STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001149	A. BUILDING: ______ B. WING ______	R-C **09/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANE ST RETIREMENT HOME	**625 LANE STREET** **BURLINGTON, NC 27217**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Alamance County Department of Social Services conducted a follow-up survey and a complaint investigation on September 21-22, 2017 and on September 25-28, 2017.	D 000		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to repair and maintain the railing/banister on the porch/ side exit ramp that the residents' used to exit the building and go out to smoke in a safe condition. The findings are: Observation on 9/26/17 at 11:15 a.m. of a ramp and railing outside the facility exit door at the end of the hall revealed: -The ramp was approximately 15 feet long by 3 feet wide with a railing that was 3 ½ feet tall. -The top railing had wood that was not painted and spindles and boards near the bottom of the railing that had chipping and missing paint. -There were eight spindles in one section that were loose and not attached to the bottom piece	D 072		

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D 072	Continued From page 1	D 072		

of wood.
-The railing moved back and forth when leaned on.

Observation of the side porch on 9/26/17 at 3:10 p.m. revealed a resident was leaning against the broken railing.

Interview with the maintenance man (MM) on 9/26/17 11:25 a.m. revealed:
-He came to the facility on an as needed bases when called by the staff or administrator.
-The top railing on the ramp banister was replaced last year.
- He would check the railing today.
-He noticed the railing/banister was loose on his last visit to the facility 2 weeks ago and had not come back to fix it.
-He did not believe the administrator was aware of the loose railing.

Interview with the Nurse Manager (NM) on 9/26/17 at 3:11 p.m. revealed:
-She was not aware the railing/banister was broken.
-The MM had been out on the back porch earlier but did not mention it.
-She would call the MM and ask him to fix it right away.
-She would post a sign to caution residents.

Interview with a medication aide (MA) on 9/26/17 at 3:12 p.m. revealed:
-She had not noticed the railing was loose.
-She had no complaints from the residents about the railing/banister being loose.
-She had not heard of anybody tripping or falling due to the loose railing.

Interview with another MA on 9/26/17 at 5:30 p.m.

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D 072	Continued From page 2	D 072		

revealed:
-She was aware of the loose porch railing/banister because construction saw it on their visit in 2017.
-It was on the MM list to fix.

Interview with the second MA on 9/28/17 at 10:11 a.m. revealed:
-The MM came out yesterday to look at the railing.
-The MM was getting wood supplies today to fix the railing.

Telephone Interview with the facility NM on 9/28/17 at 10:40 a.m. revealed:
-The facility MM was out working on the railing on 9/27/17.
- She was not aware of any resident falls.

Confidential interview with a resident revealed:
-The resident did not go out the side exit door because the railing was unsafe.
-The railing had been unsafe for over a year.
-The resident had not told the staff.

Telephone interview with the Administrator on 09/28/17 at 4:23 p.m. revealed:
-She was not aware the railing on the banister on the side exit door was loose at the facility.
-It had to just happened recently.
-The staff notified me of the loose railing on 9/26/17.
-A staff person posted a sign on the banister warning that the railing on the banister was loose on 9/26/17.
-The facility was in the process of fixing the railing on the banister.
-She did not give a time frame for the railing on the banister to be fixed.
-The staff were responsible for calling the

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D 072	Continued From page 3 maintenance man or the Administrator if repairs were needed at the facility. -The facility did not keep a maintenance book.	D 072		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Non compliance continues Based on observations, interviews, and record reviews the facility failed to ensure wall, ceilings, and floors were in good repair in 3 of 3 resident rooms, 2 of 2 community bathrooms, the hallway, and 1 of 1 dining room. The findings are: Observation of the hallway on 9/21/17 at 11:52 a.m. revealed: -There was a five foot area of the wall covered in splattered, brown stains. -There was a light switch covered in brown rusted areas. -There were cobwebs above the back exit door on the wall. Observation of Resident Room #3 on 9/21/17 at 11:59 a.m. revealed there was a three foot area	D 074		

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D 074	Continued From page 4 of the baseboard missing by the closet. Observation of Resident Room #5 on 9/21/17 at 12:10 p.m. revealed: -There were multiple scratches on the lower half of the door. -The wall to the right of the door when entering was covered in brown liquid stains. -There was a buildup of dirt around the vent on the floor. -There was a two inch area of brown discoloration on the white wall around the light switch . -There was a foot long crack in the wall to the left of the door frame. -There was a greenish, gray liquid smear about three feet long on the wall to the left of the door. -There was a three foot area covered in dark smudges below the window . -There was an outlet cover missing on the wall to the left of the door. Observation of Resident Room #4 on 9/21/17 at 12:23 p.m. revealed: -There were a two foot area of the wall covered in black smudges. -There was a black handprint on the wall behind the television. -There were two clusters of brown stains on the wall behind the door. -There was a two foot area of missing baseboard by the closet. -There were two 12 inch areas of broken tile, exposing the wood floor underneath. -There was a foot-long dark smudge on the wall to the right and the left of the window. Observation of the men's bathroom on 9/21/17 at 12:41 p.m. revealed: -There were several cracks in the tile flooring. -There was a cobweb behind the door on the wall.	D 074		

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D 074	Continued From page 5 -There were two, long brown stains on the wall by the light fixture. -The grout between the tiles on the wall to the left of the sink were brown. -Both sinks were covered in white and brown buildup. -The door hinge and post separaring the bathroom stalls were rusted at the base. -There was an inch wide brown area on the tile surrounding the toilet. -There were rusted areas under the stall door handles and on the back of the door. Observation of the men's bathroom on 9/21/17 at 12:42 p.m. revealed there was a light fixture with one bulb not working. Observation of the women's community bathroom 9/21/17 at 12:29 p.m. revealed: -The tiled floor had brown stains throughout the floor. -There was dust and dirt on the baseboard behind the toilet and the under the sink. -There was dust on the floor vent. -The sprinkler on the ceiling was and the metal curtain rod were rusted. -There was black mold on the tile and the caulking around the tub. Observation of the dining room area on 9/22/17 at 4:28 p.m. revealed: -There was a long, three foot black streak to the left of the door on the wall. -There were long, brown stains on the lower wall to the right of the door. -There was a brown and black dirt build up on the tile in the right corner of the room. -There was an area of brown smudges below the light switch. -There was a three foot area of black smudges	D 074		

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D 074	Continued From page 6	D 074		

and long, brown stains on the wall next to the kitchen.
-There was a light cover missing on one of the celing lights.
-The vent on the floor was dirty and the grates were covered in dust.
-There was a two foot black smudge on the wall to the left.
-There were various brown stains on the tiled floor.
-The wallpaper was covered in brown smudges.

Interview with a resident on 9/21/17 at 2:35 p.m. revealed:
-Staff cleaned daily.
-Staff would sweep the floor, dust, and mop daily.

Interview with a Medication Aide (MA)/Supervisor on 9/26/17 at 3:12 p.m. revealed:
-She was the assigned live in staff for one week.
-The resident rooms were swept and mopped daily.
-The walls were cleaned as needed.
-The toilets, sinks and floors were cleaned as needed in the bathroom.
-Every other day, she cleaned the tiles in the bathrooms.
-She dusted the vents weekly.
-The floor and walls were cleaned in the dining room as needed.
-The dining room floor and floor vents were swept after each meal.
-The dining room floor were mopped after breakfast and as needed.
-No residents complained about the cleanliness of the facility.

Interview with a second MA/Supervisor on 9/26/17 at 5:03 p.m. revealed:
-The walls in the bathroom were supposed to be

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D 074	Continued From page 7	D 074		

wiped as needed.
-The vents and baseboards were cleaned every two weeks or monthly.
-Two weeks ago, the floors in the facility were being cleaned daily, because a clear coating was being placed on the floors.
-The walls in the facility were painted every year.
-The walls were last painted October 2016.
-The dining room wall needed to be painted.
-The dining room was mopped during the day.
-The men's bathroom floor was pressure washed one year ago.
-The Administrator will buy curtain rods for the women's bathroom.

Telephone interview with a Personal Care Aide (PCA) on 9/28/17 at 9:13 a.m. revealed:
-She did not know if the facility had a cleaning schedule.
-She cleaned the toilets, sink, showers and mopped the bathrooms daily.
-She last cleaned the bathroom the morning of 9/26/17.
-The halls were mopped every morning before breakfast and at night.
-The floors in the resident rooms were cleaned every other day.
-She last cleaned the floors on 9/25/17 or 9/26/17.
-The walls in the resident rooms were wiped every Friday.
-The walls in the dining room were wiped every Wednesday or Friday.

Confidential interview with a resident family member revealed the facility was cleaned when the family member came to the facility.

Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:

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D 074	Continued From page 8 -The bathrooms were painted once yearly. -The floors, sinks, toilets, showers and tubs are cleaned daily by the MA or PCA daily. -The floors in the halls and resident rooms was swept and mopped daily. -The floors in the dining room are swept after each meal and mopped daily. -The walls in the dining room are cleaned every three months. -The MA or PCA monitored the cleanliness of the facility daily. -She monitored the cleanliness of the facility every two weeks. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -Her expectation was for staff to clean the walls, ceilings and floors at the facility daily. -The bathrooms including the tiles should be cleaned with a cleaning solution daily. -The rusted curtain rod and the rusted sprinkler in the women's bathroom would be repaired. -The Supervisor's were supposed to monitor the cleanliness of the facility daily. -She monitored the cleanliness of the facility monthly.	D 074		
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, interviews, and record	D 076		

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D 076	Continued From page 9 reviews the facility failed to assure one nightstand and two dressers drawers were in good repair in 3 of 6 resident rooms. The findings are: Observation of Resident Room #5 on 9/21/17 at 12:12 p.m. revealed there was a nightstand by the closet with a broken bottom drawer. Observation of Resident Room #4 on 9/21/17 at 12:25 p.m. revealed: -There was a dresser with three broken drawers. -The front top of the dresser was scratched on the right. -There was a nightstand with two broken drawers. -The top of the nightstand was covered in scratches. Interview with a resident on 9/21/17 at 12:34 p.m. revealed: -The nightstand had been broken for a year. -The dresser had been broken for at least six months. -The resident had not complained about the broken furniture. Observation of Resident Room #2 revealed: -There was a dresser with three broken drawers. -There was a nightstand with several scratches on the top. Interview with a second resident on 9/26/17 at 11:23 a.m. revealed: -The dresser had been broken since the resident lived at the facility. -The resident had been living at the facility for a year and seven months. Observation of the dining room on 9/22/17 at 4:28	D 076		

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p.m. revealed:
-There were three broken chairs off to the side of the room.
-Each chair had a broken front leg.
-Six of the backs of the chairs were covered in food and dust particles.
-There was a rusted file cabinet in the dining room.

Interview with a Medication Aide (MA)/Supervisor on 9/26/17 at 3:12 p.m. revealed no one used the broken chairs in the dining room.

Telephone interview with a Personal Care Aide (PCA) on 9/28/17 at 9:13 a.m. revealed:
-She dusted the furniture in the resident's room every other day.
-Two week ago, the dresser drawers in one of the resident's rooms had just broken.
-She reported the broken drawers to the Medication Aide.

Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:
-If the furniture was not safe, she told the Administrator.
-The dresser drawers break frequently, because the residents stuff the drawers.
-She was aware of broken drawers at the facility.
-She came to the facility every two weeks and monitored the furniture.

Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed:
-She replaced the dresser drawers as needed in the resident rooms.
-She last replaced the drawers and nightstands in 2016.
-If something needed to be fixed, she called the Maintenance Man.

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D 076	Continued From page 11 -She monitored the facility monthly for broken furniture.	D 076		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record review, the Administrator failed to assure the total operations of the facility as evidenced by noncompliance related to physical environment, housekeeping and furnishings, resident assessments, personal care and supervision, health care, snacks, sanitation of food, activities, health care personnel registry, infection prevention, medication aide training and resident rights. The findings are:	D 176		

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Interview with a Personal Care Aide on 9/21/17 at 11:00 a.m. revealed:
-The Administrator was not at the facility.
-The census was 12.

Telephone interview with a Medication Aide on 9/27/17 at 9:47 a.m. revealed:
-The Administrator came to the facility 3 to 4 times monthly.
-She was last at the facility on 9/24/17.

Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:
-She monitored the facility every two weeks.
-She did not know how often the Administrator came to the facility.
-It is hard to get in touch with the Administrator.

Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed periodically she monitored the facility monthly.

Confidential interview with a resident revealed the Administrator was more concerned about the "dollar" than the residents.

The Administrator was not at the facility during the survey on September 21-22, 25-26, 2017.

1. Based on observations and interviews, the facility failed to repair and maintain the railing/banister on the porch/ side exit ramp that the residents' used to exit the building and go out to smoke in a safe condition. [Refer to Tag D072, 10A NCAC 13F .0305(m)(1) Physical Environment.]

2. Based on observations, interviews, and record reviews the facility failed to ensure wall, ceilings,

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and floors were in good repair in 3 of 3 resident rooms, 2 of 2 community bathrooms, the hallway, and 1 of 1 dining room. [Refer to Tag D074, 10A NCAC 13F .0306 (a)(1) Housekeeping and Furnishings.]

3. Based on observations, interviews, and record reviews the facility failed to assure one nightstand and two dressers drawers were in good repair in 3 of 6 resident rooms. [Refer to Tag D076, 10A NCAC 13F .0306 (a)(3) Housekeeping and Furnishings.]

4. Based on observations, interviews, and record reviews the facility failed to complete an annual Care Plan for 1 of 6 sampled residents (#2). [Refer to Tag D254, 10A NCAC 13F .0801 (b) Resident Assessment.]

5. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Resident #2, and #5) who had a history of smoking inside the building. [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)]

6. Based on observations, interviews and record reviews, the facility failed to assure the primary care physician (PCP) was notified for 1 of 6 residents (#1), who had orders to be evaluated by Physical Therapy (PT) and Occupational Therapy (OT), that the resident had not been seen by PT/OT. [Refer to Tag D273, 10A NCAC 13F .0902 (b) Health Care.]

7. Based on observations, interviews and record reviews, the facility failed to assure that occupational therapy (OT) orders were implemented for 1 of 6 (#6) sampled residents.

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[Refer to Tag D276, 10A NCAC 13F .0901 (c) (3-4) Health Care.]

8. Based on observations, interviews, and record reviews, the facility failed to ensure snacks were passed out to the residents in a manner to prevent contamination. [Refer to Tag D283, 10A NCAC 13F .0904 (a)(2) Nutrition and Food Service.]

9. Based on observations and interviews, the facility failed to assure snacks were offered to residents three times daily. [Refer to Tag D298, 10A NCAC 13F .0904 (d)(2) Nutrition and Food Service.]

10. Based on record reviews, interviews and observation, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills for the 12 residents currently living in the facility. [Refer to Tag D317, 10A NCAC 13F .0905 (d) Activities Program.]

11. Based on observations, interviews and record reviews, the facility failed to assure that each resident had the opportunity to participate in at least one outing every other month. [Refer to Tag D319, 10A NCAC 13F .0905 (f) Activities Program.]

12. Based on observations, record reviews, and interviews, the facility failed to assure every resident's rights were maintained as related to residents not being treated with dignity and respect, residents being free of abuse and residents being free of neglect by the facility'

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failure to report Staff B to the Health Care Personnel Registry. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights.]

13. Based on interviews and record reviews, the facility failed to report allegations of verbal and mental abuse of one Staff (B) affecting four residents (#1, #4, #6, #7) to the Health Care Personnel Registry (HCPR). [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)]

14. Based on interviews and observations, the facility failed to assure residents had access to clean cups to use when taking medications. [Refer to Tag D911, G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)]

15. Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. and qualified staff administering medications to residents. [Refer to Tag D912, G.S. 131D-21(2) Declaration of Resident Rights (Type A2 Violation)]

16. Based on interviews and observations, the facility failed to ensure 4 of 7 sampled residents (#1, #4, #6, #7) were free of verbal and mental abuse by Staff (B). [Refer to Tag D914, G.S. 131D-21(4) Declaration of Resident Rights (Type A2 Violation)]

17. Based on observations and interviews, the facility failed to assure residents had a right to communicate with people privately and without restrictions. [Refer to Tag D918, G.S. 131D-21(8)

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D 176	Continued From page 16 Declaration of Resident Rights.] 18. Based on observations, interviews and record reviews, the facility failed to assure 1 of 2 Medication Aides (MA) (Staff C) received the state annual infection control training. [Refer to Tag D934, G.S. 131D-4.5B(a) Adult Care Home Infection Prevention Requirements.] 19. Based on observations, interviews and record review, the facility failed to assure 1 of 1 Staff (B), who had not passed the written examination within 60 days of hire, did not perform any unsupervised medication aide duties. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)] ______________________ The failure of the Administrator to be responsible for the operation of the facility resulted in the lack of supervision of residents smoking inside the facility which endangered the safety and welfare of all residents; residents being physically and mentally abused by staff B, and Staff B not being reported to the Health Care Personnel Registry. The non-compliance placed all residents at substantial risk for serious physical harm, abuse and neglect and constitutes a Type A2 Violation. ______________________ The Plan of Protection was requested on 9/29/17. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 28, 2017	D 176		
D 254	10A NCAC 13F .0801(b) Resident Assessment	D 254		

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D 254	Continued From page 17 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to complete an annual Care Plan for 1 of 6 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 9/11/17 revealed: -Diagnoses included Schizophrenia, Diabetes, and Duodenal Ulcer. -Resident #2 was intermittently oriented, ambulatory, and could be verbally abusive. -Resident #2 was admitted on 8/24/1999.	D 254		

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Review of Resident #2's care plan records revealed the last Care Plan was completed 1/28/16.

Review of the Care Plan dated 1/28/16 revealed:
-Resident #2 was independent with tasks of eating, toileting, ambulation, bathing, dressing, grooming, and transferring.
-He was seen by a mental health provider.
-Resident #2 could be forgetful, had wandering behavior, and was verbally abusive.

