STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Davie County Department of Social Services conducted an Annual Survey and complaint investigation on 8/22/17 to 8/24/17 with a telephone exit on 8/25/17. Complaint investigations were initiated on 7/12/17 and 8/16/17 by Davie County DSS.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 two couches in the common area (day room located in the front of the facility) were kept clean and in good repair. The findings are: Observation on 8/22/17 between 10:30 am and 12:30 pm during the initial tour revealed: -The facility had a common day room area with two small blackish color plastic upholstery couches. -One couch was against the back wall and the other was against the right wall. -The couch that was against the back wall had three large torn areas approximately 10 to 12 inches long and 1.5 inches wide across the right armrest of the couch, exposing the foam padding. -Both couches had areas of worn material (plastic) in the corners of all edges of the seat cushions.	D 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 076	Continued From page 1 -The cushions were sagging and the upholstery was worn around the edges of all the corners. -Both of the couches appeared to be sagging in the middle and appeared to be unstable to sit on. Interview on 8/22/17 at 11:10 am with a resident revealed: -The couches had been torn for several months, "maybe 6 months." -He never sat on the couches and he never saw any one else sit on the couches. Interview on 8/23/17 at 1:50 pm with the Medication Aide revealed: -He was aware the couches in the day room were torn and sagging, "I think a resident tore the couch." -He thought management was aware of the damaged couches. Interview on 08/24/17 at 1:56 pm with the Director revealed: -The owner was in the process of remodeling the building. -The plan was to purchase new furniture by December 2017. -There was no documented plan that stated specifically what furniture was going to be purchased in December	D 076		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on	D 080		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 080	Continued From page 2	D 080		

hand at all times;
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 all residents had a readily accessible supply of pillow cases, clean towels, and clean wash cloths on hand for use at all times.

The findings are:

Observation on 08/23/17 at 10:54 pm revealed the facility had a census of 33 residents.

Observation on 8/23/17 at 12:30 pm of the laundry room revealed:
-There were 6 washcloths folded and on the shelf behind the door of the laundry room.
-There was one bath towel folded on the top of the dryer.

Observation on 8/23/17 of the shower room located on the 100 hall revealed there were two bath towels which appeared to be clean folded on the shelf in the shower room with a resident's clothes and a leather beth laying folded on top of the towels.

Observation on 8/23/17 between 12:40 pm and 1:10 pm of the resident's rooms located on the 100 hall revealed:
-There were two residents in room 103, there was one bath towel hanging on the bathroom door.
-There was one bath towel in room 104, hanging on the bathroom door.
-There were two residents in room 105, there were no bath towels in the room.
-There was one resident in room 106, there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 080	Continued From page 3	D 080		

no bath towels in the room or shared bathroom.
-There were two residents in room 108, there were no bath towels in the room or in the shared bathroom.
-There were two residents in room 107, there were no bath towels in the room.

Observation on 8/23/17 at 10:20 pm of the laundry room revealed:
-There were four bath towels folded on the shelf in the laundry room.
-There were 6 washcloths folded on the shelf in the laundry room.

Interview on 8/23/17 at 12:45 pm and at 11:00 pm with three residents revealed:
-There were no bath towels in the room, "you had to ask for one."
-In the morning the staff used the towels for showers, "So I had to take my shower later in the day."
-If you ask for a towel the staff would get you one, "if they had a clean one."
-"I never had two towels to use."
-One Resident said "usually you can find a washcloth."

B. Observation on 08/23/17 at 10:54 pm revealed:
-Towels observed in the laundry were five face towels folded on the shelf;
6 bath towels; 4 were severely faded with bleach spots; 2 white towels were discolored to a darkened ash gray.
-8 hand towels were observed in residents' bathrooms.
-7 wash cloths were observed in residents' bathrooms.

Observation of resident rooms revealed no towels

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 080	Continued From page 4	D 080		

were in the rooms as follows:
-Room 210, one resident, there were no bath or paper towels.
-Room 208, two residents, there were no bath or paper towels.
-Room 206, two residents, there were no bath or paper towels.
-Room 204, two residents, there were no bath or paper towels.
-Room 202, two residents, there were no bath or paper towels.
-Room 201, two residents, there were no bath or paper towels.

Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed:
-She never had towels in the bathroom.
-She used her bathroom, but went to the residents' common bathroom to wash her hands because there were paper towels in that bathroom.

Interview on 08/22/17 at 10:42 am with one resident in room 206 revealed there were never paper towels or cloth towels in the bathroom

Based on observation on 08/22/17 and record review it was determined that both residents in room 204 were not interviewable.

Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed there were never towels in the bathroom.

Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable.

Interview on 08/23/17 at 10:40 pm with the second shift Personal Care Aide (PCA) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 080	Continued From page 5	D 080		

-Third shift staff were supposed to wash towels and put them in the bathrooms.
-Tonight he put towels in the bathrooms.
-He did not put one towel per resident because he did not know each resident should have a towel.

Interview on 08/24/17 at 1:56 pm with the General Manager (GM) revealed:
-The common bathrooms had paper towels.
-The resident rooms should have towels.

Interview on 08/23/17 at 10:53 pm with the staff working in the laundry room revealed:
-She worked 7:00 pm to 7:00 am.
-There were just not enough towels.
-She washed towels daily, but there was not one for each resident.

Based on observation and interviews there were only 15 towels for the 33 residents, there were not enough towels for each resident.

Interview on 08/22/17 at 10:30 pm with the housekeeper revealed:
-She worked at the facility for 14 years.
-Some days there were cloth hand towels in the bathroom, but most days there were no towels in the residents bathrooms.
-There was never one towel per resident, but one hand towel was in the bathroom for all residents' to use.

Interview on 8/23/17 at 10:40 with a Personal Care Aide revealed all linens, bath towels and washcloths were stored in the laundry room.

Interview on 08/23/17 at 12:38 pm the first shift Resident Care Director (RCD) and the Office Manager revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 080	Continued From page 6 -She was unaware the facility did not have enough towels. -The third shift staff were responsible for washing towels and ensuring towels were put in every bathroom used by a resident. -No one checked to ensure the third shift staff put towels in the bathroom.	D 080		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; 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 33 of the facility's 33 residents had pillows, top and bottom sheets, and pillowcases clean and in good repair. The findings are:	D 087		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 087	Continued From page 7 Observation on 8/22/17 between 10:30 am and 12:30 pm of the 100 hall revealed: -Room 101 had two beds in the room, the first bed near the door had a bottom fitted sheet, no top sheet, a pillow in a pillow case, and a bedspread, the second bed had a bottom sheet, a top sheet, a pillow in a pillowcase, and a bedspread. -Room 105 had two beds in the room, both beds had a fitted bottom sheet, no top sheet, a pillow in a pillow case, and a bedspread. -Room 107 had 2 beds in the room, the first bed near the door had a fitted sheet, no top sheet, a pillow in a pillow case, and a bedspread, the second bed had a bottom sheet, a top sheet, a pillow in a pillowcase, and a bedspread. Observation of room 212 at 10:12 am, revealed: -Two residents resided in the room. -Both beds had a mattress cover over the vinyl mattress, and a blanket covering the bed. -There were no fitted or flat sheets on the beds. -The resident in the bed by the window did not have a pillow. Observation on 08/22/17 at 10:14 am revealed: -The housekeeper brought the resident in the bed by the window a pillow. -The pillow case had a hole larger than a quarter. -The hole had frayed and shredded material that were loose and hanging. Interview on 08/22/17 at 10:10 am with one resident resided in room 212 revealed: -He had lived at the facility for several months. -He had asked for a pillow over a week ago, but he did not get one until just now. -The housekeeper came into the room and handed the resident a pillow.	D 087		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 087	Continued From page 8 -The resident said that he just got a pillow because the surveyor was in the room. -The only sheets that he had ever received was the one fitted mattress cover that was currently on the bed. -There was always mattress covers, and a blanket. Observation of room 208 at 10:38 am revealed: -Two residents resided in the room. -Both beds had one fitted sheet, and a blanket. -There were no flat sheets. Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed: -She lived at the facility for several years. -There was usually a fitted sheet on the bed. -There was never a flat sheet on the beds. Observation of room 206, at 10:40 am revealed: -Two residents resided in the room. -There was a fitted sheet and blanket on each bed. -There were no flat sheet on the beds. Interview on 08/22/17 at 10:42 am with one resident in room 206 revealed the beds were made the same every day with a fitted sheet and blanket. Observation of room 204, at 10:44 am revealed: -Two residents resided in the room. -Both beds in the room had fitted sheets and blankets. -There were no flat sheet on the beds. Based on observation on 08/22/17 and record review it was determined that both residents in room 204 were not interviewable.	D 087		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 087	Continued From page 9	D 087		

Observation of room 202 at 10:55 am revealed:
-Two residents resided in the room.
-The two beds had one fitted sheet each and a blanket.
-There was no flat sheet on the beds.

Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed:
-Beds were always made the same.
-What was observed on the bed is what was put on the bed everyday.

Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable.

Observation on 8/23/17 at 12:30 pm of the laundry room revealed:
-There were 13 top sheets folded and on the shelf.
-There were approximately 30 or 40 fitted white sheets on a shelf near the back wall of the laundry room.
-There were 11 blankets on the top shelf, and above the washer/dryers there were multiple resident blankets.
-There were 3 pillow cases on one of the shelves in the laundry room.
-There was one pillow.

Interview on 8/23/17 at 1:40 pm with a Medication Aide (MA) revealed:
-The Personal Care Aide (PCA) removed the resident's sheets and took them to the laundry room for washing.
-All staff, the PCAs, and housekeeping assist with the laundry on all shifts
-The PCAs made the residents' beds in the morning and as needed, if they got soiled.
-The MA was not aware residents were required

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 087	Continued From page 10 to have a top sheet and a bottom sheet on their beds. Observation on 8/23/17 between 11:00 am and 1:00 pm of the laundry cart in the halls revealed: -A PCA was pushing the cart from room to room. -The cart had 1 pillow, 2 top sheets, and 1 washcloth. Interview on 8/23/17 at 1:00 with a PCA revealed: -All shifts were responsible for laundry which included washing, drying, folding and distributing clothes to the residents. -The PCA would put one towel in a shared resident's bathroom. -When the residents clothes were washed and dried they were brought to the resident's room. -She thought there were plenty of top sheets for all the residents' beds. -She was unsure where they all were, "They must be in the washer or dryer."	D 087		
D 088	10A NCAC 13F .0306(b)(2) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (2) a bedside type table; 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 provide bedside tables for 4 of 18 resident's rooms (Rooms #212, #208, #206, and	D 088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 088	Continued From page 11 #204) as required. The findings are: Observation on 08/22/17 from 10:00 am to 11:45 am during the initial tour of the facility revealed the following rooms did not have a bed side table for each resident: -Resident room 212, had two residents, there were no bedside tables for either residents. -Resident room 208, had two residents, and one bedside table. -Resident room 206, had two residents, and one bedside table. -Resident room 204, had two residents, there were no bedside tables for either residents Interview on 08/22/17 at 10:10 am with one resident that resided in room 212 revealed: -He had lived at the facility for several months. -There was never a nightstand or bedside table in the room. Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed: -She lived at the facility for several years. -She had never had a table beside her bed. -She would like to have a table near the bed to sit a lamp on, when she gets the lamp. Observation on 08/24/17 at 10:38 am with of a resident in room 208 revealed the nightstand was near the bathroom door and was not near either bed. Interview on 08/24/17 at 1:56 pm with the facility Director revealed: -She was aware that most resident rooms did not have chairs, lamps, mirrors, and bedside tables, but this was never a problem before this survey.	D 088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 088	Continued From page 12 -The owner was in the process of remodeling the building. -The plan was to purchase new furniture by December 2017. -There was no documented plan that stated specifically what furniture was going to be purchased in December.	D 088		
D 090	10A NCAC 13F .0306(b)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (4) a wall or dresser mirror that can be used by each resident; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to furnish a wall or dresser mirror in 5 of 5 residents' rooms that could be used by each resident (Rooms #102, #103, #105, #106, #107, #108, and #202). The findings are: Observation on 8/22/17 during the initial tour revealed room 102, 103, 105, 106, 107, 108, and 202 had no mirrors. Observation on 8/23/17 between 12:40 pm and 1:10 pm of the residents rooms located on the 100 hall revealed: -There were two residents in room 103; there were no mirrors.	D 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 090	Continued From page 13 -There were two residents in room 105; there were no mirrors. -There was one resident in room 106; there was no mirror. -There were two resident in room 108; there were no mirrors. -There were two residents in room 107; there were no mirrors. -There were two residents in room 202, there were no mirrors Interview on 8/23/17 at 12:45 pm and at 11:00 pm with three residents revealed: -There were never mirrors in the rooms, you must go the bathroom to use the mirror. -"I never asked for a mirror in my room, I did not think we could have one." -"I used the mirror on the wall in the bathroom located between our rooms in the morning to comb my hair." -"It would be nice to have a mirror in my room." Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed: -He lived at the facility for more than one year. -There was never a mirror in the room. Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable. Interview on 08/24/17 at 1:56 pm with the facility Director revealed: -She was aware that most resident rooms did not have mirrors, but this was never a problem before this survey. -The owner was in the process of remodeling the building. -The plan was to purchase new furniture by December 2017.	D 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 090	Continued From page 14 -There was no documented plan that stated specifically what furniture was going to be purchased in December.	D 090		
D 091	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; 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 11 of 18 (#102, #103, #105, #106, #107, #201, #202, #204, #206, #208, #210, and #212) rooms occupied by two residents had at least 1 comfortable chair for each resident. The findings are: Observation on 08/22/17 at from 10:00 am to 11:45 am during the initial tour of the facility revealed not enough chairs for each resident residing in the facility as follows: -Resident room 212, had two residents, no chairs. -Resident room 210, had one resident, no chair. -Resident room 208, had two residents, no chairs. -Resident room 206, had two residents, no chairs. -Resident room 204, had two residents, no chairs. -Resident room 202, had two residents, no chairs.	D 091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 091	Continued From page 15 -Resident room 201, had two residents, no chairs. Interview on 08/22/17 at 10:10 am with one resident that resided in room 212 revealed: -He had lived at the facility for several months. -There had never been chairs in the room. -When he wanted to sit down, he had to sit on the bed or in his wheelchair. -He was able to walk and sit in other chairs. -If given a chair he would sit in the chair instead of on the bed. The resident in room 210 was out at a day program and not available for interview. Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed: -She lived at the facility for several years. -There had never been a chair in the room. -The only place she had to sit was on the bed. -She would like to have a chair so that she did not have to sit on the bed. Interview on 08/22/17 at 10:42 am with one resident in room 206 revealed: -He used a wheelchair and was unable to sit in a regular chair. -It would be nice to have an extra chair for visitors. Based on observation on 08/22/17 and record review it was determined that both residents in room 204 were not interviewable. Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed: -He lived at the facility for more than one year. -He was in a wheelchair, but there had never been other chairs in the room.	D 091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 091	Continued From page 16 Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable. Interview on 08/24/17 at 10:38 am with a resident in room #208 revealed: -Two residents lived in the room. -She lived at the facility for more than one year and there were no chairs in the room. Observation on 8/23/17 between 12:40 pm and 1:10 pm of the residents rooms revealed: -Two residents resided in room 102, there was one chair available for residents or a guest. -Two residents resided in room 103, there was one large recliner chair and one wheelchair. -Two residents resided in room 105, there was one wheelchair and no additional chairs available for residents or a guest. -There was one resident residing in room 106, there was a wheelchair but no chair available for guest. -Two residents resided in room 107, there was one chair available for residents or a guest. Interview on 8/23/17 at 12:45 pm and at 11:00 pm with three residents revealed: -The facility had never placed additional chairs in the resident's rooms. -They used their wheelchair for sitting in the room, mobility, and transfers. Interview on 08/24/17 at 1:56 pm with the facility Director revealed: -She was aware that most resident rooms did not have mirrors. -The owner was in the process of remodeling the building. -The plan was to purchase new furniture by	D 091		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 091	Continued From page 17 December 2017. -There were folding chairs in the activity room, she could take them to put in the residents' rooms.	D 091		
D 092	10A NCAC 13F .0306(b)(7) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (7) individual clean towel, wash cloth and towel bar in the bedroom or an adjoining bathroom; and This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that each bathroom adjoined to a resident's room had one clean towel for each resident for 12 of 17 rooms (#103, #104, #105, #106, #107, #108, #201, #202, #204, #206, #208, #210). The findings are: Observation on 08/23/17 at 10:54 pm revealed the facility had a census of 33 residents, most resident rooms had adjoining bathrooms, some bathrooms were shared with two or four residents, example as follows: -Room 210, at 10:21 am, revealed one resident resided in the room. -There were no towels in the bathroom. -Room 208, at 10:38 am, revealed two residents resided in the room.	D 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 092	Continued From page 18 -The bathroom was shared by four residents. -There were no towels in the bathroom. -Room 206, at 10:40 am, revealed two residents resided in the room. -There were no towels in the bathroom. -Room 204, at 10:44 am, revealed two residents resided in the room. -There were no towels in the bathroom. -Room 202, at 10:55 am revealed two residents resided in the room. -There were no towels in the bathroom. -Room 201, at 11:20 am, revealed two residents resided in the room. -There were no towels in the bathroom for residents to use after washing their hands. The resident in room 210 was out at a day program and not available for interview. Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed: -She lived at the facility for several years. -She used her bathroom, but went to the residents' common bathroom to wash her hands because there was paper towels in that bathroom to dry her hands. -She would love to have towels in her bathroom, so that she could wash and dry her hands in her bathroom. Interview on 08/22/17 at 10:42 am with one resident in room 206 revealed: -There were never towels in the bathroom. Based on observation on 08/22/17 and record review it was determined that both residents in room 204 were not interviewable. Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed:	D 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 092	Continued From page 19 -He lived at the facility for more than one year. -He gets staff assistance to the bathroom, but there were never towels dry hands after washing them. Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable. Observation on 8/23/17 at 12:30 pm of the laundry room revealed there was one bath towel folded on the top of the dryer. Observation on 8/23/17 of the shower room located on the 100 hall revealed there were two bath towels folded on the shelf in the shower room with a resident's clothes laying on top of the towels. Observation on 8/23/17 between 12:40 pm and 1:10 pm of the resident's rooms located on the 100 hall revealed: -There were two residents in room 103, there was one bath towel hanging on the bathroom door. -There was one bath towel in room 104, hanging on the bathroom door. -There were two residents in room 105, there were no bath towels in the room. -There was one resident in room 106, there were no bath towels in the room or shared bathroom. -There were two residents in room 108, there were no bath towels in the room or in the shared bathroom. -There were two residents in room 107, there were no bath towels in the room. Observation on 8/23/17 at 10:20 pm of the laundry room revealed there were four bath towels folded on the shelf in the laundry room.	D 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 092	Continued From page 20 Interview on 8/23/17 at 12:45 pm and at 11:00 pm with three residents revealed: -There were no bath towels in the room, "you had to ask for one." -In the morning the staff used the towels for showers, "So I had to take my shower later in the day." -If you ask for a towel the staff would get you one, "if they had a clean one." -"I never had two towels to use." -One Resident said "usually you can find a washcloth." Interview on 08/23/17 at 10:40 pm with the second shift Personal Care Aide (PCA) revealed: -Third shift staff were supposed to wash towels and put them in the bathrooms. -Tonight he put towels in the bathrooms, -He did not put one towel per resident. Interview on 08/24/17 at 1:56 pm with the General Manager (GM) revealed: -The common bathrooms had paper towels. -The resident rooms should have towels. Interview on 08/23/17 at 10:53 pm with the staff working in the laundry room revealed: -She worked 7:00 pm to 7:00 am. -Her responsibilities were to wash the towels and have them available for staff to use for showering. -She was unaware that towels had to be available per resident in their bathroom for drying hands. -She verified the facility did not have enough towels to give each resident a towel. -She was unable to recall the last time towels were purchased. -She was unsure what happened to the towels, but speculated the residents were taking them and hiding them in their rooms.	D 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 092	Continued From page 21 Interview on 08/23/17 at 12:38 pm the first shift Resident Care Director (RCD) and the Office Manager. -She was unaware the facility did not have enough towels. -The third shift staff were responsible for washing towels and ensured towels were put in every bathroom used by a resident. -No one checked to ensure the third shift staff put towels in the bathroom. Interview on 08/22/17 at 10:30 pm with the housekeeper revealed: -She worked at the facility for 14 years. -Some days there were cloth hand towels in the bathroom, but most days there were no towels in the residents bathrooms. -Also, there was never one towel per resident, but one hand towel was in the bathroom for all residents to use.	D 092		
D 093	10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility	D 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 093	Continued From page 22 failed to provide each bedroom with a light overhead of bed with a switch within reach of person lying on bed for 27 of 33 residents. The findings are: Observation on 08/22/17 at from 10:00 am to 11:45 am during the initial tour of the facility revealed no lamps for each resident or lights within reach of the person lying in the bed as follows: -Room 212, two residents resided in the room, no lamps were in the room. -The only light available for the residents was the ceiling light that was only accessible by the switch on the wall by the door. -The residents would not be able to reach the light switch when lying in the bed. -Room 210, one resident resided in the room, no lamp was in the room. -The ceiling light was operable with the switch on the wall by the door. -The residents would not be able to access the light switch when lying in the bed. -Room 208, two residents resided in the room, one lamp was sitting on top of a chest of drawers that was not accessible to the residents when lying in the bed. -Room 206, two residents resided in the room, no lamps were in the room. -Room 204, two residents resided in the room, there was one lamp but it not accessible to the residents when lying in the bed. -Room 202, two residents resided in the room, no lamps were in the room. -There was a light in the ceiling only accessible by the switch on the wall. -The switch was not accessible by residents when in the bed. -Room 201, two residents resided in the room, no	D 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 093	Continued From page 23	D 093		

