Received via email 3/29/18 mw

PRINTED: 03/09/2018
FORM APPROVED

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
	HAL034098	A. BUILDING: _____ B. WING _____	R-C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 Forsyth County Department of Social Services conducted an follow-up survey and complaint investigation on February 14, 2018 through February 16, 2018. The complaint investigation was initiated on February 6, 2018 by the Forsyth County Department of Social Services.	{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 b_ 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 maintain the outside grounds in a clean and safe condition as evidenced by weather damaged fascia boards and weather damaged eave boxing on the outside of one of the 500 Hall pods. The findings are: Observation of the inside of the facility during the initial tour on 02/14/18 at 9:00 am revealed the facility had a front hallway leading from the entrance toward the south with residents' room located in pods (circular structures extending toward the front of the building) which were joined by a hallway identified by the facility as the 500	D 072	We have reached out to multiple contractors to request quotes for repairing damaged fascia boards and eave boxing noted in this Statement of Deficiencies. I am attaching the only one we have received to date which is from [redacted] We will continue to request quotes until April 13, 2018. At that time we will contract for the work from one of the submissions with expectation of work being completed by May 31, 2018 4-5-2018 The Administrator and the Maintenance Director will be responsible for assuring the completion of repairs	5/31/18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Dillon — TITLE: Executive Director — (X6) DATE: 3/29/18

STATE FORM 6899 7GVN12 If continuation sheet 1 of 72

Accepted & Addendum via phone & documentation on 4-5-2018 /ltc

Approved via phone

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Dreher

TITLE: Executive Director

(X5) DATE: 4/6/18

revision

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D 072	Continued From page 1 Hall. Observation of the outside of the facility on 02/16/18 at 10:00 am revealed: -The 500 Hall had pods that were facing the parking lot between the highway and the building. -The pods had aluminum covered eaves and fascia boards with vinyl covered soffits to protect the wooden fascia board and rafters from weather damage. -The pod located at the right end (southern end), as viewed from the street, had exposed fascia and roof rafters as a result of missing aluminum siding. -A 4 to 5 foot section of the pod's eave facing the road had missing aluminum covering which exposed decaying fascia board and decaying ends of the overhead rafter. This could allow insects and vermin (like mice, squirrels, or bats) to enter into roof area. -A 4 to 5 foot section of the pod's eave on the southern-most end of the pod had exposed and decaying fascia board and ends of overhead rafter as a result of the missing aluminum covering. This could allow insects and varmints to enter to roof area. -On the back side of the pod and next to the activity room, there was a 3 foot section of vinyl soffit detached from the corner of the eave exposing wooded structure. This could allow insects and potentially varmints to enter to roof area. Interview on 02/16/18 at 10:07 am with the facility's Maintenance Director revealed: -He was aware the fascia and soffit was in need of repair for the pod on the 500 Hall. -He had obtained estimates for repairing the fascia and soffits when the building had the roof repair about a year ag	D 072		

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D 072	Continued From page 2 -He had recommended that the fascia and any soffits be repaired when the roof was repaired because the cost would have been minimized. -He had mentioned the need for the repair again, at least 2 times with the last 4 months, to the facility's Executive Directors. -They had informed the facility's new Executive Director within the last 4 weeks, but there was a lot of repairs that needed to be done to the fascia and eaves due to the delayed roof repair. Interview on 02/16/18 at 1:00 pm with the Executive Director (ED) revealed: -She was informed by the Maintenance Director on at least 2 occasions that the facility needed repair to the fascia, eaves and soffits along areas of the roof. -She had informed the owners and they knew of the need for repairs. -At this point, no information had been provided for when the repairs to the fascia, eaves, and soffits would be corrected. Attempted telephone interview with the facility's Owner on 02/16/18 at 10:00 am was unsuccessful.	D 072		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Infomation on Home and Resident Register (a) An adult care home administrator or administrator-in-charge shall furnish and review with the resident or responsible person information on the home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as	D 243		

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D 243	Continued From page 3 required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the home. The information shall include the following: (1) the resident contract to which the following applies: (A) the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet pursuant to G.S. 131D-2(a1)(4); (C) the contract shall be signed and dated by the administrator or administrator-in-charge and the resident or responsible person, a copy given to the resident or responsible person and a copy kept in the resident's record; (D) the resident or responsible person shall be notified as soon as any change is known, but not less than 30 days before the change for rate changes initiated by the facility, of any changes in the contract and be provided an amended contract or an amendment to the contract for review and signature; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly. Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit.	D 243		

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D 243	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the Administrator notified the resident/responsible party 30 days before a change in rate was initiated for 2 of 7 sampled private pay residents (Residents #8, and #18). The findings are: 1. Review of Resident #8's current FL2 dated 03/16/17 revealed diagnoses included chronic pain, glaucoma, depression, seizures, marijuana abuse, and tobacco abuse. Review of the Resident's admission agreement dated 10/16/12 revealed: -The room rate was quoted as $1900.00 on 10/16/12. -On 03/01/15 the resident's room rate was increased to $2000.00. -There was no documentation of a signed agreement of an increase of resident's room/board rate. Interview on 02/14/18 at 10:15am with Resident #8 revealed: -The resident was private pay. -He received a little over $2000.00 a month deposited in his account. -When he went to get money from the Business Office Manager (BOM), in January 2018, he was told he only had $49 in his trust fund account. -He had glaucoma and he could not see how much money he was being given. -He had requested his family member go to the facility Business Office with him when he received his money so the family member could count the money for him, but the request was denied by the BOM.	D 243	We are aware that a change in rent rate was made without proper documentation presented and signed. This change was made improperly by a former employee in our corporate office. Resident #8 has been reimbursed. See the attached Resident Trust Ledger and supporting documentation from audit, as well as the check written to take all of these funds out of the trust at the request of resident #8. The Business Administrator will assure proper documentation for any changes in RATE. Amended via telephone Y-S 3/8 pkg	3/9/18

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D 243	Continued From page 5 -He gave his family member permission to check on his account with the corporate office. -He was tired of the BOM always telling the resident there was no money in his account when the resident knew he was supposed to have money. -He did not understand why he was told he did not have money when he knew he should have more money available than what the BOM told him he had. -He had never signed any transaction because he had glaucoma and could not see to sign. -He only received money for when his family member took the resident shopping. Interview on 02/16/18 at 2:45 pm with a family member revealed: -Resident #8 was "constantly" calling him complaining about he was being told he did not have any money in his account. -He had called the corporate office several times but no one would call him back. -He had been told by the new BOM to call corporate because they were the ones who handled the residents' funds. -He was under the impression that the money issues were taken care of in November 2017. -He was getting a little frustrated because no one was returning his calls. -He had the resident's permission to get the needed information about his account. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to the Trust Funds Account of Resident #8 revealed: -She produced Resident #8's statement which showed Resident #8's room/board rate was changed effective 03/01/2015 without documentation authorizing the change. -The resident would be reimbursed a total of	D 243		

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D 243	Continued From page 6 $3400.00. -The resident was due $1400.00 from the previous year when without authorization, an amount of $200.00 was being deposited into Trust Fund Account instead of the normal $600.00. -There was no documentation of authorization of this deposit change. -The $1600.00 would also be reimbursed to Resident #8's Trust Account Fund. Interview on 02/15/18 at 4:00 pm of the Administrator revealed: -She did not feel there was anything wrong with the room rate quoted to Resident #8. -The facility was private owned and since this was free enterprise the facility could charge any dollar amount they chose. -If a potential resident had more money than what the actual room rates were, there should not be a problem with "upping the rates" to benefit the facility. 2. Review of Resident #18's current FL2 dated 02/16/17 revealed diagnoses included Alzheimer's disease, debility, hyperlipidemia, Vitamin B12 deficiency, and paranoid schizophrenia. Review of resident agreement dated 06/06/13 showed a room rate of $4500.00 for a private room on the Special Care Unit. Review of the resident agreement dated 02/19/14 signed by Resident #18's legal guardian showed a changed room rate of $5500.00 for a private room on the Special Care Unit. There was no explanation given for the change in room rate after only eight months in the facility.	D 243	This comment attributed to the Administrator is not relevant to Resident #8. In the case of Resident #8, rents were changed in quick books but no new contract was signed as required by 10A NCAC 13F .0704 (a)(1).	

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D 243	Continued From page 7 Review of the residence monthly rates show the rate for a private room in the Special Care Unit was $3600.00 and semi private was $3350.00. Interview on 02/16/18 at 8:17 am with Resident #18's legal guardian revealed: -Resident #18 was private pay. -She had not been the guardian very long. -Everything was already in place when she was assigned the guardian case. -She knew there was another account set up through a bank that paid the room/board payments for the resident. -She only had access to the Social Security benefits funds. -She paid all of the medical and dental bills. -She was notified in November 2017 by the BOM that the resident was being charged for a private room but was actually in a semi-private room. -She contacted the Corporate Business Manager who stated to her, "The facility was a private business and they had the right to charge whatever price they chose whenever they wanted to". -She was going to look further into the situation. -It seemed the resident was being over charged because of his trust account. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to Trust Funds Account for Resident #18 revealed: -She did not know of the discrepancy in the quoted room rates in relation to the rates that were posted by the owners. -She knew there was a signed contract by the resident's legal guardian agreeing to the quoted amount. -She knew the resident's agreement reflected the room was supposed to be a private room and the resident was actually in a semi private room and	D 243		

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D 243	Continued From page 8 still being overcharged. -There was no documentation as to why Resident #18 was being charged so much more than the posted room rates. -There was no documentation to show why the room rate was increased by $1000.00 after only eight months in the facility. -The legal guardian would have to sign the new contract that would reflect a new room rate. -She did not know as to whether the facility would reimburse the resident for the difference in the room rates. Interview on 02/15/18 at 4:00 pm of the Administrator revealed: -Since the room agreement rate quoted to Resident #18's legal guardians was signed, there was nothing wrong with giving a different rate. -The facility was private owned and since this was free enterprise the facility could charge any dollar amount they chose. -If a potential resident had more money than what the actual room rates were, there should not be a problem with "upping the rates" to benefit the facility.	D 243	Previous administrator was questioned about the increase from $3600 to $5500 done on 2/19/14. It is reported that the previous Guardian felt the private room Resident #18 was in was too small for him. This Guardian was offered a semi-private room to be kept as private for him. Normally, this would require the resident to pay for both sides of this semi-private room, which would mean raising his rent to $6700 ($3350x2). The previous administrator agreed on accepting $5500 for this room instead. There will not be a refund of rents for past months. The current Guardian has been informed that she may sign a new agreement to move him back to a private room at the current private room rate.	
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269	Statement #3 is misquoted. When told we could not change a posted rate, the administrator replied that we change posted rates all the time when a potential resident could not afford the posted rate and this monitor did not question that so why was she questioning this rate. There was no intent to say we only raised this rate because this resident had more money.	

