "rude" in his approach to her. It was how he said it to her when changing clothes or assisting with toileting. -Staff D worked on the women's hall only on 3rd shift. -Staff D did not get along with Resident #6 and most of the male residents -The resident was known to be difficult with personal care tasks at times and could sometimes kick and pinch. - The resident would swing at you if you come near her sometimes. - It all depended on the staff's approach to her. - For example, Staff D would say "Come on, I'm about to change you," instead of saying, "Let's go get changed." -She will respond better if staff would sit and converse with her first. -It was not so much what Staff D was saying, but how he said it. -Staff have to wait until she calms down to provide care. Confidential interview with sixth staff member revealed: -The sixth staff member had seen a bruise on Resident #6's left arm in April 2017. -The the sixth staff member informed the MA who evaluated the resident's skin.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 54 -The procedure if bruises or injuries found was to document it in the Bath Log on the body form or on the Skin Assessment Log if noticed not during bath time and then tell the MA or SCD. Interview on 6/21/17 at 1:15 p.m. with the ED revealed: -The resident had a fall recently and it appeared someone put their hands on the resident to lift her up. -There were marks on her arms. -There was no information provided of who had lifted the resident up by the arms. -There was no investigation completed related to the hand marks on the residents arms since she had a fall and someone picked her up. -He was unaware the hand marks were a result of excessive pressure on the resident and had not been investigated. Interview on 6/21/17 at 2:20 p.m. with the ED revealed: -He was not aware of the need to report bruises of unknown origin. -He did not interview or complete any other record reviews to investigate the finding of the bruises. -He said, on 4/16/17 the accident/incident report for Resident #6 revealed the bruises were like someone picked her up and made the bruises. -PCAs were to note on the Body Assessment form any injuries and bruises and then report it to the SCD or ED and they would follow-up on it. - They would ensure primary care physician (PCP) and family would be notified. Interview on 6/22/17 at 4:40 p.m. with the SCD revealed: -She did not think Staff D gave Resident #6 any bruises.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 338	Continued From page 55 -He was a loud, tall man with large hands, but would not hurt a resident. -When he grabbed Resident #6 on her upper arms to picked her up it may have left hand mark bruises. Refer to interview on 6/22/17 at 4:08 p.m. with the SCU. E. Review of Resident #8's current FL-2 dated 6/12/17 revealed diagnoses included Dementia, Chronic Atrial Fibrillation, Idiopathic Peripheral Neuropathy, Muscle Weakness and Age Related Physical Debility. Observation on 6/14/17 at 11:45 a.m. revealed Resident #8 had a large bruise on the right side of her face. Interview with a Housekeeper/Personal Care Aide (PCA) on 6/14/17 at 11:45 a.m. revealed: -Resident #8 had gotten the bruise from a fall. -The resident had returned from the hospital with the bruise. -The resident did not fall at the hospital. -She thought the resident may have fell out of the bed and then went to the hospital. Observations on 6/19/17 at 10:58 a.m. revealed Resident #8 had bruises on her left elbow, left forearm and right hip. Interview with a Personal Care Aide (PCA) on 6/19/17 at 10:58 a.m. revealed: -She did not think the bruises were from the last fall Resident #8 had because she had a bruise on her face and behind her knee when she fell. -She had showered the resident the morning of 6/19/17 and did not see any bruises.	D 338		

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D 338	Continued From page 56 Based on observations, interviews and record reviews, Resident #8 was not interviewable. Attempted interview with the family member on 6/23/17 at 2:16 p.m. was unsuccessful. Interview on 6/20/17 at 1:15 p.m. with the Special Care Director (SCD) revealed: -She was not aware of any residents with bruises at this time. -When a resident was seen to have bruises during baths or on routine observations, the care staff were to write on the Skin Assessment sheets and give them to the medication aide to review and pass onto the SCD. -When aides were bathing a resident, the Body Assessment was to be completed on the sheets for personal care sheets daily. and put in the personal care log notebook. Interview on 6/21/17 at 4:46 p.m. with the ED revealed he had just been made aware of the bruises on some residents. Interview on 6/22/17 at 4:10 p.m. with the SCD revealed: -The process for report of bruises and injuries was for each PCA and NA and MA to document it and report it to the SCD. -Document on the Bath Body form and/or the Skin Assessment form and report it to the MA and or the SCD for further follow-up and investigation as necessary. -MA were to review the reports weekly. -There was no system of review of all reports for the SCD to assess needs and for reporting of injuries and bruising. Refer to interview with the SCD on 6/22/17 at 4:08 p.m.	D 338		

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D 338	Continued From page 57 2. Review of Resident #13's current FL-2 dated 6/12/17 revealed diagnoses included Alzheimer's Dementia, Peripheral Vascular Disease and Hypertension. Based on observations, interviews and record reviews, Resident #13 was not interviewable. Confidential interview with a staff revealed: -There was an incident between Resident #13 and Resident #7. -The facility management brought Resident #7 back to the facility knowing he was sexually abusive. -Resident #7 was at the facility before 6/01/17 and was on top of another resident then. Telephone interview with the family member of Resident #13 on 6/19/17 at 11:34 a.m. revealed: -The facility had contacted another family member on Monday last week (6/12/17) about an incident involving another resident. -There was a problem with another resident they had to move out of Resident #13's room because he was standing over Resident #13 "or something like that." -She was concerned and wanted more details about the incident. -A woman who identified herself as the person in charge contacted the family member. -The woman said the staff at the facility "checked" Resident #13 and "did not think anything happened." Interview with a Personal Care Aide (PCA) on 6/20/17 at 2:34 p.m revealed: -She was at work the night the incident happened with Resident #7 and Resident #13 (3rd shift 6/8/17) and had completed an Incident/Accident	D 338		

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D 338	Continued From page 58	D 338		

Report for Resident #7.
-She found Resident #7 standing in front of Resident #13.
-Resident #7 was holding Resident #13's penis.
-When she tried to get Resident #7 away from Resident #13, Resident #7 swung at her.
-Resident #7 said he was helping Resident #13 with his shoe, but he wasn't.
-Resident #13 was trying to put his pants back on, but Resident #7 would not let him.
-Staff at the facility knew Resident #7 had had these kind of behaviors before.
-The PCA did not know why Resident #7 was put in the room with Resident #13 or even this type of facility.
-The PCA was told to "just keep an eye on (Resident #7) because he was constantly trying to get into other (residents') rooms."
-There was no incident report completed for Resident #13.

Review of "Nurse's Notes" for Resident #13 revealed there was no documentation on the incident that occurred on 6/9/17.

Review of electronic notes for Resident #13 dated 2/09/17 through 5/20/17 revealed there was no documentation after 5/20/17 and no documentation of any incidents.