lamps were in the room.
-There was a ceiling light, but it was only accessible by the light switch near the door.
-There were no lamps that were accessible to the residents when in bed.

Interview on 08/22/17 at 10:10 am with one resident that resided in room 212 revealed:
-He had lived at the facility for several months.
-There had never been a lamp in the room.
-If he wanted light he had to go over the switch on the wall.

The resident in room 210 was out at a day program and not available for interview.

Interview on 08/24/17 at 10:50 am with one resident in room 208 revealed:
-She lived at the facility for several years.
-There had never been a lamp in her reach.
-She wished that she had a lamp near her bed to turn on when it was dark.
-There was a ceiling light, but the switch for the ceiling light was on the wall by the door.
-It was more than 10 feet from her bed and in the dark she was unable to get to the light switch.

Interview on 08/22/17 at 10:42 am with one resident in room 206 revealed:
-He used a wheelchair and required staff assistance when getting up.
-There was a light in the ceiling, but it was only accessible from the light switch on the wall near the door.
-A lamp near the bed could possibly be a good idea.

Based on observation on 08/22/17 and record review it was determined that both residents in room 204 were not interviewable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 093	Continued From page 24 Interview on 08/22/17 at 11:10 am with one resident in room 202 revealed: -He lived at the facility for more than one year. -There had never been a lamp in his room accessible to him. -He required staff assistance to get out of the bed. -When it was dark, it was dark, he was unable to reach the light switch by the door. Based on observation on 08/22/17 and record review it was determined that the second resident in room 202 was not interviewable. Observation on 8/23/17 between 12:40 pm and 1:10 pm of the resident's rooms on the 100 hall revealed: -The only light available for the residents was the ceiling light that was only accessible by the switch on the wall by the door. -Room 212, two residents resided in the room, no lamps were in the room. -The only light available for the residents was the ceiling light that was only accessible by the switch on the wall by the door. -The residents would not be able to reach the light switch when lying in the bed. -Room 101, there were two beds in the room, no lamp were in the room. -Room 102, two residents resided in the room, no lamps were in the room. -Room 103, two residents resided in the room, no lamps were in the room. -Room 105, two residents resided in the room, no lamps were in the room. -Room 106, one residents resided in the room, no lamp was in the room. -Room 107, two residents resided in the room, no lamps were in the room.	D 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 093	Continued From page 25 -Room 108, two residents resided in the room, no lamps were in the room. -There was a ceiling light in all the rooms, but it was only accessible by the light switch near the door. -There were no lamps that were accessible to the residents when in bed. -The ceiling light was operable with the switch on the wall by the door. Interview on 8/23/17 at 12:45 pm and at 11:00 pm with three residents revealed: -"I have a lamp my family bought for me, I keep it on all night in my room." -"I have to get out of the bed to turn the light on by the switch on the wall near the door." -"I did not know we could have a lamp in our room." -"Sometimes we leave the bathroom light on at night, and close the door halfway." Interview on 08/24/17 at 1:56 pm with the facility Director revealed: -She was aware that most resident rooms did not have lamps, but this was never a problem before this survey. -The owner was in the process of remodeling the building. -The plan was to purchase new furniture by December 2017. -Lamps would be purchased for each resident.	D 093		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1,	D 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 129	Continued From page 26 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the designated person for Activity Director had completed the basic course for assisted living Activity Director within 9 months of employment. The findings are: Observations of Staff F revealed the following: -On 08/22/17 at 9:50 am Staff F was working at the facility assisting the Assistant Director with paperwork. -On 08/24/17 at 2:20 pm Staff F was in the dining room doing coloring activities with residents. Record review of Staff F's personnel record revealed: -Staff F had a hire date of 12/20/06 as the Activity Director. -Staff F had a job description of for Activity Director. -Staff F had no documentation of completion of the activity's training within 9 months employed as	D 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 129	Continued From page 27 the Activity Director. Interview with Staff F on 8/24/17 at 11:24 am, and 12:25 pm and at 2:20 pm revealed: -She was responsible for daily activities in the facility. -She had not obtained Activity Director training, and she was unaware that she needed training for activity director. -Staff F was aware the minimum of 14 hours of activities were to be scheduled weekly. -She and Director completed the monthly calendar together. -She worked at the facility two days per week on Tuesdays and Thursdays. -On the days she did not work the Assistant Director conducted the activities. Interview with facility Director on 8/24/17 at 1:25 pm revealed: -She was aware the Activity Director was required to have activity training and had 9 months after hire to obtain the training. -She said Staff F has not had any activities training as of yet. -She did not have time to schedule the Activity Director training for Staff F.	D 129		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 139	Continued From page 28 Based on observations, interviews, and review of personnel files, the facility failed to assure 1 of 6 sampled staff (Staff E) had a criminal background check upon hire. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired on 03/03/16 as a Personal Care Aide (PCA). -There was a consent to complete a criminal record check in the record. -There was no documentation a criminal background check had been completed in Staff E's personnel record. Observation on 08/23/17 between 10:00 am and 11:45 am revealed Staff E was providing personal care to the residents which include bathing and showering. Staff E was not available for interview. Confidential interview with a former resident of the facility revealed: -Staff E was giving her a shower and Staff E put shaving cream in "my mouth." -The resident slapped her (Staff E) in the face. -Staff E then slapped the resident back in the face. Telephone interview with Law Enforcement on 08/23/17 at 3:05 pm revealed the magistrate had issued a criminal summons for Staff E for assault on a handicapped person. Interview with the facility Director on 08/24/17 at 1:30 pm revealed: -Staff E duties and responsibilities included personal care to the residents.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 139	Continued From page 29 -The Assistant Director was responsible for obtaining criminal background checks for new employees. -She was aware Staff E had assaulted a female resident at the facility. -She was unable to provide a copy of the criminal background check for Staff E. -She had not completed a background check on Staff E prior to hire. _____ Based on observations, interviews, and review of personnel files, the facility failed to assure Staff E had a criminal background check upon hire. Staff E had an allegation of assault on a female resident while working at the facility and continued to work at the facility as of 8/23/17. All residents safety and welfare were at risk and detrimental, and this constitutes a Type B Violation. _____ The Plan of Protection provided by the facility on 8/24/17 revealed: -Criminal background check will be completed and placed in employees file prior to hire. -All filing for new hires will be completed on 8/25/17. -The Director will monitor all new hire documents prior to start date and ensure they are placed in the file prior to employment. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2017.	D 139		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training	D 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 150	Continued From page 30 And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff E) successfully completed an 80-hour Personal Care Training and Competency Evaluation program within six months of hire. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired on 03/03/16 as a Personal Care Aide (PCA). -There was no documentation Staff E has completed the 80 hour personal care training and competency evaluation program. -There was no documentation of successfully	D 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 150	Continued From page 31 completion of the Nursing Assistant (NA) training. Review of facility employee schedule revealed: -Staff E was on the employee schedule 16 days of 31 days in July 2017. -Staff E was on the employee schedule 14 days of 23 days in August 2017. Observation on 08/23/17 between 10:00 am and 11:45 am revealed Staff E she was providing personal care to the residents which included bathing and showering. Staff E was not available for interview. Interview with the facility Director on 08/24/17 at 1:30 pm revealed: -Staff E obtained NA certification in another state. -She was not able to provide documentation Staff E had completed the NA training. -Staff E was hired on 03/03/16; she was not able to provide documentation Staff E had completed the 80 hour Personal Care training. -She was aware Staff E was providing personal care to residents in the facility. -She was responsible for hiring new employees. -She was responsible to ensure all required training and the completion of employees files.	D 150		
D 227	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the resident's health or safety is endangered	D 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 227	Continued From page 32	D 227		

and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or
(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

This Rule is not met as evidenced by:
Based on interviews and records reviews the facility failed to assure proper discharge of 1 of 1 resident (Resident #3) sampled with documentation of notification of discharge or the right to appeal notice.

The findings are:

The county DSS received a complaint from another county agency on 07/11/17, alleging that Resident #3 was abused by a staff member.

Review of facility's incident reports revealed:
-On 06/30/17 (no time documented) an incident involving Resident #3 being hit by Staff E.

Review of Resident #3 Resident Register which was not dated revealed:
-She was admitted to the facility on 06/19/15.
-She was her own guardian.

Review of Resident #3's current FL-2 dated 04/29/17 revealed:
-The resident's diagnoses included mood disorder and dementia without behavior disturbance.
-The resident was intermittently disoriented.

Review of Resident #3's record on 08/22/17 revealed there was no written notice of discharge or right to appeal in the record.

Interview with Resident #3 on 07/12/17 at 2:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 227	Continued From page 33	D 227		

pm revealed:
-Resident #3 was being discharged to another assisted living facility in another county.
-Resident #3 had not received a notice in writing about being discharged from the facility.
-Initially, she was not given a reason for the discharge from the facility.

Interview with Resident #3 on 07/14/17 at 11:20 am revealed:
-She made the local Ombudsman aware she was being discharged from the facility without being provided written documentation for the reason of the discharge.
-The Ombudsman requested a three way call with her (Resident #4), the Ombudsman, and the facility's Director regarding the discharge.
-After the meeting the facility still had not provide written documentation of the discharge or notice of her right to appeal the discharge.
-At point she would be uncomfortable staying at the facility and would leave when another home was found for her.

Interview with Resident #3 on 07/20/17 at 12:05 pm revealed:
-She was moving to another assisted living facility in another county today.
-She still had not received a written notice of discharge as of 07/20/17.
-She wanted to leave the facility and would be uncomfortable staying.

Interview with the facility Director on 07/12/17 at 3:04 pm revealed:
-She was aware a 30 day discharge notice and the right to appeal were to be completed and given to the resident when discharging from the facility.
-Resident #3 was being discharged from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 227	Continued From page 34 facility in regards to Resident #3 not getting along with other residents and staff. -Resident #3 would be moved to another assisted living facility in another county once the facility made arrangements to move Resident #3's bedroom furniture. -Resident #3 had not been given a written notice of discharge or the right to appeal notice as of 07/12/17. Interview with the Supervisor on 07/20/17 at 12:15 pm revealed Resident #3 was being moved today to another assisted living facility in another county. Interview with the Resident Care Director on 07/25/17 at 10:50 am revealed Resident #3 was no longer residing at the facility, the resident moved on 07/20/17.	D 227		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 5 sampled residents as evidenced by one resident (Resident #1) who repeatedly went into a female	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35	D 270		

resident's (Resident #2) room and touched her inappropriately sexually.

The findings are:

Telephone interview on 07/11/17 and 08/16/17 with a local county agency revealed:
-Yesterday, Resident #2 complained that Resident #1 continually came to her room and forced himself sexually on her.
-She was afraid of Resident #1, and had informed facility of the incident.

Review of Resident #1's current FL-2 dated 4/11/17 revealed:
-Diagnoses included Hypertension, Hyperlipidemia, Carotid Artery Disease, Schizoaffective disorder Bipolar Type, Pedophilia, Onychomycosis.

Review of Resident #1's Resident Register dated and signed on 11/09/11 revealed "activities strongly disliked or to be avoided: STAY AWAY FROM CHILDREN."

Review of Resident #1's Care Plan dated and signed 5/29/17 and 6/6/17 revealed:
-Social/Mental Health History: "Sexually inappropriate and aggressive. Has Pedophilia diagnosis. Must be monitored 24/7."
-Resident currently receiving medications for mental illness/behavior.
-History of mental illness.
-Disruptive Behavior/Socially Inappropriate.
-Resident currently receiving mental health services.

Review of the Nurses Notes for Resident #1 revealed:
-On 10/19/16, "concerns: Resident #1 keeps

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 36	D 270		

following female resident around and was in shower room with female resident."
-On 04/19/17, facility staff documented "concerns: Resident #1 had been sexually aggressive towards a female resident on several occasions; resident has been given a 30 day notice."
-On 04/26/17, "concerns Resident #1 had sexual incident of inappropriate behavior; called guardian to give notice to move out."

Review of Incident/Accident reports for Resident #1 revealed:
-On 04/06/17 Resident #1 had sexual aggressive act towards a female resident.
-On 04/23/17 Resident #1 was touching another resident showing sexual aggression.
-On 06/11/17 Resident #1 said a female wanted him to touch her.
-On 08/08/17 Resident #1 hit another resident's hand and cut "her" because he was mad at another resident for turning the radio up.

Review of Resident #1's Psychotherapy Notes prepared by the Physician Assistant (PA) on 04/25/17 revealed:
-The PA documented that Resident #1 had a history of anxiety, Season Affective Disorder (SAD), and bipolar disorder.
-He discussed with Resident #1 about going into residents' rooms at night and touching them while they slept.
-Resident #1 admitted to the PA that he had a few episodes of touching others residents' before staff noticed what he was doing, and staff told him it was wrong.
-Resident #1 told the PA that he masturbated and abused his roommate.
-The PA documented that he would discuss the issues with facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 37 Review of Incident/Accident reports for Resident #2 revealed: -One 03/10/17 (no time) Resident #2 told staff Resident #1 had touched her while she was lying in bed, "had she did something wrong." -On 03/16/17 (no time) Resident #2 told staff Resident #1 keeps coming in her room without being asked, he comes in and just stands there. -On 03/29/17 Resident #2 told staff Resident #1 went in her room again without asking her. -On 03/30/17 Resident #2 told a staff that Resident #1 was going into her room and rubbing on her breast and touching himself on the penis with his pants down. Review of the facility's Adult Care Home Admission Agreement and Policies revealed: -Residents will be free of mental and physical abuse, neglect, and exploitation. -The ownership and management does not permit or support indiscreet sexual activity by residents of the facility. -The touching of another without his/her consent for the purpose of harassment, abuse, or exploitation will not be permitted. -The facility will request the resident, family, responsible person or agency to make another placement immediately when it is believed that a delay would jeopardize the resident's or others health or safety. Interview with Resident #2 on 8/16/17 at 11:00 am revealed: -Resident #1 had been following her around the facility. -Resident #1 "has been doing things" she didn't like and wasn't comfortable with. -Resident #1 had came into her room at night and touched her breasts.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 38 -She told staff and she was moved to another room, she was unable to recall the date that she moved. -Resident #1 had not been her room in "a very long time," at least a "couple of weeks". -Resident #1 had not had sexual contact with her since she was moved to another room (unable to recall the exact date). -Resident #1 had looked at her strangely, which made her uncomfortable. -Recently, when she was in the residents' common sitting area, Resident #1 came into the room, so she left because she felt uncomfortable and was afraid Resident #1 would touch her. -She had never said anything to Resident #1 about what he had done her, she notifies staff when Resident #1 came around her. -She had notified her family member about Resident #1's touching her, "I do not feel safe," "my family is looking for another facility but hasn't found one yet". -She stated she wanted to move "asap". -She is unsure if facility is doing enough to keep her safe. Interview with Resident #2 on 08/22/17 at 10:30 am and at 3:40 pm revealed: -Previously, (can't recall specific date) Resident #1 pulled her clothes off and forced himself on her. -She told Resident #1 not to touch her. -She told staff, and they instructed Resident #1 "not to do it." -She does not feel safe in her room at night when she goes to sleep. -Resident #1 assaulted her last night (08/21/17). -Resident #1 "wanted me to do things I didn't want to do, he wanted me to feel him and he feel me." -Resident #1 stuck his penis in her vagina,"it	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 39	D 270		

happened last night (08/21/17) around 10:00 pm when there was a shift change."
-She needed to be checked out at a hospital.
-She had talked with the Assistant Director and was told that Resident #1 needed to stop, and she needed to be checked out.

