Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	R-C **12/08/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Davie County Department of Social Services conducted a follow-up survey and complaint investigation December 5, 2017- December 8, 2017. The complaint investigations were initiated by the Davie County Department of Social Services on November 18, 2017 and December 4, 2017.	{D 000}		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related the proper use of door alarms to assure the safety for 1 of 5 sampled residents as evidenced by one resident (Resident #4) who wandered from the facility without the staff's knowledge.	D 067		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The findings are:

Review of Resident #4's current FL-2 dated 01/27/17 revealed:
-Diagnoses included Huntington's Disease, diabetes mellitus II, delusional, and tremors.
-There was documentation Resident #4 was intermittently disoriented.

Review of Resident #4's Resident Register revealed:
-The resident was admitted to the facility on 01/29/16.
-Resident #4 had a guardian to make decisions for him.

Review of Resident #4's Care Plan dated 05/30/17 revealed there was no documentation related to supervision needs.

Review of Resident #4's record on 12/05/17 revealed:
-A local county agency was the guardian of Resident #4.
-There was no documentation that the resident had ever wandered away from the facility.

Review of the facility's Resident Daily Sign-in/Sign-out book revealed Resident #4 had not signed out at any time from 11/10/17 to 12/08/17.

Telephone interview on 12/06/17 at 12:02 pm with a local law enforcement officer revealed:
-The officer responded to a 911 call on the night of 11/18/17.
-He was informed of a suspicious person walking on a major highway within one-half mile of the facility.
-The officer responded to the scene and found

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Resident #4 walking in the middle of the busy highway.
-He recalled the temperature to be in the "50's."
-He found Resident #4 crying and appeared "disheveled and unkept."
-Resident #4 "smelled very badly" and appeared to "have messed himself."
-He asked Resident #4 where he was going and Resident #4 did not respond.
-He asked Resident #4 if he was from [named facility] and Resident #4 responded "Rock, Rock."
-The officer transported Resident #4 back to the facility.
-The facility staff did not know he was missing until the officer brought him back to the facility at 9:54 pm.

Interview on 11/20/17 at 10:40 am with Resident #4 revealed:
-He took his black dog for a walk outside last night at 10:30 pm.
-He sometimes went out of the facility.
-He said he would not leave again.

Interview on 12/06/17 at 3:43 pm with Resident #4 revealed:
-He left the facility because he "liked to walk."
-He did not inform facility staff that he was leaving.
-He did not see any facility staff as he was leaving.
-He "walked across the street, not far."
-He couldn't figure out how to get back to the facility.
-He was by himself.

Observation of Resident #4 on 12/6/17 at 3:43 pm revealed Resident #4 did not have a dog.

Review of Resident #4's Nurse's Notes revealed:

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-On 11/18/17 at 7:30 am, Resident #4 was non-compliant with medications.
-Resident #4 punched a staff member in the face.

Review of Resident #4's Report of Incident/Accident revealed:
-On 11/18/17 at 7:30 am, Resident #4 was non-compliant with medications. Resident #4 punched a staff member in the face.
-On 11/18/17 in the pm, Resident #4 walked off facility property. Resident #4 was brought back by the police at 9:54 pm. Resident #4 was given as needed (PRN) medication. Resident #4 was placed on 15 minute watches.

Review of Resident #4's Medication Administration Record (MAR) on 12/05/17 at 11:05 am revealed:
-Resident #4 refused all morning medications on 11/18/17.
-Resident #4 was given PRN (as needed) Ativan on 11/18/17 at 10:29 pm. (Ativan is used to treat anxiety.)

Review of the facility Wandering Resident Policy revealed:
-All exit doors are equipped with alarms.
-All alarms are on 24 hours per day with the exception of the front and back entrance.
-Main door and back door alarms are turned off between 8:00 am and 6:00 pm.
-Residents diagnosed as wanderers, disoriented, and Alzheimer's, will be visually checked by staff every 30 minutes.

Interview with Resident #4's guardian on 12/05/17 revealed:
-The local county agency was made aware of the incident on 11/18/17.
-The local county agency had never been notified

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D 067	Continued From page 4 of the resident wandering away from the facility. Telephone interview on 11/21/17 at 2:18 pm with a staff member revealed: -She was working on 11/18/17 from 7:00 pm to 11/19/17 at 7:00 am. -There was one other staff member on duty. -She was making nightly rounds and the Supervisor was at the nurse's station. -She heard a "commotion" at the nurse's station on the night of 11/18/17. -At the nurse's station, staff member observed Resident #4 with a a local law enforcement officer at 9:54 pm. -Staff members were not aware Resident #4 left the facility. -The staff completed visual resident checks every 2 to 4 hours, depending on the resident. -She could not recall the time she last had seen the resident. -The staff were aware of alarms on doors. -She said the door is "propped open" when residents go outside to smoke. -She did not know why alarms did not go off. Telephone interview on 12/07/17 at 2:27 pm with a second staff member revealed: -She was in the room with another resident when police arrived with Resident #4. -The supervisor completed "a head to toe check" on Resident #4. -The staff member was not sure if this was documented. Interview on 11/20/17 at 11:00 am with the Director revealed: -Two staff members were working on the 11/18/17 evening shift. -Weekend evening shift was 7:00 pm to 7:00 am. -Staff was unaware that Resident #4 had left the	D 067		

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facility on the night of 11/18/17.
-Front door alarms should be turned on at 9:00 pm.
-Staff would "prop" the door open when residents go out to smoke.
-Hourly checks were to be completed on the residents.
-The Director was made aware of the incident involving Resident #4 around 10:30 pm on 11/18/17.
-Resident #4 was placed on 15 minute visual checks which included documentation.
-There was no supervision procedure for Resident #4 in place prior to 11/18/17.

