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MAGNOLIA HOUSE RETIREMENT CENTER	1115 CARTHAGE STREET SANFORD, NC 27330

(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 Lee County the Department of Social Services conducted an annual survey, follow up survey and complaint investigation on 05/22/2018 - 05/25/2018 and 05/29/2018-05/31/2018 with an exit conference conducted by telephone on 05/31/2018. The Lee County Department of Social Services initiated the complaint investigation on 05/21/2018.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 4 staff sampled (Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to having direct contact with residents while performing incidental maintenance work and management oversight in resident areas. The findings are: Interview with Staff D on 05/22/2018 at 12:15 p.m. revealed: -He was the head maintenance person and was over the current maintenance person who had been employed by the facility for about 2 weeks. -He did not work at the facility, however certain	D 137		

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days he brought needed supplies and items and then left the facility.
-He came to the facility "every now and then" and walked through the facility, however, the head of housekeeping and the maintenance person done most of the work.

Interview with the Administrator on 05/25/2018 at 11:52 a.m. revealed:
-Staff D was an owner of the facility and had no title or position.
-Staff D did not have a personnel file.

Telephone interview with the Administrator on 05/30/2018 at 11:56 a.m. revealed it was the human resource person's responsibility to assure a Health Care Personnel Registry (HCPR) screenings had been completed on all employees.

Telephone interview with Staff D on 05/30/2018 at 12:07 p.m. revealed:
-He had never had a HCPR screening done that he knew of.
-The current maintenance staff had recently came back to work as an employee at the facility.
-He was doing maintenance work for the facility during the time the facility had a vacant maintenance position which was about a month ago around March or April of 2018.
-He was fixing whatever, fixing simple things during that time.
-He also performed safety checks and would repair such things as toilets running or stopped up if observed.

Review of a faxed copy of Staff D's Health Care Personnel Registry verification on 05/30/2018 revealed:
-The verification had been completed on

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D 137	Continued From page 2 05/30/2018. -There were no pending investigations or substantiated findings.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 1 of 4 staff sampled (Staff D) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents while performing maintenance job responsibilities, providing ongoing walk-throughs of the facility and management oversight in resident areas. The findings are: Interview with Staff D on 05/22/2018 at 12:15 p.m. revealed: -He was the head maintenance person and was over the current maintenance person who had been employed by the facility for about 2 weeks. -He did not work at the facility, however certain days he brought needed supplies and items and then left the facility. -He came to the facility "every now and then" and walked through the facility, however, the head of housekeeping and the maintenance person done most of the work.	D 139		

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D 139	Continued From page 3 Interview with the Administrator on 05/25/2018 at 11:52 a.m. revealed: -Staff D was an owner of the facility and had no title of position. -Staff D did not have a personnel file. Telephone interview with the Administrator on 05/30/2018 at 11:56 a.m. revealed it was the Administrator and the human resource person's responsibility to assure a criminal background check had been completed on all employees. Telephone interview with Staff D on 05/30/2018 at 12:07 p.m. revealed: -He was not sure if he had a criminal background check done before unless it was with the previous three other jobs he had his whole life. -The current maintenance staff had recently came back to work as an employee at the facility. -He was doing maintenance work for the facility during the time the facility had a vacant maintenance position which was about a month ago around March or April of 2018. -He was fixing whatever, fixing simple things during that time. A second telephone interview with the Administrator on 05/30/2018 at 1:37 p.m. revealed she thought Staff D had a criminal background check done before and would check to see if one was done. Review of a faxed copy of Staff D's criminal background check on 05/31/2018 revealed the request was made by the Administrator, requested on 05/30/2018 at 2:48 p.m. and the status of the criminal background check was completed and reviewed. The facility failed to assure Staff D who had a	D 139		

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D 139	Continued From page 4 criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents while performing maintenance job responsibilities. This failure was detrimental to the safety and welfare of the residents by not verifying a criminal background check and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/2018 with an addendum per a telephone conversation on 05/31/2018 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2018.	D 139		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 1 residents (#2) sampled with known behaviors of drinking hand sanitizer and the resident's own urine. The findings are:	D 270		

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D 270	Continued From page 5 Review of Resident #2's current FL-2 dated 01/30/18 revealed diagnoses included dementia with behavior disturbances, psychogenic polydipsia, hyponatremia, schizophrenia, inhalant use disorder, cocaine use disorder, and alcohol use disorder. Review of Resident #2's care plan dated 04/26/18 revealed: -The resident was sometimes disoriented. -The resident had significant memory loss and must be directed. -The resident was assessed to have wandering behavior. -The resident currently received medications for mental illness/behaviors. -The resident currently received mental health services. -The resident's documented social/mental health history was "resident drinks any fluid. Staff is to maintain routinely to prevent ingestion." Review of Nurses Notes for Resident #2 revealed an undated staff note documented "stole the hand sanitizer and took it to his room and drank some ... immediately called EMS [Emergency Medical Services] for help." Review of a local hospital discharge instruction for Resident #2 dated 04/06/18 revealed: -On 04/06/18, Resident #2 was seen in the emergency room for chief complaint of drank hand sanitizer and diagnosed with alcohol intoxication. The resident was discharged on 04/06/18. Interview with the Special Care Unit Coordinator (SCUC) on 05/23/18 at 11:45am revealed: -Resident #2 went to the hospital on 04/06/18	D 270		

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because staff smelled sanitizer when staff walked by Resident #2 and staff found an empty sanitizer bottle in Resident #2's room.
-Resident #2 returned to the facility after being seen in the hospital emergency room.

Interview with the SCUC on 05/23/18 at 5:40pm revealed:
-There was a bottle of sanitizer missing from the medication cart on 04/06/18.
-The missing bottle of sanitizer was either 32 - 48 ounces and was about ¼ full.
-The first place the MA [named] looked was in Resident #2's room and found the empty sanitizer bottle under Resident #2's bed.
-The guardian and physician assistant were notified that Resident #2 was sent out to the hospital for evaluation.

Review of Nurses Notes for Resident #2 revealed on 04/15/18, staff documented "sent pt [patient] to the ER [emergency room] due to drinking mouthwash. Was really out of it."

Review of a local hospital discharge instruction for Resident #2 dated 04/15/18 revealed:
-On 04/15/18, Resident #2 was seen in the emergency room for chief complaint of drank mouthwash and diagnosed with alcohol intoxication.
-The resident was discharged on 04/15/18.

Review of Nurses Notes for Resident #2 revealed on 04/24/18, staff documented "drinking sanitizer, send out again."

Review of a local hospital discharge instruction for Resident #2 dated 04/24/18 revealed:
-On 04/24/18, Resident #2 was seen in the emergency room for chief complaint of overdose

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and diagnosed with alcohol intoxication, non-toxic overdose.
-The resident was noted to drink as much as 16 ounces of hand sanitizer.
-Symptoms were of moderate intensity.
-The resident was discharged back to the facility on 04/24/18 with instructions to "avoid patient has access to these types of things that he is getting intoxicated on."

Review of the facility personal care and supervision policy revealed:
-The facility would provide personal care to residents according to residents care plan and attend to any other personal care needs residents may be able to attend to for themselves.
-The facility would provide supervision of residents in accordance with each residents assessed needs, care plan and current symptoms.
-The facility staff would respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedure.

Interview with a housekeeping staff on 05/23/18 at 4:45pm revealed:
-Staff kept an eye on Resident #2. "They observe him, they really do."
-Resident #2 got all the water he needed.
-Two or three months ago, nursing staff alerted housekeeping staff about Resident #2 drinking his own urine.
-A personal care aide (PCA) said Resident #2 would drink anything, but he was not sure who the PCA was.
-He thought Resident #2 had been seen dipping liquids from the commode.
-Resident #2 would go into the trash cans in the halls and remove bottles and cans, and the

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resident would "pop up with cans and cups".
-Resident #2 paced back and forth and liked to be alone.
-Resident #2 stayed "pretty much" on the hall.
-The housekeeping cart was always kept in view of the housekeeping staff.

Interview with the same housekeeping staff on 05/25/2018 at 8:43am revealed:
-Resident # 2 liked to drink water and played in the trash cans a lot.
-All staff had to keep an eye on Resident #2 because he would go through trash cans and could not have a trash can in his room.
-He caught Resident #2 dipping water out of the toilet bowl in his bathroom room using a disposable cup just last week during the morning hours.
-He did not witness Resident #2 drinking any of the water from the toilet bowl and told the resident to throw the cup in the trash. Resident #2 threw the cup in the trash and the head of housekeeping emptied the trash containing the empty cup.
-Staff had been instructed not to leave any cups in residents' room.
-Starting on the men's hall, housekeeping collected trash throughout the facility 2 to 3 times per day in the morning, around noon and in the late afternoon.

Interview with the SCUC on 05/23/18 at 5:40pm revealed:
-She had never witnessed Resident #2 drinking anything other than tea, water, or soda.
-The facility was currently working on placement for Resident #2.

Interview with the Administrator on 05/23/18 at 5:45pm revealed:

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-When Resident #2 was sent out to the emergency room after stealing the bottle of hand sanitizer from the medication cart, Resident #2's guardian was informed that was "too much."
-Resident #2 was "watched" all day long.
-"Watched" meant everybody knew to check in his room when the resident was in his room.
-Everybody knew to pay attention to Resident #2.
-Most of the time Resident #2 walked in the hall and staff was up and down the hall.
-If Resident #2 was not on the hall, staff knew to go look for him.
-Staff knew not to have bottles on the unit for their personal use.
-Staff got cups back from Resident #2 after used.
-There were occasions when Resident #2 would take a cup to his room.
-Resident #2 was "sneaky, fly under the radar" sometimes.
-Resident #2's behaviors had decreased since the 04/06/18 incident.
-She had never witnessed Resident #2 drinking his urine.
-Staff suspected Resident #2 drank the sanitizer because the empty bottle was under Resident #2's bed.
-The medication carts were always in view of the MAs.
-She had a discussion with the SCUC about alternate placement in a group home, and maybe the need for one-on-one supervision and was in the process of hiring new staff.

Observations of Resident #2 on 05/22/18 at 4:13pm revealed:
-The resident walked past the nursing station with a small clear plastic cup in his hand.
-The resident went into room #4.
-The resident came out of the adjoining bathroom drinking a clear liquid from the small plastic cup.