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D 269	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 7 sampled residents (Resident # 19) was provided staff assistance with transfers from a wheelchair and assistance with moving personal belongings to another resident room. The findings are: Review of the facility's Staff Rounds Policy revealed: -All residents were to be routinely checked at 2 hour intervals. -Two hour intervals were the maximum time allowed between rounds and staff were expected to interact with residents throughout their shift. -Incontinent residents were to be monitored every 2 hours or more frequently to maintain personal hygiene. Review of Resident #19's current FL2 dated 2/5/2018 revealed: -Diagnoses of end stage renal disease, type 2 diabetes, hypertension, bilateral leg amputation, neurogenic bladder, left arm paresis, colostomy, and chronic back pain. -Resident #19 was non-ambulatory. -Resident #19 needed assistance with bathing and dressing due to immobility. Observation on 02/15/18 at 3:00 pm revealed Resident #19 had been placed in a different room with a new roommate Interview on 02/16/18 at 9:30 am with Resident #19 revealed: -She had been moved from her previous room on 02/15/18 to another resident room with a new roommate.	D 269		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 10 -She was new to the facility and had arrived on 02/05/18. -She was non-ambulatory and relied on a power chair and staff assistance to complete her activities of daily living. -She could not transfer from her power chair to bed, or vice versa, without staff assistance. -She had asked for staff to help her into bed around 11:00 pm the previous night on 02/15/18. -No one had come to assist her to bed, or to check on her roommate throughout third shift. -She had slept sitting up in her power chair overnight, to the point that her dentures fell out of her mouth. -Her new roommate had picked up and cleaned her dentures for her that morning. -Her new roommate had helped her move belongings and boxes that morning, because they had requested staffs' assistance and staff told them it "wasn't their job" to help them unpack or organize the room. Interview on 02/16/18 at 10:50 am with the Director of Nursing (DON) revealed: -She did not know third shift staff were not performing rounds on residents. -Her expectation was that rounds were completed per policy (every 2 hours) or more frequently as needed. Interview on 02/16/18 at 10:20 am with a first shift medication aide (MA) revealed: -Resident #19 had informed her this morning when she came in for her shift that third shift staff had not helped the resident to bed the night before and she had slept in her power chair. The resident had told her third shift staff had not been in the room all night. -The DON knew of the situation.	D 269	In-service was done on 2/15/18 and again on3/5/18 regarding proper personal care and supervision including proper rounding expectations. Also done as part of in-service on 3/22/18 on personal care and supervision. Personal Care and Supervision will also be part of future in-services done for staff by our DON and at orientation. Resident Care Coordinator and Special Care Coordinator will be responsible for their direct report staff attending future inservices.	2/15/18 3/05/18 3/22/18

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D 269	Continued From page 11 Interview on 02/16/18 at 9:35 am with Resident #19's roommate revealed: -Staff had not performed any rounds on third shift to her knowledge, and had left her new roommate in her power wheelchair all night long when she was supposed to be put to bed. -She was attempting to move boxes, furniture, and other belongings around the room for both her and her new roommate because staff would not help them. -She and her new roommate were getting along very well and were enjoying sharing a room together. "It's much better than my previous roommate."	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 7 sampled residents (Resident #5) related to physically and verbally aggressive behaviors toward staff, and other residents, and outside agency staff members. The findings are: Review of Resident #5's current FL2 dated 03/22/17 revealed:	D 273		

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D 273	Continued From page 12 -Diagnoses of multiple falls, impaired mobility, and deep vein thrombosis. -She was listed as "constantly oriented." -She was non-ambulatory and required assistance with bathing, dressing, and feeding. -She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16. Review on 02/15/18 of Resident #5's Resident Notes revealed: -An entry dated 04/17/17 documented verbal aggression toward outside physical therapy staff. -An entry dated 04/26/17 documented a disagreement with her roommate over the heating and cooling unit in the room. Staff wrote that the resident was agitated and that they encouraged her to come to a compromise with her roommate. -An entry dated 05/03/17 documented verbal aggression to an outside home health agency staff member. -An entry dated 05/17/17 documented verbal aggression, rude and disrespectful behavior to other residents, staff and outside agencies. -An entry dated 06/22/17 documented verbal aggression toward "the new lady" and another resident, which caused the "new lady" to cry and the other resident to threaten to fight Resident #5. -An entry dated 06/23/17 documented another instance of verbal aggression to several residents in the dining room. The Director of Nursing was called to speak with her. -An entry dated 07/12/17 documented Resident #5 was given a new roommate. -An entry dated 07/28/17 documented an altercation with another resident, where Resident #5 ran over the resident with her wheelchair. -An entry dated 09/0[illegible]17 documented an	D 273		

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D 273	Continued From page 13 argument with her roommate. -An entry dated 09/03/17 documented a physical altercation with her roommate. -An entry dated 09/05/17 documented Resident #5 demanding staff move her roommate out of her room because the roommate's remote changed Resident #5's TV channels. -An entry dated 10/29/17 documented a disagreement with her roommate (unknown resident) regarding "her side of the room." -An entry dated 11/05/17 documented Resident #5 threatening to "throw her roommate on the floor" because staff placed the roommate's wheelchair in her exit path. -An entry dated 11/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial slurs. 911 was called to help redirect the resident. Resident also referred to the responding officer with racial slurs when they entered the facility. -An entry dated 01/22/18 documented of unexplained bruising around Resident #5's left eye. -An entry dated 02/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 02/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5 refused to go to the hospital for psychiatric evaluation. -An entry dated 02/14/18 documented Resident #5 was finally transported via EMS to a hospital for a psychiatric evaluation. -An entry dated 02/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Interview on 02/14/18 at 10:20 am with Resident	D 273		

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D 273	Continued From page 14 #5 revealed: -She had had several different roommates since moving to the facility. -She was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence care. -She was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but that the roommate "made it all up, and how did she (Resident #4) even know Resident #5 had a salt shaker under there." -She did not know how Resident #4 was injured because she "was asleep." -She wanted a private room but could not afford it. -She had "ran off her roommates" several times. Interview on 02/14/18 at 10:30 am with Resident #5's family member revealed: -They were aware of the altercation on 2/13/18. -Resident #5 had had several different roommates since moving to the facility. -Resident #5 could be difficult to get along with. -They wanted to move Resident #5 to a private room but could not afford the cost. -Resident #5 insisted she was not responsible for Resident #4's injuries as she did not hit her "on purpose" and wasn't "aiming for her" when she threw the salt shaker. -They were currently in the facility to facilitate Resident #5 going to the hospital for an evaluation and to talk to administration about options for moving Resident #5 or the roommate to avoid future conflicts. -They had spoken with staff before regarding Resident #5's behaviors when she had prior issues with other roommates, where they requested a private room, but could not afford the increased cost they were quoted.	D 273		

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D 273	Continued From page 15 -They were the responsible party for Resident #5. Observation on 02/14/18 at 11:00 am revealed law enforcement was called to assist EMS in transporting Resident #5 to the hospital for evaluation due to her volatile behavior on 2/13/18. She had refused to be transported on 2/13/18 and was not cooperative with staff, law enforcement, or EMS until law enforcement informed her she could be arrested for assault. Interview on 2/16/18 at 10:20 am with a first shift medication aide (MA) revealed: -She knew of Resident #5's frequent behaviors and had written several behavior reports before to send to the PCP. -She had requested an order for a PRN (as needed) Ativan to reduce agitation with Resident #5, but had been denied by the PCP. -She could not recall a date for when she sent a request to the PCP regarding the PRN Ativan. -Staff were unable to locate any behavior reports or requests for medication for Resident #5 in the facility. Interview on 02/16/18 at 9:45 am with Resident #5's primary care provider (PCP) revealed: -He did not know Resident #5 had any previous behavior issues before being contacted by the hospital on 2/14/18. -He did not have any documentation that staff at the facility had notified him of any incidents other than the unexplained bruised eye. -He had last seen Resident #5 in January 2018 and had not been informed by staff of any aggressive behaviors at that time. -Resident #5 had never mentioned any of her altercations with staff or other residents and appeared to be lucid and healthy for her age. -He had given a verbal order for Depakote for	D 273		

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D 273	Continued From page 16 agitation, at bedtime to begin immediately, until he could see Resident #5 during his facility visit on Wednesday, 2/28/18. -He had no record of a request from the facility for any medication for agitation for Resident #5. Interview on 02/14/18 at 11:50 am with Administrator revealed: -She had been told by staff after the incident on 2/13/18 that the altercation started after Resident #5 drew a line on the floor to separate "her part" of the room from Resident #4's "part." -Resident #4 had moved to the facility on 2/9/18. -Staff's normal response to Resident #5's behaviors was to redirect her or remove her from the situation. -She was new to the administrator position at this facility, so she was not sure if staff would be able to locate any documented behavior reports or communication with the PCP, because she and her staff were still working to "organize everything" from the previous staff. -Her plan now was to keep Resident #4 and Resident #5 separated and have Resident #5 "medicated" to avoid further issues. -She had requested a psychiatric evaluation for Resident #5 after the assault incident and had Resident #5 sent to a local hospital. -She had been contacted by the hospital after Resident #5 arrived and told that the resident's PCP informed the hospital staff Resident #5 did not have any mental health issues, so the hospital did not perform a psychiatric evaluation. -Resident #5 was brought back to the facility because "she didn't have a choice to send her anywhere else." -She had moved residents around to separate Resident #4 and Resident #5 into rooms in two different areas of the building. -She had spoken to the resident and family	D 273	By "medicated", Administrator was referring to the Depakote Resident #5's PCP had ordered pending next visit.	