Second interview on 11/20/17 at 11:38 am with the Director revealed:
-Another staff member was in the facility parking lot at the time of the incident.
-The staff member witnessed Resident #4 leaving the facility's premises on the night of 11/18/17.
-The staff member reported the incident to Director on 11/20/17.

Interview on 11/20/17 at 12:10 pm with the Director and Assistant Director (AD) revealed:
-Resident #4 "used to walk off and would come back".
-Resident #4 "hasn't done that in years".

Interview on 11/20/17 at 12:20 pm with the Resident Care Director (RCD) revealed:
-Resident #4 was seen by the Primary Care Physician (PCP) on 11/17/17.
-Resident #4 was referred for a mental health evaluation during the PCP visit on 11/17/17 due to recent change in behavior.

Third interview on 11/20/17 around 1:00 pm with the Director revealed:

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D 067	Continued From page 6 -The Director had reviewed video footage of the night of the incident on 11/18/17. -The supervisor was sitting with back turned to the walkway at the nurse's station and was on the telephone. -Resident #4 walked past the nurse's station, unobserved. Interview on 12/07/17 at 4:47 pm with the Director revealed the weekend staff had been increased by one staff member since 11/18/17. Confidential interviews with five staff members revealed: -The foyer door was locked and the alarm was set at 9:30 pm daily. -The foyer door leads to main door of the facility which remains unlocked. -Alarms were activated all the time except for the front door. -Visual checks on residents were completed every 30 minutes. Review of facility video footage revealed: -Resident was observed walking past the nurse's station at 9:27 pm on 11/18/17 towards the foyer door. -The Supervisor was observed sitting at the nurse's station talking on the telephone. -The Supervisor's back was turned facing away from the resident and the front door. -Resident #4 left the facility at 9:27 pm through the front door. -Resident #4 was brought back to the facility at 9:54 pm by a local law enforcement officer. Attempted telephone interviews on 11/21/17 at 2:14 pm and 12/06/17 at 11:46 am with the Supervisor on the evening shift of 11/18/17 were unsuccessful.	D 067		

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D 067	Continued From page 7 Attempted telephone interviews on 11/21/17 at 2:30 pm and 12/06/17 at 11:48 am to another staff member on the facility's premises at time of incident were unsuccessful. _______________ Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related to safety for 1 resident (Resident #4) who wandered from the facility without the facility's knowledge, and was returned to the facility by local law enforcement. This failure to supervisor Resident #4, incorporating the facility's door alarms, was detrimental to the health, safety and welfare of the resident which constitutes a Type B Violation. _______________ A Plan of Protection was provided by the facility on 12/28/17 as follows: -Imediately, after supper front door alarms will be activated and residents smoking will be monitored from 5:30 pm to 12:00 midnight. -Door will only be opened for smoking residents and staff will attend to ensure safety and monitor those who are outside. -A new policy for 2nd and 3rd shifts are to monitor and stay with smoking residents and those who go outside between 5:30 pm and 12:00 midnight. -After midnight, doors will be closed and alarms activated until 1st shift arrives at 7:00 am. -The alarm company will be notified to change the front door alarm time to 5:00 pm. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2017.	D 067		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

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{D 273}	Continued From page 8 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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician or guardian notification for 3 of 4 sampled residents (Resident #3, #4, and #5) regarding a resident exhibiting aggressive behaviors (Resident #5), a resident wandering away from the facility without staff being aware (Resident #4), and a resident being pushed to the ground by a staff member (Resident #3). The findings are: A. Review of Resident #5's current FL2 dated 08/31/17 revealed diagnoses included Tourette's disorder, schizoaffective disorder, and generalized anxiety disorder. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 09/04/17. Review of Resident #5's facility generated medication clarification list dated 09/04/17 revealed medication ordered included:	{D 273}		

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-Cymbalta 60 mg daily (used to treat general anxiety disorder).
-Pimozide 0.5 mg twice a day (an antipsychotic medication used to treat Tourette's disorder).
-Trazodone 100 mg at bedtime (used to treat depression and anxiety disorders).
-Abilify 20 mg daily (used to treat schizophrenia).
-Ativan 0.5 mg one every 12 hours as needed for anxiety (used to treat anxiety).

Review of Resident #5's Care Plan signed by the physician on 09/12/17 revealed:
-The form was not complete.
-The assessment, section 1 was blank.
-There was no documentation for social/mental health history.
-Documentation Resident #5 was receiving mental health services; a referral had been made to Mental Health was documented for 09/04/17, and the mental health provider was listed.

Review of Resident #5's Incident/Accident Reports and Nurse's Notes revealed the following documentation:
-On 10/14/17, third shift, the Nurse's Notes documented Resident #5 "got agitated cause staff took another resident's wheelchair to clean it, called staff a thief, told staff that God don't like that". There was no documentation for notifying the primary care physician or mental health provider.
-On 10/19/17 at 1:40 pm, the Nurse's Notes documented Resident #5 was playing bingo in the dining room, passed out and fell from a chair. An Incident/Accident Report was completed, resident was transported to the local hospital emergency department and returned with no new orders. There was no documentation the primary care physician was notified.
-On 11/06/17 at Noon, an Incident/Accident