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D 270	Continued From page 10 Interview with Resident #2 on 05/22/18 at 4:13pm revealed: -He was drinking water he had gotten from the adjoining bathroom sink. -He was drinking from the small plastic cup provided with his snack. Interview with the MA on 05/22/18 at 4:15pm revealed: -Staff would "monitor" Resident #2. -Staff monitored Resident #2 to know how far the resident went up and down the hall, when the resident went outside to smoke, and what the resident ate. -Staff saw Resident #2 "most of the day, most of the day we got our eyes on him." -Facility staff did not document every two hour resident checks. -The MA's were responsible for documenting on residents at the end of each shift. Interview with the Administrator on 05/22/18 at 4:20pm revealed: -Resident #2 would drink his own urine. -Resident #2 was not allowed to bring cups from the dining room. -When the resident was administered medications, the MA's got the water cup back from the resident. Observations of the Administrator on 05/22/18 at 4:20pm revealed: -The Administrator went into Resident #2's room and entered the adjoining bathroom. -The Administrator removed an empty small clear plastic cup from the top of the sink. -Resident #2 entered the room, as the Administrator exited the bathroom, and was eating a snack from a small clear plastic cup.	D 270		

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-The Administrator disposed of both cups in a trash can outside Resident #2's room after the resident finished the snack.

Observations of Resident #2 on 05/23/18 from 8:20am to 9:00am revealed:
-At 8:20am, Resident #2 came out of his bedroom with a PCA. The resident went into the dining room for breakfast.
-At 8:23am, Resident #2 got up from the dining room table and walked in the hallway.
-At 8:50am, Resident #2 was assisted with incontinent care in his room by a PCA.
-At 8:57am, Resident #2 walked in the hallway with his hands in his pockets in view of the MA who stood by the medication cart.
-At 8:59am, Resident #2 went into the common bathroom and closed the door.
-At 9:00am, Resident #2 exited the common bathroom with his hands in his pockets.

Observations of Resident #2 on 05/24/18 from 8:33am to 8:35am revealed:
-At 8:33am, Resident #2 was served milk in the dining room. The resident walked out of the dining room into the hall drinking the glass of milk. The MA told Resident #2 to leave the cup in the dining room. Resident #2 returned to the dining room with the empty milk cup and sat the cup on a tray.
-At 8:35am, Resident #2 was walking in the hall. The resident went into his room. The resident came out of the room within 15 seconds and began pacing in the hall.

Observations of Resident #2 on 05/24/18 from 5:20pm to 5:48pm revealed:
-At 5:20pm, Resident #2 was served dinner in the dining room.
-At 5:30pm, the resident left out of the dining

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room.
-At 5:40pm, the resident returned to the dining room and ate a bowl of mandarin oranges.
-At 5:43pm, Resident #2 left out of the dining room and paced in the hall for short distances, would turn around and went back towards his room.
-At 5:44pm, Resident #2 went into his room.
-At 5:44pm, Resident #2 came out of his room and walked out the door to the men's hall, when the SCUC redirected the resident back on the men's hall.
-At 5:45pm, Resident #2 paced in his room from the room door to the window.
-At 5:46pm, Resident #2 walked in the hall.
-At 5:48pm, Resident #2 went back in his room.

Interview with a PCA working on the men's hall on 05/22/18 at 4:00pm revealed:
-Staff had to "watch" Resident #2 with any kind of liquid item.
-Resident #2 would drink liquid from a cup left on a table.
-Resident #2 thought any liquid was something to drink.
-Staff had caught Resident #2 "dipping urine out of the commode in his room."
-Staff had caught Resident #2 with urine in a coke bottle about 2 weeks ago.
-When the PCA saw resident dipping the urine out of the commode, the PCA called the resident by name and told Resident #2 not to play in the commode because it was unsanitary.
-The staff knew it was urine because "you could smell it".
-The staff felt if Resident #2 would get urine, the resident needed to be watched for any kind of liquid, including cleaning supplies.
-Another resident would tell staff if they saw Resident #2 with a drinking cup and would say

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"he's at it again".
-Staff had to check on all the residents every two hours and had to "watch" for Resident #2.
-The staff reported to the Medication Aide (MA) Resident #2's behaviors and the MA would tell staff to be observant.

Interview with a second PCA on 05/23/18 at 9:03am revealed:
-Staff had to watch Resident #2.
-Staff had to keep an eye on Resident #2 because he liked to drink things.
-She had last seen Resident #2 about 15 minutes ago outside smoking.

Telephone interview with a third PCA on 05/24/2018 at 12:20 p.m. revealed:
-She mostly worked on the women's hall and worked on the men's hall at times.
-Resident #2 did not have any particular behaviors other than occasionally becoming agitated at staff by yelling when reminded to do something and he was a "floor walker".
-Resident #2 constantly wanted what others had and would often ask for a snack or something to drink.
-She was not aware of any special precautions for Resident #2 and was not aware of any issues with him drinking anything that was undrinkable.

Interview with a fourth PCA on 05/24/18 at 10:00am revealed:
-On 05/20/18 around 10:00am or 10:30am, she heard a noise, found Resident #2 at the door in a room but was not sure it was Resident #2's room. Resident #2 was sitting on the floor against the door with a sanitizer bottle in his hand and his hand was going away from his mouth. There was a smell of sanitizer "probably on his breath and around the bottle." There was no top on the

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bottle. The bottle size was about an 8 ounce bottle which was half gone.
-She, the MA, and another PCA (whose name she did not remember) went into the room at the same time.
-She did not report the 05/20/18 incident to anyone because the MA was present in the room.
-She had seen Resident #2 drinking urine before. It had "been a while, couple of months." When she saw it, she took the cup and reported it to the MA [named].

Interview with the named MA on 05/24/18 at 6:00pm revealed:
-She worked 7:00am to 7:00pm on 05/20/18 on the men's and women's hall.
-There were two PCA's working on the men's hall on 05/20/18.
-There were no incidences with Resident #2 on 05/20/18.
-She did not see Resident #2 drinking anything he was not supposed to drink.
-The third PC said she saw the resident on the floor "and he had a bottle", but did not say what kind of bottle it was.
-When she (MA) went to Resident #2's room when the PCA said that, the resident did not have anything.
-She had heard rumors of Resident #2 drinking sanitizer, but had never seen it.
-She did not know why the staff would say she had seen Resident #2 drinking hand sanitizer.
-She did not smell anything when she went straight to the resident's room once the PCA told her the resident had a bottle. The resident was laying on his bed when she went in the room.

Interviews with the two PCAs who worked on 7a - 7p on the men's hall on 5/20/18 at 6:45pm on 5/24/18 revealed:

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-Neither of the PCAs saw or heard anything on 05/20/18 about Resident #2 being "at it again."
-Resident #2 did not drink any hand sanitizer on 05/20/18 during the 7a - 7p shift.
-Resident #2 was his "normal self" on 05/20/18 during the 7a - 7p shift.

Interview with the Psychiatric Nurse Practitioner on 05/24/18 at 9:25am revealed:
-She evaluated Resident #2 on 04/26/18.
-The resident was very confused and disorganized.
-She was told this morning from staff that the resident was on every 30 minute checks and guardian was actively seeking placement.
-She was not aware of or had any prior knowledge of the resident drinking sanitizer, had no notifications of behaviors or worsening psychiatric conditions, and had not received any calls from the facility after 04/26/18.
-Resident #2 was initially evaluated on 10/13/17 when the resident was urinating in a drinking cup.
-Resident #2 was hospitalized in an inpatient setting from 10/19/17 - 12/06/17.
-Resident #2 had been seen by the psychiatric provider on 12/12/17, 1/30/18, 3/23/18, and 4/26/18.
-Resident #2 has a diagnosis of psychogenic polydipsia which had been noted in visit notes. Medications had been adjusted to try and help the psychogenic polydipsia.
-In her professional opinion, drinking urine would cause thirst and lower the resident's sodium.
-Hand sanitizer and mouthwash had a high content of alcohol, and she would prefer not to answer whether sanitizer or mouthwash would cause physical harm or detriment.

Interview with the Medical Nurse Practitioner on 05/24/18 at 10:55am revealed:

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D 270	Continued From page 16 -He was aware of the 04/06/18 and 04/15/18 incidents when Resident #2 had consumed hand sanitizer and was found drinking it out of a bottle. The resident went to the hospital and was monitored. There was no specific treatment. -When considering Resident #2's diagnosis, it made sense that the resident would drink anything that would provide relief for his thirst. The resident was not after the fluids for the alcohol content but for the fluid content. -Drinking urine was a constant thing for Resident #2. -There were not supposed to be any cups or vessels to be left out or made available to Resident #2. -Resident #2's room was supposed to be monitored for cups and vessels. -He could not come up with anything smarter. -The approach the facility had implemented was as good as any approach, but required diligence of staff. -Resident #2 required a certain level of protection. -He was not privy to information about 5/20/18 where the resident may have drank hand sanitizer. -With regards to detriment or harm caused by drinking urine, it would come down to the quantity. The resident would need to ingest "several liters before it would cause hyponatremia (low sodium) which would be a big concern. Drinking 8 ounces, 32 ounces, 64 ounces would cause no harm. -When Resident #2 looked at hand sanitizer, he thought of it as water. It was not the alcoholism but the thirst that was driving him. It has not been established how much he would have to drink for there to be detriment or harm. The treatment for hand sanitizer ingestion would be to monitor for effects of alcohol - dizziness, gittiness, and gait	D 270		

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imbalance. There would be more physical imbalances before electrolyte imbalances - would have intoxication occur before electrolyte imbalances.
-The ingestion of hand sanitizer was new probably since 04/2018.
-The facility would need to look at appropriate placement of the hand sanitizer.
-Resident #2 required more monitoring than the typical resident at the facility and as long as those measures were being carried out, he felt the resident was appropriately placed.
-Alternate placement had come up but short of a strict psychiatric setting, he did not know of a better place for the resident or if it would be in the resident's best interest.

Telephone interview with Resident #2's guardian on 05/24/18 at 12:52pm revealed:
-Resident #2 had been at the facility for about one year.
-She has had phone contacts with the Administrator and SCUC concerning Resident #2 drinking urine and sanitizer, and wandering behavior.
-The resident had the drinking behavior prior to admission to the facility.
-She was aware when Resident #2 was sent to the hospital emergency room on 04/06/18, 04/15/18, and 04/24/18.
-Limiting access to drinking containers had been recommended and the facility had been doing that.
-She thought the facility had recommended putting the resident on a schedule to get a drink.
-Resident #2 drank excessively and did not have control to wait.
-She had been searching for alternate placement since December 2017 when the resident had been given a 30 day notice. Every place she had

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called would say the resident is too young and could go anywhere and get cups because the resident is ambulatory.
-The resident was on a wait list for a specialized center for Dementia.
-She felt Resident #2 was as safe as could be at the facility.
-The facility knew the "strategy" of Resident #2.
-She knew Resident #2 had drank urine and hand sanitizer.