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D 273	Continued From page 17 before regarding a private room for Resident #5, but Resident #5 cannot pay for the different rate each month for a private room. -She "couldn't find any other placement for Resident #5 because she didn't have enough money." -She thought that Resident #5 "acted out to try and get a private room," so she "wasn't going to reward her behavior." -If Resident #4 took out a restraining order on Resident #5, she would move Resident #4 out of the facility and keep Resident #5, because she "couldn't get rid of anyone that's a problem." -If Resident #5 had any further altercations, she would send her back out to the hospital for another evaluation. The facility's failure to notify Resident #5's physician related to physically and verbally aggressive behaviors toward staff, other residents, and outside agency staff members placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. Review of the Plan of Protection submitted by the facility dated 02/16/18 revealed: -The facility will inservice staff on the steps to take when a resident shows a change in mental status, as well as physicial status, to ensure that routine and acute health care needs are brought to the apprropriate provider. -All residents will be assessed today (02/16/18) to determine if any residents meet the need for physician referrals today, and refferral will be made immediately by the Director of Nursing. -The Director of Nursing will be responsible for ensuring ongoing compliance. CORRECTION DATE FOR THE TYPE A2	D 273	'Get rid of' sounds more harsh than intended. It is common knowledge that when sending out placement requests, few facilities will accept a resident that is known to be violent or aggressive. Fortunately, no restraining order was made and keeping Resident #4 and Resident #5 separated has taken care of the issue between them. In-services were done as written in POP. See attached sign in sheets and topics covered during in-services. These topics included staff response to aggressive behavior by residents. Potential residents were assessed as noted in POP. No further action on noted residents necessary at time of assessment. Both in house doctors have been educated as to the location of nurses notes which were quoted under this tag. Going forward DON will require behavior reports be presented at shift change stand up daily. DON will be responsible for these reports being placed in Doctors box. Administrator will require notification of behavior reports at weekly manager meetings and will montior that procedures are followed.	2/15/18 2/16/18 2/19/18 3/14/18 2/16/18

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D 273	Continued From page 18 VIOLATION SHALL NOT EXCEED, March 18, 2018.	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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents were provided a safe environment at the facility regarding 1 resident (Resident #5) who displayed physically and verbally aggressive behaviors resulting in physical injury to another resident (Resident #4). The findings are: 1. Review of Resident #5's current FL2 dated 03/22/17 revealed: -Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. -She was listed as "constantly oriented." -She was non-ambulatory and required assistance with bathing, dressing, and feeding. -She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16. Review of Resident #5's Resident Notes revealed:	D 338	Resident Rights are covered at orientation and new employees sign that they have been made aware. Our Ombudsman recently held two Resident Rights Bingo with all staff required to attend. All managers are tasked with calling to staff attention any time they witness a residents rights being violated. Administrator makes it a point to call it to staff attention when a residents rights are being respected by a staff member during daily rounds of the whole facility and to do it publicly so others are aware it is important. 3/20/18 Admin on leave 4-6-2018 ITAG	

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D 338	Continued From page 19 -An entry dated 04/17/17 documented verbal aggression toward outside physical therapy staff. -An entry dated 04/26/17 documented a disagreement with her roommate over the heating and cooling unit in the room. Staff documented the resident was agitated and they encouraged her to come to a compromise with her roommate. -An entry dated 05/3/17 documented verbal aggression to an outside home health agency staff. -An entry dated 05/17/17 documented verbal aggression, rude and disrespectful behavior to other residents, staff and outside agencies. -An entry dated 06/22/17 documented verbal aggression toward "the new lady" and another resident, which caused the "new lady" to cry and the other resident to threaten to fight Resident #5. -An entry dated 6/23/17 documented another instance of verbal aggression to several residents in the dining room. The Director of Nursing was called to speak with her. -An entry dated 7/12/17 documented Resident #5 was given a new roommate. -An entry dated 7/28/17 documented an altercation with another resident, where Resident #5 ran over the resident with her wheelchair. -An entry dated 9/2/17 documented an argument with her roommate. -An entry dated 9/3/17 documented a physical altercation with her roommate. -An entry dated 9/5/17 documented Resident #5 demanding staff move her roommate out of her room because the roommate's remote changed Resident #5's TV channels. -An entry dated 10/29/17 documented a disagreement with her roommate regarding "her side of the room." -An entry dated 11/5/17 documented Resident #5 threatening to "throw her roommate on the floor"	D 338		

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D 338	Continued From page 20 because staff placed the roommate's wheelchair in her exit path. -An entry dated 11/12/17 documented Resident #5 threatened her roommate, attacked a staff person with her wheelchair, and threatened staff using racial slurs. 911 was called to help redirect the resident. Resident also referred to the responding officer with racial slurs when they entered the facility. -An entry dated 1/22/18 documented an unexplained bruising around Resident #5's left eye. -An entry dated 2/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 2/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5 refused to go to the hospital for psychiatric evaluation. -An entry dated 2/14/18 documented Resident #5 was finally transported via EMS to a hospital for a psychiatric evaluation. -An entry dated 2/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of Resident #5's incident reports revealed: -There were no behavior reports found on file for any incident before the 2/13/18 physical assault. -There was one incident report detailing Resident #5's unexplained bruising to her left eye on 1/22/18, which documented the resident denied falling, any physical altercations, or hitting her face on any object. The incident report was sent to Resident #5's physician and to the local county Department of Social Services, and her family was notified.	D 338		

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D 338	Continued From page 21 Interview on 02/14/18 at 10:20 am with Resident #5 revealed: -She had several different roommates since moving to the facility. -She was wheelchair bound and relied on staff to assist her with bathing, dressing, eating, and incontinence care. -She was being accused of hitting her roommate with a crystal salt shaker that she had hidden under her refrigerator, but the roommate "made it all up". -She did not know how Resident #4 was injured because Resident #5 "was asleep." -She wanted a private room but could not afford it. Interview on 02/14/18 at 10:30 am with Resident #5's family member revealed: -They were aware of the altercation on 2/13/18. -Resident #5 had had several different roommates since moving to the facility. -Resident #5 could be difficult to get along with. -The family member wanted to move Resident #5 to a private room but could not afford the cost. -Resident #5 insisted she was not responsible for Resident #4's injuries as she did not hit her "on purpose" and wasn't "aiming for her" when she threw the salt shaker. -The family member was currently in the facility to facilitate Resident #5 going to the hospital for an evaluation and to talk to administration about options for moving Resident #5 or the roommate to avoid future conflicts. -The family member had spoken with staff before regarding Resident #5's behaviors when she had prior issues with other roommates, where the family member requested a private room, but could not afford the increased cost the family member was quoted. -The family member was the responsible party for	D 338		

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D 338	Continued From page 22 Resident #5. Observation on 02/15/18 at 12:25 pm of an interaction between a first shift MA and the Administrator revealed: -The first shift MA requested to feed Resident #5 in her temporary room per Resident #5's request to avoid the dining room. -The Administrator instructed staff that they were not to feed residents meals in their rooms. -The Administrator stated "If they get hungry enough they'll come eat." Interview on 02/16/18 at 9:45 am with Resident #5's primary care provider (PCP) revealed: -He did not know Resident #5 had had any previous behavior issues before being contacted by the hospital on 2/14/18. -He did not have any documentation that staff at the facility had notified him of any incidents other than the unexplained bruised eye. -He had last seen Resident #5 in January 2018 and had not been informed by staff of any aggressive behaviors. -Resident #5 had never mentioned any of her altercations with staff or other residents and appeared to be lucid and healthy for her age. -He had given a verbal order for Depakote, used to treat agitation, at bedtime to begin immediately, until he could see Resident #5 during his facility visit on Wednesday, 2/28/18. Interview on 2/16/18 at 10:20 am with a first shift medication aide (MA) revealed: -She knew of Resident #5's frequent behaviors and had written several behavior reports before to send to the PCP. -She had requested an order for a PRN (as needed) Ativan to reduce agitation with Resident #5, but had been denied by the PCP.	D 338	Nowhere do I see note of the interview between the surveyor and administrator concerning residents eating in their room. The Administrator explained that not only does eating in rooms often cause insect infestations but that eating in the dining room is a social activity that helps residents avoid issues of loneliness and depression. It was also explained that if a resident eats in their room, a staff member must be there for safety reasons, taking this staff member away from the rest of the residents in the dining room. When asked about Policy, the Resident Agreement (P.3 E.6) was produced. See attached.	

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D 338	Continued From page 23 -She could not recall a date for when she sent a request to the PCP regarding the PRN Ativan. -Staff were unable to locate any behavior reports or requests for medication for Resident #5 in the facility. Interview on 2/14/18 at 11:50 am with the Administrator revealed: -She had been told by staff after the incident on 2/13/18 that the altercation started after Resident #5 drew a line on the floor to separate "her part" of the room from Resident #4's "part." -Resident #4 had moved to the facility on 2/9/18. -Staff's normal response to Resident #5's behaviors was to redirect her or remove her from the situation. -She was new to the Administrator position at this facility, so she was not sure if staff would be able to locate any documented behavior reports or communication with the PCP, because she and her staff were still working to "organize everything" from the previous staff. -Her plan now was to keep Resident #4 and Resident #5 separated and have Resident #5 "medicated" to avoid further issues. -She had requested a psychiatric evaluation for Resident #5 after the assault incident and had Resident #5 sent to a local hospital. -She had been contacted by the hospital after Resident #5 arrived and told that the resident's PCP informed the hospital staff Resident #5 did not have any mental health issues, so the hospital did not perform a psychiatric evaluation. -Resident #5 was brought back to the facility because "she didn't have a choice to send her anywhere else." -She had moved residents around to separate Resident #4 and Resident #5 into rooms in two different areas of the building. -She had spoken to the resident and family	D 338		

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D 338	Continued From page 24 before regarding a private room for Resident #5, but Resident #5 cannot pay for the different rate each month for a private room. -She "couldn't find any other placement for Resident #5 because she didn't have enough money." -She thought that Resident #5 "acted out to try and get a private room," so she "wasn't going to reward her behavior." -If Resident #4 took out a restraining order on Resident #5, she would move Resident #4 out of the facility and keep Resident #5, because she "couldn't get rid of anyone that's a problem." -If Resident #5 had any further altercations, she would send her back out to the hospital for another evaluation. 2. Review of Resident #4's current FL2 dated 02/02/18 revealed: -Diagnoses included degenerative disc disease of the cervical spine, cerebrovascular accident with hemiplegia, multi-infarct dementia, rheumatoid arthritis, chronic regional pain syndrome, and an abnormal gait. -The resident was intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder. Review of Resident #4's Resident Register revealed an admission date of 02/09/18. Observation on 02/14/18 of Resident #4's current room location revealed: -Resident #4 had been placed in a spare room containing only a bed frame, box spring, and mattress. -All of Resident #4's belongings were located in her previous room she had shared with Resident #5. -There was no call bell in place in the spare room,	D 338	'Get rid of' sounds more harsh than intended. It is common knowledge that when sending out placement requests, few facilities will accept a resident that is known to be violent or aggressive. Fortunately, no restraining order was made and keepping Resident #4 and Resident #5 separated has taken care of the issue between them.	