Interview with Resident #2's Guardian on 8/23/17 at 9:50 am revealed:
- Resident #2 first made Guardian aware of the alleged sexual abuse before May 2017.
-Resident #2 told Guardian that Resident #1 was coming into her room at night and touching her.
-Guardian informed Medication Aide (MA) of the alleged sexual abuse, and the MA had told her, "it will be taken care of on Monday."
-Guardian demanded Resident #2 to be moved away from Resident #1 immediately.
-Resident #1 was moved onto another hallway.
-She visited Resident #2 in June 2017, and noticed Resident #1 was moved back onto Resident #2's hallway.
-Resident #2 informed her that she had spoken with someone from the local agency and she going to talk with staff.
-Resident #2 was moved into a new room in August after talking with person from local agency.
-Guardian unsure if Resident #2 knows timeframe.
-Resident #2 informed Guardian the staff did not complete 2 hour checks.
-Guardian believe something happened, and Resident #1 is doing something Resident #2 did not like.

Interview and presentation of a Plan of Protection on 8/22/17 at 3:00 pm to the Assistant Director revealed:
-The facility's plan to immediately keep Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 40	D 270		

#2 and other residents' safe was to initiate a 15 minute watch for Resident #1 to determine his whereabouts in the community.
-She will put the camera on Resident #2's door 24/7.

Review of the facility's document "15 minute watch" for Resident #1 revealed:
-The watch was document as initiated on 8/22/17.
-There was some documented observations of Resident #1's whereabouts.
-Most time slots were not documented as to the identified whereabouts of Resident #1.

Interview with Resident #1 on 08/22/17 at 10:30 am revealed:
-He lived at the facility since 2008.
-He went to jail in 1978 for raping a minor and was there for 15 years.
-When he went to bed he slept 6-8 hours per night.
-Nothing has happened between him and Resident #2, "I hasn't touched her."
-Now he only looked at Resident #2, but he did touch Resident #2 "a long time ago".
-He and Resident #2 were friends and Resident #2 agreed to let him touch her.
-Staff did not know about him touching Resident #2.
-He only touched Resident #2's "shin and back."
-He had a wife and "she is pregnant."
-His wife went to the hospital about a week ago.
-He was not interested in other female residents at the facility.

Interview with the Assistant Director on 8/22/17 at 4:05 pm revealed:
-Resident #1 did not make decisions about his healthcare, he had a guardian.
-She heard about "it" (incident with Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 41	D 270		

and Resident #2) before she went on maternity leave.
-She had "heard" that a local county agency told the Director that Resident #2 was touched by Resident #1.
-She had also "heard" the facility Director was going to discharge Resident #1.
-She was aware Resident #2 reported the incident to the facility Director, and the facility Director had talked to a detective, the resident's guardian, and staff members about the incident, but she not aware what was discussed.
-The facility Director had documentation pertaining to the incident, but she was unsure where the documentation was kept.
-Resident #1 and Resident #2 used to have rooms next to each other.
-Both residents were moved to different rooms at opposite ends of the hallway.
-Resident #2 nor anyone else at the facility had mentioned the incident to her.
-She obtained all information by hearing others' conversation.
-She suspected that Resident #2 reported the incident because staff saw Resident #1 coming out of her room.
-Currently, there was no system in place to supervise Resident #1's whereabouts.

Interview with the Assistant Director on 8/22/17 at 4:15 pm revealed:
-No one had told her that Resident #1 entered Resident #2's room on 08/21/17.
-The Director had previously spoken to Resident #1 about the alleged sexual abuse against Resident #2, but she was unsure of the date.
-To her knowledge no interventions were put in place.
-Resident #2 had not disclosed anything to her about Resident #1 sexually abusing her; "She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 42	D 270		

ain't never talked to me."
-Resident #2 had talked to her sister, who was her guardian about Resident #1 allegedly sexually abusing her.
-If Resident #1 went into Resident #2's room at night it would be on the video camera, because camera was positioned right outside Resident #2' room.
-She was the only one that had access to the video camera to review footage recorded.
-She worked Monday through Friday, so when she returned to work Monday morning she usually checked the recording on the camera to observe happening in the facility from the time she left to the time she was back in the facility.
-She would send Resident #2 to the Emergency Department to be checked out for sexual abuse.

Observation on 08/22/17 from 2:00 pm to 5:00 pm of the camera surveillance from 8/20/17 to 8/22/17 revealed no observations that showed Resident #1 entered Resident #2's room.

Interview with the Assistant Director on 8/23/17 at 9:45 am revealed she was unable to provide any other incident reports concerning Resident #1, policy on supervision, or any other documentation on Residents #1 and #2 in regards to sexual conduct or supervision.

Interview on 8/17/17 at 1:20 pm with the first shift Medication Aide/Supervisor (MA/S) revealed:
-He heard about the "alleged sexual abuse four or five months ago" during a shift change report.
-He was informed by another employee on the 3rd shift that Resident #2 had reported Resident #1 came into her room and he had touched her.
-Since the alleged sexual abuse, he made sure to keep Resident #1 away from Resident #2 while working his shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 43	D 270		

-If Resident #1 was found to be near Resident #2, he would redirect Resident #1 to his room.
-During his shift he monitored the hallways for Resident #2's location.
-Resident #2 had not informed him that Resident #1 sexually assaulting her.
-Resident #2 had not reported any recent incidents with Resident #1 to him, but he "heard" the resident had reported alleged sexual abuse to a person at a local county agency last week.
-He "heard" that Resident #2 reported the incident to a Supervisor on the third shift, but she had not reported an incident to him.

Interview on 8/22/17 at 5:00 pm with a Medication Aide on the second shift revealed:
-She recalled Resident #1 began going in Resident #2's room in September 2016.
-She wrote incident reports at least two times per week on the 3 pm-11 pm shift regarding Resident #1's behavior (going into Resident #2's room).
-She had given the reports directly to the facility Director, or if she was not in her office she slid the reports under the door.
-She noted in the reports that Resident #1 had been in other "people's" rooms.
-She recalled Resident #1 had walked in on another resident when they were taking a bath.
-She also verbally told the Assistant Director and the Director that she had observed Resident #1 going into Resident #2's and other residents rooms.
-She was not afraid of Resident #1, but thought other residents were afraid of Resident #1.

Confidential interview with 4 staff member revealed:
-Three staff members were unaware of Resident #1's current location.
-Management had not discussed supervision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44	D 270		

plans with staff.
-One staff member was aware of the supervision plans, and identified that Resident #1 was currently in his room.
-The staff member said to "watch him at all times and who he is with," they knew to "keep an eye on him".
-One staff said the facility's policy was 2 hour checks for Resident #1 and all residents.
-Management had not discussed any other supervision plans besides checks every 2 hours all residents.

Interview with Resident #1's Guardian on 8/23/17 at 12:36 pm revealed:
-She was informed there was a 30 day notice for Resident #1.
-She thought it was given in April 2017, but was not sure because it was a long time ago.
-The facility Director rescinded the notice because she was unsuccessful finding placement, and she did not want to put "Resident #1 on the street."
-There had not been any discharge notices since.

Interview with the Assistant Director on 8/22/17 at 6:00 pm revealed:
-Resident #2 was sent to the ER to be checked and have a rape kit completed.
-She would initiate 15 minute watch for Resident #1 to be monitored around all females because Resident #1 is not being watched regularly.
-She would contact Resident #2 guardian.
-She would position the camera on Resident #2's door for 24/7 to see if Resident #1 goes in the room.

Interview with the mental health agency on 8/24/17 at 11:30 am revealed:
-The PA informed the facility staff about Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45 #1's sexual behaviors. -The facility staff informed the PA that Resident #1 had been issued a 21 day discharge. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 resident (Resident #1) who repeatedly went into a female resident's (Resident #2) room and touched her inappropriately sexually beginning on 10/19/16. The female resident was not moved from across the hall until several months after the allegation. These failures to supervisor Resident #1 resulted in substantial risk for harm and jeopardized the health and safety of residents in the facility, which constitutes a Type A2 Violation. The Plan of Protection provided by the facility on 8/22/17 revealed: Immediately the resident in question will be sent to the ED for evaluation due to the accusation. -There will be a mandatory meeting held with all staff to ensure that the accused resident will be supervised around the clock and documentation will be completed. -Surveillance cameras will be continuously recording all incoming and outgoing visitors of the said resident room. -The doctor and the psychiatrist will be informed of the incident immediately about both residents. -Both residents' guardian will be informed and everything documented. -The Assistant Director will talk to the accused about having no contact with the accuser and all will be documented. -Staff will document accused resident's whereabouts every 15 minutes. -Investigation has been initiated by the Assistant Director 8/22/17 and will continue until findings	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 46 are completed and documented. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure 2 of 5 sampled residents' (Resident #4 and #6) physician notification regarding elevated finger stick blood sugars (FSBS), refusal of medications, physical therapy ordered and aggressive behaviors. The findings are: A. Review of Resident #6's current FL2 dated 8/2/17 revealed: -Diagnoses included diabetes with hyperglycemia, bipolar, peripheral vascular disease and dermatitis. -An order to check FSBS before breakfast, lunch, and at night. -An order to check FSBS at 5:00 pm but do not give Sliding Scale insulin. -Medication orders included Novolog (a fast acting insulin used for reducing blood sugars)	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 47 Sliding Scale Insulin (SSI) as follows: If FSBS 200-250 give 2 units If FSBS 251-300 give 4 units If FSBS 301-351 give 6 units If FSBS 351-400 give 8 units If FSBS 401-450 give 10 units If FSBS 451 give 12 units and recheck FSBS in one hour, if FSBS not decreased call MD. -Medications ordered included Lantus (a long acting insulin used to reduce blood sugar levels) insulin 20 units in the morning and 70 units at night. -Medication orders included Novolog 20 units subcutaneous scheduled three times daily with meals at 6:30 am, 11:30 am, and at 5:00 pm. -Medication orders included buspirone (used to treat anxiety) 15 mg two times daily. Review of Resident #6's quarterly Licensed Health Professional Support (LHPS) evaluation dated 6/20/17 revealed: -Personal care task included collecting and testing of FSBS. -Recommendation to meet the resident's needs was documented "avoid concentrated sweets." Review of Resident #6's Electronic Medication Administration Record (eMAR) for the month of August 2017 revealed: -An entry for Novolog SSI check FSBS prior to breakfast, lunch, and bedtime, give SSI 200-250 give 2 units, 251-300 give 4 units, 301-351 give 6 units, 351-400 give 8 units, 401-450 give 10 units, above 451 give 12 units and recheck in one hour, if no decrease call MD. -An entry for FSBS at 6:30 am, 11:30 am and 8:00 pm. -An entry for Novolog 20 units Subsequently (SQ) 3 times daily scheduled for 6:30 am, 11:30 am, and 5:00 pm.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 48 -An entry for FSBS at 5:00 pm, give no SSI. -Documentation on the August 2017 eMAR from 8/1/17 - 8/23/17 Resident #6's FSBS were greater than 451 six times, the range of the 6 FSBS was between 600-472. -There was no documentation in the medication notes or the comment section on the August 2017 eMAR the above FSBS greater than 451 were rechecked in one hour or the MD had been notified. -Documentation on 8/1/17 through 8/4/17 Resident #6 refused the scheduled Novolog 20 units at 5:00 pm as well as FSBS. -Documentation fourteen times from 8/1/17 to 8/23/17 Resident #6 refused the scheduled Lantus 70 units at bedtime. -Documentation on 8/4/17 at 6:30 am and at 11:30 am Resident #6 refused the FSBS. -Documentation eight times from 8/1/17 to 8/23/17 Resident #6 refused FSBS's at 5:00 pm and the scheduled 20 units of Novolog insulin. -Documentation ten times from 8/1/17 to 8/23/17 Resident #6 refused FSBS check and the SSI at 8:00 pm. -Documentation on the eMAR medication PRN/notes Resident #6 had refused some of the FSBS check, but no documentation the MD had been notified of the refusals of FSBS checks, Novolog scheduled insulin, the Novolog SSI insulin, or the Lantus at bedtime. . Review of the Nurse's Notes for August 2017 for Resident #6 revealed there was no documentation the staff had notified the physician as ordered for FSBS greater than 451, or the 13 times Resident #6 refused insulin and FSBS checks. Review of Resident #6's eMAR for the month of July 2017 revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 49 -An entry for Novolog SSI check FSBS prior to breakfast, lunch, and bedtime, give SSI 200-250 give 2 units, 251-300 give 4 units, 301-351 give 6 units, 351-400 give 8 units, 401-450 give 10 units, above 451 give 12 units and recheck in one hour, if no decrease call MD. -An entry for FSBS at 6:30 am, 11:30 am and 8:00 pm. -An entry for Novolog 20 units SQ 3 times daily scheduled for 6:30 am, 11:30 am, and 5:00 pm. -An entry for FSBS at 5:00 pm, give no SSI. -Documentation on the July 2017 eMAR Resident #6's FSBS were greater than 451 eight times, the range of the 8 FSBS were between 454-522. -Documentation 21 times out of 31 days at 5:00 pm Resident #6 refused the FSBS checks and the scheduled 20 units of Novolog insulin. -Documentation 19 times out of 31 days at 8:00 pm Resident #6 refused the FSBS checks and SSI insulin. -There was documentation a FSBS was rechecked on 7/29/17 at 6:58 am and FSBS was 435. -There was documentation a FSBS of 522 had been rechecked at 7:08 am on 7/8/17 and FSBS was now 474. -There was no additional documentation in the medication PRN/notes on the July 2017 eMAR the above FSBS greater than 451 were rechecked in one hour, or the MD had been notified as ordered. -Documentation in the eMAR medication PRN/notes Resident #6 had refused FSBS, but no documentation the MD had been notified Resident #6 had refused insulin. Review of the nurse's notes for July 2017 for Resident #6 revealed: -There was no documentation the staff had rechecked the FSBS or notified the physician as	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 50	D 273		

ordered of FSBS greater than 451.
-There was documentation on 7/3/17 on 2nd shift, Resident #6 had refused FSBS at 5:00 pm and 7:00 pm, no documentation the physician had been notified.
-There was documentation on 7/11/17, 7/12/17, 7/13/17, 7/17/17, 7/24/17, 7/25/17, 7/26/17 and on 7/31/17 all on second shift, Resident #6 had refused medications and FSBS checks at 5:00 pm and at 7:00 pm, no documentation the physician had been notified.
-There was no additional documentation for the month of July 2017, the physician was notified Resident #6 had refused 21 times FSBS checks and scheduled insulin at 5:00 pm, or the 19 times Resident #6 refused the FSBS checks and SSI at 8:00 pm.

Review of Resident #6's record revealed a laboratory study for a Hemoglobin A1C (a blood test for diabetes) dated 2/16/17, according to the laboratory results sheet, the result of 12.8 was "High" (normal reference range is less than 5.7).

Interview on 8/23/17 at 10:40 pm with a second shift Medication Aide (MA) revealed:
-She worked second shift and was also the supervisor.
-She was aware Resident #6 refused his medications and FSBS checks often.
-She was unaware Resident #6 had refused FSBS checks and insulin 21 times in August 2017.
-"I try to bribe him to take his medication by giving him a cigarette."
-She documented on the eMAR medications refused when Resident #6 refused.
-She documented in the Nurses Notes when he refused FSBS checks, medications, and insulin.
-"I don't think the doctor is aware."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 51	D 273		

-She was not aware if the facility had a policy on refusal of medications.
-She was unaware who would notify the physician of resident's refusal of medications or FSBS checks.
-She would report to the next oncoming shift (MA) if Resident #6 refused his medications.
-She reported off to the third shift MA when Resident #6 refused his medications.
-She never contacted the physician in regards to Resident #6's refusing medications, FSBS checks, or insulin.
-"He needs his meds."

Interview on 8/24/17 at 11:55 pm with a third shift MA revealed:
-She worked in the facility for 2 years.
-She was responsible for obtaining the morning 6:30 am FSBS for the residents.
-She was aware of the SSI ordered for Resident #6.
-She recalled Resident #6's FSBS being higher that 451 on several occasions.
-She had given Resident #6 12 units of Novolog insulin on 3rd shift around 6:00 am or 6:30 am.
-She had forgotten to report to the first shift MA to recheck the FSBS for Resident #6.
-"I am human, I forgot."
-She was unaware Resident #6 refused FSBS checks and insulin 21 times in August 2017.
-She documented on the eMAR when Resident #6 refused medications, FSBS checks, and insulin.
-She never contacted the physician in regard to Resident #6 refusing medications, FSBS checks, or insulin.
-She was unaware if the facility had a refusal policy on medications or insulin.
-She was unaware if the physician had been notified Resident #6 refused FSBS checks and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 52 insulin, "he should be." Interview on 8/24/17 at 12:45 pm with a first shift MA revealed: -He was unaware Resident #6 had refused FSBS checks and insulin 21 times in August 2017. -He was not aware if the facility had a policy on refusal of medications. -He stated, "I would definitely call the physician if Resident #6's FSBS was 600. -He was unsure why the physician was not notified of the refusals of FSBS and the high blood sugars. -He was not aware MAs were not rechecking Resident #6's FSBS if the FSBS was over 451 or not calling the physician. -"If I am aware I would recheck the FSBS, but I have not been made aware by the third shift MAs to recheck Resident #6's FSBS." Interview on 8/23/17 at 2:00 pm with Resident #6 revealed: -He was aware the staff took his FSBS four times daily. -He was aware the staff administered insulin three times daily per the SSI. -He never refused FSBS checks or medications, "They just don't give it to me." -He was unaware if the physician was made aware of the times he had not been administered the insulin or the FSBS checks. Review of the pharmacy quarterly review completed on 7/19/17 revealed a recommendation to inform the physician of the increase in refusal of FSBS. Telephone interview on 8/24/17 at 11:30 am with Resident #6's physician revealed: -He was not aware in August 2017 Resident #6	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 53	D 273		

refused FSBS checks and insulin 21 times.
-He was not aware in July 2017 Resident #6 refused FSBS checks and insulin 19 times.
-The facility contacted the physician "maybe once or twice but definitely not 19 or 21 times."
-He was unaware Resident #6's FSBS on 8/4/17 was 600, or the FSBS on 8/17/17 was 571.
-He was not aware the facility staff were not rechecking Resident #6's FSBS that were greater than 451 in 1 hour, and calling MD if not decreased.
-He relied on the facility staff to follow the orders as written for Resident #6.
-"This is a safety issue for the resident, how can I treat the diabetes if I am unaware of the finger stick results."

Interview on 8/24/17 at 12:30 pm with the facility Director revealed:
-She was unaware the MA were not contacting the physician or rechecking Resident #6's FSBS as ordered.
-She was unaware some of Resident #6's FSBS were over 500 and 1 was 600.
-She would immediately initiate a new blood sugar form to assist MA with contacting the physician and rechecking FSBS.
-She and the Resident Care Director would oversee this new process.