Interview with a MA on 05/24/18 at 5:35pm revealed:
-Resident #2 was offered fluids at breakfast, 10:00am, lunch, 2:00pm, dinner time, and 8:00pm.
-About every two hours staff offered residents water.
-Resident #2 was not on any specific fluid program and there was no order to give Resident #2 fluids on any regular frequency other than the routine schedule.

Interview with the SCUC on 05/25/18 at 12:20pm revealed:
-If Resident #2 was suspected of drinking sanitizer or mouthwash, the staff were instructed to send the resident to the hospital for evaluation.
-Resident #2 was never to have cups.
-As of today, the facility planned to start bringing in extra staff to provide one-to-one supervision for Resident #2.
-Resident #2 did not have any restrictions on his fluid intake.
-She gave Resident #2 water if the resident asked.
-It had been a couple months since she was told Resident #2 had drank hand sanitizer.

Interview with the Administrator on 05/25/18 at

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D 270	Continued From page 19 2:40pm revealed: -She had considered one-on-one supervision for Resident #2 and planned to start it by close of business today. -She planned to move Resident #2 to a private room so the one-to-one could be implemented without infringes on another residents rights. There was no one-to-one supervision observed for Resident #2 on 05/25/18. The facility's failure to provide supervision for Resident #2 who was known to ingest undrinkable liquids of urine and hand sanitizer resulted in Resident #2 being transported to the local hospital emergency department three times. The noncompliance placed the resident at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 05/23/18 with an addendum provided on 05/25/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 30, 2018.	D 270		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.	D 283		

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D 283	Continued From page 20 This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure foods were stored in a manner to prevent contamination as evidenced by not labeling food with contents and date opened, sticky and stained substances in the refrigerator's storage areas and on food containers, and loose debris and build-up on two dry food storage bins in the kitchen pantry. The findings are: Observation of the pantry on 05/22/2018 at 3:58 p.m. revealed: -There was a white bin with a clear lid used to store loose granulated sugar. There was a beige colored hardened substance, resembling granulated sugar, and black and gray stains along the top outer rim of the container. -There was a second white bin used to store a large open bag of flour with yellow and black colored stains along the outer rim of the container and small loose black and yellow loose debris scattered across the bottom of the inside of the container. Interview with the cook on 05/22/2018 at 4:10 p.m. revealed: -She had not noticed the stains and loose debris in the white bins used to store the sugar and flour. -She thought the dietary aide (DA) was responsible for cleaning the food storage bins 2 times per month. The clear light bin lids were removed and cleaned daily in the dishwasher after the end of the meals. Interview with the DA on 05/22/2018 at 4:48 p.m. revealed:	D 283		

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D 283	Continued From page 21 -He had worked at the facility for about a month. -He was not sure how often the food storage bins should be cleaned. He did wash the storage bin lids daily by placing them in the dishwasher. -He had not noticed the stains and loose debris in the white bins used to store sugar and flour. -He just cleaned the bins a "few minutes ago" after the cook told him that they needed cleaning. Observation of the three door reach-in cooler on 05/23/2018 at 9:02 a.m. revealed: -There was a large clear container with a yellow lid containing pineapple tidbits in juice. -There were multiple handwritten entries on the lid consisting of "ketchup 10-24", a second labeled handwritten entry "11-1-17", a third labeled handwritten entry "11-9-17", a fourth labeled handwritten entry "Swedish meatballs" and two other handwritten labels that were faded and unreadable. -There was a large white colored container of cake frosting that had multiple yellow colored sticky stains on the top and sides of the lid. -There was a re-sealable plastic bag containing approximately 10 slices of deli meat that was not labeled with a date or contents stored on the middle rack of the reach-in cooler. -There was a second re-sealable plastic bag containing approximately 10 slices of deli meat with no labeled date or contents stored on the middle rack of the reach-in cooler. -There was an opened plastic bag with no opened date and no manufactured label on the opened plastic bag of iceberg lettuce stored beside the two packages of deli meat . -There was a two gallon container of pickles with a light green colored sticky substance on side of and lid of the container. -There were two large stacks of sliced cheese wrapped in plastic wrap and a third stack with	D 283		

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approximately 5 slices of cheese wrapped in plastic wrap with no labeled date.
-There was approximately 10 mini cinnamon rolls in an opened clear plastic bag with no labeled date.
-There was a reusable plastic condiment bottle containing a red thick substance that was not labeled with a date or contents and a second reusable plastic condiment bottle containing a mustard colored thick substance labeled "French" and no labeled date or contents.
-There was a large clear container with a yellow lid containing peaches in liquid that was with a handwritten entry on the lid "chicken 4-23-14".
-There was a 5 lb. container of pimento cheese with brown colored sticky stain on the lid.
-There was a large container of dessert icing with multiple stains varying in color from yellow to red on the lid and sides of the container.
-There was a large clear container with a yellow lid containing a brown colored liquid with no labeled contents and a faded handwritten entry on the lid "11/27/15".
-There was a 4 lb. opened container of cherries in juice with a shipping date of 11/17/2016 on a yellow sticker and a handwritten entry date of 11/17/2016 on the lid.
-There was an opened one gallon bottle of Dijon honey dressing with less than 50 % of the dressing remaining that was sticky and heavily soiled around the lid and sides with a thick substance that was the same yellow color of the dressing; there was no opened date and a yellow purchase sticker with a date of 10/22/2015.
-There was a one gallon container of classic honey mustard dressing with less than 25% of the dressing remaining that had a date of "July 20" tapped across the container's lid. The lid and sides of the container was heavily soiled with a yellow, brown, and red colored substance and a

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D 283	Continued From page 23 stamped packaged date of 07/06/2015 on the side of the container. -There was a one gallon container of prepared yellow mustard with approximately 25 percent remaining, a handwritten entry of "11/28" on the side of the container and a heavy thick brown colored build-up around the lid and down one side of the container. -There was a one gallon container salad dressing with no labeled opened date and a yellow purchase sticker with a date of 02/22/2018 with approximately 25 percent of the dressing remaining. One side of the container had a thick and sticky light yellow colored substance near the lid of the container. -All of the storage racks in the 3 door reach- in cooler had scattered areas of dried and moist substances that varied from a yellow, red and brown colors on the underside of the racks. Interview with the DA on 05/23/2018 at 9:30 a.m. revealed: -He was responsible for cleaning the inside of the refrigerator. He was unsure how often he should clean the inside of the refrigerator. -The facility did not have a written cleaning schedule. -He had never removed the storage racks in the reach-in cooler. He did wipe the storage racks with a cloth using dish detergent and water about 2 weeks ago. -He had not noticed that the racks were soiled. -He had received training through a class when he started working at the facility that covered the importance of cleaning. -He was not responsible for removing any food from the reach-in coolers. Interview with the dietary manager (DM) on 05/23/2018 at 9:45 a.m. revealed:	D 283		

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D 283	Continued From page 24 -It was expected for staff to label and date all foods when any food package was opened. -All foods repackaged should be labeled and dated. -She was not sure why there was food in the reach-in -cooler with no labeled opened date or contents because all staff were aware to label and date everything and there were black markers in the kitchen used for labeling for staff to use. -She had not noticed the containers in the refrigerator that were not labeled and dated and would throw all of the food in those containers away since she could not verify when the food was repackaged or how long it had been there but knew the sliced cheese had been recently opened. -A lot of the larger gallon containers of dressings and mustard were stored in the back section of the reach-in-coolers, "looks like they're old" and would be disposed. -There was a cleaning schedule and she had been working on updating but had not posted it yet. -She was responsible for assuring all areas of the kitchen were kept clean including the reach-in-cooler. Interview with the Administrator on 0 5/24/2018 at 4:45 p.m. revealed: -The DM was in place to handle dietary issues. -She randomly monitored the cleanliness, food supply and general inspection of the kitchen. -They had started working on a new cleaning schedule for the kitchen last week. -It was expected for all foods that had been opened or repackaged to be labeled with a date and the contents. -Staff were responsible to check foods not labeled and dated and expiration dates weekly on	D 283		

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D 283	Continued From page 25 the day the food delivery truck came and rotate the foods by placing the food on hand in the front and the newly delivered foods in the back. -She expected the refrigerator storage racks to be cleaned weekly and wiped as needed when spills occurred.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all residents received a place setting that included a knife, spoon and fork. The findings are: Observation of the lunch meal in the facility dining room adjacent to the kitchen on 05/23/2018 at 12:25 p.m. revealed: -Table service included one napkin, a spoon, a fork, and beverage containers of water and tea. -Staff served the residents a plated meal from the kitchen consisting of a bone in pork chop, noodles with brown gravy, beets, ½ slice of white bread and sliced apples. -Two residents were observed being assisted with	D 287		

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eating their meal by individual personal care aides (PCAs) feeding them. The two PCAs had a knife using it to cut up the resident's pork chop as they assisted them to eat.
-A resident was having difficulty cutting into the pork chop by using a spoon and their hand.
-Several residents were using their hands, picking up the pork chop and biting into the meat.
-Forty two residents were served in the dining room that did not receive a knife with table service.

Confidential interview with a resident revealed:
-The resident had lived at the facility for a little over a year.
-A knife was never provided to the residents.
-"A knife is a knife", and staff were afraid they (residents) would use them on each other.

Confidential interview with a second resident revealed:
-The pork chop was not tender at all.
-Residents were never offered a knife at meals because "may use on others".

Confidential interview with a third resident revealed a knife probably would have made it easier to eat the pork chop today (05/23/2018) but it would still have been tough because it was not tender at all.

Confidential interview with a staff revealed:
-Knives were not offered to the residents unless the residents were served a pork chop or something.
-The staff did not think it was appropriate to provide a knife to all of the residents at the facility because most of the residents had dementia.