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D 338	Continued From page 25 and Resident #4 did not have a call bell pendant on her person. Review of Resident #4's Resident Notes and Incident Reports since admission revealed: -Resident #4 was physically assaulted by Resident #5 on 02/13/18. -The assault resulted in a loss of consciousness. -Emergency Medical Services (EMS) was called to attend to Resident #4. -Resident #4 was taken to a local hospital for examination and treatment for her injuries. -Documented injuries included a facial hematoma on the right temple, and a concussion. Review of EMS notes dated 02/13/18 for Resident #4 revealed EMS notes documented Resident #4 had a loss of consciousness for 2 hours. Review of hospital Emergency Department (ED) discharge paperwork dated 02/13/18 for Resident #4 revealed: -Resident #4 was evaluated for a head injury and diagnosed with a mild concussion. -The reason for visit and primary diagnosis listed on the hospital discharge information was "assault victim." -Discharge instructions included, "have someone stay with you for the first 24 hours after your injury." Review of the police report for the incident on 02/13/18 revealed: -Officers responded to the facility on 02/13/18 at 11:10 pm for a report of simple assault. -Law Enforcement at was contacted by staff 11:00 pm when they were alerted to Resident #4's injuries. -Officers named resident #5 as the offender in the	D 338		

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D 338	Continued From page 26 assault. -Resident #5 laughed at officers and refused to speak to them until they threatened her with jail time. -Resident #4 was interviewed at the hospital and found to have injuries consistent with assault. -It was unknown whether Resident #5 assaulted Resident #4 with an object or her hands. -The incident was routed to the domestic violence unit for further investigation. Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 10:20 am revealed a black line was drawn with a marker or crayon on the floor separating the room into two sections. Interview on 02/14/18 at 10:30 am with Resident #4 revealed: -Resident #5 was her roommate. -She had just moved into the facility on 02/09/18. -Resident #5 had been verbally aggressive toward her since she moved in. -Resident #5 had drawn a line separating the room and told Resident #4 she could not cross it. -Resident #4 was unsteady on her feet and used a walker, which caused her to occasionally step over the line when trying to get to the restroom. -On 02/13/18, she and Resident #5 got into an argument regarding sharing the room. -Resident #5 then began throwing Resident #4's belongings in the floor. -When Resident #4 bent over to retrieve her belongings from the floor, Resident #5 hit her in the head with an unknown object. -Resident #4 was told by EMS she had lost consciousness for an unknown amount of time between 45 minutes to 2 hours. -Staff did not discover Resident #4 unconscious in her room, and Resident #5 did not report Resident #4's injuries to staff.	D 338		

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D 338	Continued From page 27 -When Resident #4 regained consciousness, she went to the nurse's station and requested assistance from staff. -Staff called 911 and law enforcement and EMS came to the facility. -She was transported by EMS to a hospital where she received a CAT scan and neurological testing to determine the seriousness of her head injury. -She returned to the facility by EMS around 4:00 am. -When she arrived back at the facility, staff tried to place her back in the same room with her roommate that assaulted her. -She complained and EMS told staff that she needed to be placed separately from the roommate. -Staff then moved her mattress from her bed and placed it on an empty box spring in an unoccupied room that was undergoing renovations. -She was placed in the spare room without access to any of her belongings. -Staff placed her wheelchair and walker across the room where she could not access them from her bed to be able to reach the restroom. -No staff checked on her again until morning when she got up for breakfast. -Resident #5 had bragged to her that she "always ran off her roommates." Observation on 02/15/18 at 12:25 pm of an interaction between a first shift MA and the Administrator revealed when asked about separating Resident #4 and Resident #5, the Administrator stated, "There's no restraining order so they don't have to be kept separate. If Resident #4 has a problem with Resident #5 coming to the dining room, then we'll deal with her (Resident #4)."	D 338		

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D 338	Continued From page 28 Observation on 02/15/18 at 3:00 pm revealed Resident #4 had been placed back in her original room with a new roommate, and Resident #5 had been removed from the room and placed in a room on a different section of the hall.	D 338		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 3 of 7 residents sampled (#7,#14, and #1) who were prescribed controlled substances including oxycodone, clonazepam, and Ativan (lorazepam). The findings are: Review of the facility's Counting and Returning of Controlled Substances Policy revealed "Each Controlled drug order shall have a Narcotic Administration Record supplied by the pharmacy or Assisted Living at the time of delivery of the controlled drug so that staff members shall document the administration of each dose as to date, time, and quantity. Review of the facility's Medication Administration	D 392		

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D 392	Continued From page 29 Record (MAR) policy revealed: -"All staff members administering medication shall indicated administered doses with his/her initials in the appropriate block on the MAR. -Staff should document the date, time, and outcome on the back of the MAR for medications given as needed (PRN). 1. Review of Resident #7's current FL2 dated 06/08/17 revealed diagnoses included arthritis, atrial flutter, and congestive heart failure. Review of Resident #7's Resident Register an admission date of 06/06/17. A. Review of Resident #7's physician's orders dated 10/05/17 revealed an order for oxycodone 10 mg (a narcotic pain reliever used to treat moderate to extreme pain) take 1 tablet by mouth 3 times a day for pain. Review of Resident #7's physician's orders dated 11/02/17 revealed a subsequent physician's order for oxycodone 10 mg (a narcotic pain reliever used to treat moderate to extreme pain) take 1 tablet by mouth 3 times a day, as needed for pain. Review of Resident #7's November 2017 Medication Administration Record (MAR) revealed: -An entry for Oxycodone 10 mg one tablet 3 times a day was transcribed on the MAR, scheduled for administration at 8:00 am, 2:00 pm, and 8:00 pm. Administration was documented from 11/01/17 to 11/09/17. -An entry for Oxycodone 10 mg one tablet 3 times a day was handwritten on the MAR and documented for administration as needed (prn) from 11/10/17 to 11/30/17. (Medications	D 392		

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D 392	Continued From page 30	D 392		

administered "prn" should have documentation for time and by whom administered, reason for administration, and effectiveness of the medication.)

Review of Resident #7's December 2017 Medication Administration Record (MAR) revealed oxycodone 10 mg one tablet 3 times a day was transcribed on the MAR, listed for administration as needed (prn) from 12/01/17 to 12/21/17.

Review of Resident #7's CSCS (Controlled Substance Count Sheet) for oxycodone 10 mg dispensed on 11/02/17 and documented for administration from 11/10/17 to 12/10/17 compared to Resident #7's November 2017 and December 2017 MARs revealed:
-There were 20 doses of oxycodone 10 mg documented as administered on the CSCS that were not documented on the November 2017 MAR.
-There were 9 doses of oxycodone 10 mg documented as administered on the CSCS that were not documented on the December 2017 MAR.

Examples of oxycodone 10 mg documented on the CSCS as administered but not documented on Resident #7's November 2017 MAR including time administered, reason for administering and effectiveness were as follows:
-Oxycodone 10 mg was documented on the CSCS on 11/10/17 at 8:00 pm as administered, but was not documented on the resident's MAR.
-Oxycodone 10 mg was documented on the CSCS on 11/11/17 at 12:30 pm as administered, but was not documented on the resident's MAR.
-Oxycodone 10 mg was documented on the CSCS on 11/13/17 at 8:00 am, 2:00 pm, and 8:00

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D 392	Continued From page 31 pm as administered, but was not documented on the resident's MAR. -Oxycodone 10 mg was documented on the CSCS on 11/18/17 at 8:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 10 mg was documented on the CSCS on 11/27/17 at 2:00 pm as administered, but was not documented on the resident's MAR. Examples of oxycodone 10 mg documented on the CSCS as administered but not documented on Resident #7's December 2017 MAR including time administered, reason for administering and effectiveness were as follows: -Oxycodone 10 mg was documented on the CSCS on 12/01/17 at 9:00 am as administered, but was not documented on the resident's MAR for time. -Oxycodone 10 mg was documented on the CSCS on 12/03/17 at 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 10 mg was documented on the CSCS on 12/05/17 at 8:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 10 mg was documented on the CSCS on 12/07/17 at 8:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 10 mg was documented on the CSCS on 12/09/17 at 8:30 pm as administered, but was not documented on the resident's MAR. Interview on 02/16/18 at 8:45 am with Resident #7 revealed: -She received her pain medication 3 times a day. -She had to request the pain medication for a while but now it was scheduled 3 times a day. -She was not aware of a time when she did not receive her pain medication 3 times in a day. Refer to interview on 02/16/18 at 8:11 a.m. with	D 392		

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D 392	Continued From page 32 the Staff Development Coordinator. Refer to interview on 02/16/18 at 8:35 a.m. with a medication aide (MA). Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS). Refer to interview on 02/16/18 at 11:10 a.m. with the Director of Nursing. Refer to interview on 02/16/18 at 2:35 pm with the Administrator. B. Review of Resident #7's physician's orders dated 11/27/17 revealed an order for clonazepam 0.5 mg (used to treat anxiety) one tablet twice daily as needed. Not to exceed 2 tablets in 24 hour period. Telephone interview on 02/15/18 at 11:10 am with the contract pharmacy revealed Resident #7 had clonazepam 0.5 mg one tablet twice a day, as needed, dispensed on 11/27/17 for a quantity of 60 tablets and on 12/21/17 for a quantity of 60 tablets. Review of Resident #7's November 2017 Medication Administration Record (MAR) revealed clonazepam 0.5 mg (used to treat anxiety) one tablet twice daily as needed for anxiety; Not to exceed 2 tablets in 24 hour period was transcribed on the MAR and documented for administration 5 times from 11/28/17 to 11/30/17. (Medications administered "prn" should have documentation for time and by whom administered, reason for administration, and effectiveness of the medication.) Review of Resident #7's December 2017 MAR	D 392		

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D 392	Continued From page 33 revealed clonazepam 0.5 mg one tablet 2 times a day, as needed for anxiety, was transcribed on the MAR and documented for administration as needed (prn) from 12/01/17 to 12/31/17. Review of Resident #7's January 2018 MAR revealed clonazepam 0.5 mg one tablet 2 times a day, as needed for anxiety, was transcribed on the MAR and documented for administration as needed (prn) from 01/01/17 to 01/26/17. Review of Resident #7's CSCS (Controlled Substance Count Sheet) for clonazepam 0.5 mg dispensed on 11/27/17 and documented for administration from 11/27/17 to 12/26/17 (at 8:00 am) compared to Resident #7's November 2017 and December 2017 MARs revealed: -There was 1 dose of clonazepam 0.5 mg documented as administered on the CSCS that was not documented on the November 2017 MAR. -There were 9 doses of clonazepam 0.5 mg documented as administered on the CSCS that were not documented on the December 2017 MAR. Examples of clonazepam 0.5 mg documented on the CSCS as administered but not documented on Resident #7's November 2017 and December 2017 MAR (including time administered, reason for administering and effectiveness) were as follows: -Clonazepam 0.5 mg was documented on the CSCS on 11/29/17 at 4:00 pm as administered, but was not documented on the resident's November 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/01/17 at 8:00 am and 4:00 pm as administered, but was not documented on the resident's December 2017 MAR.	D 392		