Interview with the Personal Care Aide (PCA) on 9/25/17 at 1:00 p.m. revealed:
-Staff assisted Resident # 2 with bathing.
-Staff also helped him pick out his clothing for the day.
-Resident #2 did everything else on his own.

Telephone interview with Resident #2's Power of Attorney (POA) on 9/27/17 at 2:28 p.m. revealed:
-Resident #2 required assistance with bathing and dressing.
-He had some issues with his left arm due to an old injury and thus needed the help.

Interview with the MA on 9/28/17 at 9:15 a.m. revealed:
-Staff assisted Resident #2 with washing his back.
-Staff also helped shave Resident #2 and laced his shoes.
-Resident #2 was able to do everything else on his own.

Telephone interview with the Nurse Manager on 9/27/17 at 11:15 a.m. revealed:
-Resident #2 was pretty much independent.
-Staff monitored his showers.
-Resident #2 required minimal assistance with

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D 254	Continued From page 19 activities of daily living. -The Care Plan had been faxed to Resident #2's PCP but due to ongoing problems with the fax machine at the PCP's office they had not been able to get the document signed. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -Resident Care Plans were done annually. -She, the Nurse Manager or the MA completed the Care Plan and submitted it to the resident's PCP. -She was not aware Resident #2's Care Plan had not been completed. Based on observations, interviews and record review, Resident #2 was not interviewable. Resident #2's primary care physician could not be reached by the end of the survey.	D 254		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Resident #2, and #5) who had a history of smoking inside the	D 270		

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building.

The findings are:

1. Review of Resident #2's current FL-2 dated 9/11/17 revealed:
-Diagnoses included Schizophrenia, Diabetes, and Duodenal Ulcer.
-Resident #2 was intermittently oriented, ambulatory, and could be verbally abusive.

Review of Resident #2's most recent Assessment & Care Plan dated 1/28/16 revealed:
-Resident #2 was verbally abusive.
-Resident #2 received mental health services.
-Resident #2 was oriented but forgetful and sometimes needed reminders.

Review of Resident #2's Assessment & Care Plan dated 9/22/16 (unsigned) revealed:
-Resident #2 had disruptive behavior.
-Resident #2 was followed by a mental health provider.

Observation of Resident #2's room on 9/21/17 at 12:12 p.m. revealed:
-There was a plastic soda bottle and an open container of petroleum jelly on the nightstand by Resident #2's bed that both contained cigarette ashes.
-The room smelled of cigarette smoke.

Review of Resident #2's Notice of Transfer/Discharge dated 3/21/16 revealed Resident #2 had been given a written warning after being caught smoking in his room with a date of transfer/discharge on 4/19/16.

Interview with the Personal Care Aide (PCA) on 9/25/17 at 11:50 a.m. revealed:

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D 270	Continued From page 21 -Resident #2 came in and out of the back door smoking. -She had never caught the resident smoking in his room. -She had not seen any cigarette ashes in Resident #2's room. Interview with Resident #2's roommate on 9/25/17 at 11:21 a.m. revealed he had never seen his roommate smoking in the room. Interview with the PCA on 9/25/17 at 1:25 p.m. revealed: -Staff took residents' cigarettes and lighters at night. -Everyone was expected to smoke outside. -There had been no incidents with anyone smoking inside the facility. Interview with the Medication Aide (MA)/Supervisor on 9/25/17 at 1:27 p.m. revealed: -Staff took residents' lighters and open cigarettes at night. -Each resident had a carton of cigarettes in the file cabinet in the office. -She had not caught Resident #2 smoking in his room this year. -Resident #2 usually smoked on the back porch. -Sometimes he would stand in the doorway and smoke to avoid the door locking behind him. -This could be the reason his room smelled of smoke. -The cigarette ashes in his room might have come from him putting out the cigarette in his room. Interview with the same MA/Supervisor on 9/25/17 at 3:57 p.m. revealed: -Residents were given a verbal warning the first	D 270		

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time they were caught smoking inside the building.
-The second time a resident was caught smoking inside the building he would receive a written warning.
-The third time a resident was caught smoking inside the building he would be discharged.
-There had been no recent issues with Resident #2 smoking inside the building.

Observation of Resident #2's room on 9/25/17 at 3:50 p.m. revealed:
-Resident #2 was lying in bed with a cigarette pack and a lighter in his hand.
-There were cigarette ashes in the petroleum jelly container on the nightstand.
-The resident was seated on the bed and permitted staff to search his room.

Interview with the Nurse Manager on 9/25/17 at 4:04 p.m. revealed:
-The Administrator had to be contacted for the formal smoking policy.
-She had spoken to Resident #2 about smoking in his room before.
-The resident's family member assisted staff with helping Resident #2 follow the rules.
-Resident #2 had a history of getting violent when confronted about smoking.
-Staff would now give the resident his cigarette prior to going out to smoke and light the cigarette outside for him.

Review of Resident #2's record revealed:
-The no smoking policy was signed on 8/28/99 when the facility was under a different name.
-There was a second no smoking policy signed by the resident and the Administrator or Supervisor at that time, but it was not dated.

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D 270	Continued From page 23 Observation of Resident #2 on 9/26/17 from 12:34 p.m. to 1:01 p.m. revealed the resident seated on the porch holding a pack of cigarettes and a purple lighter. Interview with a second MA/Supervisor on 9/26/17 at 3:05 p.m. revealed: -Resident #2 was now back in his room. -Staff had taken Resident #2's cigarettes. -Staff could not locate the purple lighter Resident #2 was using. Observation of Resident #2 on 9/26/17 at 3:10 p.m. revealed: -He was seated on the back porch smoking a cigarette holding a black lighter. -Staff asked Resident #2 for the lighter. -Resident #2 became very agitated and threatening to staff. -Resident #2 cursed at staff and went in to his bedroom and slammed the door. Interview with the second MA on 9/26/17 at 3:53 p.m. revealed: -Resident #2 sometimes smoked in his room. -He was last caught smoking in his room about two months ago. -Resident #2 smoked whenever he wanted to do so. -The MA notified the Nurse Manager. -She did not address smoking with the resident because he would become combative. -The MA did not document this incident anywhere. Interview with the Nurse Manager on 9/26/17 at 5:20 p.m. revealed: -She had not gotten Resident #2 to sign anything regarding the new policy last night when she collected cigarettes.	D 270		

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-The residents were so upset and reacted poorly to the new rule.

Interview with Resident #2's Power of Attorney (POA) on 9/27/17 at 2:28 p.m. revealed:
-Resident #2 had been warned about smoking in the facility before at least twice.
-The last warning occurred several months ago.
-He had spoken to Resident #2 and tried to help him understand the rules.
-Resident #2 often got upset when the smoking issue was being addressed.
-He was at the facility on Monday 9/25/17 and tried to help staff confiscate the resident's cigarettes.
-Resident #2 was schizophrenic and a Vietnam veteran and smoking seemed to help keep him calm.
-He visited the facility three to four times weekly.

Interview with the Nurse Manager on 9/28/17 at 11:15 a.m. revealed:
-Resident #2 was now being given one to two cigarettes at a time and staff would light the cigarettes for him.
-The last incident with Resident #2 smoking in the facility occurred about a month ago.
-Staff smelled smoke in the resident's room but did not find the cigarette.
-Staff had not issued Resident #2 another discharge notice because they did not want him to be homeless.

Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed:
-Residents were not supposed to smoke inside of the facility.
-The designated smoking areas are in the front of the facility or on the side of the facility.
-The first time a resident was caught smoking

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inside the facility they received a verbal warning.
-The second time a resident was caught smoking in side of the facility they received a written notice.
-The third time a resident was caught smoking inside of the facility, they were discharged from the facility.
-She was not aware he had been smoking inside of the facility or cigarette ashes had been found in his room.
-She never caught the resident smoking inside of the facility.
-For one year, staff was supposed to give him one cigarette at a time.
-One year ago, she told Resident #2's POA, if he was caught smoking inside of the facility again, he would be discharged from the facility.
-She told staff if they found ashes or cigarettes in the resident's room, to give him a 30 day notice.
-She told staff to give Resident #2 a warning on 9/25/17 or 9/26/17, since there were cigarette ashes in his room.

Resident #2's primary care physician could not be reached by the end of the survey.

Based on observation, interviews, and record reviews Resident #2 was not interviewable.

Refer to the facility's smoking policy.

Refer to the facility's addendum to the smoking policy.
2. Review of Resident #5's current FL-2 dated 5/10/17 revealed:
-Diagnoses included schizoaffective-bipolar type, tobacco use disorder and hypertension.
-Resident was listed as ambulatory and intermittent disoriented.