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D 287	Continued From page 27 Confidential interview with a second staff revealed: -Spoons, forks and napkins were provided for the residents' meals. -The staff was not sure why knives were not included in the table service but if a resident asked for a knife, staff provided one for them. Confidential interview with a third staff member revealed: -Knives had not been included in the residents' place setting for the last 3 months. -Staff were told to stop providing knives to the residents because a lot of knives were missing. -The staff could not remember who told staff to no longer provide the residents with a knife at meals. -Some of the residents could get violent. Interview with the Dietary Manager (DM) on 05/24/2018 at 6:13 p.m. revealed: -She had been the DM for about 3 weeks and worked as a cook with the facility for one year prior to her new position. -Dietary aides (DAs) were responsible for setting the residents' place setting. -It was her responsibility to oversee the DAs. -She would talk with the DAs to make sure that a knife was included in the table service for each meal. Interview with the Administrator on 05/24/2018 at 4:45 p.m. revealed: -A knife should be included in the residents table service during meals. -The facility had enough knives for each resident to have a knife during the meals. -There was no rule in place to exclude knives because they could have been used as a weapon.	D 287		

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D 287	Continued From page 28 -She monitored the residents' meal service periodically and had observed knives were included in the place setting and then sometimes not. -She last observed the residents' dinner meal yesterday (05/23/2018) and saw that a knife, spoon and fork were included in the table service.	D 287		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure milk was served at least twice daily to residents. The findings are: Observation in the kitchen on 05/22/2018 at 4:45 p.m. revealed there was a large stainless steel pan containing ice and one gallon container of milk sitting on a prep table. Confidential interviews with a staff revealed: -Residents were supposed to be served milk at breakfast and dinner.	D 299		

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D 299	Continued From page 29 -The Administrator had instructed staff today (05/22/2018) to place the stainless steel pan with the ice and milk on a table in the large dining room located on the left side of the kitchen's door. -Residents were never served milk unless they asked for it and milk had always been left in the kitchen in the reach-in cooler. Confidential interview with a second staff revealed: -Milk had never been placed in a steel container in the dining room before today (05/22/2018). -A lot of the residents did not drink milk. Confidential interview with a third staff revealed: -Staff asked residents during certain meals if they wanted milk but the milk was not served like tea and water was. -The staff had never seen residents individually asked if they wanted milk. Review of the "Week 2 Day 10" regular and therapeutic diet menu spreadsheet revealed residents were to be served milk for breakfast and dinner. Observation of the breakfast meal in the large dining room on 05/23/2018 at 8:17 a.m. revealed: -The dietary aide (DA) stopped and asked 3 residents as they were walking to their seats if they wanted milk. -There were 36 residents in the dining room. -There was a large stainless steel container of milk sitting in ice at the front of the dining room. Interview with the DA on 05/24/2018 at 8:22 a.m. revealed: -As long as the residents see the container of milk it was alright and they could ask for it if they wanted any.	D 299		

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D 299	Continued From page 30 -He did not carry the milk container around to each table to ask if they would like milk. Confidential interview with two residents revealed: -The resident liked milk but got milk "only once in a while". -Milk was not served often to the residents. Interview with the Dietary Manager on 05/24/2018 at 6:13 p.m. revealed: -The residents were offered milk two times daily at meal time. -Milk was not placed on the tables like other beverages. -Milk was placed in a container of ice on a table in the large dining room. -Staff at one time served all residents milk, but, a lot of the milk was wasted because some residents would not drink it. -Staff offered milk to residents by asking them if they wanted milk but did not take the container of milk around the dining room and individually asked if they wanted milk. -She understood some residents might not understand when asked and not visibly shown if they wanted milk because of dementia. Interview with the Administrator on 05/24/2018 at 4:45 p.m. revealed: -Residents were supposed to get milk 2 times each day. -Milk was placed in a container of ice on a table in front of the large dining room with cups. -Staff were expected to offer the milk to the residents by asking them if they wanted milk. -Some residents liked milk and some did not. -When she monitored the resident meals, dietary aides offered milk to the residents.	D 299		

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D 338	10A NCAC 13F .0909 Resident Rights	D 338		

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

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

Based on observations, interviews, and record reviews, the facility failed to assure dignity, respect, and privacy was maintained for all residents as related to Staff D, who did not perform personal care tasks, entering rooms and closing doors with multiple female residents including repetitive incidents with Resident #8 and Resident #9, withholding smoking privileges from Resident #2, and performing personal care without privacy for Resident #2.

The findings are:

Interview with the Administrator on 05/25/2018 at 5:21 p.m. revealed:
-There were "allegations" concerning Staff D that had been investigated and unsubstantiated in 2016.
-She had received information today (05/25/2018) that calls were being made concerning Staff D about the incident that had occurred in 2016 which had already been investigated.
-The local detectives had spoken with Staff D yesterday (05/24/2018) and asked Staff D if he

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would agree to take a "lie detector test" and Staff D had agreed.

Interview with Staff D on 05/25/2018 at 12:35 p.m. revealed:
-He had spoken with the local police department yesterday (05/24/2018) about a rumor that had been reported to the local police about him "messing with women at the facility" and "sexual harassment". He did not know any more than that and was told by the police that they had to investigate it. He did not know "who put that out there."
-He could not believe the allegations against him.
-He had never been in a female residents' room or any residents' room where he had to close the door. The door might would close on its own but he would not close the door.
-He had never been in a room alone with a resident.
-He felt that allegations were made against him by staff at the facility because staff at the facility did not like him immediately reporting any issues he saw with their job duties when he walked through the facility to the Administrator who would in turn immediately follow up on what he had reported.
-The same allegations came up back a while back against him (Staff D referred to the time frame as 4 to 5 months, then stated 2016, and he was not good with time) but when the accusation was made, they (Staff D and the Administrator were out of town).
-He performed a walk through at the facility but did not perform any physical work.
-He walked through the hallways of the facility to make sure he did not hear any "water sounds" and if there was any type of leak he would fix the leak if able, have maintenance repair it or call a contracted provider.

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D 338	Continued From page 33 -He usually performed a walk though of the facility three times per week around 11:00 a.m. to 12:00 p.m. -He never came to the facility at night unless there was an unusual circumstance like a busted pipe, and would come with other maintenance staff. -There were cameras in the facility and he did not come at night. Confidential interview with a former staff revealed: -The staff was concerned that Staff D went in and out of the female residents' rooms and would shut the door while he was in the rooms. -Staff D did this "constantly" during the time the staff worked there (dates withheld to maintain confidentiality). -Staff D came into the facility "maybe 3 to 4 times a week" at all times of the day and evening. -Every time Staff D was in the facility, he would go into female residents' rooms, close the door, and stay in the room with the female residents' for 15 to 20 minutes. -Staff D was not providing personal care and had no reason to be in the rooms with the doors closed. -The staff member and several staff reported their concerns of Staff D's behavior to the Administrator (who is a family member of Staff D) sometime one to one and one half year ago in 2016. There was a "big investigation" sometime in 2016. After the investigation, Staff D continued the behavior. -Other staff noticed Staff D's continued behavior of going into the female residents' rooms but were "fearful" to report it because they needed a job and thought they would lose their job if they reported.	D 338		

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D 338	Continued From page 34 Confidential interview with a second former staff revealed: -The staff had observed Staff D going into multiple (named) female residents' rooms on numerous occasions and closed the door. -The staff was also getting complaints from other staff about Staff D going into female residents' rooms and closing the door. -Staff D would come in to the facility on 3rd shift and enter through the side door on the women's hall. (He would not enter the facility through the main entrance). -Staff D did not have the need to be in the female residents' rooms with the door closed without another staff present. -Staff D was "never" on the men's hall in the rooms with the doors closed. -Staff D was a maintenance person; his job did not require him to go into the females rooms and close the door. -"We could not understand why he needed to go in these ladies rooms and close the door." -Staff D would be in the female residents' rooms with the door closed for 10-15 minutes. -Staff reported their concerns about Staff D's behavior to the Administrator. -The Administrator said staff "were lying." -The staff had observed another (named) former staff tell the Administrator and Staff D that the staff had walked into Resident #9's room and observed Resident #9 sitting on her bed without her pants on and Staff D was on his knees on the floor in front of the resident. -Even after "being accused" Staff D continued to go into female residents' rooms and close the door. -There were other staff members that were concerned about Staff D but "they changed their story" because they were afraid of being fired. -"It's always bothered me" (Staff D's behavior).	D 338		

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D 338	Continued From page 35 Confidential telephone interview with a third former staff revealed: -The former staff had a concern about Staff D's "inappropriate behavior." -Staff D "raped all these ladies who could not take care of themselves." -The staff tried to do something about it "but all that happened was everyone backed out and I got fired." -The former staff could not talk at that time and would call back. Attempted follow up telephone interview with the third former staff on 05/30/18 was unsuccessful and the former staff did not call back prior to survey exit. Confidential staff interview revealed: -Staff D had behaviors that always concerned the staff. -The staff had observed on different occasions, Staff D going into rooms with female residents, closing the room door and staying in the room with the female residents for approximately 5 to 10 minutes, "sometimes longer and sometimes less." -Staff D came on the women's hall daily until a couple of months ago, but currently, visited the women's hall only "sporadically." -The staff had never reported their concerns to the Administrator and stated, "I wouldn't." Confidential interview with a second staff revealed: -The staff recalled an incident in March 2018 when Staff D went into a (named) female resident's room (named) and the door was closed. -The staff wanted to see what was going on and	D 338		

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when the staff opened the female resident's room door, the female resident was sitting in a chair and Staff D was standing up close in front of the female resident.
-Staff D looked "like he seen a ghost."
-Staff D was known to come to the facility in the evening after the Administrator had left for the day or in the mornings before the Administrator got there.
-The Administrator had asked staff about Staff D recently; but some staff lied to her and did not report what they had seen.
-Staff were afraid to report Staff D for fear of losing their jobs.

Confidential telephone interview with a family member revealed:
-The family member often seen Staff D on the women's hall of the facility when the family member was visiting a resident and assumed Staff D was a visitor.
-Staff D was mostly seen around the residents' dinner time.

1. Review of Resident #8's current FL-2 dated 05/15/2018 revealed:
-Diagnoses included severe sepsis secondary to pyelonephritis, urinary tract infection and pyelonephritis as a result E. Coli pansensitive to antibiotics, acute kidney injury appears to be secondary to dehydration, hypokalemia, normocytic anemia, advanced Alzheimer's dementia.
-The resident was constantly disoriented and semi-ambulatory.

Review of Resident #8's Resident Register revealed an admission date of 01/18/2017.

Review of Resident #8's Assessment and Care

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Plan dated 01/18/2018 revealed:
-The resident was always disoriented and had significant memory loss and had to be directed.
-The resident wandered and resisted care.
-In the Social and Mental Health History of the assessment there was documentation the resident had dementia that impaired her judgment severely, she wandered constantly, dressed in layers, could not communicate well and babbled.