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D 392	Continued From page 34 -Clonazepam 0.5 mg was documented on the CSCS on 12/07/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/08/17 at 8:00 am as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/09/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 12/21/17 at 4:00 pm as administered, but was not documented on the resident's December 2017 MAR. Review of Resident #7's CSCS for clonazepam 0.5 mg dispensed on 12/21/17 and documented for administration from 12/26/17 to 01/24/18 (at 8:00 am) compared to Resident #7's December 2017 and January 2018 MARs revealed there were 3 doses of clonazepam 0.5 mg documented as administered on the CSCS that were not documented on the January 2018 MAR. Doses of clonazepam 0.5 mg documented on the CSCS as administered but not documented on Resident #7's January 2018 MAR (including time administered, reason for administering and effectiveness) were as follows: -Clonazepam 0.5 mg was documented on the CSCS on 01/14/18 at 8:00 am as administered, but was not documented on the resident's January 2018 MAR. -Clonazepam 0.5 mg was documented on the CSCS on 01/14/18 at 4:00 pm as administered, but was not documented on the resident's January 2018 MAR. -Clonazepam 0.5 mg was documented on the	D 392		

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	HAL034098	A. BUILDING: _____ B. WING _____	R-C 02/16/2018

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D 392	Continued From page 35 CSCS on 01/23/18 at 8:00 pm as administered, but was not documented on the resident's January 2018 MAR. Interview on 02/16/18 at 8:45 am with Resident #7 revealed: -She received her medication for anxiety 2 times a day. -She had to request the anxiety medication for a while but now it was scheduled 2 times a day. -She was not aware of a time when she did not receive her medication 2 times in a day. Refer to interview on 02/16/18 at 8:11 a.m. with the Staff Development Coordinator. Refer to interview on 02/16/18 at 8:35 a.m. with a medication aide (MA). Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS). Refer to interview on 02/16/18 at 11:10 a.m. with the Director of Nursing. Refer to interview on 02/16/18 at 2:35 pm with the Administrator. 2. Review of Resident #14's current FL2 dated 11/10/17 revealed diagnoses that included hypertension, diabetes mellitus, and chronic back pain. Review of Resident #14's Resident Register revealed an admission date of 05/08/17. Review of Resident #14's physician's orders revealed: -There was an order dated 11/17/17 for oxycodone 15 mg one tablet every 6 hours as	D 392		

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D 392	Continued From page 36 needed for pain (Do not use more than 3 tablets per day). -There was an order dated 12/11/17 for oxycodone 15 mg one tablet every 6 hours as needed for pain (Do not use more than 3 tablets per day). -There was an order dated 12/22/17 for oxycodone 15 mg one tablet 3 times a day as needed for pain (Do not use more than 3 tablets per day). -There was an order dated 01/22/18 for oxycodone 15 mg one tablet 3 times a day as needed for pain (Do not use more than 3 tablets per day). Telephone interview on 02/15/18 at 11:10 am with the contract pharmacy revealed Resident #14 had oxycodone 15 mg dispensed as follows: -On 11/17/17, oxycodone 15 mg one tablet every 6 hours as needed for pain (Do not use more than 3 tablets per day) was dispensed for quantity of 60. -On 12/11/17, oxycodone 15 mg one tablet every 6 hours as needed for pain (Do not use more than 3 tablets per day) was dispensed for quantity of 30. -On 12/22/17, oxycodone 15 mg one tablet 3 times a day as needed for pain (Do not use more than 3 tablets per day) was dispensed for quantity of 90. -On 01/22/18, oxycodone 15 mg one tablet 3 times a day as needed for pain (Do not use more than 3 tablets per day) was dispensed for quantity of 60. Review of Resident #14's CSCS (Controlled Drug Count Sheet) for oxycodone 15 mg for dispense date 11/17/17 administered from 11/22/17 to 12/12/17 compared to Resident #14's Medication Administration Records (MARs) revealed:	D 392		

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D 392	Continued From page 37 -There were 7 doses of oxycodone 15 mg documented as administered on the CSCS that were not documented on Resident #14's December 2017 MARs. -Oxycodone 15 mg was documented on the CSCS on 12/03/17 at 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/04/17 at 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/07/17 at 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/08/17 at 8:00 am and 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/10/17 at 4:30 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/11/17 at 8:00 pm as administered, but was not documented on the resident's MAR. Review of Resident #14's CSCS for oxycodone 15 mg for dispense date 12/11/17 administered from 12/12/17 to 12/23/17 compared to Resident #14's Medication Administration Records (MARs) revealed there were 11 doses of oxycodone 15 mg documented as administered on the CSCS that were not documented on Resident #14's December 2017 MARs. Examples were as follows: -Oxycodone 15 mg was documented on the CSCS on 12/15/17 at 8:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/19/17 at 8:00 am and 3:00 pm as administered, but was not documented on the resident's MAR.	D 392		

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D 392	Continued From page 38 -Oxycodone 15 mg was documented on the CSCS on 12/21/17 at 2:05 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/22/17 at 8:00 am and 2:00 pm as administered, but was not documented on the resident's MAR. -Oxycodone 15 mg was documented on the CSCS on 12/23/17 at 2:00 pm as administered, but was not documented on the resident's MAR. Review of Resident #14's CSCS for oxycodone 15 mg for dispense date 12/22/17 administered from 12/23/17 to 01/12/18 compared to Resident #14's MARs revealed there were 11 doses of oxycodone 15 mg documented as administered on the CSCS that were not documented on Resident #14's December 2017 and January 2018 MARs. Examples were as follows: -Oxycodone 15 mg was documented on the CSCS on 12/23/17 at 8:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Oxycodone 15 mg was documented on the CSCS on 12/26/17 at 8:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Oxycodone 15 mg was documented on the CSCS on 12/31/17 at 8:00 am and 2:00 pm as administered, but was not documented on the resident's December 2017 MAR. -Oxycodone 15 mg was documented on the CSCS on 01/08/18 at 8:00 pm as administered, but was not documented on the resident's January 2018 MAR. -Oxycodone 15 mg was documented on the CSCS on 01/10/18 at 2:00 pm as administered, but was not documented on the resident's January 2018 MAR.	D 392		

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D 392	Continued From page 39 -Oxycodone 15 mg was documented on the CSCS on 01/18/18 at 5:00 pm as administered, but was not documented on the resident's January 2018 MAR. Review of Resident #14's CSCS for oxycodone 15 mg for dispense date 01/22/18 administered from 01/23/17 to 02/14/18 compared to Resident #14's MARs revealed there were 16 doses of oxycodone 15 mg documented as administered on the CSCS that were not documented on Resident #14's January 2018 and February 2018 MARs. Examples were as follows: -Oxycodone 15 mg was documented on the CSCS on 01/23/18 at 6:00 pm as administered, but was not documented on the resident's January 2018 MAR. -Oxycodone 15 mg was documented on the CSCS on 01/26/18 at 8:25 am as administered, but was not documented on the resident's January 2018 MAR. -Oxycodone 15 mg was documented on the CSCS on 01/29/18 at 5:00 pm as administered, but was not documented on the resident's January 2018 MAR. -Oxycodone 15 mg was documented on the CSCS on 02/04/18 at 12:00 pm as administered, but was not documented on the resident's February 2018 MAR. -Oxycodone 15 mg was documented on the CSCS on 02/06/18 at 8:00 am as administered, but was not documented on the resident's February 2018 MAR. Interview on 02/16/18 at 9:00 am with Resident #14 revealed: -She received her pain medication 3 times a day. -Her pain medication was ordered prn (as needed) and she knew to request the medication.	D 392		

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D 392	Continued From page 40 -She was not aware of a time when she did not receive 3 tablets daily. Refer to interview on 02/16/18 at 8:11 a.m. with the Staff Development Coordinator. Refer to interview on 02/16/18 at 8:35 a.m. with a medication aide (MA). Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS). Refer to interview on 02/16/18 at 11:10 a.m. with the Director of Nursing. Refer to interview on 02/16/18 at 2:35 pm with the Administrator. 3. Review of Resident #1's current FL2 dated 04/06/17 revealed diagnoses included dementia, obstruction sleep apnea and back pain. Review of Resident #1's physician's orders dated 04/06/17 revealed an order for Ativan 0.5 mg (used to treat anxiety) take ½ tablet 0.25mg every 6 hours as needed for agitation not to exceed 2 tablets in 24 hours. Review of Resident #1's Controlled Substance Count Sheet (CSCS) for Ativan 0.5mg from 12/01/17 to 01/31/18 compared to Resident #1's Medication Administration Records (Mars) revealed: -There were 6 doses of Ativan 0.25mg documented as administered on the CDCS that were not documented on the MARs (12/16, 12/28, 1/14, 1/15, 1/21, and 2/13). -Ativan 0.25mg was documented on the CSCS on 12/16/18 at 8:00 am as administered, but was not documented on the resident's MAR.	D 392		

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D 392	Continued From page 41 -Ativan 0.25mg was documented on the CSCS on 12/28/18 at 8:30 am as administered, but was not documented on the resident's MAR. -Ativan 0.25mg was documented on the CSCS on 01/14/18 at 8:00 pm as administered, but was not documented on the resident's MAR. -Ativan 0.25mg was documented on the CSCS on 01/15/18 at 8:00 pm as administered, but was not documented on the resident's MAR. -Ativan 0.25mg was documented on the CSCS on 01/12/18 at 8:00 pm as administered, but was not documented on the resident's MAR. -Ativan 0.25mg was documented on the CSCS on 02/12/18 at 8:00 pm as administered, but was not documented on the resident's MAR. Interview on 02/15/18 at 5:15 pm with a medication aide (MA) revealed: -She administered medications to Resident #1. -When she pulled a PRN (as needed) controlled medication she initialed it on the MAR and then signed it out on the CSCS. -If the resident took the medication, she would then document on the MAR the time, medication and reason given. -If they did not take the medication, she would circle her initial and then document why the resident did not take the medication and dispose of it. -If they did take the medication, she would go back later and check on the effectiveness of it with the resident and document. -She had been taught in training and on her state test that she was supposed to document it. -She did not know why she had documented a prn medication on the CSCS but had not documented it on the MAR, "it was a mistake." Refer to interview on 02/16/18 at 8:11 am with the Staff Development Coordinator.	D 392		