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D 270	Continued From page 26 Review of Resident #5's Resident Registry revealed an admission date of 7/1/13. Observation of Resident #5 room on 9/21/17 at 12:12 p.m. revealed: -There was a plastic soda bottle on Resident #5's night stand which contained cigarette ashes. -There was a plastic soda bottle containing cigarette ashes on the floor beside the window. -The room smelled of smoke. Interview with Resident #5 on 9/25/17 at 11:21 a.m. revealed: -He did not smoke in the room. -He had never seen his roommate smoking in the room. Interview with the Medication Aide (MA) on 9/26/17 at 3:12 p.m. revealed: -Resident #5 was independent with his personal care. -Resident #5 did not buy cigarettes with his own money but bought other things with his money. -Resident #5 smoked out in the front or the back of the facility. -She has no knowledge of the resident smoking in his room or inside the facility. -Resident #5 does not need to be monitored when smoking. -Staff have not needed to take resident #5's cigarette lighter. -Staff checked on Resident #5 every 2 hours when he was at the facility. Telephone interview on 9/26/17 at 4:58 p.m. with the resident's primary care physician (PCP) revealed: -As far as she knew, the resident was a safe smoker. -She had offered smoking cessation help to	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANE ST RETIREMENT HOME	**625 LANE STREET BURLINGTON, NC 27217**

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D 270	Continued From page 27	D 270		

Resident #5 on every visit, but he has refused.
-She did not think he needed staff supervision to smoke.
-She had no knowledge of him smoking in the facility.
-She was not sure if he may have sneaked out at night to smoke.
-He was his own guardian.

Interview on 9/26/17 at 5:30 p.m. with another MA revealed:
-Resident #5 smoked outside, and he had not been caught smoking in his room or the facility.
-Resident #5 bummed his cigarettes from other residents, and only had one or two cigarettes on him at a time.

Telephone interview with the resident's family member on 9/26/17 at 2:38 p.m. revealed:
-When he visited the facility, he did not stay long and did not bring the resident cigarettes.
-He was not sure where the resident smoked at the facility.
-He did not know if the resident ever smoked inside the facility.

Interview with the Nurse Manager (NM) on 9/26/17 at 5:45 p.m. revealed:
-She was not aware that Resident #6 smoked in his room.
-Since there was evidence of cigarette ashes in Resident #6's room, he would not be allowed to keep cigarettes or cigarette lighter in his room.
-Resident #6 would be given only one lit cigarette at a time.

Refer to the facility's smoking policy.

Refer to the facility's addendum to the smoking policy.

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D 270	Continued From page 28 Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -She was not aware Resident #5 was smoking in the building. -"I am saying that he had not been smoking in the building". -Resident #5 was not supposed to have a cigarette lighter in his room, and it had been like that over a year ago. . -"We just saw ashes in a can in his room over a year ago". -He could only have one lighted cigarette at the time. -If Resident #5 was smoking in the room, he had to find another place to go. -The staff had not notified her that Resident #5 was smoking in his room. -If Resident #5 had cigarettes, the staff should keep the cigarettes locked up in the office. -Resident #5 should only be given one cigarette at the time. -Re -If staff found evidence of ashes or smoking material in a resident's room, the resident should not have a cigarette lighter. -The resident's first warning would be a verbal warning, -The resident's second warning would be written warning, and the resident would be given only one lighted cigarette at the time and not allowed to keep a cigarette lighter. -The resident's third warning would be a thirty day notice of discharge. ______________________________ Review of facility's smoking policy [undated] revealed: -Smoking was only allowed outside of the facility. -Staff would supervise residents while smoking.	D 270		

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D 270	Continued From page 29 -Staff would keep resident's physicians informed of their smoking habits. Review of the facility's addendum to the smoking policy [undated] revealed: -The first time a resident was caught smoking inside the facility a verbal warning would be given. -The second time the resident would be given a written warning. -The third time the resident would be given a thirty day notice of discharge. ______________________________ The facility's failure to enforce a system of supervision for Residents #2 and #5, who had a past history of smoking inside the facility, placed all residents in the facility at risk of a fire hazard. This noncompliance resulted in substantial risk for serious physical harm and constitutes a Type A2 Violation. ______________________________ A plan of protection was requested on 9/29/17.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the primary care physician (PCP) was notified for 1 of 6 residents (#1), who had orders to be evaluated by	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 30 Physical Therapy (PT) and Occupational Therapy (OT), that the resident had not been seen by PT/OT. The findings are: Review of Resident #1's current FL-2 dated 9/22/17 revealed: -Diagnoses were Thoracic (T) lumbar 8 compression fracture, T12 Burst fracture, Lower (L) lumbar 2 endplate fracture, Bilateral Sacral ALA fracture, bipolar disorder alcohol and drug abuse and paraplegia. -The resident was non-ambulatory using a wheel chair. -There was an order for the resident to be seen by PT/OT. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 8/24/17. Review of Resident #1's current Care Plan dated 8/31/17 revealed: -The resident used a Hoyer lift and sliding board for transfers. -The resident ambulated using a wheel chair. -The resident required total assistance with bathing. -The resident required extensive assistance with toileting and transferring. -The resident required limited assistance with ambulation, dressing and grooming. -The resident was independent with eating. Review of Resident #1's physician's orders dated 9/1/17 revealed: -There was an order for a PT/OT evaluation to be completed to help increase independence and to help get the needed equipment for the resident.	D 273		

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D 273	Continued From page 31 -There was an order for 1/2 bed rails and a hospital bed. Observation of Resident #1's room on 9/21/17 at 12:45 p.m. revealed the resident had 1/2 bed rails, a hospital bed, a transfer sliding board and a Hoyer lift. Observation of Resident #1 on 9/26/17 at 11:30 a.m. revealed the resident was rolling herself down the hall in her wheel chair. Interview with the Nurse Manager on 9/21/17 at 3:00 p.m. revealed: -Within the past two weeks (between 9/3/17 to 9/16/17), she contacted a home health agency to evaluate Resident #1 twice, but she had not heard anything from the agency. -She recently contacted a second home health agency to have the resident evaluated for service. Telephone interview with a home health agency on 9/22/17 at 12:48 p.m. revealed: -They received the referral for Resident #1 on 9/6/17. -The resident was not admitted due to her insurance provider being out of network. -There was no note in the system as to whether the facility had been notified. -The marketer for that region should have contacted the facility with this information. -The marketer for that region was no longer employed by the agency. Telephone interview with a second home health agency on 9/22/17 at 12:10 p.m. revealed: -Resident #1 was currently not being seen for therapy. -They received a referral for the patient on 9/12/17.	D 273		

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D 273	Continued From page 32 -This referral was sent by the Nurse Manager. -An office note from the physician and also the PCP's signature was needed to complete the referral. -The agency had not yet received a response from the facility. Telephone interview with Resident #1's Responsible Party on 9/25/17 at 11:24 a.m. revealed: -The resident used a sliding board to transfer from her wheel chair to her bed. -The resident had not had any falls at the current facility. -At the prior facility, the resident was being seen by PT/OT, but the resident became uncooperative with therapy. Interview with a Medication Aide (MA)/Supervisor on 9/26/17 at 5:03 p.m. revealed: -Resident #1 required assistance with bathing and incontinent care if the resident had a bowel movement. -She thought Resident #1 had been evaluated by PT/OT. -Anytime a resident had an order for PT/OT evaluation, the Nurse Manager contacted the company. Telephone interview with the same MA/Supervisor on 9/27/17 at 9:47 a.m. revealed: -Resident #1 required a two person assist for bathing. -Resident #1 used a sliding board for transfers. -The resident had a Hoyer lift, but the resident was uncomfortable using it. -The resident dressed herself, combed her hair, and ambulated with a wheelchair independently. -The resident had good arm strength. -She did not know if the resident would benefit	D 273		

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D 273	Continued From page 33	D 273		

from PT/OT or not.

Telephone interview with Resident #1's PCP on 9/25/17 at 5:10 p.m. revealed:
-She has only seen the resident once, when the resident was first admitted to the facility.
-She wrote on 9/7/17 (unsure of date) for the resident to be evaluated by PT/OT.
-The PT/OT order was written so the resident could get hand rails and anything else needed for the resident.
-The resident did not have any issues with falls that she was aware of.
-The resident told the PCP she could get in her wheel chair and change her incontinent brief independently. The resident needed assistance with incontinent care if she had a bowel movement.
-She was unaware the resident had not been evaluated by PT/OT and they needed paperwork from her to approve the therapy. She thought the resident had been evaluated by PT/OT.
-If she would have known the resident had not been seen by PT/OT and other paperwork was needed for the resident to be approved for therapy, she would have made sure the home health agency had what they needed.

Interview with the Nurse Manager on 9/26/17 at 4:22 p.m. revealed she was not aware the second home health agency had not approved Resident #1's therapy, because they were waiting on a signed office note from the resident's PCP.

Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:
-She submitted a referral for PT/OT for Resident #1 to be evaluated to a home health agency.
-Within two days, they never came to the facility to evaluate the resident.