Confidential staff interview revealed:
-The Administrator was out of the facility on vacation for one week in March 2018.
-During the time the Administrator was on vacation, Staff D would come into the facility and go into a room with Resident #8 and close the door.
-Several staff observed the incidents; Staff D and Resident #8 were alone in a room with the door closed for about 10-15 minutes.
-The room they went in was not Resident #8's room; it was the 2nd to the last room on the right side of the women's hall that was used for storage.
-The week the Administrator was gone (March 2018), Staff D came into the facility at breakfast, lunch, and dinner time when he knew staff would be in the dining room and were not supposed to be on the halls.
-Staff D would walk the halls and find Resident #8.
-The staff was aware of three (named) staff had reported their concerns about Staff D's behavior to the Special Care Unit Coordinator (SCUC) in March 2018.
-The SCUC said she had seen Staff D on the cameras but the Administrator was not going to believe it.
-The SCUC told staff to sit Resident #8 at the

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desk to watch her.
-The staff started sitting Resident #8 at the desk to watch her.
-At times when Resident #8 was sitting at the desk, Staff D would ask staff what was going on and why she was at the desk.
-Resident #8 had "fake breasts" and would "constantly" say "the boobs, wash it, wash it" after being in the room alone with Staff D with the door closed.
-After staff started sitting Resident #8 at the desk, Staff D went into another (named) female resident's room, closed the door, and was in there for 10-15 minutes.
-Near the end of March 2018, Resident #8 had a bruise on her wrist of unknown origin.
-Resident #8 told staff the bruise hurt and "he hurt me" but she would not say who he was. (On this same day, Staff D was in the facility and staff were not able to find Resident #8 "for a while.")

Confidential interview with a second staff revealed:
-The staff had observed Staff D and Resident #8 coming out of the room on the right side at the end of the women's hall "numerous times" over the last three months.
-When Staff D and Resident #8 were in the room, the door would be closed.
-When Staff D was in the facility, he mostly walked the women's hall; he did not go on the men's hall.

Confidential interview with a third staff revealed:
-The staff thought Staff D behavior of going into rooms with female residents and closing the doors was concerning because if anything was going on behind closed doors, the female residents would not be able to report those concerns, but "their emotions would tell me

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though."
-The staff had witnessed an incident about a couple of months ago after the dinner meal was served to the residents.
-The staff observed Staff D coming out of a room that Resident #8 was in.
-The staff went into the room after Staff D left the room and observed Resident #8 to be "emotional" by crying repeating "it hurts, it hurts," when asked where it hurt, Resident #8 grabbed her arm (the resident grabbed her own arm). The staff did not observe any redness, skin marks, or limited movement with the resident's arm.

Telephone interview with Staff D on 05/30/2018 at 12:07 p.m. revealed:
-Staff D really did not know Resident #8 because she did not talk.
-He had no interactions with Resident #8 except to get her out and had staff to get the resident out of a room close to the end on the right side of the women's hall that was used for storage.
-Resident #8 was always going into this room used for storage.
-When staff tried to get Resident #8 out of the storage room she would "fight with workers", they would "have a time with her."
-He had no reason to be in a room with Resident #8 or any resident with the door closed.

Telephone interview with the Administrator on 05/30/2018 at 1:37 p.m. revealed:
-Resident #8 had a tendency to go into the end rooms on the right side of the women's hall and would be "piddling."
-If Staff D was in a room with Resident #8 for 30 minutes with the door closed, she could not imagine why no one would not have brought that to her attention.
-If Staff D was in a room with Resident #8, then

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Staff D was working on something in the room.
-She was not sure why anyone reported that Resident #8 was in a room for 30 minutes because she was a constant walker and stayed in the women's day room a lot.

Refer to the interview with the lead housekeeper on 05/25/2018 at 8:43 a.m.

Refer to the interview with a housekeeper on 05/29/2018 at 5:07 p.m.

Refer to the interview with the resident care coordinator (RCC) on 05/29/2018 at 4:45 p.m.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/29/2018 at 11:20 a.m.

Refer to the interview with Staff D on 05/30/2018 at 12:07 p.m.

Refer to the interviews with the Administrator on 05/25/2018 at 2:40 p.m. and 05/30/2018 at 1:34 p.m.

2. Review of Resident #9's FL2 dated 03/09/2017 revealed:
-Diagnoses included dementia, Alzheimer's disease, urinary tract infection, seasonal allergies, hypertension, and tachycardia.
-The resident was constantly disoriented.

Review of Resident #9's Resident Register revealed and admission date of 11/18/2016.

Review of Resident #9's last Assessment and Care Plan dated 03/09/2017 revealed:
-There was documentation under the Social/Mental health History section of the assessment that the resident was incompetent

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and could not make rational decisions and was in need of immediate and consistent supervision.
-The resident was always disoriented and had significant memory loss and had to be directed.

Confidential interview with a former staff revealed:
-Staff D and Resident #9 went "behind closed doors too many times."
-Resident #9 told the staff and two other (named) staff that she and Staff D did not have sex but he would touch her an then have her touch him.
-The three staff asked Resident #9 where Staff D touched her and she told the staff "you know where."

Confidential interview with a second former staff revealed:
-The staff was concerned that Staff D went in and out of the female residents' rooms and would shut the door while he was in the rooms.
-The staff recalled seeing Staff D in the room of at least three (named) female residents' rooms.
-One of the named residents was Resident #9; Resident #9 called Staff D her "boyfriend."
-Staff D mainly went into Resident #9's room before she passed away, then started to go into another female resident's room.

Telephone interview with Staff D on 05/30/2018 at 12:07 p.m. revealed:
-Resident #9 walked and cried a lot.
-There was a rumor about him regarding Resident #9 about a year ago and he had to talk with the county about that, however, he was out of town on the dates the allegation had supposedly taken place.
-He had no reason to be in a room with Resident #9 or any resident with the door closed.

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D 338	Continued From page 42 Refer to the interview with the lead housekeeper on 05/25/2018 at 8:43 a.m. Refer to the interview with a housekeeper on 05/29/2018 at 5:07 p.m. Refer to the interview with the resident care coordinator (RCC) on 05/29/2018 at 4:45 p.m. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/29/2018 at 11:20 a.m. Refer to the interview with Staff D on 05/30/2018 at 12:07 p.m. Refer to the interview with the Administrator on 05/25/2018 at 2:40 p.m. and 05/30/2018 at 1:34 p.m. _____ Interview with the lead housekeeper on 05/25/2018 at 8:43 a.m. revealed: -He had worked at the facility for 3 years. -No housekeepers worked at night. -Staff D made "security checks" at night to assure the residents were alright and checked on staff. Telephone interview with a housekeeper on 05/29/2018 at 5:07 p.m. revealed: -She had worked at the facility since February 2018. -Staff D was always working in maintenance, mowing grass at the facility, or bringing supplies to the facility. -She usually saw Staff D in the facility approximately one time a week or he would come just when needed. -Her job responsibilities included cleaning in resident rooms and she would always keep the residents room doors open when she had to enter a residents' room because she had to keep an	D 338		

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eye on her cart.
-She had never observed any housekeepers or maintenance staff go into any residents' rooms and shut the door since she had worked there because "it shouldn't happen."

Telephone interview with the RCC on 05/29/2018 at 4:45 p.m. revealed:
-She had been the RCC since September 2017.
-She worked all shifts.
-She had no knowledge, had not witnessed and had not received any reports from staff regarding any resident to resident, staff to resident concerns or any issues that would impede on any of the residents' rights concerning abuse, neglect or exploitation.
-She had not observed any out of the ordinary behavior of any staff or residents.
-No staff had voiced any concerns or fears to her involving any residents' rights or safety.

Telephone interview with the SCUC on 05/30/2018 at 11:20 a.m. revealed:
-She had been the SCUC position since February 2018.
-She had been in and out of work a lot lately.
-She worked Monday through Friday from 8:00 a.m. to 5:00 p.m., and worked all other shifts when needed.
-She was not on the floor a lot, the only way she would know of any resident concerns would be through verbal reports from staff or if she was on the floor and discovered a resident concern herself.
-If staff had chosen not to tell her a concern involving a resident, she would have no way of knowing about that concern.
-There had been no reports made to her from staff concerning Staff D's behavior.
-She expected to be informed of any issues

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D 338	Continued From page 44 involving the rights of a resident at the time it happened so that something could be done immediately and if something had happened here, no one had reported to her. -All staff had been trained in resident rights training during orientation and staff were required to sign a form indicating they were aware of resident rights. -Staff were responsible for reporting any concerns of resident rights to anyone in management either by verbal, texting or phone calls. Telephone interview with Staff D on 05/30/2018 at 12:07 p.m. revealed: -When he performed walk-throughs, he always knocked on resident room doors and waited until someone answered prior to going in; if the resident did not answer to the knock on the door then he did not go in. -He did not provide personal care assistance to any residents. -He had never seen any residents unclothed. -He would have no reason to close any doors while he was in a room with a resident, but some of the doors at the facility closed on their own. -He thought staff at the facility were trying to get him out of the building by starting rumors because he would "get on them" about their job responsibilities if he saw something they were not doing and they (staff) did not like that. -Everyone had to go through the front door of the facility. -He did not do any walk-throughs at night. He walked down the hallways of the facility but not in any resident rooms at night. -No staff had voiced any concerns to him about him going into rooms with female residents and closing the doors.	D 338		

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D 338	Continued From page 45 Interview with the Administrator on 05/25/2018 at 2:40 p.m. revealed: -If there was any type of concerns regarding a resident, she expected staff should immediately report those concerns to the Medication Aide (MA), unless the concern involved the MA; then staff would be expected to report the concern to other management staff such as the resident care coordinator (RCC), special care unit coordinator (SCUC) or the Human Resource (HR) person. -If a resident concern could not be handled and was not something simple, then staff were expected to come to the Administrator immediately. -All staff were expected to notify her of any reports of any abuse (physical or verbal) immediately. -All staff had been trained on how to report any and all allegations of resident right concerns which was reviewed with all staff during their orientation process. -Once an allegation of abuse or neglect was reported, she initiated an internal investigation. -She had spoken with local law enforcement detectives yesterday (05/24/2018) and a complaint was made regarding Staff D. -She could not exactly remember what the detective "named it" regarding the allegation against Staff D and she had called the detective several times today (05/25/2018) and left a message to find out exactly what the detective had reported to her but knew it was concerning "messing with female residents." -She had not started an internal investigation today. She had intended to start her internal investigation today and had planned to fill out the initial report to HCPR today (05/25/2018). A second telephone interview with the Administrator on 05/30/2018 at 1:34 p.m.	D 338		

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D 338	Continued From page 46 revealed: -Staff D did not provide personal care assistance to any residents. -There was an investigation "about 2015" involving Staff D. -She sent the allegation that was made to Health Care Personnel Registry (HCPR) which came back unsubstantiated. -She started her own internal investigation on 05/25/2018 by interviewing staff randomly. -She had received feedback that one staff (named) had started a rumor about Staff D coming into the facility late at night. -No other staff had reported anything else to her during her current investigation which she had not completed.. -All staff were educated on resident rights during orientation, they were told who to go to. If the staff did not feel comfortable reporting to that person, then the concern could be reported to someone else. -The Adult Home Specialist (AHS) was also available to staff to report any concerns. -Staff D never came to the facility at night, she was the one that came. -Staff were aware if they walked in on a resident being abused, that first you make them safe, then you report it. -Staff had told her one thing and the "state" another. -The facility did not have a resident right policy. The facility used the North Carolina General Statutes that they reviewed with staff and had them to sign. -She expected staff to report any concerns or issues involving residents or staff and if they were not comfortable talking to her, especially if it was about her, then they could report to any of the management or to the AHS.	D 338		