Review of the facility Blood Sugar Policy revealed:
-Blood sugar less than 60 if responsive give 10 packs sugar in soda or juice or milk. Recheck in 30 minutes to ensure over 60. If not over 60 call MD.
-If responsive and refuse sugar and soda call MD for instructions.
-If Unresponsive call EMS and MD.
-Do not administer insulin if BS less than 60.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 54	D 273		

-Document what was done on the 24 hour report and in the nurse's notes of resident's chart.
-If blood sugar greater than 451-inject 12 units regular insulin SQ.
-Recheck BS in 1 hour, if no decrease call MD.
-Document what was done on the 24 hour report and in the Nurse's Notes of resident's record.
-Note: some residents have on their MAR different parameters for BS always check MAR first.
-The policy was signed by the physician on 5/24/16, 10/7/16, and on 3/14/17.

2. Review of Resident #6's current FL2 dated 8/2/17 revealed:
-Diagnoses included diabetes with hyperglycemia, bipolar, peripheral vascular disease and dermatitis.
-Medication orders included buspirone (used to treat anxiety) 15 mg two times daily.

Review of Resident #6's Care Plan date 5/29/17 revealed:
-Resident #6 was seen by a Mental Health Provider.
-It was documented Resident #6 was verbally abusive and disruptive behavior/socially inappropriate.
-It was documented Resident #6 was injurious to property.
-It was documented Resident #6 was receiving medications for mental illness.

Review of Resident #6's Mental Health Provider notes revealed Resident #6 had a Mental Health encounter on 7/4/17 for a routine visit, with no changes to current medication list.

Review of Resident #6's Electronic Medication Administration Record (eMAR) for the month of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 55 August 2017 revealed: -An entry for buspirone 15 mg two times daily at 8:00 am and 8:00 pm. -Documentation 13 out of 23 days Resident #6 had refused the buspirone 15 mg at 8:00 pm. -Documentation on the eMAR medication PRN/notes Resident #6 refused buspirone 15 mg five times in August from 8/1/17 to 8/23/17. -There were no additional documented times Resident #6 refused buspirone 15 mg at 8:00 pm on the August 2017 eMAR. -There was no documentation the MD had been notified Resident #6 had refused buspirone 15 mg 13 times out of the 23 days in August 2017. Review of Resident #6's eMAR for the month of July 2017 revealed: -An entry for buspirone 15 mg two times daily at 8:00 am and 8:00 pm. -Documentation 19 out of 31 days Resident #6 had refused the buspirone 15 mg at 8:00 pm. -Documentation on 7/20/17 at 8:00 am Resident #6 refused buspirone 15 mg. -Documentation on the eMAR medication PRN/notes Resident #6 refused buspirone 15 mg on 7/3/17 at 8:00 pm, 7/4/17 at 8:00 pm, 7/5/17 at 8:00 pm, 7/12/17 at 8:00 pm, 7/13/17 at 8:00 pm, 7/21/17 at 8:00 pm, 7/24/17 at 8:00 pm, and on 7/25/17 at 8:00 pm. -There were no additional documented times Resident #6 refused buspirone 15 mg on the July 2017 eMAR. -There was no documentation the MD had been notified Resident #6 had refused buspirone 19 times out of the 31 days in July 2017. Interview on 8/23/17 at 10:40 pm with a second shift Medication Aide (MA) revealed: -She worked second shift and was also the supervisor.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 56 -She was aware Resident #6 refused his medications. -She was unaware Resident #6 had refused buspirone 13 times in August 2017 or 19 times in July 2017. -She documented on the eMAR when Resident #6 refused his medications. -She documented in the Nurses Notes when he refused medications. -"I don't think the doctor is aware." -She was not aware if the facility had a policy on refusal of medications. -She never contacted the physician in regard to Resident #6's refusing buspirone at 8:00 pm. -She was not aware why Resident #6 was taking buspirone 15 mg two times daily, or what buspirone was used for. -"He needs his meds." Interview on 8/24/17 at 11:55 pm with a third shift MA revealed: -She worked in the facility for 2 years. -She was unaware Resident #6 refused buspirone 15 mg at 8:00 pm 13 times in August 2017, "I do not give that med on my shift." -She documented on the eMAR when Resident #6 refused medications. -She never contacted the physician in regard to Resident #6 refusing medications. -She was unaware if the facility had a refusal policy on medications. Interview on 8/24/17 at 12:45 pm with a first shift MA revealed: -He was unaware Resident #6 had refused buspirone 15 mg at 8:00 pm 13 times in August 2017. -He was unaware if the facility had a policy on refusal of medications.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 57	D 273		

Telephone interview on 8/24/17 at 2:00 pm with Resident #6's Mental Health Provider revealed:
-She had seen Resident #6 in the facility on 7/28/17 for a routine visit.
-She was not aware in August 2017 Resident #6 was not administered buspirone 13 times out 23 days, or in July 2017 Resident #6 was not administered buspirone 19 times out of 31 days.
-She thought if Resident #6 missed this many doses of buspirone in August 2017 and July 2017 the facility would contact her or the office.
-She expected the facility to follow orders as they were written.
-"If the facility had contacted me I would switched the times around so Resident #6 could get his buspirone 15 mg."
-She was worried about the increased potential of anxiety by not getting the buspirone as ordered.
-"I expect the facility staff to call with this many refusals of a medication."

B. Review of Resident #4's record revealed current FL2 signed by the physician on 8/2/17:
-Diagnoses included Erh-Duchenne palsy (birth trauma) right upper extremities (chronic), severe major depression with psychotic features, dementia due to Huntington's chorea with behavior disturbances since 2010, and abdominal pain since 2016.
-A physician's order for physical therapy with range of motion, evaluate and treat times 5.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 08/02/17.

Review of Resident #4's record revealed a second FL2 faxed and signed by the facility's house physician on 8/07/17 and a third FL2 signed by the facility's house physician on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 58 08/15/17 with the same diagnoses and medications as listed above. 1. Review of Resident #4's Care Plan signed by the physician on 08/15/17 revealed: -The form was not complete. -The assessment, section 1 was blank. -Section 2, mental health and social history had disruptive behavior/socially inappropriate and injurious to other checked. -There was no documentation for social/mental health history. -The care plan was signed by the physician on 08/15/17. Review of Resident #4's record revealed the following documentation: -08/03/17, third shift, Resident #4 came out of his room and attacked staff, yelling racial slurs and inappropriate name calling. -08/06/17, second shift, Resident #4 was up roaming the halls tonight. -08/12/17, second shift, Resident #4 refusing to take his medications. -08/13/17, second shift, Resident #4 still refusing to take his medications. -08/18/17 Resident #4 refused to see the physician. -08/22/17, first shift, Resident #4 was very violent, breaking glass, lamps and "throwing foil cans of soda" at his roommate hitting him in the head, and fighting with staff. Review of police reports from the local county emergency communications revealed: -On 08/03/17 at 10:53 pm, the facility staff called stating Resident #4 was hostile, and he left the facility. -The resident attacked two staff members on 08/03/17.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 59 -On 08/20/17 at 10:12 am, facility staff stated Resident #4 was causing problems, cussing staff, throwing things at staff. -The resident tried to kick a staff member while she was picking up "stuff" he had thrown on the floor. -On 08/22/17 at 11:35 am, the Resident #4 assaulted another resident. Review of Resident #4's record revealed the facility had no documentation of the hospital visit on 8/3/17 and there was no documentation regarding the incident when the police were called on 8/20/17. Interview on 08/22/17 at 3:52 pm with a neighbor living near the facility revealed: -Their home was within 50 feet of the facility. -From their driveway, you had a clear view of the facility. -On 08/03/17 around 11:00 pm someone repeatedly rang their doorbell. -The person was ringing the doorbell rapidly like they were in a panic. -The person stopped ringing the doorbell and started to beat on the door. -They called 911 because they thought someone was trying to break in or the person was in danger. -The banging was so loud it woke up everyone in the house. -They were all afraid because they did not know what to expect, and the children were frightened. -The person outside was screaming, saying open the "F-ing" door. -He was hitting the door so hard you could see the door frame bounce out as if it was rubber every time it was hit. -The person took all decorations off the door and threw them across the yard.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 60	D 273		

-The police finally came, there was staff from the facility outside trying to get the person to leave the premises.
-The police got the person away from the door and checked to ensure they were okay.
-The ambulance took the resident to the hospital.
-She talked with a staff person who was in tears and told her that before the resident left the facility, he was yelling at staff and trying to hit staff.
-The next morning she called and spoke with someone who identified herself as the Administrator, and the person in charge.
-The person that called herself the Administrator acted as if the resident did nothing wrong, and she brushed her off.
-She visited the facility to discuss other issues that happened with residents and wanted to inform her of the things residents did to the neighbors' houses.
-At the facility, she noticed that the person who had previously identified herself as the Administrator was not the administrator, but the Director (Director), and she was the person in charge.

Interview on 08/23/17 at 8:52 pm with Resident #4's family member revealed:
-She was Resident #4's power of attorney.
-She was in charge of all Resident #4's needs.
-The resident had Huntington's disease.
-He lived with her for six months, then became so aggressive attacking her that she had to have him hospitalized.
-Resident #4 was hospitalized for 4-6 months.
-She was sure the facility was aware of the resident's behaviors because the nurse at the hospital and the facility had communicated before Resident #4 was discharged.
-The facility had made her aware of the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 61	D 273		

when the resident left the facility, there was an incident on this past Sunday, and the incident yesterday when the resident got upset threw things and cursed.
-She was unaware if the facility had made the physician aware of Resident #4's aggressive behaviors.
-She was also unaware if the facility had contacted mental health or set-up physical therapy.
-Resident #4 did well with one-on-one care.
-When he had outburst or aggressive behaviors, the staff at the hospital would take him for a walk outside.
-She was unaware of the services the facility provided for Resident #4.

Based on record review and observation, it was determined that Resident #4's roommate (Resident #7) was not interviewable.

Interview on 08/22/17 at 5:01 pm with a resident revealed:
-Resident #4 always yelled and cursed all the time.
-The resident mostly yelled at staff, but it annoyed the residents.

Interview on 08/22/17 at 5:15 pm with a second resident revealed:
-Resident #4 started out okay until a couple of days ago.
-Yesterday he heard Resident #4 banging on the walls.
-Resident #4 was yelling and cursing.
-He heard all this because Resident #4's room was on the other side of the wall.

Interview on 08/22/17 at 4:45 pm with the second shift Personal Care Aide (PCA) revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 62 -Resident #4 had outbursts of cursing, yelling and throwing things. -Resident #4 only went two places in the facility: this room and standing in the hallway. -When the resident was in the hallway, he cursed at staff or whomever was in the hallway, he yelled obscenities, and attempted to fight staff. -When Resident #4 was in his room, he threw things around in the room. -He would throw his and his roommate's clothes around or whatever he touched with his hand, he threw it. -Resident #4 would always throw his roommate's stuffed animals and pictures in the toilet. -She had not witnessed Resident #4 abusing another resident except for today. -Resident #4 got upset and threw things around in the room as usual, but today he hit his roommate in the head with a can of pop. -The roommate had sustained a bruise but no skin breakage. -Resident #4 mostly ate his meals in his room because he yelled, and cursed loudly in the dining room. -Two nights after Resident #4 came to the facility he left and went to a nearby house and banged on the door. -Resident #4 tore ornaments off of the door and threw them in the yard. Interview on 08/23/17 at 11:03 pm with the second shift Personal Care Aide (PCA) revealed: -Resident #4 had another "outburst" today around 3:00 pm. -The facility staff was changing shifts, and Resident #4 was cursing and yelling at staff. -Resident #4 went to grab a staff person from behind, and another male staff person stepped in to prevent the resident from attacking the staff person.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 63	D 273		

-Resident #4 scratched up and bruised the staff person.
-Resident #4 always had outbursts where he yelled, cursed and threw things at anyone that got in his way; it did not matter if it was a resident or staff.
-He was not sure if other residents were afraid of Resident #4.

Interview on 08/23/17 at 12:06 pm with the physician that signed Resident #4's FL2 revealed:
-He was the house physician for of the facility.
-He had never seen or met Resident #4.
-The facility faxed him an FL2, then had him sign the same FL2 when in the facility, but he did not see the resident.
-When the resident first came to the facility, a staff person faxed a request for Xanax .25 mg three times daily for anxiety.
-He had not been informed of any other issues with Resident #4
-The facility had not notified him that Resident #4 had behavior problems.
-He was at the facility on 08/15/17, and Resident #4 refused to see him, but no one made him aware the resident was having behavior problems.
-No one at the facility had informed them sometimes Resident #4 refused his medications.
-Had he been notified he could have ordered another as needed medication.
-He had previously suggested in his history and physical report that mental health services should be setup.

Interview on 08/23/17 at 4:30 pm with the local mental health agency revealed:
-No one at the facility had called to inform them Resident #4 had a referral.
-A check of their computer showed the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 64	D 273		

#4 was nowhere in their system.
-The resident had not been seen by their psychiatrist or physician assistant.

Interview on 08/23/17 at 3:05 pm with the second shift Medication Aide (MA) revealed:
-The third night after Resident #4's admission to the facility he tried to attack her.
-After the episode, the resident routinely sat in one spot, but he still cursed and swore at staff or anyone passing by.
-Resident #4 had even refused to see the physician when he came to the facility.
-Once Resident #4 was having an episode, and he grabbed her.
-It took two staff people to get the resident off her.
-All staff were afraid that Resident #4 was going to kill someone.
-Resident #4 episodes were document and management was informed.
-She did not specifically report episodes to the resident's physician.

Interview on 08/23/17 at 12:38 pm the Resident Care Director (RCD) revealed:
-No mental health agency had been notified regarding the resident's aggressive behaviors, cursing, yelling, and attacking facility staff.
-Yesterday Resident #4 got upset and was throwing things around his room.
-Resident #4 threw cans of soda and hit his roommate with the can of soda.
-After Resident #4's first incident on 8/2/17 and another incident on this past Sunday, Resident #4 was sent to the hospital, which was the facility's policy, but the hospital always sent him back.
-There was usually no changes in medications.
-She was unaware if there was a referral to a health care provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 65 Interview on 08/25/17 at 8:43 am with the nurse at the discharging hospital revealed: -Before Resident #4 was discharged from the hospital on 08/02/17, she called the facility and spoke with the facility Director. -She told the facility Director that the resident "acts out," and did better with one-on-one care. -The conversation with the facility Director was lengthy, at least two hours long. -She explained to the facility Director all Resident #4's health problems and outburst behaviors. -She also shared the most effective interventions to calm the resident down. -At the end of the conversation, the facility Director stated she would call her back to let her know if she could take Resident #4. -Two days later the facility Director called back and informed they would take Resident #4. -Again, she informed the facility Director Resident #4 was "hard to deal with," and the resident had been placed in other homes before, but was returned to the hospital within less than 24 hours. -She also communicated to the facility Director that Resident #4 needed staff to have patience with him. -Due to resident's disease, it would take him longer than most people to process questions, and he may not respond as quickly as most people. -The resident might turn away or appear not to be listening, which could be misunderstood as him not responding. -When Resident #4 was not given time to process and respond to questions asked, he sometimes "acted-out." -The resident would have "tantrums," by cursing, throwing things, pushing or attacking others, and even trying to walk off the property. -Resident #4 did better with one-on-one care from staff.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 66 -The hospital not only divulged Resident #4's behaviors but also sent two of their staff with Resident #4 to the facility. -The hospital staff had planned to stay with the resident for several hours in an attempt to help the resident adjust to the facility. -The staff went with Resident #4 to the facility reported to her the facility Director said they could leave because her staff could handle the resident. Interview on 08/24/17 at 10:45 am with the facility's Director revealed: -Resident #4 woke up this morning at 4:00 am. -Resident #4 started throwing things. -He broke out facility windows, broke furniture, grabbed items and tried to attack staff. -Staff called 911, but had to hurry off the telephone and find a safe place, because Resident #4 was coming after her with object in his hand to attack her. -She was aware that Resident #4 had Huntington's disease, and was aware people with the disease were sometimes aggressive. -There was another resident at the facility that had the same disease, and he was sometimes aggressive, but nothing like Resident #4. -The discharging hospital had informed her of some of Resident #4's behaviors, but she did not think the behaviors were this bad. Second interview on 08/25/17 at 11:55 am with the facility Director revealed: -She was aware Resident #4 had been in the hospital for several months due to behaviors. -She was aware the resident had Huntington's disease, but was unaware the behaviors were that bad. -There was an incident on 8/3/17 when he was fighting staff, left the building and was banging on a neighbor's doors.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 67 -The physician was notified and asked for medication to calm Resident #4 down. -The physician ordered Xanax .25 mg three times daily. -Resident #4 had another incident when his roommate was given snacks by an outside agency. -Resident #4 became "ticked off" because he wanted the snacks. -The resident was aggressive toward staff and throwing things. -After the incident, she did not call the physician, but she called the discharging hospital to tell them that she could not handle the resident. -She was told the resident required snacks to help him calm down. -She started giving Resident #4 three other snacks, in addition to the three facility snacks. -She only told two other staff people (RCD and second shift medication aide/supervisor) that Resident #4 required additional snacks to calm him down. -The facility's policy when a resident got upset or became aggressive was to try and calm the resident down by giving general re-direction. -If the resident did not calm down, then law enforcement was to be called. -Also, staff should call the resident's physician to try and get an "as needed" medication for the resident. -Facility staff should have called the physician to inform of Resident #4's aggressive behaviors. -No mental health provider had been notified of Resident #4's behaviors. Interview on 8/24/17 at 11:45 am with a mental health provider visiting another resident revealed: -The mental health agency was in the building at least two to three times per weekly and available to call when an emergency situation occurred.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 68	D 273		

-The facility could have made a referral to them for Resident #4 to get assistance with the resident's behaviors.
-If the facility had informed them of Resident #4's actions, they would have "picked him up," as a client and provided the facility with assistance as possible or made recommendations for treatment to deal with the resident's behaviors.
-As of today, Resident #4 had not been referred to his agency for mental health assistance.