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{D 273}	Continued From page 10 Report documented "Resident (#5) punched brick wall in the sunroom for "attention seeking". There was no documentation the mental health provider or the primary care provider were notified. -On 11/13/17 in the PM (evening), Incident/ Accident Report documented "Resident (#5) stated to staff he wanted to hit someone. Staff asked resident where and whom: He walked away and punched the doorway and hallway walls, and punched the wall in dayroom." There was no documentation the mental health provider or the primary care provider were notified. -On 11/15/17 at 7:00 am, an Incident/Accident Report documented Resident #5 had an altercation with another resident and staff regarding Resident #5's clothing, with Resident #5 cursing and yelling at staff members. Resident #5 left the building and would not return with prompts from the staff. There was no documentation the mental health provider or the primary care provider were notified. -On 11/26/17 at 7:00 pm, Incident/Accident Report documented Resident #5 walked off this evening and refused to come back when staff asked him. The police were called and resident returned inside facility after talking with police. There was no documentation the mental health provider or the primary care provider were notified. -On 11/27/17 in the pm, an Incident/Accident Report documented Resident #5 became upset when snack was late. He cussed, pushed a desk, slammed a door and cracked the frame. He stepped on a staff member's toes. Police came out and mobile crisis worker came out. "Would not IVC (involuntary commit) due to he is not resident of the present county." There was no documentation the primary care physician. -On 11/28/17 at 10:00am, an Incident/Accident Report documented Resident #5 "banged on	{D 273}		

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walls and desk. Resident called the guardian and left inappropriate message on her voicemail. He stated, he hates certain employees and will not take meds from them. Walked outside." The Director asked him into her office to calm down after the Supervisor got him to take his medications. He threw all items off of desk, and shoved the Director into office door."
-He "Walked out of office stating I (Director) made him hit me (Director) and the lady from mobile crisis lied to him". The Director went to local court office and obtained an IVC. "Police came and took him to the hospital." There was no documentation the mental health provider or the primary care provider were notified.

Telephone interview on 12/07/17 at 1:50 pm with the primary care provider revealed:
-She was aware Resident #5 was prone to have inappropriate behaviors, mainly getting mad.
-Resident #5 had been in various facilities she had serviced through the years.
-The facility had notified her when Resident #5 punched the walls and injured both hands (11/11/17) and she ordered a mobile X-ray. The resident's hands were only bruised.
-She would expect to be notified if the resident was experiencing medical problems and if the resident went to the hospital.
-She would expect the facility to notify the mental health provider for aggressive behaviors.
-She was aware Resident #5 was sent to the hospital in late November 2017 and did not come back to the facility.

Interview on 12/07/17 at 2:15 pm with the Resident #5's guardian revealed:
-She was notified by the facility some of the times Resident #5 had aggressive behaviors.
-Resident #5 notified the guardian on at least one

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occasion, not the facility.
-Resident #5 had a history of aggressive behaviors.
-She expected to be notified when Resident #5 had a documented report of inappropriate behaviors, but felt that did not always happen.
-She was not aware of the incident documented on 09/25/17.
-Resident #5, not the facility, told her about the incident on 10/19/17.
-She was not aware of the incident on 11/06/17.
-She was not informed about the incidents on 11/11/17, and 11/12/17 until 11/13/17.
-She saw Resident #5 at the facility on 11/14/17.
-She was called on 11/15/17 and a message was left to inform the guardian Resident #5 was having "bad" behaviors.
-She was not called on 11/26/17 for the incident.
-The guardian was called on 11/28/17 by the Director regarding Resident #5 showing aggressive behaviors and the Director was trying to get an IVC to remove the resident.
-The guardian called back to the facility on 11/29/17 and was informed Resident #5 was sent to the hospital with the police on 11/28/17.
-She expected the facility to call her if Resident #5 had been IVC'd.
-The guardian had suggested to the Director that Resident #5 might benefit from some mental health day program, but no meeting had been scheduled with her for changing the Care Plan and referring to any outside program.

Telephone interview on 12/07/17 at 3:08 pm with the mental health Nurse Practitioner revealed:
-The facility should call the triage line to report any unusual behaviors to the mental health provider.
-The mental health provider had a 24 hours/7 days a week access line staff by the mental

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{D 273}	Continued From page 13 health provider available for reporting behavioral changes and requesting assistance. -The mental health provider was responsible for providing mental health care and oversight. -The mental health provider coordinated with the primary care provider in the event medical conditions needed consultation. -There was no documentation for contact regarding behaviors on 10/20/17, 11/06/17, 11/13/17, 11/15/17, and 11/28/17, including Resident #5 being sent to a local hospital for an involuntary commitment. -There was documentation for an provider encounter on 11/27/17 for Resident #5 not sleeping well and refusing to come back into the facility. Resident #5's trazodone was increased. -There was no documentation for Resident #5 regarding the hospitalization on 11/28/17. -The facility was expected to notify the mental health provider if the resident was hospitalized. Interview on 12/07/17 at 5:00 pm with the Director revealed: -Staff had received training regarding aggressive behaviors from the contracted training provider within the last year. -Resident #5 had been relocated to a room closer to the medication aide/nursing desk to provide better supervision of the Resident's interaction with staff and residents. -Resident #5 was referred to the primary care provider for the skin tears in September 2017. -Resident #5's Guardian was aware of Resident #5's aggressive behaviors and had been to the facility at least 3 times. -The Incident/Accident Reports reflected the response provided, and documented the contact of physicians, guardian, and local police (911). -The staff were trained to notify the Guardian and physician any time an Incident/Accident report	{D 273}		

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was completed. If the form did not document contact, then the staff may have forgotten to document.
-The Director reviewed and followed up on the Incident/Accident forms.
-She was not aware Resident #5's guardian had not been notified of all of Resident #5's Incident/Accident reported.

B. Review of Resident #4's current FL-2 dated 01/27/17 revealed:
-Diagnoses included Huntington's Disease, diabetes mellitus II, delusional, and tremors.
-He was intermittently disoriented as assessed.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 01/29/16.

Review of Resident #4's record on 12/05/17 revealed:
-Resident #4 had a guardian to make decisions for him.
-There was no documentation of contact with Resident #4's physician was found on 11/18/17.