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D 338	Continued From page 47 3. Review of Resident #2's current FL-2 dated 01/30/18 revealed: -Diagnoses included dementia with behavior disturbances, psychogenic polydipsia, hyponatremia, schizophrenia, inhalant use disorder, cocaine use disorder, and alcohol use disorder. -Resident #2 required prompting and some assistance with bathing, feeding, and dressing. Review of the Resident Register completed for Resident #2 revealed: -The resident was admitted to the facility on 04/25/17 from an inpatient psychiatric hospital. -The resident required assistance with toileting. -The resident enjoyed walking. Review of Resident #2's care plan dated 04/26/18 revealed: -The resident was sometimes disoriented. -The resident had significant memory loss and must be directed. -The resident required limited assistance with toileting. a. Interview with a personal care aide (PCA) on 05/23/18 at 8:25am revealed: -She had been employed at the facility since last Friday [05/18/18]. -She had some training since employed at the facility. -She had shaved and bathed residents at the facility. -A medication aide had worked with her to make sure she was doing everything right. -She was "not sure" if a skills check off had been completed. Observation of the PCA on 05/23/18 at 8:50am	D 338		

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revealed:
-The PCA escorted Resident #2 to his room and informed the resident of the need to change the resident's incontinent brief.
-The PCA secured a clean incontinent brief and went into the resident's room.
-Resident #2 sat in a chair that was visible from outside the room, with the door opened.
-The PCA began changing Resident #2's incontinent brief with the door opened.
-The PCA did not close Resident #2's room door to provide privacy for the resident while Resident #2's incontinent brief was being changed until the Administrator closed the resident's room door.

Interview with the PCA on 05/24/18 at 5:30pm revealed:
-She understood about providing privacy.
-She thought someone wanted to see her providing the care to Resident #2.
-No one had asked to observe her providing personal care to Resident #2.

A second interview with the PCA on 05/24/18 at 5:50pm revealed:
-When she was hired, the Administrator told new staff to make sure residents have privacy and to treat the residents with respect.
-This was her first job as a PCA.
-Once hired, she had to watch a video that including showing the proper way to change adults.
-She knew not to change a resident without providing for the residents privacy.
-She had trained with another PCA once she started working with the residents.

Interview with the Special Care Unit Coordinator (SCUC) on 05/25/18 at 12:15pm revealed:
-She did not know anything about Resident #2's

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incontinent brief being changed with the resident room door opened.
-The facility had a Registered Nurse that taught the 80 hour personal care training usually 2 - 4 weeks after the personal care aide had been working at the facility.
-The Administrator provided some training to new PCAs.
-New PCAs worked with a "seasoned aide."
-A "seasoned aide" was anybody who had been working more than 6 months.
-She was not involved in staff training.

Interview with the Administrator on 05/25/18 at 2:15pm revealed:
-The PCA who changed Resident #2 with the door open was a newly hired staff.
-Staff were trained to provide privacy when performing resident care.
-She thought the PCA just was not thinking when the PCA did not close the resident room door before changing the resident's incontinent brief.
-She reminded the PCA on 05/24/18 to always provide privacy.
-The PCAs formal PCA training would be done within the first 6 months of hire and the PCA had not had the training as of yet.
-She could see not providing for Resident #2's privacy when changing the residents' incontinent brief as a violation of the resident' rights.

b. Review of Nurses Notes for Resident #2 revealed:
-On 04/14/18, staff documented that Resident #2 took some coffee out of someone's room and "no smoke break for him."
-On 05/03/18, staff documented that Resident #2 was drinking urine again today and "no smoke break for him tonight."

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D 338	Continued From page 50 Interview with the medication aide (MA) on 05/22/18 at 4:15pm who documented the notes on 04/14/18 and 05/03/18 revealed: -Staff monitored Resident #2 when he went outside to smoke. -She was responsible for writing notes in the resident's record and wrote notes on the resident toward the end of the shift. Interview with the same MA on 05/25/18 at 8:45am revealed: -She had written the notes in the nurses notes on 04/14/18 and 05/03/18 as identified by her initials. -Anytime Resident #2 would take something, she would try to take something away from the resident that the resident liked. -No one had instructed her to take away Resident #2's smoking privilege. -She had heard a certain MA [named] say it and she felt like it was something she was supposed to do. -She felt like taking away Resident #2's smoking privilege was part of the rules before she was hired. -She felt like the resident should be able to go smoke a cigarette when the resident wanted to. -Her reason for taking Resident #2's smoking privilege was because she felt like the resident should not have gone into someone else' room and bothered the other resident's belongings. -Resident #2 had only missed one smoke break on each day, and had been allowed to go out and smoke at the other three smoke breaks. -On 05/03/18, she did not see Resident #2 drinking urine but was told by a PCA that the resident drank urine. -She documented in the residents nurse notes on 05/03/18, but was later told when she came to work the next day that Resident #2 was allowed to go out and smoke.	D 338		

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D 338	Continued From page 51 -Her intention was that Resident #2 was not going to go smoke that night. Interview with the Special Care Unit Coordinator (SCUC) on 05/25/18 at 12:25pm revealed: -Nobody had ever told staff to take Resident #2's smoke break that she was aware of. -She did not really agree with not allowing the resident to have a smoke break because Resident #2 had behaviors and that would agitate Resident #2. -Resident #2 looked forward to smoking. -The staff had come up with withholding Resident #2's cigarettes on their own. -She had not known staff were withholding Resident #2's right to smoke because of exhibited behaviors until she saw the May notes documented for Resident #2. -She reviewed resident nurse notes weekly. -She could see that withholding Resident #2's right to smoke was a violation of the residents' right. -She had a scheduled meeting with the MAs today and would be addressing that issue. Interview with the Administrator on 05/25/18 at 2:20pm revealed: -She was not aware that staff had been withholding Resident #2's cigarettes when the resident exhibited certain behaviors until it was bought to her attention when she copied the nurse notes on 05/22/18. -Staff were not allowed to take the residents cigarettes because the cigarettes belonged to the resident and that was their right. _____ The facility failed to assure dignity and respect of Resident #8 and Resident #9, who were cognitively impaired, was maintained as related to Staff D, who did not perform personal care tasks,	D 338		

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D 338	Continued From page 52 repeatedly entering rooms and closing doors resulting in Resident #8 crying and complaining of pain after being alone in a room with Staff D. This failure was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/2018 with an addendum per a telephone conversation on 05/31/2018 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2018.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer Prednisone as ordered by the prescribing physician for 1 of 6 sampled residents (Resident #1) after the Prednisone was entered on the resident's electronic Medication Administration	D 358		

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D 358	Continued From page 53 Record (eMAR) as a PRN medication. Review of resident #1 current FL-2 dated 05/16/18 revealed: -Diagnosis included status post hip fracture with gamma nail placement in the right hip. -A medication order for "Prednisone 5 mg 6 day taper pack take as directed". Review of resident #1's May 2018 printed Electronic Medication Administration Record (eMAR) on 05/23/18 revealed: -An entry for Prednisone 5 mg tablet take as directed dated 05/18/18. -The entry for Prednisone also indicated PRN underneath the column for hour. -There were no staff initials under the numerals for the days of the month. Observation of resident #1's medications on the medication cart on 05/23/18 at 12:30 pm revealed: -The Prednisone was located with other oral medications in the medication drawer. -The Prednisone packet had a six day regimen indicated on the side. -There were 19 of 21 tablets present in the packet. -Two blisters were punctured and no tablets were found in those blisters. Interview with a Medication Aide (MA) on 05/23/18 at 5:33 pm revealed: -Any new orders were given to the Special Care Unit Coordinator (SCUC) or Resident Care Coordinator (RCC) by the facility Nurse Practitioner (NP). -The SCUC or RCC faxed new orders to the pharmacy. -The SCUC or RCC told the MAs when there	D 358		

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D 358	Continued From page 54 were new orders for residents. -The pharmacy delivered medications to the facility by 6:00 pm each weekday. -The SCUC or RCC checked the order placed in the computer system by pharmacy. -This check had to be performed before the computer system allowed the MAs to administer any medication. -The MAs checked delivered medications in by comparing what was received from the pharmacy with the order in the computer. -The MAs did not use the original paper order when checking delivered medications. -If a MA noticed an error with a medication the SCC was notified. -The MA had not administered Prednisone to Resident #1. -The MA did not know Resident #1's Prednisone was entered as a PRN medication. Interview with another MA on 05/24/18 at 9:05 am revealed: -The MAs performed cart audits once a week. -A cart audit was completed by checking the active medication orders for each resident in comparison to the medication on the cart for each resident. -Medications without an active order were removed and returned to pharmacy. -The MAs did not use the original paper order when cart audits were performed. -The last cart audit was completed last Thursday 05/17/18 by the MAs. -Prednisone was a steroid and not a medication that would be scheduled as a PRN medication. -The MA did not know Resident #1 was prescribed Prednisone. -The MA had not administered Prednisone to Resident #1. -The SCUC was notified if an error was found on	D 358		

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D 358	Continued From page 55 the eMAR. Interview with the SCUC on 05/24/18 at 10:55 am revealed: -She was absent due to medical leave from the facility from 04/18/18 to 05/16/18. -She returned to work full duty on 05/1/18 and had several orders and documents that needed to be filed. -All new orders were given to her. -The medication orders were faxed to the pharmacy. -She filed all orders into the resident's record. -She told the MAs about new medication orders or changes. -She knew about the order for Prednisone when Resident #1 returned from the hospital on 05/16/18. -She saw the way the order was entered as a prn and called the pharmacy on 05/17/18. -She was told by pharmacy that the order would be fixed. -She did not check the order in the computer again after she spoke with pharmacy on 05/17/18. -She assumed the pharmacy would fix the order and not list as a PRN medication. -She was responsible for ensuring the accuracy of the paper MARs and eMAR entries. -She audited the previous months eMARs at the beginning of the following month and randomly. -The last time she audited the eMARs was on Monday 05/21/18. -She did not contact the pharmacy on 05/21/18 about the Prednisone order. -No one checked the medications received in comparison to the written orders. -She was made aware of the Prednisone error by a MA when the cart audit was done last Thursday 05/17/18.	D 358		

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D 358	Continued From page 56 -She did not notify the NP about the order for clarification nor about the medication being listed as a PRN on 05/16/18 nor on 05/17/18. -She was the person who had checked the medication in the computer system after pharmacy placed the order in the computer. -She reviewed the Prednisone entry from pharmacy and did not catch the error on 05/16/18. -The reason the error was not caught was because it was the end of the day when Resident #1 returned from the hospital. Interview with the pharmacy representative on 05/25/18 at 8:35 am revealed: -Another pharmacy representative entered the Prednisone order as PRN. -The pharmacy did not notify the facility when this happened. -She was made aware of the Prednisone entry on 05/24/18 by the SCC. -The date of the original order was 05/16/18. -There were no other orders for Prednisone other than the order from 05/16/18. -She was unsure if the facility administered any of the medication. -She did not know if the facility had returned the unused Prednisone to the pharmacy. Interview with Resident #1's NP on 05/24/18 at 12:00 pm revealed: -Prednisone was used for treatment of inflammation. -The Prednisone was prescribed for Resident #1 to assist with healing and decreasing inflammation after surgery. -The Prednisone was ordered at such a low dose that not receiving the medication did not affect Resident #1's healing. -He was not aware that the Prednisone was	D 358		

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D 358	Continued From page 57	D 358		

entered as PRN.
-He was not aware Resident #1 had not received the medication.
-He was not contacted by the facility prior to 05/24/18 to clarify the Prednisone order for resident #1.