Review of a "Fax" form dated 6/09/17 revealed:
-The fax form was addressed to the Department of Social Services (DSS).
-Staff documented the subject as "[Name of Resident #7] Incident report."
-Staff documented under comments "My plan of Protection was to notify [Name of sheriff department]. I moved resident to a private room. I ordered one on one for resident and put a referral for resident to be seen by the MD on Monday

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 338	Continued From page 59 [6/12/17]." -There was no documentation for what was done for Resident #13. Review of "Incident/Accident Reports" for Resident #13 revealed there was no incident report for the incident which occurred on 6/9/17 involving Resident #7. Interview with the Special Care Director (SCD) on 6/19/17 at 12:50 p.m. and 1:56 p.m. revealed: -Staff from the 3rd shift had reported finding Resident #7 standing over Resident #13 overnight on 6/08/17. -Resident #13's pants were down and Resident #7's back was turned toward staff so they did not see what he was doing. -Staff moved Resident #7 into another room immediately after the incident. -Staff were instructed to "do more checks on him than normal for a while after that," meaning for staff to "just make sure (Resident #7) was in his room at night." -The 2nd and 3rd shift staff were instructed to check Resident #7. -The Department of Social Services (DSS), the Sheriff's Department, both Residents' family and the PCP were notified. -The PCP was notified about Resident #7 and saw him at the facility on 6/12/17. -The PCP was not notified about Resident #13 and she did not know if he was seen by the PCP. -She was unable to locate an Incident/Accident Report for Resident #13. Telephone interview with the Primary Care Provider (PCP) on 6/21/17 at 4:59 p.m. revealed: -Staff had not informed her about Resident #13 related to the incident which occurred on 6/9/17 with Resident #7.	D 338		

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D 338	Continued From page 60 -Staff had notified her of Resident #7's behaviors about two weeks ago. -Resident #7 had been followed by a Mental Health Provider at the sister facility for the same behaviors. Attempted interview with the previous Mental Health Provider (MHP) on 6/23/17 at 8:25 p.m. was unsuccessful. Confidential interview with a second staff revealed: -Resident #7 was found on top of a former resident trying to insert himself in him. -The facility management knew about Resident #7 and that he had a history of attempting to have sex with other male residents when they brought him back to the facility because he was known for doing that (attempting to have sex with other male residents). Confidential interview with a third staff revealed: -He had been at the facility before when a hurricane flooded a sister facility. -Resident #7 had been back at the facility for approximately three weeks. -She had heard about an incident with Resident #7 and another resident, but did not want to talk about it. -She had heard that Resident #7 liked men. Confidential interview with a fourth staff revealed: -Staff had heard that Resident #7 was found on top of a former resident and the resident was yelling. -Most of the staff that were working when that incident happened were no longer working at the facility. -The incident with Resident #7 and the former resident happened sometime between 2/1/17 and	D 338		

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D 338	Continued From page 61 2/20/17. Telephone interview with a family member of a former resident on 6/20/17 at 9:43 a.m. and 6/21/17 at 9:16 a.m. revealed: -There was not enough staff. -She did not trust that the former resident was being watched or fed. -Staff at the facility had told her about an incident with the former resident and another resident. -She thought someone wandered into the former resident's room and "got too close or something." -She did not get the details of the incident. -The incident happened close to the time the former resident left in February 2017. -The former resident was moved to another facility related to the decline in care and services at this facility. Confidential interview with a fifth staff revealed: -"It was fair to say that when (Resident #7) came back to the facility (6/1/17), that it was known that he was like that (had a history of attempting to have sex with other male residents)." -Staff was told by other staff after the incident with Resident #13, that Resident #7 needed to "be watched to make sure he didn't go into other (residents') rooms." Interview with the assistant SCD on 6/19/17 at 1:47 p.m. revealed: -She was assisting the SCD and Executive Director (ED). -She worked at the facility during a flood related displacement of staff and residents from the sister facility. -Resident #7 was previously at the facility for approximately six months related to the flooding at a sister facility from approximately October 2016 until March 2017.	D 338		

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D 338	Continued From page 62 -He was admitted to the facility for "census purposes" on 6/1/17. -She was not aware of any previous incidents involving Resident #7 and another resident while he was at the facility related to the flood or at the sister facility. -Resident #7 had been known to wander into other residents' rooms but had not touched anyone before. -She was not aware of any interventions in place to supervise Resident #7 since admission to the facility. -Management was not aware of any previous incidents so there was no need to put interventions in place to protect other residents from possible sexual abuse by Resident #7. Interview with the Manager on 6/19/17 at 1:56 p.m. revealed: -He had not heard of any incidents involving Resident #7 other than the "dropping of his pants" with Resident #13. -There would be no interventions in place to protect residents from potential sexual abuse prior to the incident on 6/9/17, if he was not aware of the behavior. Refer to Interview with the SCD on 6/22/17 at 4:08 p.m. --- Interview with the SCD on 6/22/17 at 4:08 p.m. revealed if staff were concerned about how a resident was being treated by staff or another resident they were expected to notify their immediate Supervisor, the SCD or the ED. --- The facility failed to assure residents were protected from abuse as evidenced by alleged	D 338		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 338	Continued From page 63 physical abuse by Staff D toward three residents (#6, #10 and #11); alleged verbal abuse by two staff (D and E) toward four residents (#6, #10, #11 and #12); four residents having bruises of unknown origin (#6, #8, #10 and #11); and Resident #7, who had a diagnosis of Dementia and was known to have sexually aggressive behaviors towards other residents, being placed in Resident #13's room on admission to the facility when a private room was available. The facility's failure to assure resident were free of verbal, physical and sexual abuse resulted in serious physical, mental and emotional harm to residents, which constitutes a Type A1 Violation. _____ Review of the Plan of Protection dated 6/16/17 revealed: - Employee with allegations have been suspended. - The Executive Director (ED) will contact the facility over the weekend to ensure the employee does not return to the property. - The ED will make the 24 hour and 5 day report to the Health Care Personnel Registry. - The facility will have resident rights training class completed. - A complaint box for staff and families will be installed to ensure all complaints are known in case they did not feel comfortable speaking face to face. - The ED has an open door policy to all. - There will be monthly meetings for staff to express concerns. Review of the Plan of Protection addendum dated 6/19/17 revealed: - The facility will completed 30 minute checks on all residents for all shifts. - All supervisors will be trained and instructed if	D 338		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 338	Continued From page 64 any reports of verbal or physical abuse, the employees involved will be immediately removed from the facility and the facility will initiate and internal investigation. - If any complaint of abuse will include corporate office in it's investigation. - All staff will be trained on resident rights with assistance of the ombudsman. - The facility will have staff complete 30 minute rounds checks on all residents fro all shifts. - All staff will monitor for verbal and physical abuse and report to the supervisor immediately. - Administrative staff will be in constant communication with all staff and residents to question incidents of abuse. - Medication aides will observe and monitor floor staff each shift and report to the Resident Care Director. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 7/23/17.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 358	Continued From page 65	D 358		

reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents resulting in antibiotic eye drops (Gentamycin) not being administered for 3 days to Resident #1 who had drainage and redness of both his eyes.

The findings are:

Review of Resident #1's current FL-2 dated 9/23/16 revealed diagnoses included Dementia and Diabetes Mellitus.

Observation on 6/14/17 at 10:45am revealed:
-Resident #1 had crusted yellow drainage around his right eye.
-Resident #1 had redness to both of his eyes and eye lids.

Based on observations, interviews and record reviews, Resident #1 was not interviewable.

Review of a Primary Care Provider (PCP) visit note for Resident #1 dated 6/12/17 revealed there was an order for Gentamycin eye drops 0.3% two drops three times daily for ten days.