Telephone interview on 12/06/17 at 12:02 pm with local law enforcement officer revealed:
-The officer responded to a 911 call on the night of 11/18/17.
-He was informed of a suspicious person walking on a major highway within one-half mile of the facility.
-The officer responded to the scene and found Resident #4 walking in the middle of the busy highway.
-He recalled the temperature to be in the "50's."
-He found Resident #4 crying and appeared "disheveled and unkept."
-Resident #4 "smelled very badly" and appeared

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to "have messed himself."
-He asked Resident #4 where he was going and Resident #4 did not respond.
-He asked Resident #4 if he was from [named facility] and Resident #4 responded "Rock, Rock."
-The officer transported Resident #4 back to the facility.
-The facility staff did not know he was missing until the officer brought him back to the facility at 9:54 pm.

Interview on 11/20/17 at 10:40 am with Resident #4 revealed:
-He took his black dog for a walk outside last night at 10:30 pm.
-He sometimes went out.
-He would not leave again.

Interview on 12/06/17 at 3:43 pm with Resident #4 revealed:
-He left the facility because he "liked to walk."
-He did not inform facility staff that he was leaving.
-He did not see any facility staff as he was leaving.
-He "walked across the street, not far."
-He couldn't figure out how to get back to the facility.
-He was by himself.

Review of Resident #4 Nurse's Notes revealed:
-On 11/18/17 at 7:30 am, Resident #4 was non-compliant with medications.
-Resident #4 punched a staff member in the face.
-There was no documentation of contact with Resident #4's physician for the 11/18/17 incident.

Review of the facility Incident/Accident Reports revealed:
-On 11/18/17 at 7:30 am, Resident #4 was

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{D 273}	Continued From page 16 non-compliant with medications. -Resident #4 punched a staff member in the face. -The staff member did not contact the physician. -On 11/18/17 in the pm, Resident #4 walked off facility property. -Resident #4 was brought back by local police. -Resident #4 was given as needed (PRN) medication. -Resident #4 was placed on 15 minute watches. Review of facility video footage revealed: -The resident was observed walking pass the nurse's station at 9:27 pm on 11/18/17. -The supervisor was observed sitting at the nurse's station talking on the telephone. -The supervisor's back was turned facing away from the resident and the front door. -Resident #4 left the facility at 9:27 pm. -Resident #4 was brought back to the facility at 9:54 pm by a local law enforcement officer. Review of Resident #4's Medication Administration Record (MAR) on revealed: -Resident #4 refused all morning medications on 11/18/17. -Resident #4 was given PRN Ativan (used for agitation) on 11/18/17 at 10:29 pm. Review of Resident #4's record revealed no documentation for notifying Resident #4's physician of the elopement on 11/18/17. Telephone interview on 11/21/17 at 2:18 pm with a staff member revealed: -She was working on 11/18/17 from 7:00 pm to 11/19/17 at 7:00 am. -There was one other staff member on duty. -She was making nightly rounds and the supervisor was at the nurse's station. -She heard a "commotion" at the nurse's station.	{D 273}		

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{D 273}	Continued From page 17 -At the nurse's station, staff member observed Resident #4 with a Police Officer. -They were not aware of Resident #4 leaving the facility. -She completed visual resident checks every 2 to 4 hours depending on the resident. -Staff members were aware of alarms on doors. -She did not know why the alarms did not go off. Second telephone interview on 12/07/17 at 2:27 pm with a Staff member revealed: -Staff member was in the room with another resident when the police arrived with Resident #4. -The supervisor completed "a head to toe check" on Resident #4. -She was not sure if this was documented. Interview on 11/20/17 at 11:00 am with the Director revealed: -Two staff members were working on the 11/18/17 evening shift. -The weekend evening shift was 7:00 pm to 7:00 am. -The staff were unaware that Resident #4 had left the facility on the night of 11/18/17. -Front door alarms should be turned on at 9:00 pm. -Staff will "prop" the foyer door open when residents go out to smoke. -Hourly checks were to be completed on the residents. -She was made aware of the incident involving Resident #4 around 10:30 pm on 11/18/17. -Resident #4 was placed on 15 minute visual checks which included documentation beginning at 10:30 pm on 11/18/17. Interview on 11/20/17 at 12:10 pm with the Director and the Assistant Director (AD) revealed: -Resident #4 "used to walk off and would come	{D 273}		

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back".
-Resident #4 "hasn't done that in years".

Interview on 12/07/17 at 4:47 pm with the Director revealed:
-A staff member completed a full body check on Resident #4 after he was returned to the facility.
-A staff member did not document the full body check on Resident #4.
-Resident #4's physician was called.

Attempted telephone interview with the former facility Physician on 12/08/17 was unsuccessful.

C. Review of Resident #3's current FL-2 dated 11/08/17 revealed:
-The resident's diagnoses included Dementia, Scoliosis, Antisocial Personality, and Parkinson's Disease.
-The resident was intermittently disoriented.
-The resident displayed inappropriate behaviors that included being verbally abusive, injurious to self, and untruthful.

Interview on 12/04/17 with a local county agency revealed:
-Local law enforcement responded to a 911 call at facility on 12/04/17.
-Resident #3 allegedly keyed Staff A's (medication aide/supervisor) vehicle while Staff A was sitting in his vehicle.
-The staff member responded by pushing Resident #3 which resulted in Resident #3 falling to the ground.

Review of Nurse's Notes revealed:
-On 12/04/17, Resident #3 keyed Staff A's car.
-Resident #3's guardian and police were notified.
-There was no documentation of contact with Resident #3's physician regarding the incident.

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-There was no documentation of contact with Resident #3's mental health provider regarding the incident.

Review of facility's Accident/Incidents Reports revealed:
-On 12/04/17, Resident #3 keyed Staff A's car.
-Staff A pushed Resident #3.
-There was no documentation the staff member contacted the physician or the mental health provider.