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D 273	Continued From page 34 -So she called a second home health agency. -She submitted the paper work needed to the second home health agency the morning of 9/27/17, and they will come and evaluate Resident #1. -The agency had not set up a date for the resident to be evaluated. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -If a resident needed to be seen by PT/OT, the resident's PCP made the referral, called and scheduled the appointment. -The facility followed-up to and made sure the appointment was scheduled. -She did not know what happened to Resident #1's PT/OT evaluations. -The Nurse Manager would follow-up with the home health agency to make sure Resident #1 was seen by PT/OT. Attempted interviews were made with Resident #1, but the resient did not want to be interviewed.	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:	D 276		

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Based on observations, interviews and record reviews, the facility failed to assure that occupational therapy (OT) orders were implemented for 1 of 6 (#6) sampled residents.

The findings are:

Review of Resident #6's current FL-2 dated 2/18/17 revealed:
-Diagnosis included chronic obstructive pulmonary disease (COPD), low grade intraepithelial lesion (LGSIL), pancytopenia, seizure disorder, diabetes, human immunodeficiency virus (HIV), progressive multifocal leukoencephalopathy (PAL).
-Resident #6 was ambulatory.

Review of Resident #6's unsigned order dated 1/3/17 revealed, please start patient on [TIW] occupational therapy (OT).

Review of Resident #6's order dated 1/25/17 revealed, follow thru occupational therapy referral right side weaker 1+ handgrips.

Review of Resident #6's undated and unsigned order revealed:
- "Will schedule OT evaluation".
- There was a check mark and initials written next to the unsigned order.

Review of Resident #6's Care Plan dated 2/18/17 revealed.
-Documented under "Upper Extremities" was no problem.
-Documented under "Activities of Daily Living" was independent with dressing .

Interview with Resident #6 on 9/26/17 at 6:32 p.m. revealed:

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-She told her physician 1 year ago that she had trouble writing and her hands were shaky.
-She had not had any therapy, and she had not asked about it.
-She thought the therapy would help her hands.
-She can eat and dress ok.
-She needed help tying her shoes.

Telephone interview with the Medication Aide (MA) on 9/27/17 at 3:22 p.m. revealed:
-She did not remember anybody coming out to do therapy with Resident # 6.
-Resident #6 cannot write because her right hand was so shaky.
-Resident #6 had not had any trouble walking she had not had any falls as far as she knew.
-Resident #6 had no trouble eating and drinking.
-Resident #6 can dress and undress herself, and she can do zippers and buttons on clothing.
-The system in place for OT orders was as soon as the order came in or within one day of the order the MA would call the nurse and the nurse takes care of it.

Interview with the Nurse Manager on 9/28/27 at 10:40 a.m. revealed:
-The MA reviewed the orders when she got them after appointments.
- The MA should call the nurse manager to let her know if there was therapy orders.
-The Nurse Manager made the appointments for new OT orders.
-If the MA had not called her she would not know about OT orders.
-She did not know about the orders for OT for Resident #6.
-She would initial the orders that she reviewed.
-Resident #6 had not had any falls that she knew of.
-Resident could feed herself.

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Continued From page 37

-She did not think the resident hands shook when she smoked a cigarette.

Telephone interview with the Administrator on 09/28/17 at 4:23 p.m. revealed:
-She was not aware Resident #6 had an order for OT.
-If Resident #6 had an order for OT, she should be receiving the services.
-Staff at the physician's office made the referral to the appropriate agency.
-The Nurse Manager (NM) or the Administrator would give the staff at the PCP office a week to make the appointment.
-The NM or the Administrator would be responsible for following up on the appointment for the resident.

D 283 | D 283

10A NCAC 13F .0904(a)(2) Nutrition and Food Service

10A NCAC 13F .0904 Nutrition and Food Service
(a) Food Procurement and Safety in Adult Care Homes:
(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure snacks were passed out to the residents in a manner to prevent contamination.

The findings are:

Observation of snack time on 9/22/17 at 10:44 a.m. revealed:
-The PCA was in the hallway handing out graham

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crackers.
-The PCA handed one resident in a wheelchair two graham crackers as he exited the bathroom.
-The PCA was not wearing gloves and used her bare hands.

Interview with a resident on 9/22/17 at 10:50 a.m. revealed:
-He received two graham crackers from the PCA.
-The PCA used her bare hands to hand them to the resident.
-The resident was not given a paper towel.

Interview with a second resident on 9/22/17 at 1:11 p.m. revealed:
-The PCA gave her two graham crackers as a snack.
-The PCA handed the crackers to the resident in her hand.
-She did not wear gloves.

Interview with a third resident on 9/26/17 at 11:22 a.m. revealed:
-The PCA gave her graham crackers for snack that morning.
-The crackers were handed to her with no paper towel and staff did not wear gloves.

Interview with a fourth resident on 9/26/17 at 11:25 a.m. revealed:
-The resident got two graham crackers for snack.
-He did not notice the PCA wearing gloves.

Interview with a Medication Aide (MA) on 9/26/17 at 3:12 p.m. revealed:
-If the residents received snacks that were not wrapped in plastic, she made sure she used a napkin to hand the residents their snacks.
-She did not touch the snacks with her bare hands.

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D 283	Continued From page 39 Interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed: -She was unaware that the PCA was not using gloves or a paper towel to pass out the snack. -She expected staff to wear gloves. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -Her expectation was for staff to not pass out snacks with their bare hands. -Staff could use a napkin to pick up the food if they did not have on gloves, but they should not touch the food with their hands. -The MA was supposed to monitor snacks daily. -The Administrator did not monitor snacks. -She was not aware the PCA had not followed sanitation and safety guidelines when passing out snacks. The PCA could not be reached by the end of the survey.	D 283		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure snacks were offered to residents three times daily.	D 298		

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	HAL001149	A. BUILDING: ______ B. WING ______	R-C 09/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANE ST RETIREMENT HOME	**625 LANE STREET BURLINGTON, NC 27217**

(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 298	Continued From page 40 The findings are: Interview with a resident on 9/21/17 at 2:35 p.m. revealed: -He did not get snacks at the facility. -It had been a long time since he had gotten a snack. -Snacks stopped not long after he moved there over four years ago. Interview with a second resident on 9/22/17 at 9:15 a.m. revealed: -They did not get snacks at the facility. -The resident had lived at the facility for over a year and had not been given a snack. -The resident purchased personal snacks at the store with his money. Interview with a third resident on 9/22/17 at 9:23 a.m. revealed: -They had not been given snacks in a while. -She could not remember the last time. Interview with a fourth resident on 9/22/17 at 9:28 a.m. revealed: -The resident purchased her own snacks at the store. -Staff did not give snacks out at the facility consistently. -She was unable to remember the last time they had given out a snack. Interview with a fifth resident on 9/22/17 at 10:50 a.m. revealed: -He got four cookies for snack last night. -He was given two graham crackers this morning for snack. -He did not receive a drink.	D 298		

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Interview with a sixth resident on 9/22/17 at 10:52 a.m. revealed:
-He was offered graham crackers for a snack this morning but declined.
-He was not offered a drink.

Interview with a seventh resident on 9/22/17 at 1:11 p.m. revealed:
-She got two graham crackers for snack that morning.
-The resident had a drink already.

Observation of snack time on 9/22/17 at 10:44 a.m. revealed the PCA gave residents two graham crackers.

Interview with the PCA on 9/22/17 at 10:36 a.m. revealed:
-Residents got snacks "every hour on the hour."
-She typically gave the residents bananas, apples, and oranges.
-She passed out the snacks to the residents.

Interview with the MA on 9/22/17 at 10:40 a.m. revealed:
-Snacks were given out between 10:00 a.m. and 10:30 a.m., at 2:00 p.m. if the resident asked for it, and then at 7:00 p.m.
-The residents were given peanut butter crackers for snack last night.
-The residents usually get potato chips, crackers, or cookies as a snack.

Interview with the the same MA on 9/26/17 at 11:47 a.m. revealed:
-Snacks were given according to what was available.
-Foods varied depending on what groceries were brought to the facility.
-Staff did not follow the snack list.

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D 298	Continued From page 42 Review of the facility Snack List revealed: -Snack List A consisted of fruits, Snack List B consisted of dairy/milk, Snack List C consisted of starches, and Snack List D consisted of miscellaneous items. -Two items from two different list should be offered. -Three graham crackers was the recommended portion size on the snack list. Observation of the pantry on 9/26/17 at 11:36 a.m. revealed: -There were two boxes of vanilla wafer cookies. -There were three boxes of graham crackers. -There was a box of about eight bags of potato chips. -There were three boxes of crackers. Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed: -She was unaware residents were not receiving snacks three times daily. -She expected staff to offer residents snacks at 10:00 a.m., 2:00 p.m., and 7:00 p.m. Telephone interview with the Administrator on 9/28/17 at 4:39 p.m. revealed: -Snacks should be offered to residents daily at 10:00 a.m., at 2:00 p.m. and at 8:00 p.m. -Staff should follow the menu when offering snacks to residents. -Whoever is assigned to the kitchen, should pass out snacks to the residents. -The MA's were responsible for making sure snacks were offered to residents three times daily. -The Administrator did not monitor snacks. -Her expectation was for staff to offer snacks to residents three times daily.	D 298		

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-She was not aware residents had not been offered snacks three times daily.