Observation of medications on hand for Resident #1 on 6/15/17 at 12:10pm revealed:
-There was a prescription bottle with a pharmacy label that included Resident #1's name, instructions for Gentamycin 0.3% two drops to affected eye(s) three times daily and a dispense date of 6/12/17.
-Inside the prescription bottle there was a manufacturer's bottle of Gentamycin 0.3% eye drops that had the safety seal intact/was unopened.

Interview with the Medication Aide (MA) on

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D 358	Continued From page 66 6/15/17 at 12:10pm revealed: -There were originally two bottles of the Gentamycin eye drops from the pharmacy. -Resident #1 would not let staff give him eye drops; he would always refuse. Review of Resident #1's June 2017 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Gentamycin 0.3% two drops to affected eye(s) three times daily. -There were five staff initials documented between 6/13/17 and 6/14/17. -Three of the five initials were circled with notations under exceptions that the resident refused three doses. -There was one dose documented as given on 6/13/17 and one dose documented as given on 6/14/17. Attempted interview with Resident #1's family member on 6/15/17 at 3:24pm was unsuccessful. Interview with the Special Care Director (SCD) on 6/15/17 at 3:07pm revealed: -The initials on Resident #1's eMAR on 6/13/17 and 6/14/17 documenting the Gentamycin eye drops had been administered to the resident were her initials. -She had administered the eye drops as documented. -There was a second bottle of Gentamycin eye drops on the medication cart that she threw away on 6/14/17 after completing the medication pass because it was empty. Telephone interview with a Pharmacy Technician at the facility's contracted pharmacy on 6/15/17 at 3:26pm revealed: -The pharmacy dispensed one 5ml bottle of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 67 Gentamycin eye drops for Resident #1 on 6/12/17. -The PCP's order was for ten days and one bottle was enough for the ten days. -One bottle was all that was sent to the facility. Second interview with the SCD on 6/16/17 at 12:00pm revealed: -She "could have sworn it was Gentamycin eye drops she threw out on 6/14/17." -She gave Resident #1 his eye drops as documented. -She did not have any further comment on the pharmacy dispensing only one bottle and one bottle on the medication cart unopened. Telephone interview with the Primary Care Provider (PCP) on 6/15/17 at 4:49pm revealed: -She had ordered the Gentamycin eye drops for Resident #1 because she was concerned that the crusting and redness of his eyes may have been an infection. -She was aware the resident frequently refused medications, but wanted "to make sure we at least tried to give him something." Interview with the Executive Director (ED) on 6/16/17 at 10:39am revealed: -He and the SCD regularly reviewed eMARs. -He did a "walk through all the time to observe staff. -The pharmacy also observed random medication passes and checked the medication cart. -He was going to get pharmacy to come to the facility and do a training on medication administration and medication refusals.	D 358		
D 392	10A NCAC 13F .1008(a) Controlled Substances	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 392	Continued From page 68 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to have a readily retrievable and accurate record to account for controlled substances for 1 of 2 sampled residents (#9), resulting in 202 opiate pain reliever tablets (Percocet) being unaccounted for. The findings are: Review of Resident #9's current FL-2 dated 6/12/17 revealed: -Diagnoses included Alzheimer's Dementia, Anemia, Depression and Seizures. -There was an order for Percocet 5/325mg one tablet every eight hours as needed for pain. (Percocet is a narcotic pain reliever used to treat moderate pain.) Confidential interview with a staff revealed: -Resident #9 took Percocet every now and then. -All of sudden all of his Percocet was gone. -He had been out of Percocet for approximately two weeks. Interview with Resident #9 on 6/16/17 at 6:45pm revealed: -He took Percocet for pain in his amputated leg. -He usually only took the Percocet at night when	D 392		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 392	Continued From page 69	D 392		

his leg hurt.
-He did not take the Percocet during the day.
-The staff usually brought him Percocet when he asked for it, but he ran out.
-The staff told him they were going to get a refill, but they had not done that yet.
-It had been approximately two weeks since he ran out and staff told him they did not know what was taking so long.
-He could not remember the name of the Medication Aide that told him about the Percocet refill.
-For the past two weeks, the staff had given him Tylenol, but it did not work.

Observation of medications on hand for Resident #9 on 6/19/17 at 4:50pm revealed there were no Percocet tablets on the medication cart for Resident #9.

Interview with the Medication Aide (MA) on 6/19/17 at 4:50pm revealed:
-There were no controlled drugs on the medication cart for Resident #9.
-She thought he used to have an as needed pain medication, but she thought that was all done.

Review of prescription orders signed by the Primary Care Provider (PCP) for Resident #9 revealed:
-There was an order for Percocet 5/325mg one tablet every eight hours as needed for pain (90 tablets) dated 4/17/17.
-There was an order for Percocet 5/325mg one tablet every eight hours as needed for pain (90 tablets) dated 6/12/17.

Review of a Controlled Drug Record dated 8/30/16 for Resident #9 revealed:
-There was a Controlled Drug Record with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 392	Continued From page 70	D 392		

pharmacy label that included Resident #9's name, instructions for Percocet 10/325mg four times daily and that 120 tablets were dispensed on 8/30/16.
-There was documentation that 27 tablets were administered between 8/31/16 and 9/9/16.
-There was documentation on 9/10/16 that 82 tablets remained.
-There were no further entries.

Review of a Controlled Drug Record dated 10/24/16 for Resident #9 revealed:
-There was a Controlled Drug Record with a pharmacy label that included Resident #9's name, instructions for Percocet 5/325mg every eight hours as needed for pain and that 90 tablets were dispensed on 10/24/16.
-There was documentation that 90 tablets were administered between 10/25/16 and 5/23/17.

Upon request 6/20/17 through 6/23/17, the order for the 8/30/16 dispensing of 120 Percocet tablets for Resident #9 was not available for review.

Upon request 6/20/17 through 6/23/17, the Controlled Drug Record for the order dated 4/17/17 for Percocet tablets for Resident #9.

Review of Resident #9's April 2017 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Percocet 5325mg one tablet every eight hours as needed for pain.
-There was documentation that two doses were administered on 4/19/17 and 4/26/17.

Review of Resident #9's May 2017 eMAR revealed:
-There was an entry for Percocet 5325mg one tablet every eight hours as needed for pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 392	Continued From page 71 -There was documentation that two doses were administered on 5/8/17 and 5/23/17. Review of Resident #9's June 2017 eMAR revealed: -There was an entry for Percocet 5325mg one tablet every eight hours as needed for pain. -There was no documentation that any doses were administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 6/20/17 at 3:38pm revealed: -The pharmacy dispensed 90 Percocet tablets on 10/24/16, 4/17/17, and 6/12/17. -He would have to look into any returns from the facility of Percocet 10/325mg tablets regarding Rx# 1216544 for the return of 82 remaining Percocet tablets from the 8/30/16 dispense of 120 Percocet tablets. Upon request on 6/20/17 at 3:38pm and 6/22/17 at 4:08pm, the written pharmacy dispensing records were not available for review. Based on review of prescription orders, Controlled Drug Records and eMARs; and the pharmacy interview regarding dispensing records for Percocet tablets for Resident #9, there were 180 unaccounted for that were delivered to the facility on 4/17/17 and 6/12/17. Confidential interview with a second staff revealed Resident #9 kept to himself, hardly complained of anything and staff saw him get pain medications twice over the last three months. Confidential interview with a third staff revealed: -Resident #9 had to "really be in a lot of pain to	D 392		

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D 392	Continued From page 72	D 392		

ask" for Percocet.
-Resident #9 did not ask often.
-His Percocet went from full to none almost overnight.
-The Special Care Director (SCD) kept Resident #9's Percocet in her office.
-Resident #9 was in pain and there were no Percocet on the medication cart or in the SCD's office.