Interview on 8/24/17 at 9:21 am with the social worker at the discharging hospital revealed:
-Resident #4 was in the hospital for six months.
-Although he was used to being around the people at the hospital, the resident would still "go off," yelling, cursing, and becoming aggressive hitting staff.
-Resident #4 had two things that made him agitated.
-One was his sister, and the other was if he did not get a snack.
-Resident #4 did better with one-on-one care, and with people that were patient with him and gave him time to express his self.
-The facility that took Resident #4 was informed that the resident had Huntington's disease with aggressive behaviors (fighting, cursing, and walking off the property) and the resident responded better to one-on-one care.
-She had informed the facility Director at the facility that Resident #4 required snacks to keep him calm.
-The facility was aware of the snacks because shortly after discharge they called her asking for money to buy snacks.
-She told the facility Director Resident #4 had no money specifically for snacks, and she thought snacks were free in long-term facilities.
-The facility Director told her that snacks were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 69 free, but she would supply the snacks until some money was received. Interview on 8/24/17 at 2:09 pm with the discharging hospital Director revealed: -Resident #4 was discharged to an assisted living home the beginning of August 2017. -The resident does have a progressive terminal neurological disease with mental illness. -The resident lived at their hospital for more than five months and was hard to place. -The hospital was not set-up to care for long-term residents, but they had a difficult time placing the resident. -When they told other homes about the resident's disease and behaviors they instantly decided Resident #4 was not appropriate for their facility. -Two previous attempts had been made to put Resident #4 in homes, but the homes usually returned the resident to the hospital within 24 hours. -If the facility was having difficulty they did not have to continue taking Resident #4 back, they could have done an involuntary commitment and would have stayed in a mental health hospital. -Resident #4's behaviors were genetic neurological disorders of the brain, and the resident was not going to get better, but worse. -This information was shared with the home that took Resident #4. -Nothing was kept from the home; they were made aware Resident #4 was hard to handle. -When the resident was discharged to the home, they sent two staff to go with the resident. -Staff stayed with the resident for several hours because they were aware the previous attempts to place the resident had failed. Based on record review and observation it was determined that Resident #4 was not	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 70 interviewable. 2. Review of Resident #4's record revealed a current FL2 signed by the physician at the discharging hospital on 8/2/17: -Primary Diagnoses on the FL2 included Erh-Duchenne palsy (birth trauma) right upper extremities (chronic), severe major depression with psychotic features, dementia due to Huntington's chorea with behavior disturbances since 2010, and abdominal pain since 2016. -Medications ordered included omeprazole (used to treat acid reflux) 40 mg daily, sertraline (used to treat depression and panic disorder) 175 mg daily, docusate sodium (used to treat constipation) 200 mg twice daily, cetirizine (used to treat allergies) 10mg daily, ergocaliterol (used to treat Vitamin D2 deficiency) 50,000 units Sunday and Wednesday, and risperidone (used to treat depression) 2 mg at bedtime. Review of Resident #4's record revealed on 08/04/17 the physician signed a subsequent order for Xanax (alprazolam) (used to treat anxiety) 0.25mg three times daily. Review of Resident #4's August 2017 electronic Medication Administration Record (eMAR) revealed: -Alprazolam 0.25 mg three times daily was transcribed on the eMAR for 8:00 am, 12:00 pm and 8:00 pm administration. -Facility staff documented that Resident #4 refused the medication on 08/04/17 at 8:00 am, 08/13/17 at 8:00 pm, 08/22/17 at 12:00 pm and 8:00 pm, 08/23/17 at 8:00 pm. -Risperidone 2 mg at bedtime was transcribed on the eMAR for 8:00 pm administration. -Staff documented the resident refused the medication on 08/13/17 at 8:00 pm, 08/22/17 and	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 71 08/23/17 at 8:00 pm. -Docusate Sodium 100 mg 2 capsules twice daily was transcribed on the eMAR for 8:00 am and 8:00 pm administration. -Staff documented the resident refused the medication on 08/06/17 at 8:00 am, 08/13/17 at 8:00 pm, 08/22/17 at 8:00 pm and 08/23/17 at 8:00 pm. -Cetirizine HCL 10mg once daily was transcribed on the eMARs for 8:00 am administration. -Staff documented the resident refused the medication on 08/06/17 at 8:00 am. -Omeprazole DR 40 mg once daily was transcribed on the eMARs for 8:00 am administration. -Staff documented the resident refused the medication on 08/06/17 at 8:00 am. -Sertraline HCL 175 mg once daily was transcribed on the eMARs for 8:00 am administration. -Staff documented the resident refused the medication on 08/06/17 at 8:00 am. Interview on 08/23/17 at 12:38 pm with the Resident Care Director (RCD) revealed: -The facility did not have a written policy for medication refusal, but there were verbal instructions that staff were required to follow. -The verbal instructions for medication refusal was if a resident refused medications after 3-4 days in a row, then staff were to notify the physician. -Resident #4's physician had not been notified regarding medication refusals because the refusals were not back to back. -No mental health agency had been notified regarding the resident's refusal of medications or the resident's aggressive behaviors, cursing, yelling, and attacking facility staff. -Yesterday, Resident #4 got upset and was	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 72	D 273		

throwing things around his room.
-The resident threw cans of soda and hit his roommate with the can of soda.

Interview on 08/23/17 at 12:06 pm with the physician that signed Resident #4's FL2 revealed:
-He was the house physician for the facility.
-He had never seen or met Resident #4.
-The facility faxed him an FL2, then had him sign the same FL2 when in the facility, but he did not see the resident.
-When the resident first came to the facility, a staff person faxed a request for "Xanax" 0.25 mg three times daily for anxiety.
-He had not been informed of any other issues with Resident #4
-No one at the facility had informed that sometimes Resident #4 refused his medications.
-Had he been notified he could have ordered another as needed medication.

Interview on 08/23/17 at 3:05 pm with the second shift Medication Aide (MA) revealed:
-Twice on her shift Resident #4 refused to take his night time medications.
-The first night Resident #4 had just returned from the dining room and was sitting up on the side of the bed.
-She told the resident it was time for his medications.
-The resident looked down inside the cup and turned his head.
-The second time Resident #4 was awake laying in the bed.
-She said to the resident it was "time for your medication."
-Resident #4 was laying on his back, then turned over in the bed with back toward her and his face toward the wall.
-She waited a few minutes later and asked the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 73	D 273		

resident again, but got no response.
-She documented the refusal on the resident's eMAR, but did not document in the resident's record.

Interview on 08/24/17 at 2:02 pm with the contracted pharmacist revealed:
-Risperidone is an antipsychotic medicine.
-It worked by changing the effects of chemicals in the brain.
-People taking this medication should not skip doses, as the medication is more effective when taken as ordered.
-Missing the medication for a couple of days may cause a person to have episodes, however not every person is the same.
-Some people may have negative episodes after missing one dose, some may have effects after two or more doses, the effect depends on the individual.
-Sertraline took time to get into the system and reach a therapeutic level.
-Doses should not be missed.
-If a resident was not taking their medications as ordered, then the physician should be notified after missing at least two doses, or if the person was skipping dosages.

3. Review of Resident #4's record revealed current FL2 signed by the physician on 8/2/17:
-An order for referral to physical therapy (PT) with range of motion, evaluate and treat times 5.

Review of Resident #4's record revealed an initial history and physical electronically signed by the facility's house doctor on 08/02/17 revealed:
-The resident's level of care was stable but guarded.
-The resident fall risk was moderate.
-The resident's cognitive function was considered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 74	D 273		

to be mildly-to-moderately impaired with mild-to-moderate dementia.
-The resident exhibited the following geriatric syndromes that contribute to the residents overall prognosis of dementia/cognitive impairment: fall risk, functional decline, urinary incontinence, frailty.
-The resident had the following physical ailments that contributed in overall prognoses such as hearing impairment, visual loss, geriatric, balance issues, and unsteady gait.
-The resident is a good candidate for PT and occupational therapy (OT) for strengthening, range of motion, transfer, ambulation, and balance and bed mobility.

Interview on 08/23/17 at 10:13 am with the Resident Care Director (RCD) revealed:
-Physical therapy was not setup for Resident #4.
-She texted one physical therapy provider and they did not take the resident's insurance.
-She did not try to contact another therapy provider to set up physical therapy.
-She was unaware why physical therapy was ordered for Resident #4.
-She was unaware why the hospital discharge report and their house physician had assessed Resident #4 as a fall risk.
-She was also unable to confirm if fall risk was the reason the physician ordered "PT eval (evaluation) and treat, range of motion, X5," on the 08/02/17 FL2.
-She left off the order for physical therapy when she re-wrote the FL2.

Interview on 08/25/17 at 8:43 am with the nurse at the discharging hospital revealed:
-She noticed that Resident #4 hands were curving inward, so she asked physical therapy to work with the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 75 -Resident #4 did well with physical therapy, and he liked the one-on-one contact with the therapist. -The facility should have scheduled physical therapy for Resident #4 because it was listed on the discharge FL2. Interview on 8/24/17 at 9:21 am with the social worker at the discharging hospital revealed: -Resident #4 was in the hospital for six months. -Resident #4 was ordered physical therapy five days per week. -The physical therapy was vital, and the resident benefited greatly from the one-on-one received during physical therapy. _____ Based on observations, interviews, and record reviews the facility failed to contact the physician in regards to medication refusals, FSBS documented 500-600 on multiple occasions without rechecking FSBS as ordered one hour after administered 12 units of Novolog insulin, as well as buspirone 15 mg (to treat anxiety) documented as not administered 19 times in July 2017 and 13 times in August 2017 for Resident #6, and the facility failed to contact the physician in regards to aggressive behavior resulting in ER visits, physical therapy referral not completed as ordered, and multiple medication refusals for Resident #4. These failures to notify the physician resulted in substantial risk for serious physical harm for Resident #6 and for those in contact with Resident #4, constitutes a Type A2 Violation. _____ The Plan of Protection provided by the facility on 8/24/17 revealed: -Immediately, referral for services ordered by the physician will be setup within 24 hours of the order, and completed by the Resident Care Director or the Director.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 76 -The RCD will follow up with agencies to setup evaluations and services. -Documentation will be in the Nurse's Notes and reported to the facility Director if further follow up is necessary. -Documentation will also be reported to the facility Director, and the physician in the event (the payee) will not approve or pay for services ordered. -Medication Aides will receive extra training on documentation of resident's healthcare and call/conversations with physician, this will be monitored by the Director. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2017.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications and treatments were implemented as ordered by the physician in regard to Finger Stick Blood Sugar (FSBS), Sliding Scale Insulin (SSI) Novolog (a fasting acting insulin for lowering the	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 77	D 276		

blood sugar) for 1 of 6 residents (Resident #6).

The findings are:

Review of Resident #6's current FL2 dated 8/2/17 revealed:
-Diagnoses included diabetes with hyperglycemia, bipolar, peripheral vascular disease and dermatitis.
-An order to check FSBS before breakfast, lunch, and at night.
-An order to check FSBS at 5:00 pm, do not give sliding scale insulin.
-Medication orders included Novolog (a fast acting insulin used for reducing blood sugars) per SSI as follows:
If FSBS 200-250 give 2 units
If FSBS 251-300 give 4 units
If FSBS 301-351 give 6 units
If FSBS 351-400 give 8 units
If FSBS 401-450 give 10 units
If FSBS 451 give 12 units and recheck FSBS in one hour, if FSBS not decreased call MD.
-Medications ordered included Lantus (a long acting insulin used to reduce blood sugar levels) insulin 20 units in the morning and 70 units at night.
-Medication orders included Novolog 20 units subcutaneous three times daily.
-Medication orders included buspirone (used to treat anxiety) 15 mg two times daily.

Review of Resident #6's Electronic Medication Administration Record (eMAR) for August 2017 revealed:
-An entry for Novolog SSI check FSBS prior to breakfast, lunch, and bedtime, give SSI 200-250 give 2 units, 251-300 give 4 units, 301-351 give 6 units, 351-400 give 8 units, 401-450 give 10 units, above 451 give 12 units and recheck in one hour,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 78 if no decrease call MD. -An entry for FSBS at 6:30 am, 11:30 am and 8:00 pm. -An entry for Novolog 20 units SQ 3 times daily scheduled for 6:30 am, 11:30 am, and 5:00 pm. -An entry for FSBS at 5:00 pm, give no SSI. -Documentation on 8/5/17 at 5:00 pm FSBS was 600 and Novolog 20 units was administered, no documentation on the eMAR a FSBS was rechecked in one hour. -Documentation on 8/12/17 at 11:30 am FSBS was 472 and 10 units of Novolog was administered, (12 units should had been administered per SSI order), no documentation on the eMAR a FSBS was rechecked in one hour as ordered by the physician. -Documentation on 8/13/17 at 5:00 pm FSBS was 557 and Novolog 20 units was administered and on 8/13/17 at 8:00 pm FSBS was 480 and 12 units of Novolog was administered, no documentation on the eMAR either FSBS was rechecked in one hour as ordered by the physician. -Documentation on 8/13/17 at 8:00 pm FSBS was 480 and 12 units of Novolog was administered, no documentation on the eMAR a FSBS was rechecked in one hour as ordered by the physician. -Documentation on 8/17/17 at 5:00 pm FSBS was 571 and Novolog 20 units was administered, no documentation on the eMAR a FSBS was rechecked in one hour as ordered by the physician. -Documentation on 8/21/17 at 8:00 pm FSBS was 521 and 12 units on Novolog was administered, no documentation on the eMAR a FSBS was rechecked in one hour as ordered by the physician. -There were no additional documentation entries in the medication notes on the August 2017	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 79 eMAR the above FSBS greater than 451 were rechecked in one hour. -Documentation on the eMAR medication PRN/notes Resident #6 had refused FSBS's, but no additional documentation the FSBS over 451 were rechecked in one hour. Review of Resident #6's eMAR for the month of July 2017 revealed: -An entry for Novolog SSI check FSBS prior to breakfast, lunch, and bedtime, give SSI 200-250 give 2 units, 251-300 give 4 units, 301-351 give 6 units, 351-400 give 8 units, 401-450 give 10 units, above 451 give 12 units and recheck in one hour, if no decrease call MD. -An entry for FSBS at 6:30 am, 11:30 am and 8:00 pm. -An entry for Novolog 20 units SQ 3 times daily scheduled for 6:30 am, 11:30 am, and 5:00 pm. -An entry for FSBS at 5:00 pm, give no SSI. -Documentation on 7/6/17 at 6:30 am FSBS was 522 and 12 units of Novolog was administered, no documentation on the eMAR the FSBS was rechecked in one hour as ordered by the physician. -Documentation on 7/15/17 at 6:30 am FSBS was 476 and 12 units of Novolog was administered, no documentation on the eMAR the FSBS was rechecked in one hour as ordered by the physician. -Documentation on 7/16/17 at 11:30 FSBS was 494 and 12 units on Novolog was administered, no documentation on the eMAR the FSBS was rechecked in one hour as ordered by the physician. -Documentation on 7/22/17 "above" was documented and 12 units of Novolog was administered, no documentation on the eMAR the FSBS was rechecked in one hour as ordered by the physician.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 80 -Documentation on 7/1/17 at 8:00 pm FSBS was 508 and 12 units of Novolog was administered, on 7/6/17 at 8:00 pm "HI" was documented and 12 units of Novolog were administered, on 7/10/17 at 8:00 pm FSBS was 454 and 12 units of Novolog were administered, and on 7/29/17 at 8:00 pm FSBS was 501 and 12 units of Novolog was administered, no documentation the above FSBS at 8:00 pm were rechecked in one hour as ordered by the physician. -There were no additional documentation entries in the medication PRN/notes on the July 2017 eMAR the above FSBS greater than 451 were rechecked in one hour. Interview on 8/24/17 at 12:45 pm with a first shift MA revealed: -He was aware Resident #6 was to have recheck on FSBS greater than 451. -He was not aware that MA were not rechecking Resident #6's FSBS if the FSBS was over 451, and not documenting the rechecks. -The third shift MA had not reported to him Resident #6's FSBS needed to be rechecked or that Resident #6's FSBS was higher than 451 in August 2017 or July 2017. -He was unaware if the facility had a policy on documenting on the eMAR refusal of medications. Interview on 8/23/17 at 2:00 pm with Resident #6 revealed: -He was aware the staff took his FSBS four times daily. -He was aware the staff administered insulin three times daily per the SSI. -He never refused FSBS or medications, "They just don't give it to me." -He was unaware if the MAs were documenting on the eMAR each time he did not take his insulin	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 81 or FSBS. Interview on 8/23/17 at 10:40 pm with a second shift Medication Aide (MA) revealed; -She documented in the nurses notes when Resident #6 refused FSBS, medications, and insulin. -"He refused his medications a lot." -"I did recheck his the FSBS in one hour." -She had forgotten to document the results of the recheck FSBS's for Resident #6 on the eMAR, "I am human." Interview on 8/24/17 at 11:55 pm with a third shift MA revealed: -She recalled Resident #6's FSBS being higher that 451 on several occasions. -She documented on the eMAR when Resident #6 refused medications, FSBS, and insulin. -She was responsible for taken the 6:30 am FSBS on third shift. -She stated, " I forgot to tell the first shift MA to recheck his FSBS in one hour after I administered the insulin." Telephone interview on 8/24/17 at 11:30 am with Resident #6's physician revealed: -He was not aware the facility staff were not rechecking Resident #6's FSBS that were greater than 451 in 1 hour as ordered. -He was unaware Resident #6's FSBS on 8/4/17 was 600, or the FSBS on 8/17/17 was 571. -He relied on the facility staff to follow the orders as written for Resident #6. -"This is a safety issue for the resident, how can I treat the diabetes if I am unaware of the finger stick results." Interview on 8/24/17 at 12:30 pm with the facility Director revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 276	Continued From page 82 -She was unaware the MA were not rechecking Resident #6's FSBS as ordered. -She was unaware some of Resident #6's FSBS were over 500 and 1 was 600. -She would immediately initiate a new blood sugar form to assist MA with rechecking FSBS. -She and the Resident Care Director would oversee this new process.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the table service included a non-disposable place setting. The findings are: Observation 08/22/17 of the lunch from 12:50 pm to 1:20 pm of the lunch meal service revealed: -There were 26 residents present for the lunch meal. -The meal consisted of potato salad, chicken sandwich, and peach cake. -The peach cake was served to all 26 residents in Styrofoam bowls.	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 287	Continued From page 83 Interview on 08/22/17 at 1:17 pm with the Dietary Manager (DM) revealed: -He was not sure why Styrofoam bowls were used today, but they were not usually used. -It was a floor staff person that decided to use the Styrofoam bowls for the dessert. Interview on 08/22/17 at 1:20 pm with the Personal Care Aide (PCA) that made the decision to use Styrofoam bowels revealed: -The facility had hard plastic bowls. -She decided to use Styrofoam for no specific reason. -Styrofoam bowls were usually for seconds and sometimes dessert. Observation on 08/22/17 at 1:23 pm of the kitchen supply of non-disposable serve ware revealed there were 32 hard plastic bowls available for staff to serve the residents dessert. Interview on 08/22/17 at 1:32 pm with a second PCA that helped to serve the meal revealed most desserts and seconds were served in Styrofoam bowls Confidential interviews with 5 residents revealed: -Styrofoam was used almost daily with meals and for seconds. -Most desserts were served in Styrofoam bowls. -They were not sure why desserts only were put in Styrofoam bowls today.	D 287		
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
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 84 (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 observation, interview and record review the facility failed to assure physician ordered therapeutic diets (No Concentrated Sweets/NCS) were served as ordered for 2 of 5 sample residents (Residents #5 and #6). The findings are: Review of the seven day Week-at-glance menu revealed the dinner meal was to consist of fish and chips, sweet and sour coleslaw, strawberry gelatin, bread, and milk. Review of the therapeutic diet menu for NCS diet revealed: -Residents ordered this diet were to be served fish and chips, sweet & sour coleslaw, reduced calorie gelatin, no fruit, dinner roll, and 8 ounces of milk. -The menu also noted that all beverages, gelatin, syrup, jelly and sweeteners except milk should be sugar-free A. Review of Resident #6's current FL2 dated 08/02/17 revealed: -Diagnoses included diabetes mellitus. -Diet order for NCS diet Review of the facility's diet list posted in the kitchen revealed Resident #6 was to be served a NCS diet. Observation on 08/22/17 from 6:00 pm to 6:50	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 85	D 310		

pm of the dinner meal service revealed:
-Resident #6's meal consisted of tacos, baked beans, corn and chocolate brownies with chocolate icing.
-The resident consumed 100% of the meal.