D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

10A NCAC 13F .0905 Activities Program

(d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on record reviews, interviews and observation, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills for the 12 residents currently living in the facility.

The findings are:

Observation on 9/26/17 at 9:30 a.m. revealed:
-An activity calendar in the hallway next to the living room door.

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-The month and the days of the week were not documented on the activity calendar.

Review of the activity calendar revealed there were 13 hours of activities for the last week of the month. The following activities were documented
-11:00 a.m.-1:00 p.m.-Sunday Worship
-10:00 a.m. - 11:00 a.m. -Fitness
-9:00 a.m.-11:00 a.m.-Music
-9:00 a.m.-11:00 a.m.-Movie
-9:00 a.m.-11:00 a.m.-work out
-9:00 a.m.-10:00 a.m.-Headlines
-2:00 p.m.-4:00 p.m.-Card Board Games

Confidential interviews with 7 of 7 residents revealed:
-Three of the 7 residents stated we do not do activities.
-Four of the 7 residents stated we do activities every other day.
-One of the 7 residents stated the activity board was for "show."

Interview with the Personal Care Aide (PCA) on 9/26/17 at 9:45 a.m. revealed:
-Staff were responsible for doing activities at the facility.
-No planned activities were offered to the residents on 9/21-9/22/17 and 9/25-9/26/17.
-She did activities at the facility every other day.
-She had no designated times to do the activities.
-She did not do the activities on the calendar.

Interview with the Medication Aide (MA) on 9/26/17 at 11:51 a.m. revealed:
-Staff were responsible for doing activities at the facility.
-She did activities at the facility every other day.
-No planned activities were offered to the residents on 9/21-9/22/17 and 9/25-9/26/17.

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D 317	Continued From page 45 -She had no designated times to do the activities. -She was responsible for doing the monthly activity calendar. -The monthly activity calendar posted did not have the month and days of the week written because the activities never changed. -She would start writing the month and the days of the week on the monthly activity calendar. Observation revealed no activities were offered to residents on 9/22/17 and 9/25-9/26/17 between the hours of 11:00 a.m.-1:00 p.m. and 2:00 p.m. and 5:00 p.m. Interview with the Nurse Manager (NM) on 9/26/17 at 3:34 p.m. revealed: -She was not aware that the staff were not doing daily activities at the facilities. -The staff were responsible for doing daily activities at the facility. -A daily activity log would be kept at the facility. -She was not aware the month and the days of the week were not documented on the activity calendar. -The staff were responsible for doing the monthly activity calendar. -She would make sure the staff wrote the month and the days of the week on the activity calendar. -She would be responsible for making sure staff did daily activities at the facility. -She came to the facility at least once a week. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -She was not aware that the staff were not doing daily activities at the facility. -The staff should be doing daily activities at the facility. -She was not aware the month and the days of the week were not documented on the activity	D 317		

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D 317	Continued From page 46 calendar. -The staff were responsible for doing the monthly activity calendar. -The staff know how to handle activities. -The staff should have a book which document the daily activities. -The NM was responsible for monitoring activities weekly at the facility. -She monitored the activities every two weeks at the facility.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that each resident had the opportunity to participate in at least one outing every other month. The findings are: Observation and review of the activity calendar (no month) revealed there were no outings scheduled on the calendar. Confidential interviews with 7 of 7 residents revealed: -Three of the 7 residents stated we do not go on	D 319		

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outings.
-Three of the 4 residents stated the facility did not have a van.
-One of the 7 residents stated the last time the residents had an outing was when the facility was last being cleaned several months ago.

Interview with the Personal Care Aide (PCA) on 9/26/17 at 9:45 a.m. revealed she did not remember the last time the residents had been on an outing.

Interview with the Medication Aide (MA) on 9/26/17 at 11:51 a.m. revealed she could not recall the last time the residents had been on an outing.

Interview with a resident's family member on 9/27/17 at 2:28 p.m. revealed:
-The facility did not have a van.
-He would like for the resident to be able to go out into the community more.
-The facility had only taken residents out when the facility was last being cleaned several months ago.
-The resident had voiced to him that he felt like he was "locked up."
-He visited the facility three to four times a week.

Interview with the Nurse Manager (NM) on 9/26/17 at 3:34 p.m. revealed:
-She came to the facility at least once a week.
-She was not sure when the residents had their last outing.

Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed:
-The residents went shopping around the 1st week of September 2017.
-The facility had a van.

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D 319	Continued From page 48 -The NM was responsible for monitoring residents' outing at the facility. -She also monitored the resident's outing at the facility.	D 319		
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: Based on observations, record reviews, and interviews, the facility failed to assure every resident's rights were maintained as related to residents not being treated with dignity and respect, residents being free of abuse and residents being free of neglect by the facility' failure to report Staff B to the Health Care Personnel Registry. The findings are: 1. Based on interviews and record reviews, the facility failed to report allegations of verbal and mental abuse of one Staff (B) affecting four residents (#1, #4, #6, #7) to the Health Care Personnel Registry (HCPR). [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)] 2. Based on interviews and observations, the facility failed to assure residents had access to clean cups to use when taking medications.	D 338		

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D 338	Continued From page 49 [Refer to Tag D911, G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)] 3. Based on interviews and observations, the facility failed to ensure 4 of 7 sampled residents (#1, #4, #6, #7) were free of verbal and mental abuse by Staff (B). [Refer to Tag D914, G.S. 131D-21(4) Declaration of Resident Rights (Type A2 Violation)]	D 338		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to report allegations of verbal and mental abuse of one Staff (B) affecting four residents (#1, #4, #6, #7) to the Health Care Personnel Registry (HCPR). The findings are: Confidential interviews with two residents revealed they had heard verbal abuse by Staff B to Residents #1, #4, #6. Two confidential residents interviews related to	D 438		

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verbal abuse on Resident #7 were as follows:

Confidential interview with a resident revealed:
-Resident #7 was often called fat, guerilla, or fat pig.
-This last happened on 9/20/17.
-Resident #7 felt bad when Staff B made fun of her.
-Sometimes the resident did not eat because of it.

Confidential interview with a second resident revealed:
-The resident had witnessed Staff B calling Resident #7 fat about a week ago.
-Resident #7 had complained to the "wrong one" (the Nurse Manager) and nothing was done.

A confidential staff interview revealed:
-The staff had heard verbal abuse by Staff B to Residents #1, #4 and #6.
-The Nurse Manager and the Administrator were aware of how Staff B treated residents.

Confidential interviews with two residents revealed:
They witnessed or experienced verbal or mental abuse by Staff B.
-They did not report the incident to the staff or the Administrator.

Confidential interview with a resident revealed:
-The resident witnessed Staff B pulled Resident #4 and #6 by their collar.
-The resident was afraid to report the incident to the staff.
-The resident was afraid because Staff B might retaliate against him.
-The resident could not recall the dates.

Telephone interview with the Nurse Manager

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Continued From page 51

(NM) on 7/28/17 at 10:34 p.m. revealed:
-She was aware Staff B took Resident #6's phone away about a month ago.
-It had something to do with the resident being incontinent.
-The Medication Aide (MA) gave the phone back to the resident.
-Staff B should not be punishing the resident by taking her cell phone.
It was not appropriate for staff to pull on the residents' clothing.
"It would be like leading the resident like a dog.
-I have heard Staff B calling the residents names and cursing within the last month.
Staff B was very moody.
-I have been concerned about Staff B because she can be good to you one minute and snap at you the next minute.
-Staff B had snapped on the NM.
-No resident or staff reported Staff B physically abusing the residents.
-She reported to the Administrator about a month ago about Staff B calling the residents names and cursing and taking away Resident #6's cell phone.

Interview with the Administrator on 9/28/17 at 4:23 p.m. revealed:
-She was not aware Staff B was being rude to the residents.
-She would not let any staff be rude to the residents.
-I cannot do anything about Staff B being rude to the residents unless the residents or staff notify me.
-If I had known about Staff B being rude to the residents, I would have let her go.
-I am not sure if Staff B will continue to work at the facility.
-"I have seen Staff B in a bad mood, but she does

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D 438	Continued From page 52 not say anything she just looked away". __________________________ The failure of the facility to investigate and report known allegations of abuse by 1 staff member (Staff B) to the Health Care Personnel Registry resulted in the alleged perpetrator of abuse being allowed to continue to work around residents at the facility, putting Residents #1, #4, #6 and #7 and all other residents at substantial risk of abuse, which constitutes a Type A2 Violation. __________________________ The Plan of Protection was requested on 9/29/17. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 28, 2017	D 438		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and observations, the facility failed to assure residents had access to clean cups to use when taking medications. The findings are: Observation on 9/26/17 at 12:58 p.m. revealed: -A Medication Aide (MA) was administering	D911		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D911	Continued From page 53	D911		

medications in the hall in front of the office.
-She instructed the resident to get a cup from a tray on a small table in the hall near the kitchen.
-There were 5 red plastic cups tuned upside down on the tray; no names were written on the cups; and the cups all looked the same.
-The resident picked up one of the cups and filled it with water from the water cooler.
-The resident took his medication and drank all the water.
- The MA went back into the office.
-The resident then put the used cup back on the tray upside down.