Second interview with the MA on 6/20/17 at 4:25pm revealed:
-Resident #9 had been out of Percocet for approximately two weeks.
-She had asked the PCP to refill the Percocet on 6/12/17 because the resident asked for a pain pill and he was out.
-She called the pharmacy for a refill and the pharmacy told her she would need a new prescription.

Telephone interview with the PCP on 6/21/17 at 4:59pm revealed:
-She had seen Resident #9 approximately two to three weeks ago and refilled his prescription for Percocet.
-The resident was getting Percocet as needed for Peripheral Vascular Disease pain that he experienced off and on.
-She was not aware of any "big pain issues" for Resident #9.

Telephone interview with a second MA on 6/21/17 at 9:57am revealed:
-Resident #9 was getting Percocet for pain, but he did not take it every day.
-He asked for a pain pill about a month ago and was out.
-He did not reorder narcotics before checking with the Administrative staff, so he reported to the

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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 392	Continued From page 73 oncoming MA to follow up. Interview with a third MA on 6/21/17 at 1:40pm and 4:26pm revealed: -There were no Percocet tablets on the medication cart for Resident #9. -The controlled drugs were stored on the medication cart only. Interview with the Special Care Director (SCD) on 6/21/17 at 4:37pm revealed: -She had the overflow supply of controlled drugs in a locked file cabinet in her office. -She had Percocet tablets for Resident #9 -The MAs were aware that she kept the overflow supply in her office. -The MAs knew that when they got down to about ten tablets on the medication cart to come see her. -All medications including controlled drugs were delivered to the facility on 3rd shift by the pharmacy. -The MA on duty at the time of the pharmacy delivery verified the contents of the delivery tote and signed a packing slip. -One bubble pack was put on the cart and the rest were given to the SCD. -There should have been 30 Percocet tablets on the medication cart with a controlled drug sheet. -The process to monitor the accounting of controlled drugs was for staff to complete a count at the change of shift unless that MA was working a double shift, then no count was done. -One MA looks at the actual medication and the second MA looks at the controlled drug sheet to verify the count. -If there was a problem, the MAs were supposed to report to the SCD. -She kept the overflow supply in her office to prevent incidents where there were controlled	D 392		

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D 392	Continued From page 74 drugs that were not accounted for. -There was no system in place to double check that controlled drug that were delivered were on the cart with a Controlled Drug Record. Observation of "Overflow" controlled drugs for Resident #9 stored in the SCD office on 6/21/17 at 4:37pm revealed: -There were two bubble packs of 30 tablets each with a pharmacy label with Resident #9's name and documentation that 90 Percocet tablets were dispensed on 6/12/17. -There was one Controlled Drug Record sheet with a pharmacy label. Review of the facility's copy of pharmacy packing slips dated 4/17/17 and 6/12/17 revealed: -There was documentation that 90 Percocet tablets were delivered to the facility on 4/17/17 and 6/12/17 for Resident #9. -The packing slips were not signed. Interview with a SCD of a sister facility on 6/21/17 at 5:40pm and 6/22/17 at 4:08pm revealed: -The MA was supposed to sign the facility's copy of the packing slip, but they did not always do this. -She did not know if the pharmacy had a separate delivery sheet that they took with them. -The packing slips for all pharmacy deliveries were kept in a binder in the medication room. -The SCD was responsible for checking the packing slips after pharmacy deliveries to verify what came in. -The controlled drug counts were kept on paper only, they were not counted in the eMAR system. -She had not been able to locate the Controlled Drug Records for 4/17/17 or the return sheets for the 82 tablets from the 8/30/17 dispense of Percocet.	D 392		