Review of Resident #3's record revealed:
-Resident #3 had a guardian to make decisions for him.
-The resident was admitted to the facility on 04/08/17.
-There was no documentation of follow up with the mental health provider and primary physician after incident on 12/04/17.

Review of Resident #3's Psychotherapy Notes revealed:
-Resident #3 was seen by a mental health agency on 10/27/17 and 11/09/17.
-There were no concerns were reported by staff on those dates.

Interview on 12/05/17 at 10:15 am with Resident #3 revealed:
-Resident #3 was leaving the facility to go for a walk on 12/04/17.
-He walked past Staff A's vehicle and observed a scratch on passenger side door.
-He observed Staff A sitting in the drivers' seat of his vehicle.
-Resident #3 "ran his finger across" the scratch to show Staff A.
-Staff A then got out of his vehicle and "ran to me."

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-Staff A then "hits me on the chest. I hit the fence and went unconscious."
-He "came to" after Staff A picked him up and "dragged me into the building."
-Resident #3 said Staff A "hit me so hard, I .... my pants."
-Resident #3 then proceeded to walk into his room and take a shower.
-He was being accused of scratching another vehicle also.
-He had lost his smoking privileges.
-He kept a room key in his pocket.
-He did not inform the Director as "she has a one track mind and believes I did it."
-He says that Staff A "seems normal and not pissed off."
-He says that Staff A "yelled at me for smoking a couple of weeks ago" during an undesignated smoke time.
-Resident #3 was allowed to leave the facility.

Second interview on 12/05/17 at 3:45 pm with Resident #3 revealed:
-Resident #3 stated that "no one examined me after the incident."
-Resident #3 complained of back pain after the incident.
-Resident #3 did not disclose back pain to staff members.

Observation on 12/05/7 at 10:25 am of Resident #3 revealed:
-He had 3 linear scratches just below his right elbow that were light reddish in color.
-He had 2 circular scratches on his right shoulder that were each ¼' in diameter.
-There was no bruising found on Resident #3.
-Resident #3 had his room key in his pocket.

Interview with Staff A on 12/05/17 at 10:38 am

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{D 273}	Continued From page 21 revealed: -He was sitting in his personal vehicle on a 10 minute break on the morning of 12/04/17. -Resident #3 "came up and started keying my car" on the passenger side door. -He then got out of his vehicle and "pushed him, Resident #4 fell on his butt, then his side, and then he got up." -He then walked into the building and informed the Resident Care Director (RCD) of the incident. -He informed the Director of the incident once the Director arrived to the facility. -Resident #3 became angry with him earlier on 12/04/17 as Resident #3 and another resident were smoking outside of designated smoking time. Interview on 12/07/17 at 11:27 am with the RCD revealed: -Staff A approached the RCD while in the facility kitchen on 12/04/17. -Staff A was "cussing and very hot" and stated "he just keyed my car." -She asked Staff A who he was talking about and Staff A said Resident #3. -She was unable to leave the kitchen at that moment. -She texted the Director about the incident involving Staff A and Resident #3. -She and the Director walked to Resident #3's room. -Resident #3 was getting out of the shower. -She observed Resident #3 with no marks, bruising, or bleeding on his body. -Resident #3 did not request further medical attention. -The Director informed the RCD she was calling law enforcement. -Resident #3 stated "I want to call the law" on Staff A.	{D 273}		

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{D 273}	Continued From page 22 -The facility physician should be contacted for resident's medical incidents per policy. -The mental health provider should be contacted for changes in resident's behaviors per policy. -Residents should be checked for bruising after any falls per policy. Interview on 12/07/17 at 4:47 pm with the Director revealed: -Upon arrival to the facility, Staff A informed her of the incident with Resident #3. -She proceeded to Resident #3's room and he was taking a shower. -Resident #3 "screamed for me to get out and I stepped out." -She came back to the resident's room and he was dressed. -The Director observed no bruising, bleeding, or scratches on Resident #3. Telephone interview on 12/07/17 at 9:55 am with the current primary physician revealed: -The physician was not made aware of the incident involving Resident #3 and Staff A on 12/04/17. -The last visit with Resident #3 was on 11/27/17. -There were no concerns with Resident #3 on last visit. -The physician would like to be notified of behavior changes and any incidents involving residents. Telephone interview on 12/07/17 at 1:55 pm with the Nurse Practitioner (NP) revealed: -She was not made aware of the incident involving Resident #3 and Staff on 12/04/17. -The last visit with Resident #3 was on 12/01/17 for pain management. -Resident #3 "always complains of back pain". -The facility should notify the mental health	{D 273}		

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{D 273}	Continued From page 23 provider of any behaviors. -The mental health provider would follow up with the primary physician, if needed. -The staff should check for abrasions, bleeding, and range of motion following any incidents with residents. -Any resident requiring medical attention should be taken immediately to the emergency room (ER). Telephone interview on 12/07/17 at 2:49 pm with the current mental health provider revealed: -She was not aware of the incident involving Resident #3 and Staff A on 12/04/17. -The last visit with Resident #3 was on 11/27/17. -The facility should document any new behaviors of residents and inform the mental health provider or primary physician. -After a fall, staff should observe any resident for injuries and check vital signs. Telephone interview on 12/07/17 at 3:08 pm with the former mental health provider revealed: -She was never informed of any combative behaviors by Resident #3. -She was never made aware of any past incidents involving Resident #3. -The facility should contact the mental health provider for resident's behaviors. -The facility should contact triage to report incidents or behaviors. -Triage would contact the mental health provider or primary physician depending on the circumstances. -Any medical injuries would be followed up by the primary physician. ________________________________ Based on observations, interviews, and record reviews the facility failed to contact the physician regarding a resident exhibiting aggressive	{D 273}		