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D 392	Continued From page 42 Refer to interview on 02/16/18 at 8:35 am with a medication aide (MA). Refer to interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MAS). Refer to interview on 02/16/18 at 11:10 am with the Director of Nursing. Refer to interview on 02/16/18 at 2:35 pm with the Administrator. --- Interview on 02/16/18 at 8:11 am with the Staff Development Coordinator revealed: -The MA's were supposed to initial on the front of the MAR, turn over on the back and document date, route and reason and then wait and go back to document the effectiveness. -They were supposed to sign the medication out in the CSCS book. -Sometimes they would document in the nursing notes that they gave it but it was not required. -She was responsible for checking the MARs to make sure there were no holes in them, and that MAs had documented the reason given and signed. -She had been trying to check on this daily. -She started this process in January (she did not recall the exact date). -She would check 1st shift right after the medication pass, so the MARs could be corrected while the staff were still there. -For other shifts and weekends, she would check them the next day and document the hole and leave it for the MA to fix on their next shift. -The MARs were not supposed to be filed in the medical record until all the holes were fixed. -She looked at the CSCS to make sure	D 392		

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D 392	Continued From page 43 medications had been signed out for. -She had not compared the CSCS to the MARs as part of her audit. Interview on 02/16/18 at 8:35 am with a MA revealed: -She started with the CSCS log, documenting the required information first. -If the resident took the medication she would then document it on the MARs. -She did not know of a system that was in place to audit the MARs, but they did have the CSCS sheet that was audited at the end of the week. -She had been trained on how to complete the documentation required for giving medication. -She was told at the end of the shift to check the MARs to make sure she had completed her documentation. Interview on 02/16/18 at 10:20 am with a Medication Aide/Supervisor (MA/S) revealed: -Medication aide (MA) staff should be logging medication out on the CSCS, then documenting administration on the residents' MAR, including completing the information on back of the MAR for reason, effectiveness, time of administration, and initials. -MAs were supposed to review the MARs for completeness prior to leaving their shift. -The facility did not have a system in place for routinely auditing the CSCS sheets compared to the residents' MARs for the "prn" medications. Interview on 02/16/18 at 11:10 am with the Director of Nursing revealed: -She expected the MAs to know how to document on the MARs and CSCS. -They were taught how as part of their orientation program. -She observed all new MAs to make sure they	D 392		

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D 392	Continued From page 44 were verifying the resident with the medication, signing off on the MARs and narcotic sheets. -The MARs were audited daily for holes by the Staff Development Coordinator. -Prior to the Staff Development Coordinator being assigned the responsibility to check the MARs daily, the Resident Care Coordinators (RCCs) were responsible for checking the MARs daily. -There was a shift communication sheet completed that showed who had MARs that needed to be finished. -The Staff Development Coordinator called the staff back in to correct when holes were found on the MARs. -Weekend problems were captured on Mondays. -They did not have any documentation prior to the new system (02/01/18) to show their chart audits. -They educated their staff by looking at medication errors and then gearing classes and training on the problem areas. -She did not know that the record audits did not include matching the MARs with the CSCS and would add this to their process. Interview on 02/16/18 at 2:35 pm with the Administrator revealed: -She came to the facility as Administrator the first week of January 2018. -She did not know medication aides were not documenting the administration of "prn" controlled medications properly. -The Resident Care Coordinator (RCC) and Special Care Unit Coordinator (SCUC) were responsible to managing medication administration including compliance with control drug documentation of administration.	D 392	In-services were done with medtech's on several issues including correctly documenting MAR for PRN meds given. These in-services will continue to be held both in orientation and on going by the DON. Resident Care Coordinator and Special Care Coordinator will monitor MARs for correct completion daily Medical Records will monitor MARs for correct completion before filling them monthly.	02/22/18 03/22/18
{D 421}	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds	{D 421}		

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{D 421}	Continued From page 45 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for 7 of 7 sampled residents (Resident #8, #9, #10. #11, #12, #18 and #17). The findings are: 1. Review of Resident #8's current FL2 dated 03/16/17 revealed diagnoses included chronic pain, glaucoma, depression, seizures, marijuana abuse, and tobacco abuse. Review of Resident #8's record revealed no signed documentation for permission by Resident #8 or designee for the facility to manage the resident's funds.	{D 421}		

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{D 421}	Continued From page 46 Interview on 2/14/18 at 10:15am with Resident #8 revealed: -The resident was private pay. -He received a little over $2000.00 a month deposited in his account. -When he went to get money from the Business Office Manager (BOM), in January 2018, he was told he only had $49 in his trust fund account. -He had glaucoma and he could not see how much money he was being given. -He had requested his family member go to the facility Business Office with him when he received his money so the family member could count the money for him, but the request was denied by the BOM. -He gave his family member permission to check on his account with the corporate office. -He was tired of the BOM always telling the resident there was no money in his account when the resident knew he was supposed to have money. -He did not understand why he was told he did not have money when he knew he should have more money available than what the BOM told him he had. -He had never signed any transaction because he had glaucoma and could not see to sign. -He only received money for when his family member took the resident shopping. Interview on 02/16/18 at 2:45 pm with a family member revealed: -Resident #8 was "constantly" calling him complaining about ne was being told he did not have any money in his account. -He had called the corporate office several times but no one would call him back. -He had been told by the new BOM to call corporate because they were the ones who handled the residents' funds.	{D 421}		

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	HAL034098	A. BUILDING: _____ B. WING _____	R-C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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{D 421}	Continued From page 47 -He was under the impression that the money issues were taken care of in November 2017 when someone from the state did an investigation. -He was getting a little frustrated because no one was returning his calls. -He had the resident's permission to get the needed information about his account. Review of Resident #8's Trust Account Ledger for December 2017 and January 2018 revealed: -The trust account ledger for December 2017 was unavailable for review. -The beginning balance for 01/01/18 was $118.79. -There was a deposit of $ 515.41 on 01/09/18. -There was a withdrawal of $100.00 on 01/09/18 for pharmacy. -There was a withdrawal of $430.00 on 01/10/18 (no reason documented for the withdrawal). -There was a withdrawal of $50.00 on 01/22/18 (no reason documented for the withdrawal). -An amount of $54.20 remaining would have been in the resident's trust account ledger for January 2018. -The ledger contained no signatures. Observation of Resident #8's Trust Account funds in the facility on 01/22/18 revealed that $54.20 was on hand for the resident to receive. Based on review of Resident #8's account balance and observation of the account funds available on hand, an accurate accounting of Resident #8's funds could not be calculated due to the missing December 2017 ledger . Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to the Trust Funds Account of Resident #8 revealed:	{D 421}		

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{D 421}	Continued From page 48 -She was unable to complete the audit for Resident #8 because the trust fund account ledger for December 2017 and January 2018 was not located. -The resident was due $1400.00 from the previous year when without authorization, an amount of $200.00 was being deposited into Trust Fund Account instead of the normal $600.00. -There was no documentation of authorization of this deposit change. -The $1600.00 would also be reimbursed to Resident #8's Trust Account Fund. -They were trying to prevent the resident's family member from stealing his money. -There was no documentation of Resident #8 complaining of his family member stealing his money. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 2. Review of Resident #9's current FL2 dated 03/09/17 revealed diagnoses included seizures, partial epilepsy, hypertension, diabetes, history of colostomy, gunshot wounds post exploratory laparotomy, history of subdural hematoma, traumatic brain injury, hyponatremia, hyperduibinemia, altered mental status related to seizures. Review of Resident #9's record revealed no	{D 421}		

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{D 421}	Continued From page 49 signed documentation for permission by Resident #9 or designee for the facility to manage the resident's funds. Interview on 02/14/18 at 10:30 am with Resident #9 revealed: -He received Medicaid funds. -He was told last month by the BOM that he did not have any money in his trust account. -He was offered $10 but refused to take it. -He was given paperwork to sign but he refused to sign the paperwork. -He did not remember what the paperwork was for. -At the end of the January 2018, he was given $86.00. -He did not remember ever being told that he did not have money in his account. -He only received $66.00 each month. Review of Resident #9's Trust Fund Account Ledger for December 2017 and January 2018 revealed: -The beginning balance for December 2017 was zero. -There was a deposit of $67.00 on 12/07/17. -There was a withdrawal of $9.60 on 12/07/17 for the pharmacy bill. -There was a withdrawal of $57.40 on 12/08/17 (no reason documented for the withdrawal). -The beginning balance for January 2018 was zero. -There was a deposit $66.00 on 01/16/18. -There was a withdrawal of $66 on 01/16/18 (no reason documented for the withdrawal). -The ledger contained no signatures. Observation of Resident #9's Trust Account Funds in the facility on 02/14/18 revealed that $0.00 was on hand.	{D 421}		

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{D 421}	Continued From page 50 Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to the Trust Funds Account of Resident #9 revealed: -The resident asked for money from his account in January 2018. -He was told he did not have any funds but was offered $20.00, but he refused to take the money. -The following month, February 2018, $111.00 was deposited into his trust fund account. -There was no documentation for the deposit. -She did not know about the deposit to Resident #9's account. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 3. Review of Resident #10's current FL2 dated 02/08/18 revealed diagnoses which included diabetes mellitus 2, hyperlipemia, Vitamin B12 Deficiency, Vitamin D deficiency, insomnia, depression, and urinary incontinence. Review of Resident #10's record revealed no signed documentation for permission by Resident #10 or designee for the facility to manage the resident's funds. Interview on 02/14/18 at 11:00 am with Resident #10 revealed: -The resident received Medicaid funds. -She had not experienced any issues with getting	{D 421}		

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{D 421}	Continued From page 51 money out of her account. -Whenever she made a request for funds she was always able to get her requested amount. -She only received $66.00 per month. Review of Resident #10's Trust Fund Account Ledger for December 2017 and January 2018 revealed: -The beginning balance for December 2017 was zero. -There was a deposit of $66.00 on 12/07/17. -There was a withdrawal of $5.00 for pharmacy bill on 12/07/17. -There was a withdrawal of $50.00 on 12/08/17 (no reason documented for the withdrawal). -The ending balance for December 2017 was $11.00. -The beginning balance for January was recorded as $0.00. -There was a deposit of $67.00 on 01/09/18. -There was a withdrawal of $5.00 on 01/09/18 for pharmacy. -There was a withdrawal of $61.00 on 01/10/18 (no reason documented for the withdrawal). -The ending balance was $0.00. -The ending balance should have reflected an amount of $12.00 remaining in the account. -The ledger contained no signatures. Review of Resident #10's Trust Account Ledger on 02/14/18 revealed: -There was a discrepancy of $12.00 for the resident trust account for January 2018. -The amount of $12.00 was not accounted for. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to the Trust Funds Account for Resident #10 revealed: -There was a balance of $11.00 for January. -The only explanation was poor math skills.	{D 421}		