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D 392	Continued From page 75 Telephone interview with a Pharmacy Technician from the facility's contracted pharmacy on 6/22/17 at 5:31pm revealed: -There were two copies of the packing slips; one for the facility and one for the pharmacy. -The facility staff signed the pharmacy copy after verifying the contents of the delivery tote. -The facility staff circle or underline anything not in the tote. -The pharmacy driver kept the signed copy. Interview with the Executive Director (ED) on 6/21/17 at 5:40pm revealed: -He checked with the pharmacy to see if any of the Percocet dispensed on 4/17/17 and 6/12/17 had been returned to the pharmacy. -He was waiting on a return call after they checked the pharmacy records. -Not having a control sheet was "awfully suspicious." -Contacting law enforcement would be his next step. Second telephone interview with the Pharmacist at the facility's contacted pharmacy on 6/22/17 at 4:08pm revealed: -The facility had been in touch with the pharmacy and requested return sheets for controlled drugs for Resident #9 also. -There were no records of any returns for Percocet for Resident #9 from August 2016 until now. Based on review of prescription orders, Controlled Drug Records, eMARs and packing slips; the pharmacy interview regarding dispensing and return records and the observation of the overflow supply of Percocet tablets for Resident #9, there were 120 tablets of	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 76 Percocet 5/325mg tablets unaccounted for that were delivered to the facility on 4/17/17 and 6/12/17; and 82 Percocet 10/325mg tablets unaccounted for that were dispensed on 8/30/16. Interview with the Manager on 6/23/17 at 4:01pm revealed: -The 202 Percocet tablets for Resident #9 that were unaccounted for were reported to law enforcement. -Law enforcement would conduct an investigation. -There was nothing more the facility could do; there were no tablets and no Controlled Drug Records. _____ The facility's failure to accurately account for 202 Percocet tablets resulted in pain relieving medication being unavailable for three weeks for Resident #9. The facility's failure to maintain accurate controlled substance records was detrimental to the wellbeing of Resident #9, which constitutes a Type B Violation. _____ Review of the Plan of Protection dated 6/21/17 revealed: - The Executive Director contacted the pharmacy immediately. - The facility will complete random medication cart audits. - The resident care director will complete the first audit today of all controlled substances. and ensure all medications are delivered counted and placed on the medication cart with proper medication counts. - The RCD will complete medication cart audits on the first of the week and at every end of the week.	D 392		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 392	Continued From page 77 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 8/07/17.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to report allegations of verbal and physical abuse to the Health Care Personnel Registry (HCPR) of two staff (D and E) affecting four residents (#6, #10, #11 and #12.); and bruises of unknown origin on three residents (#6, #10, #11). The findings are: Multiple confidential staff interviews related to verbal and physical abuse on Residents #6, # 7, #10, #11, #12 and a confidental resident # by Staff E were as follows: Multiple confidential interviews related to Staff E revealed: -Five staff had heard verbal abuse and three staff had observed physical abuse by Staff E to	D 438		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 438	Continued From page 78 Residents #6, #10, #11, #12 and a (confidental resident #). -One staff member said many staff reported this incident to Special Care Director (SCU). reported from an incident dated 6/15/17 Resident #7 related to verbal abuse and cursing. Confidential interviews with two residents revealed: -They whitnessed or experienced verbal and/or physical abuse by Staff E. -One resident repoerted the concerns to the Executive Director several times. -The resident could not recall any of the dates. Confidential interviews related to Staff D revealed: -Six staff had observed verbal abuse of Staff D with residents #6 #10, #11, #12 and seven staff had observed physical abuse of residents on a routine basis while providing dressing and toileting... Confidential interviews with two residents revealed: -Staff D was physically and verbally abusive to residents. -One resident repoerted the concerns to the Executive Director several times. Skin and Shower Assessments documenting bruises of an unknown origin were as follows. Shower Skin Assessments dated 4/13/17, 5/10/17 and 6/07/17 revealed: -There was documentation of bruising on Resident #11. -Review of Resident #11's Shower and Skin Assessments revealed was no documentation of a Health Care Personnel Registry investigation	D 438		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 438	Continued From page 79 and reporting related to the buises of unknown origin. Review of an Accident/Incident Report for Resident #6 dated 5/10/17 revealed: -There was bruising on both arms. -The ED reviewed the report but there was no doumentation of a HCPR investigation and reporting having been completed. Review of two Skin Assessments and two Accident/Incident Reports for Resident #10 revealed: - There was bruising of unknown origin for the resident. - There was no documentation of a HCPR investigation and reporting of the bruises of unknown origin. Observations on 6/19/17 at 10:58 a.m. revealed Resident #8 had bruises on her left elbow, left forearm and right hip. Interview with a Personal Care Aide (PCA) on 6/19/17 at 10:58 a.m. revealed: -She did not think the bruises were from the last fall Resident #8 had because she had a bruise on her face and behind her knee when she fell. -She had showered the resident the morning of 6/19/17 and did not see any bruises. Review of the Resident #8's record revealed there was no documentation of a HCPR investigation of the bruises of unknown origin. Multiple interviews on 6/16/17, 6/19/17, 6/20/17, 6/21/17 and 6/22/17 with the executive Director (ED) and/or the Special Care Director (SCD) revealed: -They were not aware of any HCPR investigation	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 438	Continued From page 80 by the facility for resident bruises of unknown origin nor alleged verbal and physical abuse by Staff D and Staff E. -He had not completed a HCPR report for any bruises of unknown origin nor for alleged verbal and physical abuse by Staff D and Staff E. -The ED had just been made aware of the bruises on some residents. -He was not aware an investigation was to be completed and sent to the HCPR. -He had not investigated all of the bruises with unknown injuries. -One resident with bruised was revied by him but he thought ist was just from the resident being picked up. -The SCD was not aware a HCPR investigation should have been completed for bruises of unknown origin. -When a resident was seen to have bruises during baths or on routine observations, the care staff were to write on the Skin Assessment sheets and give them to the medication aide to review and pass onto the SCD for review. -There was not a system to ensure a review of the skin and bath reports and HCPR reports were completed when the injuries were of unknown origin. -There was no system of review of all reports for the SCD to assess needs and for reporting of injuries and bruising. -HCPR investigations and reports would be completed by the ED. Based on both verbal reporting by residents and staff related to verbal and physical abuse and documentation on facility forms of Skin Assessments and Accident/Incident reports of bruising of unknown origion, the facility failed to investigate and report to the HCPR until during the survey on 6/16/17 and 6/20/16.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 438	Continued From page 81 Review of the 24 hour HCPR Initial Report dated 6/16/17 and the 5-Working Day Report dated 6/16/17 for the HCPR investigation by the facility for Staff D, Nursing Assistant revealed: -Under the Allegation Description sectionof the 24 Hour Report form there was no date and time the information was listed. -There was documentation of an allegation of sexual abuse by "an employee", but that was not the case. It was a physical abuse allegation. -There was no specific information documented from an initial investigation. -There were no affected residents listed on the form. -The 5-Working Day report revealedit was submitted the same day the allegations were alleged. -There was no result checked under "Is there reasonable suspicion a crime related to any allegation checked below? __ Yes ___ No ." -Under the section of Allegatio/Incident Details there was no information exept that an allegation of sexual abuse and verbal abuse had been alleged. -There were no specific residents listed -No information was listed in the area of social services reporting. -The section listing whether and accused individual's employment had been terminated was marked "No." -There was no signature of the person preparing the report. Review of the 24 -Hour Initial Report dated 6/20/17 for the HCPR investigation report related to Staff E, Personal Care Aide revealed: -Under the Allegation Description the Incident Date was listed as 6/19/17. -This was not a specific date of the incident(s) as	D 438		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D 438	Continued From page 82 it had been an ongoing situation. -There was no detail of an investigation documented , only what the surveyors told the faciilty as a concern about Staff E. -There was no description of Physical or Mental Injury/Harm documented. -Under the section on the for for Resident information only "several residents" was documented with no actual resident names and other resident information. _____ The facility failed to report investigations to the HCPR into the allegations of verbal and physical abuse of two staff (D and E) affecting four residents (#6, #10, #11 and #12); and bruises of an unknown origin on three residents (#6, #10 and #11). The facility's failure to report allegations of verbal and physical abuse was detrimental to the safety and wellbeing of all residents, which constitutes a Type B Violation. _____ Review of the Plan of Protection dated 6/22/17 revealed: -The facility will report all known and unknown bruising on all residents upon discovery. -Facility staff will be trained on how to report incidents and all bruising that is found. -All reports will be signed by the Administrator. -All alleged verbal and physical abuse will be investigated and reported to the HCPR. -Reports will be sent to the Department of Social Services and the Health Care Personnel Registry. -The Resident Care Coordinator will monitor all reports and follow-up with the Administrator.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff	D 465		

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D 465	Continued From page 83 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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to maintain minimum staffing for 18 of 30, eight hour shifts reviewed resulting in inadequate staff to meet the needs of residents. The findings are: Confidential interview with a staff revealed: -The facility was frequently short staffed, especially on 2nd and 3rd shift. -They had been short from March through May 2017. -There were residents who fell and were neglected because there was not enough staff. -Staff had brought staffing concerns to the SCD and she told staff the census was down and they would be fine. -There were more staff lately because of inspections by the Department of Social Services (DSS) and the State. Telephone interview with the family member of a former resident on 6/20/17 at 9:43am revealed:	D 465		