-Confidential interview with a resident revealed:
-When the residents took their medications, they use the cups on the tray in the hallway to get water.
-The cups do not get washed after each use.
-She did not used the cups on the tray in the hallway to get water.
-They have been doing it this way for 6 months.

Confidential interview with another resident revealed:
-The resident was aware there were cups sitting on a table near the kitchen door.
-The resident did not use the cups because other residents were drinking out of the cups and putting them back on the table.
-The cups had been sitting there for over a year.

Confidential interview with a third resident revealed:
-The resident refused to drink out of the cups up front "behind everyone else."
-Staff did not wash those cups.

Telephone interview with the MA on 9/27/17 at 3:22 p.m. revealed:

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D911	Continued From page 54	D911		

Continued From page 54

-Every resident as of 9/26/17 had a cup in the medication/office with their name on them.
-There were five residents that used the cups.
- She gave residents cups with their name on it on 9/26/17 to get water for taking medications.
- When the residents finished taking their medications, they give the cup back to the MA.
- She put the cups on a towel in the medication room.
- The cups were washed at night after the residents took their bedtime medications.
-The other residents used their own cups/ bottles in their room to get water to take their medications and take the cups/bottles back to their room after taking their medications
-There were some residents that were leaving used cups on the tray in the hallway.
-The cups were removed from the tray on the table in the hallway near the kitchen on 9/26/17.

Telephone interview with facility Nurse Manager on 9/28/17 12:45 p.m. revealed:
-The cups needed to be thrown away after each use.
-She was getting rid of the tray and cups.
-She was getting smaller cups that will be thrown away after each use.
-She will review the procedure with the staff.

Interview with the Administrator on 9/28/17 at 4:23 p.m. revealed:
-She was not aware cups were sitting on a table near the kitchen door.
-She had no idea what the cups were used for.
-She was not sure why the cups had been set on the table.
-The cups should not be left out on the table.
-Staff would remove the cups from the table.

____

The facility's failure to provide residents with

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D911	Continued From page 55 clean or disposable cups for water to drink with their medications resulted in residents being exposed to transferring germs, and possibly infections, from one resident to another. The facility noncompliance was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. ______________________ A plan of protection was requested on 9/29/17. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 12, 2017.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. and qualified staff administering medications to residents. The findings are: 1. Based on observations, interviews, and record	D912		

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D912	Continued From page 56 reviews, the facility failed to provide supervision for 2 of 2 sampled residents (Resident #2, and #5) who had a history of smoking inside the building. [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)] 2. Based on observations, interviews and record review, the facility failed to assure 1 of 1 Staff (B), who had not passed the written examination within 60 days of hire, did not perform any unsupervised medication aide duties. [Refer to Tag D935, G.S. 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and observations, the facility failed to ensure 4 of 7 sampled residents (#1, #4, #6, #7) were free of verbal and mental abuse by Staff (B). The findings are: 1. Confidential interview with a family member revealed: -Staff B was "rough around the edges." -When the resident was first admitted to the facility, Staff B refused to assist the resident with incontinent care.	D914		

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D914	Continued From page 57 -Staff B said the resident needed to do their own incontinent care. Confidential interview with a staff member revealed: -Residents had complained about how Staff B treated and talked to the residents to the staff member. -The staff member told Staff B, "It's not what you say, it's how you say it and you get better results." -Within the last two months, a resident complained that Staff B had refused to provide personal care to the resident. -The Nurse Manager and Administrator were aware of how Staff B treated residents. Interview with the Nurse Manager on 9/27/17 at 6:30 p.m. revealed: -Two weeks ago (between 9/10/17 to 9/16/17), Staff B had requested Resident #1's cigarettes from the resident. -The resident refused to give Staff B the cigarettes. -The resident asked Staff B why the resident was the only resident, who had to turn in cigarettes. -The Nurse Manager told Staff B the resident had no reason to have the cigarettes taken. -If she was going to take cigarettes from one resident, she had to take them from all of the residents. -Within the past two months, the same resident also complained to the Nurse Manager about Staff B refusing to assist the resident with incontinent care, because the resident had a bowel movement. -She told Staff B she could not refuse personal care to a resident. -Because of the reports about the residents' concerns, Staff B was sent home on 9/27/17 for 1 week and was told to "think about" what	D914		

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D914	Continued From page 58	D914		

happened.

Attempted interviews were made with Resident #1, but the resient did not want to be interviewed.

Refer to telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m.

Refer to telephone interview with the Administrator on 9/28/17 at 4:23 p.m.

2. Confidential interview with a resident revealed:
-The resident did not like the way the residents were treated there.
-Staff B yelled and cursed at the residents about every day of the week.
-Staff B "did not need to be working there."
-Staff B pulled Resident #4 by the shirt.
-Resident #4 tried to keep up with Staff B as the resident's shirt was being pulled.

Confidential interview with a second resident revealed:
-Staff B called the residents names.
-Staff B also called Resident #4 names.

Confidential interview with a third resident revealed:
-Staff B had cursed the resident out about two weeks ago.
-The resident did not remember specifically what Staff B said.
-The resident was unable to recall what caused Staff B to get upset.
-The resident did not recall being pulled by his clothes.

Refer to Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m.

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D914	Continued From page 59	D914		

Refer to telephone interview with the Administrator on 9/28/17 at 4:23 p.m.

3.Confidential interview with a resident revealed:
-The resident was often called fat, guerilla, or fat pig.
-This last happened on 9/20/17.
-The resident felt bad when Staff B made fun of the resident.
-Sometimes the resident did not eat because of it.

Confidential interview with a second resident revealed:
-The resident had witnessed Staff B calling Resident #7 fat about a week ago.
-Resident #7 had complained to the "wrong one" (the Nurse Manager) and nothing was done.

Review of the incident report book revealed a note written by Staff B that the Resident #7 had refused breakfast, lunch, and dinner beginning on 7/25/17 thorugh 7/28/17 due to being in a mood.

Refer to Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m.

Refer to telephone interview with the Administrator on 9/28/17 at 4:23 p.m.

4. Confidential interview with a resident revealed:
-Resident #6 had also been pushed and pulled by Staff B.
-This used to happen a couple of times a week.
-It happened less now that Resident #6 went to a day program during the day.
-Staff B would take Resident #6's phone away.
-Resident #6's phone was just returned prior to 9/21/17.
-Resident #6 was often sent to her room.
-Staff B called another resident fat.

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D914	Continued From page 60	D914		

-That resident got so upset that the resident often would not eat.
-The resident had complained about Staff B to the Supervisor.
-Staff were aware of Staff B's behavior and Staff B had threatened the Nurse Manager.

Confidential interview with a second resident revealed:
-Staff B often sent Resident #6 to her room when she wet the bed.
-Residents usually sat outside on the porch smoking.
-Staff B also took away Resident #6's phone when she wet the bed.
-Staff B had got in Resident #6's face and cursed and yelled at her.
-Staff B had threatened Resident #6 that she would get on the bus and go to the day program and tell them Resident #6 wet the bed.
-The resident had never witnessed Resident #6 being hit or pulled.

Confidential interview with a third resident:
-Staff B had not been mean to Resident #6.
-Staff B took the resident's phone away for a week after the resident wet the bed.
-Reisdent #6 got the phone back on Monday 9/18/17.
-The resident's feelings were hurt when the phone was taken away because it was the only way the resident could call people.
-The resident wet the bed about once a week.
-Staff B sent the resident to the room if the resident made a "smart" comment.

Confidentail interview with the same resident revealed:
-Staff B took Resident #6's phone last week for three days.

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D914	Continued From page 61	D914		

-Resident #6 usually talked to her friends every night.
-Staff B took Resident #6's phone one year ago for a week after Resident #6 wet the bed.
-Staff B sent Resident #6 to her room for being "smart" then came to get Resident #6 to go outside and smoke.
-The resident had not seen Staff B be "mean" to anyone else.
-Staff B did not pull on Resident #6's clothes.

Telephone interview with the Nurse Manager (NM) on 9/27/17 at 10:39 a.m. revealed:
-She was aware Staff B took Resident #6's phone away about a month ago.
-It had something to do with the resident being incontinent.
-The medication aide gave the phone back to the resident.
-Staff B should not be punishing the resident by taking her cell phone.
It was not appropriate for staff to pull on the resident's clothing.
"It would be like leading the resident like a dog.

Refer to Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m.

Refer to telephone interview with the Administrator on 9/28/17 at 4:23 p.m.

Telephone interview with the Nurse Manager (NM) on 9/27/17 at 10:39 a.m. revealed:
-I have heard Staff B calling the residents' name and cursing within the last month
Staff B was very moody
-I have been concerned about Staff B because she can be good to you one minute and snap at you the next minute.