Review of the NCS diet menu revealed due to the deviation from the menu, there was no meal specific to the meal served dinner.

Review of the sugar contents for the meal served to Resident #6 revealed:
-The chocolate brownies had 17 grams of sugar per serving, with sugar being the second ingredient.
-There was no container for the icing to obtain the ingredients.
-The baked beans had 11 grams of sugar per serving, with the third ingredient being sugar.

Review of Resident #6's electronic Medication Administration Record (eMAR) for the month of August 2017 revealed blood sugar ranged between 112 to 600 from 08/01/17 to 08/23/17.

Interview on 08/23/17 at 4:00 pm with Resident #6 revealed:
-He was a diabetic and his blood sugar was checked three times daily.
-He did not know what a therapeutic diet was, and he was not on a therapeutic diet.
-He was always served the same meal and dessert as other residents.

Refer to interview on 08/22/17 at 6:38 pm with the Dietary Manager (DM).

Refer to interview on 08/23/17 at 2:31 pm with the Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 86 B. Review of Resident #5's current FL2 dated 05/16/17 revealed: -Diagnoses of diabetes mellitus. -Diet order for NCS diet. Review of the facility's diet list posted in the kitchen revealed Resident #5 was to be served a NCS diet. Observation on 08/22/17 from 6:00 pm to 6:50 pm of the dinner meal service revealed Resident #5's meal consisted of tacos, baked beans, corn and chocolate brownies with chocolate icing. -The resident consumed 100% of the meal. Review of the NCS therapeutic diet menu for the dinner meal on 08/22/17 revealed due to the deviation from the menu, there was no meal specific to the meal served. Review of the sugar contents for the meal served to Resident #6 revealed: The chocolate brownies had 17 grams of sugar per serving, with sugar being the second ingredient. -There was no container for the icing to obtain the ingredients. -The baked beans had 11 grams of sugar per serving, with the third ingredient being sugar. Review of Resident #5 eMAR for July 2017 revealed blood sugars ranged between 129 and 336 from 07/01/17 to 07/31/17. Based on record review and observation it was determined, Resident #5 was not interviewable. Refer to interview on 08/22/17 at 6:38 pm with the Dietary Manager (DM).	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 87 Refer to interview on 08/23/17 at 2:31 pm with the Director. _____ Interview on 08/22/17 at 6:38 pm with the DM revealed: -The dessert for the dinner meal was chocolate brownies with icing. -He did not have sugar-free brownie mix so he served all the residents the same dessert. -He did not consider the baked beans had a high sugar content. -The corn was not sweet corn, and he did not add sugar to the corn. -He was aware that residents ordered NCS diets were to receive sugar-free desserts. -He did not have time to prepare another sugar-free dessert in place of the brownies. Interview on 08/23/17 at 2:31 pm with the facility Director revealed: -She would have to check her last order, but she was sure there was a sugar-free brownie mix available in the kitchen. -The DM was aware that resident's who were ordered NCS diets were to be given sugar-free desserts. -The DM should be looking at the diet menu.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 317	Continued From page 88	D 317		

exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and capabilities in order to promote socialization and physical needs of the residents residing in the facility.

The findings are:

Observations on 08/22/17 and 08/24/17 of Staff F, Activity Director throughout the day revealed:
-On 08/22/17 the Activity Director assisted the Assistant Director with paper work.
-On 08/24/17 Activity Director provided coloring activities for the residents in the dining room.

Confidential interview with a resident revealed:
-Activities happened once in a while.
-Bingo usually happened once in a while, she participated, but not everyone got asked to participate.

Observation on 8/22/17 at 11:57 am of the Activity calendar posted on the wall by the front desk, main hallway revealed:
-The calendar was current for August 2017.
-There was at least 14 hours documented per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 317	Continued From page 89 week. Example of documented activities on 8/22/17 revealed: -Walk 9-9:30 am. -Bingo 1pm-3pm: Observation from 1pm - 3pm no Bingo activity was provided for the residents. Example of documented activities on 8/23/17 revealed: -Spa Day 9am-11am: Observation from 9am - 11am, no Spa day was provided for the resident. -Spa Day 1pm-3pm: Observation from 1pm - 2pm, no Spa day was provided for the residents. Example of documented activities on 8/24/17 revealed: -Walk 9-9:30am. -Shopping 10am-12pm: Observation from 10am - 12pm, no activities were provided for the residents. Interview with a Housekeeper on 8/23/17 at 11:00 am revealed: -Bingo was not played on 08/22/17 -A movie and popcorn was the alternative activity held at 2:00 pm in the living room. Interview with Activity Director on 8/24/17 at 11:24 am and 08/24/17 at 12:25 pm revealed: -She worked two days per week on Tuesdays and Thursdays. -She worked as the Activity Director and assisted the Assistant Director. -The facility Director and her completed the monthly activity calendar. -There was a minimum of 14 hours of activities scheduled weekly. -Activities were going on today, but she was unaware what the activity was, she had to look at	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 317	Continued From page 90 the calendar. -She did not play Bingo on 08/22/17, because there was not enough prizes for the game. -A movie was played and the residents were given soda and chips instead popcorn. -The residents are not going shopping today as listed on the activity calendar because they do not have money, so she would do coloring today. -A a lot of residents only participated in activities that have food and drinks. Confidential interview with a resident revealed: -No activities had happened today. -The resident liked to watch television, and often did that for activity. Interview with the facility Director on 8/24/17 at 3:45 pm revealed: -Residents had interactive activities like religious services every Sunday, and some picked up residents and took them out to church services. -Activities were not done daily, but there was at least 14 hours weekly.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 91 facility failed to protect 3 of 5 sampled residents (Resident #2, #3 and #4) residing in the facility from mental, physical, and sexual abuse. The findings are: [Refer to TAG 914, G. S. 131D-21-4 Declaration of Resident Rights (Type A2 Violation)].	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 reviews the facility failed to ensure medications and treatments were administered as ordered by the physician in regard to buspirone (used to treat anxiety) for 1 of 6 residents (Resident #6). The findings are: Review of Resident #6's current FL2 dated 8/2/17 revealed: -Diagnoses included diabetes with hyperglycemia, bipolar, peripheral vascular disease and dermatitis. -Medication orders included Buspirone (used to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 92 treat anxiety) 15 mg two times daily. Review of Resident #6's Electronic Medication Administration Record (eMAR) for the month of August 2017 revealed: -An entry for buspirone (used to treat anxiety) 10 mg at 8:00 am and buspirone 15 mg at 8:00 pm. -There was documentation 13 out of 23 days Resident #6 had refused the buspirone 15 mg at 8:00 pm. -There was documentation on the medication PRN/notes Resident #6 refused buspirone 15 mg at 8:00 pm five of the thirteen times from 8/1/17 to 8/23/17. -There were no additional documented entries Resident #6 refused buspirone 15 mg at 8:00 pm on the August 2017 eMAR. Review of Resident #6's eMAR for the month of July 2017 revealed: -An entry for buspirone 10 mg at 8:00 am and buspirone 15 mg at 8:00 pm. -There was documentation 19 out of 31 days Resident #6 had refused the Buspirone 15mg at 8:00 pm by circled on the eMAR. -There was documentation Resident #6 refused buspirone 10 mg on 7/20/17 at 8:00 am. -There was documentation in the medication PRN/notes Resident #6 refused buspirone 15 mg at 8:00 pm 9 of the 19 times the month of July 2017. -There were no additional documented entries Resident #6 refused buspirone 15 mg at 8:00 pm on the July 2017 eMAR. Telephone interview on 8/24/17 at 2:00 pm with Resident #6's Mental Health Provider revealed: -She had seen Resident #6 in the facility on 7/28/17 for a routine visit. -She was not aware in August 2017 Resident #6	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 93	D 358		

was not administered buspirone 15 mg as ordered at 8:00 pm.
-She expected the facility to follow orders as they were written.

Interview on 8/23/17 at 10:40 pm with a second shift Medication Aide (MA) revealed:
-Resident #6 refused his medications a lot on second shift.
-She was not aware Resident #6 refused buspirone 15 mg 13 times in August 2017, and 19 times in July 2017.
-She documented on the eMAR medications refused when Resident #6 refused.
-She was not aware if the facility had a policy on documenting on the eMAR refusals of medications.

Interview on 8/24/17 at 11:55 pm with a third shift MA revealed:
-She worked in the facility for 2 years.
-She had not administered buspirone 15 mg to Resident #6 on her shift.
-She was not aware if the facility had a policy on documenting on the eMAR refusals of medications.

Interview on 8/23/17 at 2:00 pm with Resident #6 revealed:
-He never refused medications, "They just don't give it to me."
-He was unaware if the MAs were documenting his medications on the eMAR.

Interview on 8/24/17 at 12:30 pm with the facility Director revealed:
-She was unaware Resident #6 refused buspirone 15 mg at 8:00 pm 13 times in August 2017, and 19 times in July 2017.
-She was not aware the MA were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 94 documenting medications if not administered on the eMAR. -She expected the MA to document on the eMAR when residents refused medications, or if they omitted mediations when residents were not in the facility. -She would retrain the MAs on documentation on the eMAR and in nurse's notes if medications were not given. -She and the Resident Care Director would oversee this new process.	D 358		
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 the Health Care Personnel Registry (HCPR) allegations of abuse received by Resident #3 from Staff member E, Personal Care Aide. The findings are: Interview with Resident #3 on 07/12/17 at 2:15 pm revealed: -She was getting showered, and was getting her	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 438	Continued From page 95	D 438		

face shaved, Staff E had put shaving cream in "my mouth."
-She then slapped Staff E in the face.
-Staff E then slapped Resident #3 back in her face.
-She was unable to recall the date the incident occurred.
-She did not tell anyone because a staff person was in the bathroom

Review of Resident #3's current FL-2 dated 04/29/17 revealed:
-The resident's diagnoses included Mood disorder and dementia without behavior disturbance.
-The resident was intermittently disoriented.
-The resident required assistance with bathing and dressing.

Review of Resident #3's Assessment and Care Plan dated 05/30/17 revealed:
-The resident required extensive assistance with toileting and bathing.
-The resident required limited assistance with ambulation/locomotion, dressing, grooming/personal hygiene, and transferring.
-The resident required supervision with eating.

Review of Resident #3 record did not contain documentation regarding the incident involving Staff E on 06/30/17.

Review of Staff E, PCA personnel record on 07/14/17 did not contain documentation regarding the incident of abuse to Resident #3 on 06/30/17.

Review of Employee Handbook for the facility revealed:
-There was a policy indicating immediate termination for abuse and/or neglect of residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 438	Continued From page 96	D 438		

-"Employee(s) will be suspended without pay until an abuse investigation is completed."
-"Employee(s) shall be terminated if abuse allegations are founded."
-"Abuse incidents will be reported to Department of Human Services and law enforcement."

Review of the facility's employee work schedule revealed:
-Staff E worked was scheduled as an active employee of the facility.
-Staff E worked 16 days in July 2017.
-Staff E worked 14 days in August 2017, including today (08/23/17).

Observation on 08/23/17 from 10:00 am to 3:00 pm of Staff E revealed:
-Staff E was still employed at the facility.
-She was interacted with residents performing showers, dressing and transfer assistance.

Interview with Staff E on 07/12/17 at 2:52 pm revealed:
-On 06/30/17 she was showering Resident #3,
-The resident started talking "junk", then became angry and slapped her.
-She told the resident you don't slap a "black woman."
-She responded by lightly touching Resident #3's right cheek with an open right hand.
-There was another PCA that witnessed the incident also.

Interview with the facility Director on 07/12/17 at 3:04 pm revealed:
-Staff reported to her on 06/30/17 that Staff E hit Resident #3.
-On 06/30/17 she completed an incident report.
-She also issued Staff E an employee written warning documenting Staff E was written up for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 438	Continued From page 97	D 438		

neglecting to perform duties as outlined in her job description.
-No other action was taken to discipline Staff E and an internal investigation had not been completed.
-She had not contacted the HCPR.
-She had not contacted Law Enforcement regarding the incident.
-She did not send the incident report to DSS.

Interview with on 07/14/17 at 11:46 with the PCA that witnessed the incident between Resident #3 and Staff E revealed:
-Staff E attempted to shave Resident #3 on 06/30/17, the resident "hauled off and knocked the .... out of Staff E."
-Staff E "haul off and knock the ..... out of "Resident #3."
-Staff E then talked to another staff member and stated "send me home or fire me."
-No one at the facility had talked with her or asked her about the incident on 06/30/17 with Resident #3 and Staff E.

Interview with the Director on 07/31/17 at 12:25 pm revealed:
-She did not take Staff E off the schedule or off work.
-Staff E had continually worked since the incident.
-She had not completed an investigation of the incident.
-She had not contacted the Health Care Personnel Registry.

Telephone interview with Resident #3's family member on 08/23/17 at 9:45 am revealed:
-The family member visited Resident #3 at the facility 3 - 4 times per year.
-Resident #3 told the family member that sometimes facility staff were mean to her and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 438	Continued From page 98 cursed at her. -The family member reported that sometimes Resident #3 was hard to get along with. Interview with Assistant Director (AD) on 08/23/17 at 11:00 am revealed: -She was not aware that she needed to report the incident to the HCPR. -As of 08/23/17 she had not contacted the Health Care Personnel Registry about the incident between Resident # 3 and Staff E. -She had not contacted the local Law Enforcement to report the abuse. Telephone interview with the local Law Enforcement on 08/23/17 at 3:05 pm revealed: -The magistrate had issued a criminal summons for Staff E for the assault on a handicapped person. -They would deliver the summons Staff E to the facility. Telephone interview with staff at the HCPR on 08/24/17 at 10:35 am revealed: -Staff E had not been reported to the HCPR. [Refer to Tag D 914 G.S. § 131D-21 (4) Declaration of Resident Rights (Type B Violation)]. The failure of the facility to investigate and report an allegation of abuse to Resident #3 by Staff E to the Health Care Personnel Registry resulted in alleged perpetrator of abuse being allowed to continue to work around residents at the facility, was detrimental to the health and safety of residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 8/23/17 revealed:	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 438	Continued From page 99 -When allegations of abuse or neglect are made against any employee it will be reported immediately to the Health Care Personal Registry and documented. -When allegations of abuse or neglect are made there will be an investigation started by the Director and the Assistant Director immediately and will continue for 5 days. -All information obtained during the investigation will be documented. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2017.	D 438		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to immediately notify the County Department of Social Services and the local law enforcement authority as required by law of any alleged sexual abuse (Resident #2) and alleged physical abuse by staff members in regard to (Resident #3).	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 100 The findings are: Telephone interview on 07/11/17 and 08/16/17 with a local county agency revealed: -Resident #2 complained that Resident #1 continually came to her room and forced himself on her sexually. -She was afraid of Resident #1, and had informed facility of the incidents. -Resident #3 was physically abused by Staff E, Personal Care Aide (PCA). Review of the facility's Employee Handbook revealed incidents of abuse will be reported to the Department of Human Services and law enforcement. A. Review of Resident #2 current FL-2 dated 4/29/17 revealed: -Diagnoses included Cerebral Palsy, seizure disorder. Review of the facility's Incident/Accident reports for Resident #2 revealed: -One 03/10/17 (no time) Resident #2 told staff Resident #1 had touched her while she was lying in bed, "had she did something wrong." -On 03/16/17 (no time) Resident #2 told staff Resident #1 keeps coming in her room without being asked, he comes in and just stands there. -On 03/29/17 Resident #2 told staff Resident #1 went in her room again without asking her. -On 03/30/17 Resident #2 told a staff that Resident #1 was going into her room and rubbing on her breast and touching himself on the penis with his pants down. Interview with Resident #2 on 8/16/17 at 11:00 am revealed: -Resident #1 had been following her around the	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 101 facility. -Resident #1 "has been doing things" she didn't like and wasn't comfortable with. -Resident #1 had come into her room at night and touched her breasts. -She told staff and she was moved to another room, she was unable to recall the date that she moved. -Resident #1 had not been her room in "a very long time," at least a "couple of weeks". -Resident #1 had not had sexual contact with her since she was moved to another room (unable to recall the exact date). -Resident #1 had looked at her strangely, which made her uncomfortable. -Recently, when she was in the residents' common sitting area, Resident #1 came into the room, so she left because she felt uncomfortable and was afraid Resident #1 would touch her. -She had never said anything to Resident #1 about what he had done to her, she notified staff when Resident #1 comes around her. -She had notified her family member about Resident #1's touching her, "I do not feel safe," "my family is looking for another facility but hasn't found one yet". -She stated she wanted to move "asap". -She was unsure if facility is doing enough to keep her safe. Interview with Resident #2 on 08/22/17 at 10:30 am and at 3:40 pm revealed: -Previously, (can't recall specific date) Resident #1 pulled her clothes off and forced himself on her. -She told Resident #1 not to touch her. -Initially she didn't tell staff and once she told staff, they instructed Resident #1 "not to do it." -She did not feel safe in her room at night when she was sleep.	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 102 -She was moved to her new room, and still Resident #1 came to her room. -Resident #1 assaulted her last night (08/21/17). -Resident #1 "wanted me to do things I didn't want to do, he wanted me to feel him and he feel me." -Resident #1 stuck his penis in her vagina,"it happened last night (08/21/17) around 10:00 pm when there was a shift change." -She needed to be checked out at a hospital. -She talked with the Assistant Director and was told that Resident #1 needed to stop, and she needed to be checked out. Review of Resident #2's record revealed: -There was no documentation that DSS was not notified of the above reports. -There was no documentation incident/accident reports that were sent to DSS or local Law Enforcement for alleged sexual abuse. -There was no documentation or incident report related to an incident on 08/21/17. Interview with Resident #1 on 8/16/17 at 11:13 am revealed: -He and Resident #2 were friends, she agreed to let him touch her. -He touched Resident #2 "a long time ago". -Nothing happened recently between him and Resident #2, he had not touched Resident #2. -He only looked at Resident #2. Review of the facility's Incident/Accident reports for Resident #1 revealed: -On 04/06/17 Resident #1 had been sexually aggressive act towards a female resident. -On 04/23/17 Resident #1 was touching another resident showing sexual aggression. -On 06/11/17 Resident #1 said a female wanted him to touch her.	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 103 -On 08/08/17 Resident #1 hit another resident's hand and cut "her" because he was mad at another resident for turning the radio up. Review of Resident #1's record revealed: -There was no documentation any reports on aggression were sent to DSS. -There was no documentation of incident/accident reports sent to the local Law Enforcement. Interview with DSS on 8/23/17 at 3:00 pm revealed none of the incident reports reviewed above had been received in the county DSS office. Interview with the facility Director on 07/12/17 at 3:04 pm revealed: -She had not faxed the incident reports to the county DSS. -She had not contacted DSS about the incidents. -Law enforcement had not been contacted about the incidents. -She was aware Incident/Accident reports had to be sent to the County DSS and local law enforcement. Interview with Resident #2's Guardian on 8/23/17 at 9:50 am revealed: - Resident #2 first made Guardian aware of the alleged sexual abuse before May 2017. -Resident #2 told the Guardian Resident #1 was coming into her room at night and touching her. -The Guardian informed Medication Aide (MA) of the alleged sexual abuse, and the MA had told her, "it will be taken care of on Monday." -The Guardian demanded Resident #2 to be moved away from Resident #1 immediately. -Resident #1 was moved onto another hallway. -She visited Resident #2 in June 2017, and	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 104	D 453		

noticed Resident #1 was moved back onto Resident #2's hallway.
-Resident #2 informed her that she had spoken with someone from the local agency and she going to talk with staff.
-Resident #2 was moved into a new room in August after talking with a person from the local agency.
-The Guardian was unsure if Resident #2 knew a timeframe.
-Resident #2 informed the Guardian facility staff did not complete 2 hour checks.
-The Guardian believed something happened, and Resident #1 was doing something Resident #2 did not like.