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D 465	Continued From page 84 -She did not trust staff watched or fed the resident. -The resident went from weighing 180 pounds when he was admitted to the facility, to weighing 140 pounds when he left a year later. -It wasn't the staff, they did the best they could; there just was not enough of them. Interview with the Special Care Director (SCD) on 6/14/17 at 9:31am revealed: -There were 31 residents in the facility on 6/14/17. -There was one Housekeeper, one Cook and three Personal Care Aides (PCAs) on duty in the facility. -She was covering as the Medication Aide (MA) until the MA came in. Review of staff time punch cards and the daily census report for 5/20/17 through 5/22/17 revealed: -There were 26 residents in the facility 5/20/17 through 5/22/17, which required 26 aide hours for 1st and 2nd shift, and 20.8 aide hours for 3rd shift. -On 5/20/17, there were 23 aide hours for 1st shift leaving the facility short staffed by 3 hours. -On 5/21/17, there were 23.5 aide hours for 1st shift, 24 aides hours for 2nd shift and 9 aide hours for 3rd shift leaving the facility short staffed by 2.5 aide hours on 1st shift, 2 aide hours on 2nd shift and 11.8 hours on 3rd shift. -On 5/22/17, there were 21.5 aide hours for 1st shift, 20.75 aide hours for 2nd shift and 17 aide hours for 3rd shift leaving the facility short staffed by 4.5 aide hours on 1st shift, 5.25 aide hours on 2nd shift and 3.8 hours on 3rd shift. Review of facility Incident/Accident Reports for 5/20/17 through 5/22/17 revealed on 5/22/17	D 465		

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D 465	Continued From page 85	D 465		

there was a report documenting that Resident #2 fell at 7:15pm sustaining a wound on the back of his head.

Review of emergency room discharge instructions for Resident #2 dated 5/22/17 revealed the resident was treated for a minor head injury with a laceration.

Based on review of staff time punch cards for 5/22/17 and the incident report for Resident #2 dated 5/22/17, the facility was short 5.25 aide hours when Resident #2 fell sustaining a minor head injury and laceration.

Interview with a PCA on 6/23/17 at 2:37pm revealed:
-The weekend of 5/20/17 she only worked one day and did not return to work until the following Friday because her hours were cut.
-She believed she worked on 5/21/17 for 3rd shift.
-There were usually three staff on duty for 3rd shift, but staff hours were cut because there were not enough residents in the facility.
-A lot of residents had been sent to the hospital.

Based on review of staff time punch cards and the staff schedule; and interviews with the SCD and the PCA, the facility had one MA on duty as the only staff in the building for 3rd shift on either 5/21/17 or 5/22/17.

Review of staff time punch cards, the staff schedule and the daily census report for 5/27/17 through 5/29/17 revealed:
-There 28 residents in the facility 5/27/17 through 5/29/17, which required 28 aide hours for 1st and 2nd shift, and 22.4 aide hours for 3rd shift for a census of 28 residents.
-On 5/27/17, there were 27 aide hours for 1st

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 465	Continued From page 86	D 465		

shift, 23 aide hours for 2nd shift and 16.5 aide hours for 3rd shift leaving the facility short staffed by 1 aide hour for 1st shift, 5 aide hours for 2nd shift and 5.9 aide hours for 3rd shift.
-On 5/28/17, there were 21.75 aide hours for 1st shift, 24 aide hours for 2nd shift and 17 aide hours for 3rd shift leaving the facility short staffed by 6.25 aide hours for 1st shift, 4 aide hours for 2nd shift and 5.4 aide hours for 3rd shift.
-On 5/29/17, there were 23 aide hours for 1st shift, 23.5 aide hours for 2nd shift and 18.25 aide hours for 3rd shift leaving the facility short staffed by 5 aide hours for 1st shift, 4.5 aide hours for 2nd shift and 4.15 aide hours for 3rd shift.

Review of staff time punch cards, the staff schedule and the daily census report for 6/10/17 through 6/13/17 revealed:
-There 29 residents in the facility on 6/11/17, which required 29 aide hours for 1st and 2nd shift, and 23.2 aide hours for 3rd shift for a census of 29 residents.
-On 6/11/17, there were 24 aide hours for 2nd shift leaving the facility short staffed by 5 aide hours.
-There were 31 residents on 6/13/17, which required 31 aide hours for 1st and 2nd shift, and 24.8 aide hours for 3rd shift for a census of 31 residents.
-On 6/13/17, there were 17 aide hours for 3rd shift leaving the facility short staffed by 7.8 aide hours.

Interview with the SCD on 6/22/17 at 4:08pm revealed:
-The facility went by eight hour shifts; 6am - 2pm for 1st shift, 2pm - 10pm for 2nd shift and 10pm - 6am for 3rd shift.
-There were a few staff that flexed their hours and worked 7am - 3pm, 3pm - 11pm and 11pm -

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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 465	Continued From page 87	D 465		

7am.
-The MAs worked 12 hour shifts from 6am - 6pm for 1st and 2nd shift and 6pm - 6am for 2nd and 3rd shift.
-The schedule changed frequently due to staff call ins, staff termination and census changes.
-She had checked the schedule and assured all staff scheduled were accounted for by time cards.
-There was one PCA and one MA scheduled for 3rd shift on 5/21/17, but she could not tell if the PCA's time punch card was for 5/21/17 or 5/22/17.

Interview with the Manager on 6/19/17 at 9:10am revealed the facility went by standard shift times; 7am - 3pm for 1st shift, 3pm - 11pm for 2nd shift and 11pm - 7am for 3rd shift.

Confidential interview with a second staff revealed the facility would cut staff numbers down when the census got down to 27-28 residents.

Confidential interview with a third staff revealed:
-There were staff that that left early on the third shift.
-Staff E was always gone before 1st shift came on duty.

Confidential interview with a fourth staff revealed there were Personal Care Aides (PCAs) that were lazy and always went missing out in back of the facility.

Confidential interview with a fifth staff revealed:
-On 3rd shift on 6/18/17, a staff left the facility for two hours leaving the MA and one PCA for 32 residents.
-This staff was known to leave the facility on 3rd shift on a regular basis.
-Staff reported the incident to the SCD on

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ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 465	Continued From page 88 6/19/17. -Staff E and another staff regularly sit outside the facility in their car for long periods also leaving residents unattended. Telephone interview with a Medication Aide (MA) on 6/21/17 at 9:57am revealed: -He had worked a 24 hour shift, but it wasn't really 24 hours because he had a two to three hour rest period. -He remained in the facility during the break period. -It was not scheduled that way, someone called in so he stayed. -There was usually a MA and two aides on duty for 3rd shift. -There were two nights recently where it was just him and one aide because the other aide quit. -He had made the SCD aware, but she could not get anyone else to come in. Interview with the Manager on 6/23/17 at 12:10pm revealed: -There had been problems with the time clock in May 2017 which may account for some errors in the time cards. -He would review the schedule and time cards for gaps. -He did not know the staffing ratio for 3rd shift was one staff for every ten residents, he thought the ratio was one staff for every twelve residents. -He would review the schedule and make sure that staffing was at least at the minimum ratio. -He understood that residents' needs could increase staffing needs also. _____ The facility failed to maintain minimum staffing for 18 of 30, eight hours shifts reviewed resulting in inadequate staff to meet the needs of residents	D 465		