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{D 273}	Continued From page 24 behaviors (Resident #5) that resulted in the resident being sent to the hospital for involuntary commitment (IVC), a resident wandering away from the facility without staff being aware (Resident #4) and being returned to the facility by the local police after being found on the edge of a major highway close to the facility, and a resident (Resident #3) being pushed to the ground by a staff member and no notification to the primary care provider for evaluation. These failures to notify the physician were detrimental to the health and safety of the residents which constitutes a Type B Violation. ______________________________ The Plan of Protection provided by the facility on 12/07/17 revealed: -All referrals and follow-ups to physicians, guardian will be reported in reference to incidents, behaviors and medical needs. -Staff will ensure appropriate providers are notified in a timely manner and all documentation is completed. -This will be monitored by the Director- weekly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2017.	{D 273}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	{D 338}		

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{D 338}	Continued From page 25 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents were free of abuse as evidenced by Resident #3 being pushed to the ground in the parking lot by a staff member, and allowing a staff member to continue to work after notifying the Health Care Personnel Registry of an allegation of resident abuse. The findings are: Refer to TAG 914, G. S. 131D-21-4 Declaration of Resident Rights (Type B Violation).	{D 338}		
{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 record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	{D912}		

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THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 26 regulations as related to health care, residents' rights, and physical environment. The findings are: A. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related the proper use of door alarms to assure the safety for 1 of 5 sampled residents as evidenced by one resident (Resident #4) who wandered from the facility without the staff's knowledge. [Refer to Tag D0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure physician or guardian notification for 3 of 4 sampled residents' (Resident #3, #4, and #5) regarding a resident exhibiting aggressive behaviors (Resident #5), a resident wandering away from the facility without staff being aware (Resident #4), and a resident being pushed to the ground by a staff member (Resident #3). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. C. Based on observations, interviews, and record reviews the Administrator failed to assure the total operations of the facility to meet and maintain rules and regulations related to physical environment, resident's rights, and health care. [Refer to Tag 980, G.S. 131D-25 Implementation (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,	{D914}		

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{D914}	Continued From page 27	{D914}		

neglect, and exploitation.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION

The Type A2 Violation is abated. Non-compliance continues.

THIS IS A TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure residents were free of abuse as evidenced by Resident #3 being pushed to the ground in the parking lot by a staff member, and allowing a staff member to continue to work after notifying the Health Care Personnel Registry of an allegation of resident abuse.

The findings are:

A. Interview on 12/04/17 with a local county agency revealed:
-Local law enforcement responded to a 911 call at the facility on this date (12/04/17).
-Resident #3 allegedly keyed Staff A's vehicle while Staff A was sitting in his vehicle.
-Staff A (Medication Aide/Supervisor) responded by pushing Resident #3 which resulted in Resident #3 falling to the ground.

Review of the facility's Adult Care Home Admission Agreement and Policies revealed residents will be free of mental and physical abuse, neglect, and exploitation.

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

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{D914}	Continued From page 28	{D914}		

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

Review of Resident #3's current FL-2 dated 11/08/17 revealed:
-The resident's diagnoses included dementia, scoliosis, antisocial personality, and Parkinson's Disease.
-Ther was documentation the resident was intermittently disoriented.
-There was documentation the resident displayed inappropriate behaviors that included being verbally abusive, injurious to self, and untruthful.

Review of Resident #3's Assessment and Care Plan dated 04/29/17 revealed Resident #3 required supervision with eating, ambulation, and grooming.

Review of Resident #3's Resident Register revealed:
-Resident #3 had a guardian to make decisions for him.
-The resident was admitted to the facility on 04/08/17.

Review of Resident #3's Psychotherapy Notes revealed:
-Resident #3 was seen by a mental health agency on 10/27/17 and 11/09/17.
-No concerns were reported by staff on those dates.

Review of facility's Nurse's Notes revealed:
-On 12/04/17, Resident #3 keyed Staff A's car.
-Resident #3's guardian and local law

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{D914}	Continued From page 29	{D914}		

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enforcement were notified.

Review of the facility's Report of Accident/Incident forms revealed:
-On 07/18/17, an employee found 2 razor blades on top of Resident #3's door frame.
-On 08/28/17, an employee found a knife and razors in Resident #3's room.
-On 12/04/17, Resident #3 keyed Staff A's car. Staff A pushed Resident #3.

Interview with Resident #3 on 12/05/17 at 10:15 am revealed:
-Resident #3 was leaving the facility to go for a walk on 12/04/17.
-He walked past Staff A's vehicle and observed a scratch on the passenger side door.
-He observed Staff A sitting in the drivers' seat of his vehicle.
-Resident #3 "ran his finger across" the scratch to show Staff A.
-Staff A then got out of his vehicle and "ran to me."
-Staff A then "hits me on the chest. I hit the fence and went unconscious."
-He "came to" after Staff A picked him up and "dragged me into the building."
-Resident #3 said Staff A "hit me so hard, I .... my pants."
-Resident #3 then proceeded to walk into his room and take a shower.
-He said he was being accused of scratching another vehicle also.
-He had lost his smoking privileges.
-He kept a room key in his pocket.
-Resident #3 did not inform the Director as "she has a one track mind and believes I did it."
-Staff A "seems normal and not p----- off."
-Staff A "yelled at me for smoking a couple of weeks ago" during an undesignated smoke time.

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{D914}	Continued From page 30	{D914}		

-Resident #3 was allowed to leave the facility.

Observation of Resident #3 on 12/05/7 at 10:25 am revealed:
-He had 3 linear scratches just below his right elbow that were light reddish in color.
-He had 2 circular scratches on his right shoulder that were each ¼' in diameter.
-There was no bruising found on Resident #3.
-Resident #3 had his room key in his pocket.