Interview with facility Director on 8/1/17 at 12:05 pm revealed:
-Resident #2 had informed Director that Resident #1 had entered her room with his penis out.
-Resident #2 had told three different stories involving Resident #1.
-Resident #1's Guardian had been contacted about alleged sexual abuse and other placement options for Resident #1.
-The plan for Resident #1's supervision was to "keep an eye out for where he is at".
-Resident #1 was a pedophile and his preference was children.
-Resident #1 would brag about his pedophilia.
-Resident #1 was usually quiet and stayed mostly in his room.
-She discussed the alleged sexual abuse with Resident #1.
-Resident #1 stated he would not do it again.

Interview with the Medication Aide/Supervisor on the first shift on 8/17/17 at 1:20 pm revealed:
-He first heard about the alleged sexual abuse four or five months ago during change of shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 105 -He was informed by another employee on 3rd shift that Resident #1 had gone into Resident #2 room and touched her. Interview with Medication Aide (MA) on the second shift on 8/22/17 at 5:00 pm revealed: -She recalled Resident #1 began going into Resident #2's room starting in September 2016. -She had completed incident reports about two times per week on her 3 pm-11 pm shift for a total of about 6-7 incident reports. - She said she had given them to the facility Director or slid them under Director's door. -She verbally told the Assistant Director and the Director that she had observed Resident #1 going into Resident #2's room and other residents' rooms. B. Review of Resident #3's current FL-2 dated 04/29/17 revealed: -The resident's diagnoses included mood disorder and dementia without behavior disturbance. -The resident was intermittently disoriented. -The resident required assistance with bathing and dressing. Interview with Resident #3 on 07/12/17 at 2:15 pm revealed: -She was getting showered, and was getting her face shaved when Staff E had put shaving cream in her mouth. -She then slapped Staff E in the face. -Staff E slapped Resident #3 back in her face. -She was unable to recall the date the incident occurred. -Resident #3 had shared the incident with other residents in the facility but could not recall speaking to management.	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 106 Interview with Staff E on 07/12/17 at 2:52 pm revealed: -On 06/30/17 she was showering Resident #3. -The resident started talking "junk", then became angry and slapped her. -She told the resident you don't slap a "black woman." -She responded by lightly touching Resident #3's right cheek with an open right hand. -There was another PCA that witnessed the incident also. Interview with the facility Director on 07/12/17 at 3:04 pm revealed: -Staff reported to her on 06/30/17 Staff E hit Resident #3. -On 06/30/17 she completed a incident report. -She did not send the incident report to DSS. -She did not provide a reason why she had not reported the incident to DSS. Interview with Assistant Director (AD) on 08/23/17 at 11:00 am revealed: -The facility had an incident report related to the incident on 06/30/17, whereby Staff E abused Resident #3. -She was unaware why DSS had not been made aware of the incident. Review of Resident #3's record on 07/12/17 revealed: -There was no documentation to showed that an incident involving Staff E, Personal Care Aide (PCA) occurred on 06/30/17. -There was no documentation to show the local law enforcement or DSS had been contacted. The facility failed to immediately notify the County Department of Social Services and the local law enforcement authority as required by law of any	D 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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 453	Continued From page 107 alleged sexual abuse (Resident #2) who alleged a male resident had inappropriately touched her while in her room at night, and alleged physical assault on (Resident #3) by an alleged perpetrator Staff E who continued to work around residents at the facility, which was detrimental to the health and safety of residents and constitutes a Type B Violation. The Plan of Protection provided by the facility on 8/23/17 revealed: -All incidents/ accidents reports will be reviewed by the Director and the Assistant Director for monitoring. -Incidents and Accidents report will be reported and sent to the necessary agencies and parties via fax and documented. -The Director will update the protocol to ensure that the local DSS is made aware of the incidents/ accidents reports sent by fax to the said agencies. -Monitoring will continue for 3 months to ensure that all reports are being sent to the local DSS. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 10, 2017.	D 453		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D912	Continued From page 108	D912		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, residents' rights, supervision, criminal background, accident and incident, and the health care personnel registry.

The findings are:

A. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 5 sampled residents as evidenced by one resident (Resident #1) who repeatedly went into a female resident's (Resident #2) room and touched her inappropriately sexually. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).]

B. Based on observations, interviews, and record reviews the facility failed to assure 2 of 5 sampled residents' (Resident #4 and #6) physician notification regarding elevated finger stick blood sugars (FSBS), refusal of medications, physical therapy ordered and aggressive behaviors. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]

C. Based on interviews and record reviews, the facility failed to protect 3 of 5 sampled residents (Resident #2, #3 and #4) residing in the facility from mental, physical, and sexual abuse. [Refer to Tag 338, 10A NCAC 13F .0909 Resident's Rights (Type A2 Violation).]

D. Based on observations, interviews, and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D912	Continued From page 109 reviews the Director failed to assure the total operations of the facility to meet and maintain rules and regulations related to housekeeping, staff training, staff qualifications, supervision, Health care personal registry, reporting incident and accidents, resident's rights, health care, nutrition and food services, activities, and medication administration. [Refer to Tag 980, GS 131-D25 Implementation (Type A2iolation).] E. Based on observations, interviews, and review of personnel files, the facility failed to assure 1 of 6 sampled staff (Staff E) had a criminal background check upon hire. [Refer to tag 139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B violation)]. F.Based on observations, interviews, and record reviews, the facility failed to report the Health Care Personnel Registry (HCPR) allegations of abuse received by Resident #3 from Staff member E, Personal Care Aide. [Refer to tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B violation)]. G. Based on interviews and record reviews, the facility failed to immediately notify the County Department of Social Services and the local law enforcement authority as required by law of any alleged sexual abuse (Resident #2) and alleged physical abuse by staff members in regard to (Resident #3). [Refer to Tag 453, 10 A NCAC 13F .1212(d) Reporting of Accidents and Incidents (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:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 110 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility's failure to ensure residents were free of neglect, abuse and exploitation as evidenced by the facilities failure to assure residents were free of physical and mental abuse, which resulted in Resident #2 continuing to reside across the hall from a male resident (Resident #1) who inappropriately touched Resident #2 on multiple occasions, Resident #3 being assaulted by a staff member who allegedly slapped Resident #3 in the face, and Resident #7 being abused by his roommate. The findings are: A. Telephone interview on 07/11/17 and 08/16/17 with a local county agency revealed: -Resident #2 complained that Resident #1 continually came to her room and forced his self sexually on her. -Resident #2 was afraid of Resident #1. Review of the facility's Adult Care Home Admission Agreement and Policies revealed: -Residents will be free of mental and physical abuse, neglect, and exploitation. -The ownership and management does not permit or support indiscreet sexual activity by residents of the facility. -The touching of another without his/her consent for the purpose of harassment, abuse, or exploitation will not be permitted. -The facility will request the resident, family, responsible person or agency to make another	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 111 placement immediately when it is believed that a delay would jeopardize the resident's or others health or safety. Review of Resident #2 current FL-2 dated 4/29/17 revealed: -Diagnoses included Cerebral Palsy, seizure disorder. -Disorientation was documented as intermittently and semi-ambulatory using a wheelchair. Review of the facility's Incident/Accident reports for Resident #2 revealed: -One 03/10/17 (no time) Resident #2 told staff Resident #1 had touched her while she was lying in bed, "had she did something wrong." -On 03/16/17 (no time) Resident #2 told staff Resident #1 kept coming in her room without being asked, "he came in and just stood there." -On 03/29/17 Resident #2 told staff Resident #1 went in her room again without asking her. -On 03/30/17 Resident #2 told staff that Resident #1 was going into her room and rubbed on her breast and touched himself on the penis with his pants down. Interview with Resident #2 on 8/16/17 at 11:00 am revealed: -Resident #1 had been following her around the facility. -Resident #1 "has been doing things" she didn't like and wasn't comfortable with. -Resident #1 had came into her room at night and touched her breasts. -She told staff and she was moved to another room, she was unable to recall the date that she moved. -Resident #1 had not been her room in "a very long time," at least a "couple of weeks". -Resident #1 had not had sexual contact with her	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 112	D914		

since she was moved to another room (unable to recall the exact date).
-Resident #1 had looked at her strangely, which made her uncomfortable.
-Recently, when she was in the residents' common sitting area, Resident #1 came into the room, so she left because she felt uncomfortable and was afraid Resident #1 would touch her.
-She had never said anything to Resident #1 about what he had done her; she notified staff when Resident #1 came around her.
-She notified her family member about Resident #1's touching her, "I do not feel safe," "my family is looking for another facility but hasn't found one yet".
-She stated she wanted to move "asap" (as soon as possible).
-She was unsure if facility was doing enough to keep her safe.

Interview with Resident #2 on 08/22/17 at 10:30 am and at 3:40 pm revealed:
-Previously, (can not recall specific date) Resident #1 pulled her clothes off and forced himself on her.
-She told Resident #1 not to touch her.
-Initially she didn't tell staff and once she told staff, they instructed Resident #1 "not to do it."
-She did not feel safe in her room at night when she goes to sleep.
-She was moved to her new room, and still Resident #1 came to her room.
-Resident #1 assaulted her last night (08/21/17).
-Resident #1 "wanted me to do things I didn't want to do, he wanted me to feel him and he feel me."
-Resident #1 stuck his penis in her vagina,"it happened last night (08/21/17) around 10:00 pm when there was a shift change."
-She needed to be checked out at a hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 113 -She had talked with the Assistant Director and was told that Resident #1 needed to stop, and she needed to be checked out. Interview with Resident #2 on 8/23/17 at 12:15 pm revealed: -She had been sent to the hospital and because Resident #1 "forced" himself on her on 08/21/17. -She had tests done, including a pregnancy test, she was "not pregnant." -Law enforcement/police spoke with her at the hospital. Review of a hospital Sexual Assault Medical Report for Resident #2 revealed: -The resident disclosed to hospital staff "he raped me." -It could not be determined if the resident had sexual contact. Review of the Nurses Notes in Resident #1's record revealed: -On 10/19/16, "concerns: Resident #1 keeps following female resident around and was in shower room with female resident." -On 04/19/17, facility staff documented "concerns: Resident #1 had been sexually aggressive towards a female resident on several occasions; resident has been given a 30 day notice." -On 04/26/17, "concerns Resident #1 had sexual incident of inappropriate behavior; called guardian to give notice to move out." Review of the facility's Incident/Accident reports for Resident #1 revealed: -On 04/06/17 Resident #1 had sexual aggressive act towards a female resident. -On 04/23/17 Resident #1 was touching another resident showing sexual aggression.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 114 -On 06/11/17 Resident #1 said a female wanted him to touch her. -On 08/08/17 Resident #1 hit another resident's hand and cut "her" because he was mad at another resident for turning the radio up. Review of Resident #1's Psychotherapy Notes prepared by the Physician Assistant (PA) on 04/25/17 revealed: -He discussed with Resident #1 about going into residents rooms at night and touching them while they slept. -Resident #1 admitted to the PA that he had a few episodes of touching other residents before staff noticed what he was doing, and told him it was wrong. -Resident #1 told the PA that he masturbated and abused his roommate. Interview with Resident #1 on 8/16/17 at 11:13 am revealed: -He and Resident #2 were friends, she agreed to let him touch her. -He touched Resident #2 "a long time ago". -Nothing happened recently between him and Resident #2, he had not touched Resident #2. -He only looked at Resident #2. Interview with Resident #1 on 08/22/17 at 10:30 am revealed: -He lived at the facility since 2008. -He went to jail in 1978 for sexual assault and was there for 15 years. -Nothing has happened between him and Resident #2, "I hasn't touched her." -Now he only looked at Resident #2, but he did touch Resident #2 "a long time ago". -He and Resident #2 were friends and Resident #2 agreed to let him touch her. -Staff didn't not know about him touching	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 115 Resident #2. -He only touched Resident #2's "shin and back." Interview with Resident #2's Guardian on 8/23/17 at 9:50 am revealed: -Resident #2 first made her Guardian aware of the alleged sexual abuse before May 2017. -Resident #2 told her that Resident #1 came into her room at night and touched her. -The Guardian informed a Medication Aide (MA) of the alleged sexual abuse, and the MA had told her, "it will be taken care of on Monday." -The Guardian demanded Resident #2 to be moved away from Resident #1 immediately. -Resident #1 was moved onto another hallway. -She visited Resident #2 in June 2017, and noticed Resident #1 was moved back onto Resident #2's hallway. -Resident #2 informed her that she had spoken with someone from the local agency and she going to talk with staff. -Resident #2 was moved into a new room in August after talking with a person from the local county agency. -The Guardian was unsure if Resident #2 knew the timeframe. -Resident #2 informed her Guardian the staff did not complete 2 hour checks. -The Guardian believed something happened, and Resident #1 was doing something Resident #2 did not like. Interview with Assistant Director on 8/22/17 at 4:05 pm revealed: -She heard about "it" (incident with Resident #1 and Resident #2) before she went on maternity leave. -She heard that a local county agency told the facility Director that Resident #2 was touched by Resident #1.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 116 -She also heard the facility Director was going to discharge Resident #1. -She was aware Resident #2 reported the incident to the facility Director, and the facility Director had talked to a detective, the resident's guardian, and staff members about the incident, but she was unaware what was discussed. -Resident #1 and Resident #2 used to have rooms next to each other. -Both residents were moved to different rooms at opposite ends of the hallway. -Resident #2 nor anyone else at the facility had mentioned the incident to her. -She obtained all information by hearing others conversation. -She suspected that Resident #2 reported the incident because staff saw Resident #1 coming out of her room. Interview with Assistant Director on 8/22/17 at 4:15 pm revealed: -No one had told her that Resident #1 entered Resident #2's room on 08/21/17. -The facility Director had previously spoken to Resident #1 about the alleged sexual abuse against Resident #2, but she was unsure of the date. -Resident #2 had not disclosed anything to her about Resident #1 sexually abusing her; "She ain't never talked to me." -Resident #2 had talked with her Guardian about Resident #1 allegedly sexually abusing her. -If Resident #1 went into Resident #2's room at night it would be on the video camera, because camera was positioned right outside Resident #2' room. -She was the only one who had access to the video camera to review footage recorded. -She worked Monday through Friday, so when she returned to work Monday morning she usually	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 117	D914		

checked the recording on camera to observe what happened in the facility from the time she left to the time she was back in the facility.
-She would send Resident #2 to the ER to be checked out for sexual abuse.

Interview with facility Director on 8/1/17 at 12:05 pm revealed:
-Resident #2 had informed her that Resident #1 had entered her room with his penis out.
-Resident #2 had told three different stories involving Resident #1.
-Resident #1's Guardian had been contacted about alleged sexual abuse and other placement options for Resident #1.
-Resident #1's supervision was to "keep an eye out for where he is at".
-Resident #1 was a pedophile and his preference was children.
-Resident #1 would brag about his pedophilia.
-Resident #1 was usually quiet and stayed mostly in his room.
-She discussed the alleged sexual abuse with Resident #1.
-Resident #1 stated he would not do it again.

Interview on 8/17/17 at 1:20 pm with the first shift Medication Aide/Supervisor (MA) revealed:
-He heard about the "alleged sexual abuse four or five months ago" during a shift change report.
-He was informed by another employee on the 3rd shift that Resident #2 had reported Resident #1 came into her room and he had touched her.
-Since the alleged sexual abuse, he made sure to keep Resident #1 away from Resident #2 while working his shift.
-If Resident #1 was found to be near Resident #2, he would redirect Resident #1 to his room.
-During his shift he monitored the hallways for Resident #2's location.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 118 -Resident #2 had not informed him that Resident #1 sexually assaulted her. -Resident #2 had not reported any recent incidents with Resident #1 to him, but he heard the resident had reported alleged sexual abuse to a person at a local county agency last week. -He heard that Resident #2 reported the incident to a Supervisor on the third shift, but she had not reported an incident to him. Interview on 8/22/17 at 5:00 pm with a Medication Aide on the second shift revealed: -She recalled Resident #1 began going in Resident #2's room in September 2016. -She wrote incident reports at least two times per week on the 3 pm-11 pm shift regarding Resident #1's behavior (going into Resident #2's room). -She had written 6 or 7 incident reports. -She had given the reports directly to the facility Director, or if she was not in her office she slid the reports under the door. -She noted in the reports that Resident #1 had been in other people's rooms. -She recalled Resident #1 had walked in on another resident when they were taking a bath. -She verbally told the Assistant Director and the facility Director that she had observed Resident #1 going into Resident #2's and other residents' rooms. -She was not afraid of Resident #1, but thought the residents were afraid of Resident #1. Confidential interview with 4 staff members revealed: -Management had not discussed supervision plans with staff. -One staff member was aware of the supervision plans, and identified that Resident #1 was currently in his room. -The staff member said to "watch him at all times	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 119	D914		

and who he is with," they knew to "keep an eye on him".
-One staff said the facility's plan was 2 hour checks for Resident #1 and all residents.
-Management had not discussed any other supervision plans besides checks every 2 hours all residents.
-Three staff members were unaware of Resident #1's current location.

Interview with the mental health agency on 8/24/17 at 11:30 am revealed:
-The Physician Assistant (PA) informed the facility staff about Resident #1 sexual behaviors.
-The facility staff informed the PA that Resident #1 had been issued a 21 day discharge.

B. Review of Resident #3's current FL-2 dated 04/29/17 revealed:
-The resident's diagnoses included Mood disorder and dementia without behavior disturbance.
-The resident was intermittently disoriented.
-The resident required assistance with bathing and dressing.