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{D 421}	Continued From page 52 -The dollar amounts were not added correctly. -The Resident's Trust Fund Account would be adjusted to reflect the $12.00 in the account. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 4. Review of Resident #11's current FL2 dated 12/12/17 revealed diagnoses included otalgia of left ear, sensoinural hearing loss of both ears, edema of both legs, recurrent UTI, chronic abdominal pain, microcytia anemia, hepatitis, gastroparesis, debility, anemia of chronic disease, atomic neurogenic bladder and vascular disease. Review of Resident #11's records revealed no documentation for permission by Resident #11 or designee for the facility to manage the resident's funds. Interview on 02/14/18 at 11:45 am with Resident #11 revealed: -She was on Medicaid. -She had not experienced any issues with her trust fund account. -She was always able to get money whenever she made a request. -She only gets $66.00 per month. Review of Resident #11's Trust Account Ledger on 02/14/18 revealed:	{D 421}		

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{D 421}	Continued From page 53 -The beginning balance for December 2017 was $1.00. -There was a deposit of $66.00 made on 12/07/17. -There was a withdrawal of $10.00 made on 12/07/17 for the pharmacy. -There was a withdrawal of $40.00 made on 12/14/17 (no reason documented for the withdrawal). -There was a withdrawal of $40.00 made on 12/19/17 (no reason documented for the withdrawal). -The ending balance was $0.00. -The beginning balance of January 2018 was $0.00. -There was a deposit of $66.00 made on 01/09/18 -There was a withdrawal of $5.00 made on 01/09/18 for the pharmacy. -There was a withdrawal of $30.00 made on 01/10/18 (no reason documented for the withdrawal). -There was a withdrawal of $31.00 made on 01/16/18 (no reason documented for the withdrawal). -The ending balance was $0.00. -The ending balance should have reflected an amount of -$23.00 in the account for December 2017 and January 2018. -The ledger contained no signatures. Observation on Trust Fund Account for December 2017 revealed there was a balance of $1.00. -Resident #11 only had one deposit for the entire month of $66.00 on 12/07/17. -The resident had a total of $99.00 in withdrawals for the month of December 2017. -There was no documentation to show how resident was able to withdraw more money from the trust account than was deposited into the trust	{D 421}		

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{D 421}	Continued From page 54 account. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to Trust Account Funds for Resident #11 revealed she had no explanation of how Resident #11 was able to withdraw $99.00 from the Trust Funds Account in December 2017, when there was only $57.00 available in the account. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 5. Review of Resident#12's current FL2 dated 05/08/17 revealed diagnoses included right side lacunar infraction, neurocognitive deficit, diabetes mellitus 2, iron deficiency anemia, depression, tobacco abuse and neuropathic pain. Review of Resident #12's record revealed no signed documentation for permission by the Resident #12 or designee for the facility to manage the resident's funds. Interview on 02/14/18 at 11:55 am with Resident #12 revealed: -She received Medicaid funds. -She did not get any money from the facility. -She did not know why she did not get any money. -She had been in the facility since 2016. -She was told by the facility she would get $66.00	{D 421}		

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{D 421}	Continued From page 55 per month. -The rest of her money would be used to pay for her room and board. Review of the residents' Trust Funds Account ledgers revealed there were no ledgers set up for Resident #12. Interview on 02/16/18 at 11:30 am with the local county Medicaid Supervisor revealed; -Resident #12 was entitled to the $66.00 per month. -Resident #12 had a 10% withholding of her Social Security payment due to a previous overpayment. -There was a form that could had been submitted that would have made sure the facility received their funds. -The facility was responsible for returning the resident her funds. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to Trust Funds Account for Resident #12 revealed: -The resident was not getting her $66.00 due to the over payment that was being taken out of her Social Security Supplement (SSI) check. -Ten percent of her check was going towards the over payment. -The overpayment prevented the resident from being able to pay the full Medicaid amount for her room. -To make up the difference, the facility decided to keep the entire $66.00 that the resident was entitled to. -She did not ask resident if she would voluntarily allow the facility to take a portion of the $66.00 to make up the difference for the shortage. -The difference was $8.00. -She did not know there was a form the Medicaid	{D 421}		

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{D 421}	Continued From page 56 worker could have sent to Social Security to have the over- payment reduced and the SA payment increased to make up the difference -She knew Resident #12 had not received personal money in over a year. Interview on 02/15/18 at 3:55 pm of the Administrator revealed she did not feel the facility should have to reimburse Resident #12 for the $66.00 she had not received due to recoupment of over payment from Social Security. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 6. Review of Resident #18's current FL2 dated 2/16/17 revealed diagnoses included Alzheimer's disease, debility, hyperlipidemia, Vitamin B12 deficiency, and paranoid schizophrenia. Review of Resident #18's record revealed no documentation for permission by the resident or designee for the facility to manage the residents funds. Interview on 02/16/18 at 8:17 am with Resident #18's legal guardian revealed: -Resident #18 was private pay. -She had not been the guardian very long. -Everything was already in place when she was assigned the guardian case. -She knew there was another account set up	{D 421}		

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{D 421}	Continued From page 57 through a bank that paid the room/board payments for the resident. -She did not know who deposited money into the Resident Trust Fund Account. -She only had access to the Social Security benefits funds. -She paid all of the medical and dental bills. -She had asked the BOM, in the past, whether Resident #18 had any needs and was told no. -It seemed the resident was being over charged because of his trust account. Review of Resident #18 Trust Account Fund ledger on 02/14/18 revealed: -The beginning balance for December 2017 was $104.00. -There were no deposits made for the month of December 2017. -There was a withdrawal of $20.00 made on 12/11/17 (no reason documented for the withdrawal). -There was a withdrawal of $5.00 made on 12/13/17 (no reason documented for the withdrawal).. -There was a withdrawal of $10.00 made on 12/19/17 (no reason documented for the withdrawal).. -There was a withdrawal of $20.00 made on 12/26/17 (no reason documented for the withdrawal). -The ending balance for December 2017 should have reflected an amount of $49.00 remaining in the account. -The beginning balance for January 2018 was $69.00. -There was no documentation of any withdrawals being made in the month of January 2018. -The ledger contained no signatures. Interview on 02/15/18 at 8:35 am with a	{D 421}		

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{D 421}	Continued From page 58 Corporate Office Manager in reference to Trust Funds Account for Resident #18 revealed she did not know the source of resident's personal funds deposits. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the Administrator. Refer to review of a police report dated 02/05/18. 7. Review of Resident #17's current FL2 dated 08/29/17 revealed diagnoses included chronic urinary tract infection, breast cancer, diabetes mellitus, and chronic artery disease. Review of Resident #17's record revealed the resident passed away on 12/14/17. Review of Resident #17 Trust Account Fund ledger for December 2017 revealed: -The beginning balance for December 2017 was $0.00. -There was no documentation of any deposits made into the account during the month of December 2017. Interview on 02/16/18 at 9:50 am with the Power of Attorney (POA) for Resident #17 revealed: -He knew there were some "discrepancies" with the trust account funds. -The discrepencies referred to the facility would tell him the Resident owed money and when the POA requested an account of the resident's funds he was never given an account statement, and he	{D 421}		

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{D 421}	Continued From page 59 felt the facility was avoiding him. -He had made requests to have a copy of resident's trust account but was not provided with one. -He knew an audit was supposed to have been completed per the co-owner. -He was assured by the co-owner that an independent audit would be completed by the 24th of November 2017. -He was told he would get a copy of the audit which was to be completed by an independent contractor. -He had been unable to make contact with the co-owner about the audit. -He had never received a final calculation of what monies that may be owed to the resident. -He had tried on numerous occasions to speak with either the owner or co-owner but they would not respond. Interview on 02/15/18 at 8:35 am with a Corporate Office Manager in reference to Trust Funds Account for Resident for #17 revealed: -Resident #17 had passed away. -She did not know there continued to be issues surrounding the resident's fund account. -She had not had any access to the account for Resident #17. -From her understanding, the conflicts with the trust account funds were being handled by the controller of the corporate office prior to her termination. Refer to interview on 02/14/18 at 12:15 pm the Owner of the facility. Refer to interview on 02/15/18 at 8:35 am with a Corporate Office Manager. Refer to interview on 02/15/18 at 4:00 pm with the	{D 421}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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{D 421}	Continued From page 60 Administrator. Refer to review of a police report dated 02/05/18. Interview on 02/14/18 at 11:50 am with the Owner of the facility revealed: -She was going to hire her own independent CPA to complete an audit. -She did not know of the results of the audit that was supposed to have been conducted in November 2017. -She had no knowledge of the audit and had nothing to do with it. -As soon as she could find the most appropriate CPA she would have the audit completed. Interview on 02/14/18 at 8:35 am with a Corporate Office Manager revealed: -There was a situation where the Business Office Manager (BOM) in the facility had been arrested for embezzling funds from the Residents Trust Accounts. - She was told in November 2017, an independent audit was ordered by the co-owner. -She was later told the audit was never completed. -She was told to remove all of the trust account ledgers and complete an audit at the Corporate Office. -Monies from private pay residents and Medicaid residents were placed in the same Trust Funds Accounts. -There was no way to determine exactly which residents had their accounts compromised. -Many entries of withdrawals were made on different days as compared with the trust account ledgers. -Copies of the residents' trust account ledgers before the audit and after the audit were provided.	{D 421}		

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{D 421}	Continued From page 61 -During the time of the embezzlement she did not have access to the trust fund accounts. -There was a spread sheet for all of the trust funds transactions, but she could not access it at that time. -The Controller of the Corporate Business Office no longer worked for the company. -The Controller of the Corporate Business Office was the only person with total access to the trust fund accounts. Interview on 02/15/18 at 4:00 pm of the Administrator revealed: -She was not the Administrator of the facility during the time in November 2017. -She had "inherited" the many issues the facility was having. -She was told by the co-owner the audit was never completed. -She was told by the co-owner the audit was to be on only 2 residents' trust funds account. -If there were not any problems with the two accounts the co-owner was going to assume the other account funds were okay. -She would personally keep abreast of the Resident Trust Accounts funds to ensure these same issues do not happen again. Review of a police report dated 02/05/18 revealed: -The BOM was arrested at the facility on 02/05/18 for using the residents' trust funds account money to make a drug purchase. -The incident actually happened on February 03, 2018. The Police was called by one of the staff that was on duty. -The Police searched the BOM with her permission and found the facility bank bag along with cash that she admitted came from the facility.	{D 421}		