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D 465	Continued From page 89 and whereby on 2nd shift on 5/22/17 the facility was short 5.25 aide hours for a census of 26 when Resident #2 fell sustaining a head injury and minor lacerations. The facility's failure to maintain minimum staffing resulted in serious neglect and contributed to the harm of Resident #2, which constitutes a Type A2 Violation. _____ Review of the Plan of Protection submitted by the facility on 6/23/17 revealed: -The Administrator will ensure the facility is staffed at a minimum ratio of one staff per eight residents for 1st and 2nd shift; and one staff per ten residents for 3rd shift. -The Administrator will ensure the facility is never below the minimum staffing level. -The Administrator will review all schedules daily to ensure the adequate required staffing. He will also calculate time cards daily to check hours for all shifts. -The Administrator will be responsible for proper staffing. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 7/23/17.	D 465		
D 477	10A NCAC 13F .1409 Special Care Unit Orientation ANd Training 10A NCAC 13F .1409 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 for residents with a mental health disability, the	D 477		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D 477	Continued From page 90 administrator shall document receipt of at least 20 hours of training specific to the population by a qualified mental health professional, as defined in 10A NCAC 27G .0104(18), 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, direct care staff shall complete 20 hours of training specific to the population being served. (4) In addition to the training required in Rule .0501 of this Subchapter, direct care staff assigned to the unit shall complete at least 8 hours of continuing education annually that is specific to the needs of the residents. This Rule is not met as evidenced by: Based on interview asnd record review, the facility failed to assure 1 of 6 sampled staff (D) in the specail care unit facility had completed the six hours of orientation and 20 hours of training specific to the population served within six months of hire. The findings are: Review of the personnel record for Staff D revealed: - There was a hire date of 8/14/12. - Staff D was hired as a persoanl care aide (PCA).	D 477		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 477	Continued From page 91 - There was no documentation of special care unit (SCU) orientation in the first week of hire and no documentation of 20 hours of special care unit training spoecific to the population served in the personnell record. Review of time cards for Staff D revealed he was logged in working March 2017, April 2017 and May 2017. Telephone interview on 6/20/17 at 10:15 a.m. with Staff D revealed: -He worked on the men's hall mostly but had worked with the women's hall on the night shift sometimes. -He worked some shifts in May 2017. -He had his training to work in the facility. Interview with a resident revealed Staff D worked the night shift on both halls of the SCU. Interview on 6/16/17 at 3:47 p.m. with the Special Care Director (SCD) revealed: - She was responsible for staff training and qualification getting completed. - She thought the 20 hour training for the SCU included the first week 6 hours of training and orientation so the total would be 20 hours of training not 26 hours. - No system was provided to ensure qualifications and training were completed. - She had worked in the facility for a short while and did not realize the training for Staff D was not in the personnell record. - She would search the thinned records for the training. No Special Care Unit orientation and training was provided by the end of the survey.	D 477		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 92	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to controlled substances accounts. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to have a readily retrievable and accurate account for controlled substances for 1 of 2 sampled residents (#9), resulting in 202 opiate pain reliever tablets (Percocet) being unaccounted for. [Refer to Tag 0392 10A NCAC 13F.1008 (a) Controlled Substances (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to assure every resident	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMER'S RELATED CARE	217 JONESBORO ROAD DUNN, NC 28334

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D914	Continued From page 93 had the right to be free of mental and physical abuse and neglect related to Health Care, Resident Rights, Special Care Unit Staffing and Health Care Personnel Registry Reporting and Special Care Unit Staffing. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to contact the Primary Care Provider for wound care orders for more than 30 days for 1 of 7 sampled residents (#8), who returned from a rehabilitation center with a stage II ulcer on her left heel. [Refer to Tag 273 10A NCAC 13F.0902 (b) Health Care (Type A2 Violation.)] 2. Based on observations, interviews and record reviews, the facility failed to assure residents were protected from abuse as evidenced by alleged physical abuse by Staff D toward three residents (#6, #10 and #11); alleged verbal abuse by two staff (D and E) toward four residents (#6, #10, #11 and #12); four residents having bruises of unknown origin (#6, #8, #10 and #11); and Resident #7, who had a diagnosis of Dementia and was known to have sexually aggressive behaviors towards other residents, being placed in Resident #13's room on admission to the facility when a private room was available. [Refer to Tag 338 10A NCAC 13F.0909 Resident Rights (Type A1 Violation.)] 3. Based on observations, interviews and record reviews, the facility failed to report allegations of verbal and physical abuse to the Health Care Personnel Registry of two staff (D and E) affecting four residents (#6, #10, #11 and #12.); and bruises of unknown origin on three residents (#6, #10, #11). [Refer to Tag 438 10A NCAC 13F	D914		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D914	Continued From page 94 .1205/GS 131E-256 (g) Health Care Personnel Registry. (Type B Violation.)] 4. Based on observations, interviews and record reviews, the facility failed to maintain minimum staffing for 18 of 30, eight hour shifts reviewed resulting in inadequate staff to meet the needs of residents. [Refer to Tag 0465 10A NCAC 13F.1308 Special Care Unit Staffing. (Type A2 Violation.)] 5. Based on observation, interview and record review, the Administrator failed to implement the provision of residents' rights, health care, personal care and supervision, Health Care Personnel Registry reporting, nutrition and food service, medication administration, controlled substances, special care unit training, housekeeping and physical environment and other requirements. [Refer to Tag 980 G.S.131D-25 Implementation. (Type A2 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 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 observation, interview and record review, the administrator failed to implement the	D980		

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	HAL043026	A. BUILDING: _____ B. WING _____	06/23/2017

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D980	Continued From page 95	D980		

provision of residents' rights, admission of residents, health care, personal care and supervision, Health Care Personnel Registry reporting, nutrition and food service, medication administration, controlled substances, special care unit training, housekeeping and physical environment and other requirements.

The findings are:

Confidential interview with a resident revealed:
- There have been incidents of verbal and physical abuse by two personal care staff members.
- There have been reports of these concerns to management, but the personal care staff were still working there.

Telephone interview with a family member of a former resident on 6/20/17 at 9:43 a.m. revealed:
- There was not enough staff.
- The family member did not trust that the resident was being watched or fed.
- The Executive Director (ED) was never at the facility.
- The ED never returned the family member's calls.

Confidential interviews with multiple staff revealed:
- Some staff "abused" several residents and would yell and curse and grab the residents.
- Management was not approachable to report incidents of bruising, staff conduct of verbal and physical abuse.
- The facility was not responsive to resident sores and wounds; residents had repeated falls and nothing was done about it; staff verbal and physical abuse to residents with cursing and grabbing residents too tight with activities of daily

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D980	Continued From page 96	D980		

living and by pulling on residents too hard.
- Some staff were not qualified to give personal care and work in the special care unit.
- Staff worked at the facility who were not qualified and did not know what they were doing.
- Residents were neglected because there was not enough staff to work on the shifts and some of the staff when at the facility did not do their job.
- Staff had fear of retaliation for reporting concerns to management and they might get fired.

Interview with the Manager on 6/19/17 at 9:10 a.m. revealed:
- He was at the facility one day per week.
- The administrator would come to the facility "sporadically" due to health issues.
- The Executive Director (ED) was at the facility every day.

Noncompliance identified during the survey included:

1. Based on observations and interviews, the facility failed to assure walls, ceilings and floors were kept clean and in good repair as evidenced by holes in the walls of four resident rooms, the hallway and beauty salon on the men's hall; wet marks and peeling paint on the ceilings in two common bathrooms; dirt/grime buildup and stains on the floors in three common bathrooms, two resident rooms and the beauty salon on the men's hall; and gouges and marks on the walls and dust in the vents in the resident exam room near the men's hall. [Refer to Tag 0074 10A NCAC 13F.0306 (a)(1) Housekeeping.]