Review of Resident #3's Assessment and Care Plan dated 05/30/17 revealed the resident required extensive assistance with toileting and bathing.

Review of Resident #3's record revealed it did not contain documentation regarding any incident that involved Staff E on 06/30/17.

Review of Staff E's, Personal Care Aide (PCA) personnel record on 07/14/17 did not contain documentation regarding the incident of abuse to Resident #3 on 06/30/17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 120	D914		

Review of Employee Handbook for the facility revealed:
-There was a policy indicating immediate termination for abuse and/or neglect of residents.
-"Employee(s) will be suspended without pay until an abuse investigation is completed."
-"Employee(s) shall be terminated if abuse allegations are founded."
-"Abused incidents will be reported to Department of Human Services and law enforcement."

Review of the facility's employee work schedule revealed:
-Staff E worked was scheduled as an active employee of the facility.
-Staff E worked 16 days in July 2017.
-Staff E worked 14 days in August 2017, including today (08/23/17).

Observation on 08/23/17 from 10:00 am to 3:00 pm of Staff E revealed:
-Staff E was still employed at the facility.
-She was interacted with residents performing showers, dressing and transfer assistance.

Interview with Resident #3 on 07/12/17 at 2:15 pm revealed:
-While she was getting showered, and getting her face shaved, Staff E put shaving cream in "my mouth."
-She slapped Staff E in the face.
-Staff E then slapped Resident #3 back in her face.
-She was unable to recall the date the incident occurred.

Interview with Staff E on 07/12/17 at 2:52 pm revealed:
-On 06/30/17 she was showering Resident #3,
-The resident started talking "junk", then became

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 121	D914		

angry and slapped her.
-She told the resident you don't slap a "black woman."
-She responded by lightly touching Resident #3's right cheek with an open right hand.
-There was another PCA that witnessed the incident also.

Interview with the facility Director on 07/12/17 at 3:04 pm revealed:
-Staff reported to her on 06/30/17 that Staff E hit Resident #3.
-On 06/30/17 she completed an incident report.
-She also issued Staff E an employee written warning showing Staff E was written up for neglecting to perform duties as outlined in her job description.
-No other action was taken to discipline Staff E and an internal investigation had not been completed.
-She had not contacted the HCPR.
-She had not contacted law enforcement regarding the incident.
-She did not send the incident report to DSS.

Interview with on 07/14/17 at 11:46 with the PCA that witnessed the incident between Resident #3 and Staff E revealed:
-Staff E attempted to shave Resident #3 on 06/30/17, the resident "hauled off and knocked the .... out of Staff E."
-Staff E "haul off and knock the ..... out of Resident #3."
-Staff E then talked to another staff member and stated "send me home or fire me."
-No one at the facility had talked with her or asked her about the incident on 06/30/17 with Resident #3 and Staff E.

Interview with the facility Director on 07/31/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 122 12:25 pm revealed: -She did not take Staff E off the schedule or off work. -Staff E had continually worked since the incident. -She had not completed an investigation of the incident. -She had not contacted the Health Care Personnel Registry. Telephone interview with Resident #3's family member on 08/23/17 at 9:45 am revealed: -The family member visited Resident #3 at the facility 3 - 4 times per year. -Resident #3 told the family member that sometimes facility staff were mean to her and cursed at her. -The family member reported that sometimes Resident #3 was hard to get along with. Interview with Assistant Director (AD) on 08/23/17 at 11:00 am revealed: -She was not aware that she needed to report the incident to the HCPR. -As of 08/23/17 she had not contacted the Health Care Personnel Registry about the incident between Resident # 3 and Staff E. -She had not contacted the local law enforcement to report the abuse. Telephone interview with the local law enforcement on 08/23/17 at 3:05 pm revealed: -The magistrate had issued a criminal summons for Staff E for the assault on a handicapped person. -They would deliver the summons Staff E to the facility. Telephone interview with staff at the HCPR on 08/24/17 at 10:35 am revealed: -Staff E had not been reported to the HCPR.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 123 C. Review of Resident #7's current FL2 dated 01/27/17 revealed: -Diagnoses included Huntington's disease, diabetes mellitus, delusions, and tremor. -The resident was intermittently disoriented. -Semi-ambulatory using a walker. -Had loss of limb control. Review of Resident #7's Care Plan signed by the physician on 05/30/17 revealed: -The resident required extensive assistance with bathing and dressing. -The resident was totally dependent on facility staff for toileting and grooming. -The resident required limited assistance with transferring and ambulation. Review of the Resident Register in Resident #7's record revealed: -The document was blank and had not been completed. Review of Resident #7's record revealed: -Resident #7 had a guardian to make decisions for him. -The resident was admitted to the facility on 01/29/16. Review of Resident #4's (Resident #7's roommate) record revealed the following documentation: -08/22/17, first shift, Resident #4 was very violent, breaking glass, lamps and "throwing full cans of soda" at his roommate (Resident #7) hitting him in the head, and fighting with staff. Observation on 08/22/17 at 11:43 am of Resident #7's head revealed: -The resident was hit in the back of head.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 124 -The was no broken skin, but a pale pinkish spot. Interview on 08/22/17 at 12:14 pm and on 08/23/17 at 9:45 am with Resident #7's court appointed guardian revealed: -The Guardian had visited the facility and communicated with Resident #7 once since Resident #4 moved into the facility. -Resident #7 was not very talkative, and mentally would not be able to explain if he was being abused by his roommate. -The Guardian was unaware that Resident #7's roommate (Resident #4) was throwing his things around the room and putting his stuffed animals and pictures in the toilet. -After observing Resident #7's head on 08/22/17, she insisted the resident be moved to another room. Interview on 08/22/17 at 5:15 pm with a second resident revealed: -Resident #4 started out okay until a couple of days ago. -Yesterday he heard Resident #4 banging on the walls. -Resident #4 was yelling loud and cursing. -He heard all this because Resident #4's room was on the other side of the wall. Interview on 08/22/17 at 4:45 pm with the second shift Personal Care Aide (PCA) revealed: -Resident #4 had outbursts of cursing, yelling and throwing things. -Resident #4 only went two places in the facility: his room and standing in the hallway. -When the resident was in the hallway, he cursed at staff or whomever was in the hallway, he yelled obscenities, and attempted to fight staff. -When Resident #4 was in his room, he threw things around in the room, this happened at least	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 125 2-3 times per week. -He would throw his and his roommate's (Resident #7) clothes around or whatever he touched with his hand, "he threw it." -Resident #4 would always throw his roommate's (Resident #7) stuffed animals and pictures in the toilet. -Resident #4 got upset and threw things around in the room as usual, but today he hit his roommate in the head with a full can of pop. -The roommate had sustained a bruise but no skin breakage. Based on record review and observation it was determined that Resident #7 was not interviewable. _____ The facility's failure to assure residents were free of physical and mental abuse resulted when Resident #2 was left unsupervised while continuing to reside across the hall from Resident #1 after facility was made aware of Resident #1's inappropriately touching Resident #2 on multiple occasions, and Resident #3 assaulted by a staff member who allegedly slapped Resident #3 in the face, and Resident #7 was subject to abuse from his roommate. This failure to assure Resident #2, #3, and #7 were safe from physical and mental abuse placed them at substantial risk for continued abuse and constitutes a Type A2 violation. _____ The Plan of Protection provided by the facility on 8/23/17 revealed: -The facility will ensure safety of all residents by the following: -The Assistant Director will immediately educate/retrain staff on residents' rights on abuse and neglect and documented said action.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D914	Continued From page 126 -Immediately all residents and staff records will be monitored and reviewed by the Director and the Assistant Director, this protocol will start 8/24/17 and will continue for 3 months to ensure compliance. -There will be a Resident Council meeting held immediately by the Director to inform all residents of Resident's rights. -The Director will ensure all residents there is an open door policy for communication. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2017.	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 A2 VIOLATION Based on observations, interviews, and record reviews the Director failed to assure the total operations of the facility to meet and maintain rules and regulations related to housekeeping, staff training, staff qualifications, supervision, Health care personal registry, reporting incident and accidents, discharge of resident, resident's rights, health care, nutrition and food services, activities, and medication administration.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 127 The findings are: Interview on 8/22/17 at 10:50 am with the Assistant Director revealed: -She had returned from a leave of absence recently and was just working as needed (PRN). -The staff came to her as there was an issue of concern. -She communicated with the facility Director daily. -The Director was available "24/7 by phone." Interview on 8/23/17 at 10:15 pm and at 10:50 pm with a second shift Medication Aide (MA) revealed: -She was also the supervisor on 2nd shift. -She administered medications to the residents, and she supervised second shift staff. -If a problem would occur on second shift , she would contact the Director who lived next to the facility. -The Director was available "24/7 via phone" if she was not in the facility. -If the Director was not available she would contact the Resident Care Director. -The Director was responsible for day to day operations in the facility. Interview on 8/23/17 at 10:40 pm with a Personal Care Aide (PCA) revealed: -The MA was in charge on second shift. -If she had an issue, she would go the MA first. -The Director of the facility was currently on a leave of absence. -She would contact the Resident Care Director or the Assistant Director if she had an issue or a problem that the MA could not handle. -The Director was responsible for day to day operations in the facility. Interview on 8/23/17 at 11:55 pm with a third shift	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 128 MA revealed: -She had worked in the facility for 2 years. -She administered medications to the residents, and supervised third shift staff. -If a problem or issue occurred, she would contact the RCD first; the Director was on a leave of absence. -The RCD was available "24/7 via phone." -The Director was responsible for day to day operations in the facility. Interview on 8/24/17 at 12:30 pm with the Director of the facility revealed: -"I am in charge of day to day operations in the facility." -She lived near by the facility and was available 24/7 either by phone or she was in the facility. -She was in the facility Monday - Friday. -The Administrator met with her in the facility quarterly. -She was in charge of overseeing all staffing issues, and resident's concerns and problems. Noncompliance identified during the survey included: A. Based on observations and interviews the facility failed to assure the two couches in the common area (day room located in the front of the facility) were kept clean and in good repair. [Refer to Tag 076, 10A NCAC 13F. 0306(a)(1) Housekeeping and Furnishings]. B. Based on observations and interviews, the facility failed to assure all residents had a readily accessible supply of pillow cases, clean towels, and clean wash cloths on hand for use at all times. [Refer to Tag 080, 10A NCAC 13F. 0306 A(6) Housekeeping and Furnishings].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 129 C. Based on observations and interviews, the facility failed to assure 33 of the facility's 33 residents had pillows, top and bottom sheets, and pillowcases clean and in good repair. [Refer to Tag 087, 10A NCAC 13F. 0306 (b)(1) Housekeeping and Furnishings]. D. Based on observations and interviews, the facility failed to provide bedside tables for 4 of 18 resident's rooms (Rooms #212, #208, #206, and #204) as required. [Refer to Tag 088, 10A NCAC 13F. 0306 b(2) Housekeeping and Furnishings]. E. Based on observation and interview, the facility failed to furnish a wall or dresser mirror in 5 of 5 residents' rooms that could be used by each resident (Rooms #102, #103, #105, #106, #107, #108, and #202). [Refer to Tag 090, 10A NCAC 13F. 0306 b(4) Housekeeping and Furnishings]. F. Based on observations and interviews, the facility failed to assure 11 of 18 (#102, #103, #105, #106, #107, #201, #202, #204, #206, #208, #210, and #212) rooms occupied by two residents had at least 1 comfortable chair for each resident. [Refer to Tag 091, 10A NCAC 13F. 0306(b)(5)(6) Housekeeping and Furnishings]. G. Based on observation and interview the facility failed to ensure that each bathroom adjoined to a resident's room had one clean towel for each resident for 12 of 17 rooms (#103, #104, #105, #106, #107, #108, #201, #202, #204, #206, #208, #210). [Refer to Tag 092, 10A NCAC 13F. 0306(b)(7) Housekeeping and Furnishings]. H. Based on observation and interview, the facility failed to provide each bedroom with a light overhead of bed with a switch within reach of person lying on bed for 27 of 33 residents. [Refer	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 130 to Tag 093, 10A NCAC 13F. 0306(b)(8) Housekeeping and Furnishings]. I. Based on observations, interviews, and record reviews the facility failed to ensure the designated person for Activity Director had completed the basic course for assisted living Activity Director within 9 months of employment. [Refer to Tag 129, 10A NCAC 13F .0404(2) Qualifications Of Activity Director]. J. Based on observations, interviews, and review of personnel files, the facility failed to assure 1 of 6 sampled staff (Staff E) had a criminal background check upon hire. [Refer to Tag 139, 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)]. K. Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff E) successfully completed an 80-hour Personal Care Training and Competency Evaluation program within six months of hire. [Refer to Tag 150, 10A NCAC 13F .0501 Personal Care Training And Competency]. L. Based on interviews and records reviews the facility failed to assure proper discharge of 1 of 1 resident (Resident #3) sampled with documentation of notification of discharge or the right to appeal notice. [Refer to Tag 227,10A NCAC 13F .0702 Discharge Of Residents]. M. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 of 5 sampled residents as evidenced by one resident (Resident #1) who repeatedly went into a female resident's (Resident #2) room and touched her inappropriately sexually. [Refer to Tag 270, 10A	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 131 NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)]. N. Based on observations, interviews, and record reviews the facility failed to assure 2 of 5 sampled residents' (Resident #4 and #6) physician notification regarding elevated finger stick blood sugars (FSBS), refusal of medications, physical therapy ordered and aggressive behaviors. [Refer to Tag 273, 10A NCAC 13F .0902 Health Care (b) (Type A2 Violation)]. O. Based on observations, interviews, and record reviews the facility failed to ensure medications and treatments were implemented as ordered by the physician in regard to Finger Stick Blood Sugar (FSBS), Sliding Scale Insulin (SSI) Novolog (a fasting acting insulin for lowering the blood sugar) for 1 of 6 residents (Resident #6). [Refer to Tag 276, 10A NCAC 13F .0902 Health Care (c)(3-4)]. P. Based on observations and interviews, the facility failed to assure the table service included a non-disposable place setting. [Refer to Tag 287, 10A NCAC 13F .0904 Nutrition And Food Service (b)(2)]. Q. Based on observation, interview and record review the facility failed to assure physician ordered therapeutic diets (No Concentrated Sweets/NCS) were served as for 2 of 5 sample residents (Residents #5 and #6). [Refer to Tag 310, 10A NCAC 13F .0904 Nutrition And Food Service (e)(2)]. R. Based on observations, interviews and record review, the facility failed to assure at least 14 hours of planned activities were provided each week based on the resident's interests and	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 132	D980		

capabilities in order to promote socialization and physical needs of the residents residing in the facility. [Refer to Tag 317, 10A NCAC 13F .0905 Activities Program (d)].

S. Based on interviews and record reviews, the facility failed to protect 3 of 5 sampled residents (Resident #2, #3 and #4) residing in the facility from mental, physical, and sexual abuse. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 violation)].

T. Based on observations, interviews, and record reviews the facility failed to ensure medications and treatments were administered as ordered by the physician in regard to buspirone (used to treat anxiety) for 1 of 6 residents (Resident #6). [Refer to Tag 358, 10A NCAC 13F .1004 Medication Administration (a)(1)].

U. Based on observations, interviews, and record reviews, the facility failed to report the Health Care Personnel Registry (HCPR) allegations of abuse received by Resident #3 from Staff member E, Personal Care Aide. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B violation)].

V. Based on interviews and record reviews, the facility failed to immediately notify the County Department of Social Services and the local law enforcement authority as required by law of any alleged sexual abuse (Resident #2) and alleged physical abuse by staff members in regard to (Resident #3). [Refer to Tag 453, 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) (Type B violation)].

W. Based on record review and interviews, the facility failed to assure every resident had the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 133 right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, residents' rights, supervision, criminal background, accident and incident, and the health care personnel registry. [Refer to Tag 912, G.S. 131D-21 Declaration of Residents' Rights (2)]. X. Based on observations, interviews and record reviews, the facility's failure to ensure residents were free of neglect, abuse and exploitation as evidenced by the facilities failure to assure residents were free of physical and mental abuse, which resulted in Resident #2 continuing to reside across the hall from a male resident (Resident #1) who inappropriately touched Resident #2 on multiple occasions, Resident #3 being assaulted by a staff member who allegedly slapped Resident #3 in the face, and Resident #7 being abused by his roommate. [Refer to Tag 914, G.S. 131D-21 Declaration of Residents' Rights (4)]. Y. Based on observation, interviews and record reviews, the facility failed to assure 1 of 8 facility staff (A) hired on or after 10/01/13 had a controlled substance screening upon hire. [Refer to Tag 992, G.S. § 131D-45 Examination and screening]. _____ Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in a resident allegation of sexual assault, an allegation of resident abuse, not report allegations to the HCPR, not reporting incidents and accidents to the proper authorities or the local DSS, violating Resident Rights to be free of harm, and abuse, not initiating referral and follow up in regard to physician not being aware of the refusal of FSBS, insulin and medications, failture	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 134 to have trained staff in control of activities program and inadequate staff training, not following therapeutic menus and failure to ensure non-disposible place settings, failure to assure adequate housekeeping and housekeeping supplies, failure to ensure criminal background checks, examination and screening and personal care training were obtained on all staff. The failure of management in providing oversight in these areas resulted in substantial risk for the health and safety for all residents and constitutes a Type A2 Violation. The Plan of Protection provided by the facility on 8/24/17 revealed: -Immediately the Director will have a daily calendar with a list of each resident and their needs that will be checked daily to ensure all needs are met and all documentation is completed and reported, effective 8/25/17. -The Director will complete the documentation and/or see that it is completed daily. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2017.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D992	Continued From page 135 be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure 1 of 8 facility staff (A) hired on or after 10/01/13 had a controlled substance screening upon hire. The findings are: Review of Staff A's personal record revealed: -There was no date of hire. -Staff A was hired as a Personal Care Aide/Supervisor. -There was no documentation Staff A completed	D992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: _____ B. WING _____	C 08/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(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
D992	Continued From page 136 a Drug Screen prior to employment. Observation on 08/22/17, 08/23/14, and 08/24/17 at 3:00 pm revealed: -Staff A worked as a Medication Aide/Supervisor on the second shift. -Staff A administered medications to residents, checked blood sugars, and gave insulin injections. Interview on 08/23/14 at 3:15 pm with Staff A revealed: -She previously worked at the facility, then resigned. -She had been gone for more than one year. -She was rehired in July or September 2016, but was unable to recall the specific date. -She thought the supervisor, which was a Medication Aide completed a drug screen. -She was unable to recall specific dates. Interview on 08/23/17 at 3:40 pm with the facility Director revealed: -Staff A was hired on 07/19/16. -She was responsible for ensuring new hires completed all requirements for employment. -She did not obtain a drug screen on Staff A. -She had planned to do it, but forgot.	D992		