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{D 421}	Continued From page 62 -She had only used a small amount of the trust fund account money, that was in the safe, and the other larger portion was still in the safe. After reviewing the safe there was only $4.00 found to have been left in the safe. _____ The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for 7 of 7 sampled residents (Resident #8, #9, #10. #11, #12, #18 and #17). The facility's failure to provide the residents' with an accurate accountability and access to funds for residents to make purchases, and billing transactions was detrimental to the safety and welfare of the residents and constitutes an Uabated Type B Violation. _____ The facility provided a Plan of Protecton on 02/15/18 as follows: -The Corporate Business Office will audit all ledgers of residents' funds for accuracy of credits received versus charges applied. -Correct balances will be available at the end of each month. -On-going audits will continue by the Corporate Business Office at the end of each month to ensure beginning balances each month, for each resident is correct. -The Corporate Business Office Manager will be responsible for auditing the residents' funds and assuring compliance with the residents' funds requirement.	{D 421}	Complete audit was completed and is attached per POP. A new business office manager is in place and corporate employees are auditing Resident Trust Account each month. Audit will be reviewed by the Administrator each month.	2/23/18
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	{D912}		

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{D912}	Continued From page 63 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 observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations related to Health Care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 7 sampled residents (Resident #5) related to physically and verbally aggressive behaviors toward staff, and other residents, and outside agency staff members. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all residents were free from exploitation related to Accounting for Residents' Personal Funds.	D914		

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D914	Continued From page 64 The findings are: Based on observations, interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and signed by the resident with two witnesses' signatures at least monthly verifying accuracy of the disbursement of personal funds for 7 of 7 sampled residents (Resident #8, #9, #10. #11, #12, #18 and #17). [Refer to Tag 0421, 10A NCAC 13F .1104(c) Accounting For Residents' Personal Funds (Unabated Type B Violation)].	D914		
D921	G.S. 131D-21(11) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 11. To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents had the right to voice complaints and be free of retaliation as evidenced by verbal threats by the Administrator to discharge Resident #4 if a restraining order was filed against Resident #5 who physically assaulted Resident #4 causing a head injury and concussion. The findings are: Review of Resident #4's current FL2 dated 02/02/18 revealed:	D921		

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D921	Continued From page 65 -Diagnoses included degenerative disc disease of the cervical spine, cerebrovascular accident with hemiplegia, multi-infarct dementia, rheumatoid arthritis, chronic regional pain syndrome, and an abnormal gait. -The resident was intermittently disoriented, semi-ambulatory, and incontinent of bowel and bladder. Review of Resident #4's Resident Register revealed an admission date of 02/09/2018. Review of Resident #4's Resident Notes and Incident Reports since admission revealed: -Resident #4 was physically assaulted by Resident #5 on 02/13/18. -The assault resulted in a loss of consciousness. -Emergency Medical Services (EMS) was called to attend to Resident #4. -Resident #4 was taken to a local hospital for examination and treatment for her injuries. -Documented injuries included a facial hematoma on the right temple, and a concussion. Review of hospital Emergency Department (ED) discharge paperwork and EMS notes dated 02/13/18 for Resident #4 revealed: -Resident #4 was evaluated for a head injury and diagnosed with a mild concussion. -The reason for visit and primary diagnosis listed on the hospital discharge information was "assault victim." Interview on 02/14/18 at 10:30 am with Resident #4 revealed: -Resident #5 was her roommate. -She had just moved into the facility on 02/09/18. -Resident #5 had been verbally aggressive toward her since she moved in. -Resident #5 had drawn a line separating the	D921		

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D921	Continued From page 66 room and told Resident #4 she could not cross it. -Resident #4 was unsteady on her feet and used a walker, which caused her to occasionally step over the line when trying to get to the restroom. -On 02/13/18, she and Resident #5 got into an argument regarding sharing the room. -Resident #5 then began throwing Resident #4's belongings in the floor. -When Resident #4 bent over to retrieve her belongings from the floor, Resident #5 hit her in the head with an unknown object. -Resident #4 was told she had lost consciousness for an unknown amount of time between 45 minutes to 2 hours. -Staff did not discover Resident #4 unconscious in her room, and Resident #5 did not report Resident #4's injuries to staff. -When Resident #4 regained consciousness, she went to the nurse's station and requested assistance from staff. -Staff called 911 and law enforcement and EMS came to the facility. -She was transported by EMS to a hospital where she received a CAT scan and neurological testing to determine the seriousness of her head injury. -She returned to the facility by EMS around 4:00 am. -When she arrived back at the facility, staff tried to place her back in the same room with her roommate that assaulted her. -She complained and EMS told staff that she needed to be placed separately from the roommate. -Staff then moved her mattress from her bed and placed it on an empty box spring in an unoccupied room that was undergoing renovations. -She was placed in the spare room without access to any of her belongings. -Staff placed her wheelchair and walker across	D921		

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D921	Continued From page 67 the room where she could not access them from her bed to be able to reach the restroom. -Resident #5 had bragged to her that she "always ran off her roommates." Observation of Resident #4 and Resident #5's shared room on 2/14/18 at 10:20 am revealed a black line appearing to be drawn with a marker or crayon on the floor separating the room into two sections. Second interview on 02/14/18 at 11:30 am with Resident #4 revealed: -She was told by the Administrator that if she filed a restraining order she would be removed from the facility for "causing trouble." -She had been harassed at breakfast by Resident #5 who approached her table while she was eating. -She told staff Resident #5 was not supposed to be near her, and left the dining room. -She felt she was threatened by the Administrator, who told her she should never have gone to the ED and that Resident #4 was "trouble." Review of Resident #5's current FL2 dated 03/22/17 revealed: -Diagnoses included multiple falls, impaired mobility, and deep vein thrombosis. -She was listed as "constantly oriented." -She was non-ambulatory and required assistance with bathing, dressing, and feeding. -She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed an admission date of 12/02/16. Review on 02/15/18 of Resident #5's Resident Notes revealed:	D921		

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D921	Continued From page 68 -An entry dated 02/10/18 documented arguments between Resident #5 and Resident #4, her new roommate. Staff were called to the room on multiple occasions. -An entry dated 02/13/18 documented Resident #5's physical aggression toward Resident #4. Resident #5 refused to go to the hospital for psychiatric evaluation. -An entry dated 02/14/18 documented Resident #5 was finally transported via EMS to a hospital for a psychiatric evaluation. -An entry dated 02/15/18 documented Resident #5 had been moved from her previous room to a new room with a different roommate. Review of the police report for the incident on 02/13/18 revealed: -Officers responded to the facility on 02/13/18 at 11:10 pm for a report of simple assault. -Staff called law enforcement at 11:00 pm when they were alerted to Resident #4's injuries. -Officers questioned named resident as the offender in the assault. -Resident #5 laughed at officers and refused to speak to them until they threatened her with jail time. -Resident #4 was interviewed at the hospital and found to have injuries consistent with assault. -It was unknown whether Resident #5 assaulted Resident #4 with an object or her hands. -The incident was routed to the domestic violence unit for further investigation. Interview on 02/16/18 at 9:35 am with Resident #4 revealed: -She was told by the Administrator that if she filed a restraining order against Resident #5, the facility would discharge her and place her somewhere else rather than moving Resident #5. -She was told by the Administrator she would be	D921		

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D921	Continued From page 69	D921		

discharged if she "caused trouble" by pursuing charges against Resident #5.
-She had decided not to press charges or file a restraining order because she had just moved to the facility and did not want to move again.
-She was afraid of retaliation by staff for talking about this to anyone.

Interview on 02/14/18 at 10:20 am with Resident #5 revealed:
-She had several different roommates since moving to the facility.
-She was being accused of hitting her roommate (Resident #4) with a crystal salt shaker that she had hidden under her refrigerator, but the roommate "made it all up".
-She did not know how Resident #4 was injured because Resident #5 "was asleep."

Observation on 02/15/18 at 12:25 pm of an interaction between a first shift MA and the Administrator revealed:
-The first shift MA requested to feed Resident #5 in her temporary room per Resident #5's request to avoid the dining room.
-When asked about separating Resident #4 and Resident #5, the Administrator stated, "There's no restraining order so they don't have to be kept separate. If Resident #4 has a problem with Resident #5 coming to the dining room, then we'll deal with her (Resident #4)."

Interview on 02/16/18 at 10:20 am with a first shift Medication Aide (MA) revealed she knew of Resident #5's frequent behaviors and had written several behavior reports before to send to the PCP.

Interview on 02/16/18 at 9:45 am with Resident #5's primary care provider (PCP) revealed:

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D921	Continued From page 70 -He did not know Resident #5 had had any previous behavior issues before being contacted by the hospital on 2/14/18. -He did not have any documentation that staff at the facility had notified him of any incidents other than the unexplained bruised eye. -He had last seen Resident #5 in January 2018 and had not been informed of any aggressive behaviors. -Resident #5 had never mentioned any of her altercations with staff or other residents and appeared to be lucid and healthy for her age. -He had given a verbal order for Depakote, used to treat agitation, at bedtime to begin immediately, until he could see Resident #5 during his facility visit on Wednesday, 02/28/18. Interview on 02/16/18 at 10:45 am with the Administrator revealed: -If Resident #4 filed a restraining order against Resident #5, she would have to find placement for Resident #4 at another facility because "she had to ensure a safe and orderly discharge and no other facility would take Resident #5 if they knew her history." -Staff's normal response to Resident #5's behaviors was to redirect her or remove her from the situation. -Her plan now was to keep Resident #4 and Resident #5 separated and have Resident #5 "medicated" to avoid further issues. -She had been contacted by the hospital after Resident #5 arrived and told that the resident's PCP informed the hospital staff Resident #5 did not have any mental health issues, so they did not perform a psychiatric evaluation. -Resident #5 was brought back to the facility because "she didn't have a choice to send her anywhere else." -She had moved residents around to separate	D921		

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D921	Continued From page 71 Resident #4 and Resident #5 into rooms in two different areas of the facility.	D921		