Interview with the Administrator on 05/29/18 at 1:07 pm revealed:
-The orders for residents were given to the SCC or RCC.
-The SCUC or RCC faxed the orders to pharmacy.
-Medications were accepted in the eMAR system by the SCUC or RCC before they could be administered.
-The written order was used when accepting medications in the eMAR system.
-The medications were delivered by pharmacy and placed in the medication carts by the MAs.
-The MAs compared the delivered medication to the eMAR entry.
-The pharmacy usually notified the facility when there was an error with a medication order.
-The pharmacy should have notified the facility when the Prednisone was entered incorrectly.
-The SCUC and RCC were responsible for ensuring the accuracy of the eMARs.
-The MAs and the SCUC were accountable for medication administration accuracy.
-The SCUC made her aware of the Prednisone error last week, but she was unsure of the day.
-Because Resident #1 came from the hospital she had not seen his orders.
-She expected an order for a Prednisone taper to be placed on a paper MAR by the SCUC and given to the MAs.
-If the order was unclear, it should have been clarified.
-She was not sure why this Prednisone order fell

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D 358	Continued From page 58 by the wayside.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the documentation of medications administered by Staff A, medication aide (MA) had not been administered to 5 of 6 sampled residents (Residents #1, #2, #3, #5 and #7) by another MA, Staff B. The findings are: Review of the facility's staffing schedule for May 2018 revealed: -Staff A was scheduled to work on May 7, 8, 11, 12, 13 and 17, 2018 from 7:00 a.m. to 7:00 p.m. -Staff B was scheduled to work on May 7, 8, 11, 12, 13 and 17, 2018 from 7:00 p.m. to 7:00 a.m. 1. Review of Resident #1's most current FL-2 dated 5/16/18 revealed diagnosis included status post hip fracture with gamma nail placement in the right hip.	D 366		

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Review of Resident #1's Medication Administration Record (MAR) for May 2018 revealed:
-Doxycycline 100 mg capsule was documented as administered by Staff A on May 17, 2018 at 8:00 a.m. and 8:00 p.m.
-Haloperidol 2 milligrams (mg) tablet was documented as administered by Staff A on May 17, 2018 at 8:00 a.m. and 8:00 p.m.
-Mucinex Extended Release 600 mg was documented as administered by Staff A on May 17, 2018 at 8:00 a.m. and 8:00 p.m.
-Mupirocin 2% ointment was documented as administered by Staff A on May 17, 2018 at 8:00 a.m. and 8:00 p.m.
-Quetiapine Fumarate 100 mg tablet was documented as administered by Staff A on May 17, 2018 at 8:00 a.m., 2:00 p.m. and 8:00 p.m.
-Trazodone 100 mg tablet was documented as administered by Staff A on May 7, 8 and 11, 2018 at 8:00 p.m.
-Trazodone 50 mg tablet was documented as administered by Staff A on May 17, 2018 at 8:00 a.m. and 8:00 p.m.

Review of the Caregiver Key on Resident #1's May 2018 MAR revealed Staff A's initials were documented on the MAR as administering the 8:00 p.m. medications on May 7, 8, 11 and 17, 2018 and did not match Staff B's initials who administered medications on May 7, 8, 11 and 17, 2018 at 8:00 p.m.

Refer to the interview with Staff A on 5/25/2018 at 12:07 p.m.

Refer to the telephone interview with Staff B on 5/25/2018 at 12:47 p.m.

Refer to the interview with the Resident Care

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Coordinator (RCC) on 5/25/2018 at 2:50 p.m.

Refer to the interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m.

Refer to the interview with the Secure Care Unit Coordinator (SCUC) on 5/25/2018 at 7:15 p.m.

Refer to the telephone interview with the Administrator on 5/29/2018 at 4:45 p.m.

2. Review of Resident #2's most current FL-2 dated 1/30/18 revealed diagnosis included dementia with behavior disturbances, psychogenic polydipsia, hyponatremia, schizophrenia, inhalant use disorder, cocaine use disorder and alcohol use disorder.

Review of Resident #2's MAR for May 2018 revealed:
-Clonazepam 0.5 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.
-Lorazepam 0.5 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.
-Olanzapine 20 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.
-Sodium Chloride 1 GM tablet was documented as administered by Staff A on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.

Review of the Caregiver Key on Resident #2, May 2018's MAR revealed Staff A's initials were documented on the MAR as administering the 8:00 p.m. medications on May 7, 8, 11, 12, 13 and 17, 2018 and did not match Staff B's initials who administered medications on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.

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D 366	Continued From page 61 Refer to the interview with Staff A on 5/25/2018 at 12:07 p.m. Refer to the telephone interview with Staff B on 5/25/2018 at 12:47 p.m. Refer to the interview with the Resident Care Coordinator (RCC) on 5/25/2018 at 2:50 p.m. Refer to the interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m. Refer to the interview with the Secure Care Unit Coordinator (SCUC) on 5/25/2018 at 7:15 p.m. Refer to the telephone interview with the Administrator on 5/29/2018 at 4:45 p.m. 3. Review of Resident #3's most current FL-2 dated 4/19/18 revealed diagnosis included neurocognitive disorder likely mixed vascular and alzheimer's dementia, major depressive disorder, borderline personality disorder, falls risk, type 2 diabetes mellitus, chronic pain, gastroesophageal reflux disease, constipation, dysuria, hypertension, obstructive sleep apnea, asthma, heart failure with a preserved ejection fracture with group 2 pulmonary hypertension and chronic normocytic anemia. Review of Resident #3's MAR for May 2018 revealed: -Atorvastatin 40 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m. -Docusate Sodium 100 mg capsule was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m. -Gabapentin 300 mg capsule was documented as	D 366		

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administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m.
-Humalog sliding scale was documented as administered by Staff A on May 7, 2018 at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m.; on May 8, 2018 at 7:30 a.m., 11:30 a.m. and 8:00 p.m.; on May 11, 2018 at 7:30 a.m., 11:30 a.m. and 8:00 p.m.; on May 12, 2018 at 7:30 a.m., 11:30 a.m. and 8:00 p.m.; and on May 13, 2018 at 7:30 a.m. and 8:00 p.m.
-Lantus 16 units was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m.
-Melatonin 3 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m.
-Metformin HCL 500 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m.
-Polyethylene Glycol 3350 powder 17 Grams in 8 ounces of liquid was documented as administered by Staff A on May 7, 2018 at 8:00 a.m. and 8:00 p.m.; on May 8, 2018 at 8:00 a.m.; on May 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m.
-Lorazepam 0.5 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m.

Review of Resident #3's controlled substance record (CSR) for the month of May 2018 revealed:
-Staff B signed CSR on 5/7/18 as giving Lorazepam 0.5 mg at 7:00 p.m.
-Staff B signed CSR on 5/8/18 as giving Lorazepam 0.5 mg at 7:00 a.m.
-Staff B signed CSR on 5/9/18 as giving Lorazepam 0.5 mg at 7:00 a.m.
-Staff B signed CSR on 5/11/18 as giving Lorazepam 0.5 mg at 8:00 p.m.

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D 366	Continued From page 63 -Staff B signed CSR on 5/12/18 as giving Lorazepam 0.5 mg at 7:00 a.m. -Staff B signed CSR on 5/12/18 as giving Lorazepam 0.5 mg at 8:00 p.m. Review of the Caregiver Key on Resident #3, May 2018's MAR revealed Staff A's initials were documented on the MAR as administering the 8:00 p.m. medications on May 7, 8, 11, 12 and 13, 2018 and did not match Staff B's initials who administered medications on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m. Refer to the interview with Staff A on 5/25/2018 at 12:07 p.m. Refer to the telephone interview with Staff B on 5/25/2018 at 12:47 p.m. Refer to the interview with the Resident Care Coordinator (RCC) on 5/25/2018 at 2:50 p.m. Refer to the interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m. Refer to the interview with the Secure Care Unit Coordinator (SCUC) on 5/25/2018 at 7:15 p.m. Refer to the telephone interview with the Administrator on 5/29/2018 at 4:45 p.m. 4. Review of Resident #5's most current FL-2 dated 4/11/18 revealed diagnosis included Acute Kidney Injury (AKI) and status post fall. Review of Resident #5's MAR for May 2018 revealed: -Allopurinol 100 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m.	D 366		

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D 366	Continued From page 64 -Carvedilol 6.25 mg tablet was documented as administered by Staff A on May 7, 8, 11 and 12, 2018 at 8:00 a.m. and 8:00 p.m. -Gabapentin 100 mg capsule was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m. -Haloperidol 0.5 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m. -Lamotrigine 25 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m. -Levetiracetam 500 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m. -Lidocaine 5% patch was documented as applied for 12 hours and removed for 12 hours by Staff A on May 7, 8, 11, 12 and 13, 2018, on at 8:00 a.m. and off at 8:00 p.m. - Quetiapine Fumarate 200 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m. -Tramadol HCL 50 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12 and 13, 2018 at 8:00 a.m. and 8:00 p.m. Review of the Caregiver Key on Resident #5's May 2018 MAR revealed Staff A's initials were documented on the MAR as administering the 8:00 p.m. medications on May 7, 8, 11, 12 and 13, 2018 and did not match Staff B's initials who administered medications on May 7, 8, 11, 12 and 13, 2018 at 8:00 p.m. Refer to the interview with Staff A on 5/25/2018 at 12:07 p.m. Refer to the telephone interview with Staff B on 5/25/2018 at 12:47 p.m.	D 366		