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D914	Continued From page 62 -Staff B had snapped on the NM. -No resident or staff reported Staff B being physically abuse to the residents. -She reported Staff B's behavior to the Administrator about a month ago. Interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -She was not aware Staff B was being rude to the residents. -She would not let any staff be rude to the residents. -She cannot do anything about Staff B being rude to the residents unless the residents or staff notify me. -If I had known about Staff B being rude to the residents, I would have let her go. -I am not sure if Staff B will continue to work at the facility. -"I have seen Staff B in a bad mood, but she does not say anything she just looked away". ________________________________ The facility's failure to provide the services necessary to protect residents from physical and mental abuse by Staff B, as evidenced by Resident #1 not being assisted with personal care, Residents #4 and #6 being physically pushed and pulled by their clothing, Resident #6 having her personal telephone taken away for having incontinent episodes and Resident #7 being called derogatory names. The noncompliance placed all residents at substantial risk of verbal and mental abuse and constitutes a Type A2 Violation. ________________________________ Review of the Plan of Protection dated 9/22/17 revealed: -Immediately, the Nurse Manager and the Administrator will set up a training to staff on	D914		

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D914	Continued From page 63 resident rights. -The training will be done within the next week. -The Nurse Manager will assure staff have ongoing classes in resident rights. -Immediately, the Nurse Manager will fire any staff being caught being verbally or physically abusive to residents. -The Nurse Manager and Admnistrator will monitor staff weekly on resident rights. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 28, 2017.	D914		
D918	G.S. 131D-21(8) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 8. To associate and communicate privately and without restriction with people and groups of his of her own choice on his or her own or their initiative and any reasonable hour. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents had a right to communicate with people privately and without restrictions. The findings are: Confidential interview with a resident's visitor revealed: -Within the past month, the visitor came to the facility to talk to a resident. -The visitor met with the resident in the bedroom, but Staff B (Personal Care Aide) stood in the doorway despite the visitor asking for privacy. -The visitor requested a private area to talk to the	D918		

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D918	Continued From page 64	D918		

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resident, because the resident's roommate was in the room.
-The visitor was sent to the living room where the television (TV) was located.
-The TV was loud.
-The visitor asked Staff B if there was a way the volume of the TV could be turned down.
-Staff B replied in a rude voice, there was no remote control and no way to turn down the volume.
-Staff B did not offer another location for the visitor to talk to the resident.
-Staff B got upset when the visitor asked if the resident had the right to have visitors.
-The visitor was forced to sign in on a log by Staff B.
-The second time the visitor came, they met in the resident's room, because the roommate was not there.

Interview with a Medication Aide/Supervisor on 9/26/17 at 3:27 p.m. revealed:
-When visitor come to see residents, they went into the resident room or the dining room, if they wanted privacy.
-No residents had complained to her about not having privacy when they had visitor.

Interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:
-When a resident had visitor, the visitor either went in the resident's room, on the porch or the living room.
-If the visitor wanted to speak privately to the resident, they could go in the living room or dining room with the resident.
-One time a resident visitor complained to her about Staff B being rude, because Staff B was trying to get the visitor to sign in.
-She apologized to the visitor for Staff B being

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D918	Continued From page 65 rude and spoke to Staff B. -Staff are required to be cooperative if the resident wanted privacy. -She monitored how staff treated visitor every two weeks, which was when she came to the facility. Telephone interview with the Administrator on 9/28/17 at 4:23 p.m. revealed: -When residents have visitors, staff were supposed to be courteous and polite. -If the resident wanted privacy with the visitor, they could go to the dining room or the resident's room. -She was not aware Staff B had been rude to resident's visitor. -Staff B had received Resident Rights training when she first started working at the facility (April 2016), but she had not received any training since then. -She monitored at the facility every other week. -She was last at the facility on 9/24/17. -When she was not at the facility, she expected the MA or the Nurse Manager to monitor the facility. Attempted interviews were made with the resident, but the resient did not want to be interviewed. Staff B was not available for interview on 9/28/17 at 9:13 a.m. and on 9/28/17 at 3:28 p.m.	D918		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health	D934		

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D934	Continued From page 66 Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 2 Medication Aides (MA) (Staff C) received the state annual infection control training. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired to work at the facility as a MA on 8/1/13. -There was documentation of a infection control training on 6/2/16. -There was no documentation of infection control training since 6/2/16. Interview with Staff C on 9/21/17 at 11:45 a.m. revealed she worked at the facility as a MA. Interview with Staff C on 9/26/17 at 5:03 p.m. revealed: -She thought she had a current infection control training, but apparently she had not. -Whatever was documented in her personnel file was her most recent infection control training.	D934		

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	HAL001149	A. BUILDING: ______ B. WING ______	R-C 09/28/2017

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D934	Continued From page 67 -The Administrator would set up a date to train her with the state annual infection control, but she was not sure when the training would occur. Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed: -The Administrator was responsible for keeping up with the MA training. -The Nurse Manager trained the MAs as needed. -She thought Staff C had a current infection control training, but she was not sure the date of the training. Telephone interview with the Administrator on 9/29/17 at 4:23 p.m. revealed: -The Nurse Manager and the Administrator kept up with staff training. -She usually trained the MA's. -She thought Staff C was current with her infection control training. -She checked staff personnel files every 3-4 months to make sure staff qualifications and trainings was in the staff's personnel file. -Her expectation was for staff to have current trainings in the personnel files.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all	D935		

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D935	Continued From page 68 of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record review, the facility failed to assure 1 of 1 Staff (B), who had not passed the written examination within 60 days of hire, did not perform any	D935		

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D935	Continued From page 69 unsupervised medication aide duties. The findings are: Review of Staff B's, Personal Care Aide (PCA), personnel file revealed: -She was hired to work at the facility as a PCA on 5/8/16. -The Medication Clinical Skills check list had been completed on 5/8/16. -The 15 hour Medication Administration training had been completed on 5/8/17. -There was a letter dated 6/24/16 from the state, which revealed she had not passed the MA written exam. Interview with Staff B on 9/21/17 at 11:00 a.m. revealed: -She only cooked and cleaned at the facility. -She did not pass out medications to the residents. Telephone interview with Staff B on 9/28/17 at 9:13 a.m. revealed: -She last passed out medications to the residents May 2015 (meant 2016). -She last took the MA written exam in 2016, but she could not remember the date. -She had not passed the MA written exam. Review of the incident report book revealed: -There was a note written by Staff B and dated 7/9/17, which revealed, Staff B gave a resident's family member the residents' medications. -The note revealed Staff B gave the resident's family member 44 Clonazepam (used to help panic and seizure disorder), Loperamide (used to help treat diarrhea) and the rest of the as needed medications (names not written).	D935		

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D935	Continued From page 70	D935		

Confidential interview with a resident revealed:
-Staff B usually gave the resident medications.
-Staff B had given the resident medications yesterday (9/20/17) and also in the morning on 9/21/17.
-The MA sometimes gave the resident medications.
-The MA was on the way over to the facility that morning when Staff B gave the medication.

Confidential interview with a second resident revealed:
-Staff B usually gave out medications.
-The MA would also give medications.
-Staff B had given the resident medications on 9/20/17.

Confidential interview with a resident visitor revealed:
-They were told by a resident that Staff B gave out medications.
-While visiting within the past month, they heard Staff B yell out "it's med time."

Telephone interview with the Nurse Manager on 9/27/17 at 10:39 a.m. revealed:
-The Administrator was responsible for keeping up with the MA training.
-Staff B had taken the MA written exam in 2016, but she had not passed the exam.
-She did not know the date Staff B had taken the MA written exam.
-She was not aware Staff B had recently been passing medications to residents.
-Staff B was told not to pass medications after she had taken her last MA written exam.
-Only the MA's were supposed to pass medications to residents.

Telephone interview with the Administrator on

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D935	Continued From page 71	D935		

9/28/17 at 4:23 p.m. revealed:
-She and the Nurse Manager kept up with staff qualifications.
-Staff B took the MA written exam three times and did not pass the exam.
-Staff B was hired to work at the facility April 2016 as a PCA.
-Staff B last passed out medications July 2016, which was within the 90 days of the completing the Medication Clinical Skills Checklist and training.
-She was not aware staff had 60 days to pass the MA written exam after completion of the MA training.
-She does not allow staff, who are not qualified, to pass medications.
-She was not aware Staff B had recently passed medications to residents.

____

The failure of the facility to assure Staff B was qualified to administer medications to residents resulted in residents receiving medications from a staff who was not a medication aide. Thus, causing risk to the detriment, health and safety of the residents. This constitutes a TYPE B VIOLATION.

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Review of the Plan of Protection dated 9/22/17 revealed:
-Immediately the Administrator and the Nurse Manager will review the Medication Aide (MA) competency on existing staff and check them off by 9/25/17.
-The Administrator and the Nurse Manager will assure only certified and qualified MA's will administer medications to the residents.
-The Administrator and the Nurse Manager will monitor staff administration of medications weekly at random times.
-The Administrator and the Nurse Manager will

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D935	Continued From page 72 provide a training to the MA's monthly and as needed on medication administration and documentation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 12, 2017	D935		