Interview with the Resident Care Director (RCD) on 12/07/17 at 11:27 am revealed:
-Staff A approached the RCD while in the facility kitchen on 12/04/17.
-Staff A was "cussing and very hot" and stated "he just keyed my car."
-She asked Staff A who he was talking about and he referred to Resident #3.
-She was unable to leave kitchen at that moment.
-She texted the Director about incident involving Staff A and Resident #3.
-She and Director walked to Resident #3's room.
-Resident #3 was getting out of the shower.
-She observed Resident #3 with no marks, bruising, or bleeding on his body.
-Resident #3 did not request further medical attention.
-The Director informed the RCD she was calling law enforcement.
-Resident #3 stated "I want to call the law" on Staff A.

Interview with the Director on 12/07/17 at 4:47 pm revealed:
-Upon arrival to the facility on 12/04/17, Staff A informed her of the incident with Resident #3.
-She proceeded to Resident #3's room and he was taking a shower.
-Resident #3 "screamed for me to get out and I

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{D914}	Continued From page 31	{D914}		

stepped out."
-She came back to the resident's room and he was dressed.
-She observed no bruising, bleeding, or scratches on Resident #3.
-She stated "I didn't see this as abuse but was protecting himself and his property."
-She stated that Resident #3 "knew what he was doing."
-She stated that employees can "restrain but not hurt" residents.
-She referred to written policy for abuse which was termination.

Interview with a local law enforcement officer on 12/08/17 at 10:00 am revealed:
-The officer responded to a 911 call at facility on the morning of 12/04/17.
-Upon arrival, the officer spoke with Staff A who reported that Resident #3 had keyed his vehicle.
-The officer then asked to review the resident's record and speak to the resident.
-The officer talked with Resident #3 and stated "he seemed nervous and denied damaging the car."
-Resident #3 did not show any signs of being assaulted and discussed no complaints of injury.
-The officer then informed Resident #3 that he was on video.
-Resident #3 said that the video was incorrect.
-Resident #3 stated the officer was called "to beat my ..."
-Resident #3 showed the officer his room key which was in his pocket.
-The officer observed Resident #3's key and didn't see any signs of paint
-The officer proceeded to the Director's office to talk with the Director, Staff A, and another employee.
-The officer watched video of incident between

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{D914}	Continued From page 32 Staff A and Resident #3. -He observed Resident #3 key Staff A's vehicle and Staff A argue with Resident #3 and push him. -Resident #3 "falls into the fence" and Staff A "walks off." -The officer asked to speak with the Director alone. -The officer explained to the Director that Staff A assaulted Resident #3 and asked "what was she going to do?" -The Director would report Staff A to Health Care Personnel Registry. -The officer discussed the incident involving Staff A and Resident #3 with the Magistrate. -No charges would be filed against Resident #3. -Simple assault charges could be filed against Staff A once the local county agency's investigation was completed. Review of the facility's video surveillance on 12/06/17 at 10:23 am revealed: -Video surveillance was located across the parking lot from Staff A's vehicle. -Staff A walked to his vehicle at 10:55 am on 12/04/17. -Resident #3 walked out of the facility, with his hand in his pocket at 11:06 am on 12/04/17. -Resident #3 approached Staff A's vehicle at 11:07 am on 12/04/17. -Resident #3 was observed moving his hand across Staff A's vehicle passenger door. -Staff A was then observed getting out of his vehicle and walking towards Resident #3. -Staff A then pushed Resident #3 with Resident #3 falling to the ground. -At 11:08 am, Staff A walked towards the facility leaving Resident #3 on the ground. -Resident #3 got up, unassisted, and walk into the facility and into his room. -At 11:09 am. Staff A walked back to his vehicle.	{D914}		

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{D914}	Continued From page 33 Based on observation, interview and review of facility video surveillance, Resident #3 had a physical altercation with Staff A. B. Interview on 12/04/17 with a local county agency revealed: -Local law enforcement responded to a 911 call at facility on this date. -Resident #3 allegedly keyed Staff A's vehicle while Staff A was sitting in his vehicle. -Staff A responded by pushing Resident #3 which resulted in Resident #3 falling to the ground. Review of the facility's Adult Care Home Admission Agreement and Policies revealed: -Residents will be free of mental and physical abuse, neglect, and exploitation. Review of Employee Handbook for the facility revealed: -There was a policy indicating immediate termination for abuse and/or neglect of residents. -"Employee(s) will be suspended without pay until an abuse investigation is completed." -"Employee(s) shall be terminated if abuse allegations are founded." -"Abused incidents will be reported to Department of Human Services and law enforcement." Review of Nurse's Notes revealed: -On 12/04/17, Resident #3 keyed Staff A's car. -Resident #3's Guardian and Police were notified. Review of the facility's Accident/Incident Reports revealed on 12/04/17, Resident #3 keyed Staff A's car; Staff A pushed Resident #3. Review of Staff A's personnel record revealed on 12/07/17 revealed:	{D914}		

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{D914}	Continued From page 34 -Staff A was hired on 01/23/14. -Staff A was hired as a Supervisor, medication aide, and personal care aide. -Staff A signed the Resident Abuse and Neglect Policy on 01/23/14. -Staff A agreed to ensure that each resident was free from any type of abuse, including sexual, verbal, physical and mental abuse as well as any form of punishment including involuntary seclusion. -The Director contacted Health Care Personnel Registry (HCPR) as required for allegation of resident abuse on 12/04/17. -The Director completed the 24-Hour Initial Report and 5-Working Day Report as required for the 12/04/17 incident. -Staff A had HCPR check dated 10/27/17 that showed no findings on file in his record. Review of the facility's employee work schedule revealed: -Staff A was scheduled as an active employee of the facility. -Staff A had worked every day since the incident occurred on 12/04/17, including today (12/08/17). Observations on 12/05/17, 12/06/17, 12/07/17, and 12/08/17 revealed: -Staff A was still employed at the facility. -Staff A was interacting with residents, including Resident #3, performing medication administration. Based on observation, interview, and record review, Staff A continued to have contact with all 29 residents residing at the facility after being reported to the HCPR according to facility policy, "Employee(s) will be suspended without pay until an abuse investigation is completed" placing the residents at risk of abuse.	{D914}		