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	HAL053026	A. BUILDING: _____ B. WING _____	R-C 05/31/2018

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D 366	Continued From page 65 Refer to the interview with the Resident Care Coordinator (RCC) on 5/25/2018 at 2:50 p.m. Refer to the interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m. Refer to the interview with the Secure Care Unit Coordinator (SCUC) on 5/25/2018 at 7:15 p.m. Refer to the telephone interview with the Administrator on 5/29/2018 at 4:45 p.m. 5. Review of Resident #7's most current FL-2 dated 8/10/17 revealed diagnosis included iron deficiency, anemia, organic brain injury, dementia, vitamin D deficiency, bipolar disorder, anxiety . Review of Resident #7's MAR for May 2018 revealed: - Docusate Sodium 100 mg capsule was documented as administered by Staff A on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m. -Risperidone 0.25 mg tablet was documented as administered by Staff A on May 7, 8, 11, 12, 13, 2018 at 8:00 p.m. and on May 17, 2018 at 8:00 a.m. and 8:00 p.m. -Valproic Acid 250 mg capsule was documented as administered by Staff A on May 7, 8, 11, 12, 13, 2018 at 8:00 p.m. and on May 17, 2018 at 8:00 a.m. and 8:00 p.m. Review of the Caregiver Key on Resident #7's May 2018 MAR revealed Staff A's initials were documented on the MAR as administering the 8:00 p.m. medications on May 7, 8, 11, 12, 13 and 17, 2018 and did not match Staff B's initials who administered medications on May 7, 8, 11, 12, 13 and 17, 2018 at 8:00 p.m.	D 366		

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D 366	Continued From page 66 Refer to the interview with Staff A on 5/25/2018 at 12:07 p.m. Refer to the telephone interview with Staff B on 5/25/2018 at 12:47 p.m. Refer to the interview with the Resident Care Coordinator (RCC) on 5/25/2018 at 2:50 p.m. Refer to the interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m. Refer to the interview with the Secure Care Unit Coordinator (SCUC) on 5/25/2018 at 7:15 p.m. Refer to the telephone interview with the Administrator on 5/29/2018 at 4:45 p.m. _____ Interview with Staff A on 5/25/2018 at 12:07 p.m. revealed: -She worked on May 7, 8, 11, 12, 13 and 17, 2018 from 7:00 a.m. to 7:00 p.m. -Staff B worked on May 7, 8, 11, 12, 13 and 17, 2018 from 7:00 p.m. to 7:00 a.m. -Staff B's password was not working so she, Staff A, gave Staff B her password to use so she could log on to the Electronic Medication Administration Record (EMAR) system. -Staff A and Staff B work on the same track and that was the only time that she gave her password to Staff B to use as log on to EMAR system. -The procedure was to report to management if you had issues with logging on with your password. -Staff B used Staff A's password for a week. -Management was not aware that Staff B was using Staff A's password as log on.	D 366		

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D 366	Continued From page 67 Telephone interview with Staff B on 5/25/2018 at 12:47 p.m. revealed: -She could not log onto the EMAR system with her password on May 7, 8, 11, 12, 13 and 17, 2018. -She used Staff A's password to sign on to the EMAR system. -She used Staff A's password for at the most three days. -The procedure was to get in touch with your supervisor if you had issues with logging on with your password. -She texted her supervisor, HR and she was told that the supervisor would handle it. -She then told Staff A to tell the supervisor, HR that she could not sign onto EMAR system. -She then called the supervisor, HR to let her know that the EMAR would not take her password. -The supervisor, HR asked her whose password she was using and she told her Staff A's password. -The supervisor, HR did not say anything about her using Staff A's password. -She only work 7:00 p.m. to 7:00 a.m. shift. -She had worked the same shift for over one year. -She did not work Wednesday and Thursday if she worked the weekend. Interview with the Resident Care Coordinator (RCC) on 5/25/2018 at 2:50 p.m. revealed: -She was not aware that Staff B's password was not working. -Staff would have gone to Human Resource or Secure Care Unit Coordinator (SCUC) about password not working. Interview with the Human Resource/ Supervisor (HR/ S) on 5/25/2018 at 6:50 p.m. revealed:	D 366		

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D 366	Continued From page 68 -She did not know why Staff B's password would not allow her to sign onto EMAR system. -She had to come in and reset Staff B's password. -Her expectation would be that staff would call her or the SCUC if their password would not let them into the EMAR system. -She did not know about Staff B's password was not working until the next day when RCC told her. -She reset Staff B's password as soon as she found out. -It does not record in the system when she reset a password. -If she was at a computer when she was told that a password was not working she would access EMAR system remotely and reset password. -Staff should call the Administrator or the SCUC to find out what they should do if they were not able to get their password reset. -She was not aware that MAs were sharing passwords. -She did not ask about how Staff B was documenting for medications she gave "because it is not my department". -According to the computer the last time Staff B's password was changed was May 16, 2018 by the SCUC. -She could not tell how Staff B was documenting in the interim when her password was not working. Interview with the SCUC on 5/25/2018 at 7:15 p.m. revealed: -The facility did not allow staff to share passwords. "It is a rule." -She knew that one day last week Staff B's password was not working. Telephone interview with the Administrator on 5/29/2018 at 4:45 p.m. revealed:	D 366		

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D 366	Continued From page 69 -Staff was to call pharmacy if they were not able to get on the EMAR system. -If pharmacy was not open, staff would call the SCUC or the Administrator and we would give them permission to use our password. -We would then change our password. -Staff would make the SCC or the SCUC aware that they were using someone else's password. -Staff just had to report what they were doing. -She did "not have a problem with that as long as they can sign off on their meds." -Staff would have signed on the Narcotic sheet and that would show who was passing medications.	D 366		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report allegations of abuse by Staff D to the health care personnel registry (HCPR) within 24 hours of Administrator's notification. The findings are:	D 438		

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D 438	Continued From page 70 Interview with Staff D on 05/25/2018 at 12:35 p.m. revealed: -Staff D had spoken with a detective from the local police department yesterday (05/24/2018) about a rumor that had been reported to the local police about him "messing with women at the facility" and "sexual harassment", however, he did not know any more than that and was told by the police that they had to investigate it. He did not know "who put that out there". -The same type of allegations had occurred a while back against him (Staff D referred to the time frame as 4 to 5 months, then stated 2016, and that he was not good with timeframes) but when the accusation was made previously, they (Staff D and the Administrator) were out of town. Review of a Incident/Investigation report from the local police department revealed: -The reported date was 05/21/2018 at 9:13 a.m.. -The location of the incident had the facility's address and premise type was "Medical facility". -The crime incident was listed as sex offenses. -There was an entry "By having unwanted sexual encounter with the victim" in a section of the form labeled "How Attacked or Committed". -The number of victims was "1". -The victims name was "restricted" -The resident status was marked as "resident". -Further investigation was marked in the case status section of the form. Interview with the investigating local detective on 05/24/2018 at 12:55 p.m. revealed: -He had spoken with the Staff D and the Administrator today (05/24/2018) regarding the allegations. -His investigation was ongoing. Interview with the Administrator on 05/25/2018 at	D 438		

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D 438	Continued From page 71 2:40 p.m. revealed: -Once an allegation of abuse or neglect was reported, she initiated an internal investigation and reported that same allegation to the Health Care Personnel Registry (HCPR). -She had spoken with local law enforcement detectives yesterday (05/24/2018) and a complaint was made regarding Staff D. -She could not exactly remember what the detective "named it" regarding the allegation against Staff D and she had called the detective several times today and left a message to find out exactly what the detective had reported to her but knew it was concerning "messing with female residents". -She had not started an internal investigation. She had intended to start her internal investigation today (05/25/2018) and had planned to fill out the initial report to HCPR today (05/25/2018). A second interview with the Administrator on 05/25/2018 at 5:21 p.m. revealed: -There were allegations concerning Staff D that had been investigated and unsubstantiated in 2016. -The local detective came yesterday (05/24/2018) related to an alleged "inappropriate something". -She had completed the 24 hour HCPR report and had several failed attempts to send the report to HCPR by fax. -She had not filled out the latest revised HCPR initial report and had utilized the form labeled "24 Hour Initial Report". -She would utilize the new form off the HCPR web page and try to refax the information today (05/25/2018) and would provide a copy of the report once a fax confirmation had been received. Review of the "24 Hour Initial Report" dated	D 438		

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D 438	Continued From page 72 05/25/2018 revealed: -The box beside resident abuse was marked with an "x". -In the allegation description section of the form "2016" was documented as the date of the incident, the time was documented as unknown and an entry "inappropriate sexual activity, No details. -In the Accused Individual Information section Staff D's name was documented and "Owner" was documented as the job title. -The form was signed by the Administrator dated 05/25/2018. The facility failed to report current allegations of inappropriate sexual contact with cognitively impaired female residents as related to Staff D, who was previously reported to the N. C. Health Care Personnel Registry (HCPR) in 2016 for the same allegations of abusing female residents. The facility's failure placed the residents at serious risk of abuse and physical harm which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/25/2018 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 30, 2018.	D 438		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration,	D911		

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D911	Continued From page 73 dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure dignity and respect for every resident. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure dignity, respect, and privacy was maintained for all residents as related to Staff D, who did not perform personal care tasks, entering rooms and closing doors with multiple female residents including repetitive incidents with Resident #8 and Resident #9, withholding smoking privileges from Resident #2, and performing personal care without privacy for Resident #2. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the	D912		

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D912	Continued From page 74 residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to criminal background checks. The findings are Based on record reviews and interviews, the facility failed to assure 1 of 4 staff sampled (Staff D) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40 prior to having direct contact with residents while performing maintenance job responsibilities, providing ongoing walk-throughs of the facility and management oversight in resident areas. [Refer to Tag 0139 , 10 NCAC 13F. 0407 (a) (7) Other Staff Qualifications; have a criminal background check in accordance with G.S. 114-19.10 and 131D-40 (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of abuse and neglect related to personal care and supervision and reporting allegations to Health Care Personnel Registry. The findings are: 1. Based on observations, interviews, and record	D914		

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D914	Continued From page 75 reviews, the facility failed to provide supervision for 1 of 1 residents (#2) sampled with known behaviors of drinking hand sanitizer and the residents own urine. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on record reviews and interviews, the facility failed to report allegations of abuse by Staff D to the health care personnel registry (HCPR) within 24 hours of Administrator's notification. [Refer to Tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].	D914		