2. Based on observations and interviews, the facility failed to assure the facility was kept clean and free of obstructions and hazards as

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D980	Continued From page 97 evidenced by damaged door handles to two rooms and a closet on the men's hall, one set of folding closet doors off the tracks in one resident room on the men's hall, broken toilet paper and towel holders in two resident bathrooms on the men's hall, six broken electrical outlets on the men's hall, a loose light fixture from the ceiling of one resident room on the men's hall, an improperly fitting toilet tank cover in one resident bathroom on the men's hall and the presence of numerous flies in resident rooms, common bathrooms, corridors and common areas. [Refer to Tag 0079 10A NCAC 13F.0306 (a)(5) Housekeeping] 3. Based on observations and interviews, the facility failed to assure the ventilation was maintained in working condition in two common bath and shower rooms with no windows on the men's hall. [Refer to Tag D 0105 10A NCAC 13F.0311 (a) Other Requirements] 4. Based on observations and interviews, the facility failed to provide an adequate number of fans for residents when air conditioning units in the facility were not working and the temperature in the main corridor was 82 degrees Fahrenheit (F). [Refer to Tag 0112 10A NCAC 13F.0311(c) Other Requirements] 5. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents diagnosed with dementia and in a special care unit resulting in Resident #2 having repeated falls with serious injuries including a fractured tibia; and Resident #8 having repeated falls with serious injuries including a broken hip and fractured facial bones. [Refer to Tag 270 10A NCAC 13F.0901 Personal Care & Supervision (Type A1 Violation.)]	D980		

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D980	Continued From page 98 6. Based on observations, interviews and record reviews, the facility failed to contact the Primary Care Provider for wound care orders for more than 30 days for 1 of 7 sampled residents (#8), who returned from a rehabilitation center with a stage II ulcer on her left heel. [Refer to Tag 0273 10A NCAC 13F.0902 (b) Health Care (Type A2 Violation.)] 7. Based on observations, interviews and record reviews, the facility failed to assure the kitchen, dining and food storage areas were kept clean, orderly and free from contamination as evidenced by a heavy amount of spilled dry foods, crumbs and wrappers under the storage shelves in the dry pantry; dirt and grease build up on the floors in the pantry, under kitchen work areas and along kitchen baseboards; a heavy concentration of a black substance resembling mold on the floor around and on the cover to the sink drain in the kitchen; and flies in the kitchen and dining area. [Refer to Tag 0282 10A NCAC 13F.0904(a)(1) Nutrition & Food Service] 8. Based on observations, interviews and record reviews, the facility failed to serve a pureed meal as ordered by the Primary Care Provider and listed on the diet sheet for two meal observations (lunch and dinner) for 1 of 2 residents (#3). [Refer to Tag 0310 10A NCAC 13F.0904(e) (4) Nutrition & Food Service.] 9. Based on observations, interviews and record reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 3 of 5 sampled residents (#3, #6 and #8) with a diagnosis of dementia and in a special care unit, who needed assistance in the dining room during two meal observations. [Refer to Tag 0311 10A	D980		

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D980	Continued From page 99 NCAC 13F.0904(f) Nutrition & Food Service] 10. Based on observations, interviews and record reviews, the facility failed to assure residents were protected from abuse as evidenced by alleged physical abuse by Staff D toward three residents (#6, #10 and #11); alleged verbal abuse by two staff (D and E) toward four residents (#6, #10, #11 and #12); four residents having bruises of unknown origin (#6, #8, #10 and #11); and Resident #7, who had a diagnosis of Dementia and was known to have sexually aggressive behaviors towards other residents, being placed in Resident #13's room on admission to the facility when a private room was available. [Refer to Tag 273 10A NCAC 13F.0909 Resident Rights (Type A1Violation)] 11. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents resulting in antibiotic eye drops (Gentamycin) not being administered for 3 days to Resident #1 who had drainage and redness of both his eyes. [Refer to Tag 0358 10A NCAC 13F.1004 (a) Medication Administration.] 12. Based on observations, interviews and record reviews, the facility failed to have a readily retrievable and accurate account for controlled substances for 1 of 2 sampled residents (#9), resulting in 202 opiate pain reliever tablets (Percocet) being unaccounted for. [Refer to Tag 0392 10A NCAC 13F.1008 (a) Controlled Substances (Type B Violation)] 13. Based on observations, interviews and record reviews, the facility failed to report allegations of verbal and physical abuse of two staff (D and E) affecting four residents (#6, #10, #11 and #12);	D980		

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D980	Continued From page 100 and bruises of unknown origin on three residents (#6, #10 and #11). [Refer to Tag 0438 10A NCAC 13F.1205 Health Care Personnel Registry. (Type B Violation.)] 14. Based on observations, interviews and record reviews, the facility failed to maintain minimum staffing for 18 of 30, eight hour shifts reviewed resulting in inadequate staff to meet the needs of residents. [Refer to Tag 0465 10A NCAC 13F.1308 Special Care Unit Staffing. (Type A2 Violation.)] 15. Based on interview and record review, the facility failed to assure 1 of 6 sampled staff (D) in the specail care unit facility had completed the 6 hours of orientation in the first week of hire and 20 hours of training specific to the population served within six months of hire. [Refer to Tag 0477 10A NCAC 13F.1409 Special Care Unit Orientation and Training.] 16. Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to controlled substances [Refer to Tag 0912 G.S 131D-21(2) Resident Rights.] 17. Based on observation, interview and record reviews, the facility failed to assure every resident had the right to be free of mental and physical abuse and neglect related to verbal abuse, bruises of unknown origin, Health Care Personnel Registry reporting, health care issues related to wound care, and supervision for falls, and a resident with sexually aggressive behaviors and special care unit staffing. [Refer to Tag 0914 131D-21 (4) Resident Rights (Type A1 Violation.)]	D980		

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D980	Continued From page 101 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 related to supervision; physical, verbal and sexual abuse; personal care and supervision; health care; controlled substances; special care unit staffing; special care unit staff training; Health Care Personnel Registry reporting; physical environment; housekeeping and furnishings; other requirements; food service; medication administration. The facility's failure to consistent overall responsibility for the implementation of all residents' rights resulted in serious harm and neglect of residents and was detrimental to the safety and wellbeing of residents, which constitutes a Type A1 Violation. Review of the Plan of Protection submitted by the facility on 6/23/17 revealed: - The corporate office will put a new licensed Administrator in the facility immediately. - The Administrator will ensure all residents will receive proper care 24 hours a day, seven days per week. - Each resident will be treated with respect and dignity by all facility staff members as assigned by the Administrator. - The Administrator will follow all of the rules that govern the facility. - Adequate numbers of staff will be hired and trained to care for each resident 24 hours a day, seven days a week. - The Administrator will assure [compliance] by daily supervision of staff and review staffing schedule and labor hours.	D980		

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D980	Continued From page 102 - The Administrator and RCC will conduct unannounced visits on all shifts routinely at a minimum of once weekly with documentation of visit. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 7/23/17.	D980		