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{D914}	Continued From page 35 C. Based on observations, interviews and record reviews, the facility failed to ensure residents were free of abuse as evidenced by Resident #3 being pushed to the ground in the parking lot by a staff member, and allowing a staff member to continue to work after notifying the Health Care Personnel Registry of an allegation of resident abuse. [Refer to Tag D0338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)]. ______________________________ The facility's failure to assure residents were free of physical and mental abuse resulted when Resident #3 had a physical altercation with Staff A, and Staff A continued to have contact with all 29 residents residing at the facility after being reported to the HCPR. This failure to assure residents, including Resident #3, were safe from physical and mental abuse was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. ______________________________ The Plan of Protection provided by the facility on 12/06/17 revealed: -The Director will ensure all staff are trained beginning on 12/07/17. -Employees shall be trained to comply with and understand Residents' Rights. -Training will be done by the Director and (named provider) will be contacted to aide in further training of specific diagnoses to help staff have a better understanding of rules and behaviors. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2017.	{D914}		
{D980}	G.S. § 131D-25 Implementation	{D980}		

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{D980}	Continued From page 36 G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews the Administrator failed to assure the total operations of the facility to meet and maintain rules and regulations related to supervision, resident's rights, and health care. The findings are: Interview on 12/07/17 at 4:00 pm with the Resident Care Director (RCD) revealed: -The Director was available "24/7 via phone" if she was not in the facility. -The Director was responsible for day to day operations in the facility. Interview on 12/08/17 at 10:30 am with the Administrator revealed: -She was listed as the Administrator of the building. -She was also the Administrator for a larger facility across the state. -She had not visited the facility since the last survey on August 25, 2017.	{D980}		

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{D980}	Continued From page 37 -The facility owner was very active in managing the facility. -She was not familiar with the citations from the last survey which were cited. -She was aware the facility had a Suspension of Admissions in effect. -She could not provide the date of the last time she actually was on site at the facility. -She did not receive the facility's incident/accident reports. -She would expect to be notified of any incidents because "my name is on the wall". -She was not aware of the number of residents (census) residing at the facility. -The Administrator was not aware the facility had a survey currently being conducted. Interview on 12/08/17 at 11:45 am with the Director of the facility revealed: -She was in charge of day to day operations in the facility. -She lived near by the facility and was available 24/7 either by phone or she was in the facility. -She was in the facility Monday - Friday. -The Administrator met with her in the facility quarterly. -The Administrator was available for phone calls during the day, but she had not had contact with the Administrator in weeks. -She was in close contact with the facility owner. -She was in charge of overseeing all staffing issues, and residents' concerns and problems. Noncompliance identified during the survey included: A. Based on interviews, record reviews, and observations, the facility failed to provide supervision/monitoring related the proper use of door alarms to assure the safety for 1 of 5	{D980}		

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THE HERITAGE OF CEDAR ROCK	191 CRESTVIEW DRIVE MOCKSVILLE, NC 27028

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{D980}	Continued From page 38 sampled residents as evidenced by one resident (Resident #4) who wandered from the facility without the staff's knowledge. [Refer to Tag D0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. B. Based on observations, interviews, and record reviews, the facility failed to assure physician or guardian notification for 3 of 4 sampled residents (Resident #3, #4, and #5) regarding a resident exhibiting aggressive behaviors (Resident #5), a resident wandering away from the facility without staff being aware (Resident #4), and a resident being pushed to the ground by a staff member (Resident #3). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. C. Based on observations, interviews, and record reviews, the facility failed to assure residents were free of physical abuse regarding Resident #3 being pushed to the ground in the parking lot by a staff member, and allowing a staff member to continue to work after notifying the Health Care Personnel Registry of an allegation of resident abuse. [Refer to Tag D0338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)]. D. Based on record review and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, residents' rights, and supervision. [Refer to Tag 912, G.S. 131D-21-2 Residents' Rights]. E. Based on observations, interviews and record reviews, the facility failed to ensure residents were free of abuse as evidenced by Resident #3 being pushed to the ground in the parking lot by a	{D980}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL030007	A. BUILDING: ______ B. WING ______	R-C 12/08/2017

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

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{D980}	Continued From page 39 staff member, and allowing a staff member to continue to work after notifying the Health Care Personnel Registry of an allegation of resident abuse. [Refer to Tag 914, G. S. 131D-21-4 Declaration of Resident Rights Type B Violation)]. ______________________________ Failure of management to provide oversight and monitor the facility for all licensure rule areas resulted in a resident wandering from the facility; violating Resident Rights to be free of harm, and abuse for a resident pushed to the ground by a staff member, and the staff member continuing to work; not initiating referral and follow up in regard to physician not being aware of aggressive behaviors, a resident not evaluate after a staff confrontation and a resident not evaluated after an elopement. The failure of management in providing oversight in these areas was detrimental to the health, safety and welfare for all residents and constitutes a Type B Violation. ______________________________ The Plan of Protection provided by the facility on 12/08/17 revealed: -Implementation of supervision forms, reference and referral for behaviors to report to Director, MD (physician), psychiatric providers, and guardians will be drawn up to ensure documentation and communication between all parties for Resident behaviors. -Executive Director (Director) will assure all policies, procedures, and rules and regulations are adhered to by all staff. -Staff training will be increased in dealing all levels of residents, their behaviors and care. -Director will document and implement all further needs of residents and proper training of staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2017.	{D980}		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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