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	HAL080020	A. BUILDING: _____ B. WING _____	R 08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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 conducted a follow-up survey on 08/22/18 through 08/24/18.	{D 000}		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the shower in the residents' common bathroom was clean and free of drain fly larvae and dirt. The findings are: Observation on 08/23/18 at 12:34pm of the residents' common shower drain on the hallway near resident room #102 revealed: -There were six small black worms. -The length of the worms was one-fourth inch to half an inch long. -The worms moved in no particular pattern, but were scattered throughout the shower floor. -On the outside shower wall was observed a two-winged drain fly that was related to the worms. Observation on 08/23/18 at 12:48pm of the residents' second common shower revealed:	D 074		

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D 074	Continued From page 1	D 074		

-No worms were observed on the shower floor.
-There was a two-winged drain fly on the outside shower wall.

Confidential interview with five residents revealed:
-They showered in the common residents' bathroom near resident room #102.
-There were worms in the shower.
-The worms were coming up through the drain in the shower floor.
-The worms had been in the shower since April 2018.
-One resident said when she took a shower she used paper towels and "scooped" the worms out of the shower, then she took a shower.
-A second resident said when she showered they had to run water to get the worms out of the shower.
-They had made the owner/Executive Director (ED) and the facility staff aware of the worms, but nothing had been done, the worms were still in the shower.
-They did not like taking showers in the bathroom knowing that worms were coming up through the shower drain.
-Taking a shower with the worms made them feel nasty and disgusting, they did not like the worms.
-They had not seen anyone treating the shower to get rid of the worms.
-The facility had another common shower but the water did not always drain properly and sometimes overflowed.

Interview on 08/23/18 at 11:58am with the local environmental health supervisor revealed:
-The worms in the shower were called "filter flies."
-The worms lived off the "guck and grime" trapped in the shower drain.
-The worms turned into flies.
-More than likely drain flies were observed near

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the shower as well because they were matured worms.
-If there was another shower with no identified worms, but flies, then that shower also had worms and needed to be treated as well.
-The drain needed to be cleaned with the appropriate cleaning agent, usually a foam.
-Repeat cleaning of the drain needed to be done frequently, at least weekly, then not as often depending on the volume of the worms.
-It was important to repeat the treatment in order to get rid of the worms.
-If the treatment was done correctly the worms would go away, but if not treated correctly they would not go away.

Interview with the ED on 08/23/18 at 1:47pm revealed:
-She did know about the worms in the shower.
-The facility had called a pipe cleaning company to put down a pesticide and clean the drain.

Review of the receipt from the pipe cleaning company dated 02/21/18 revealed:
-The service services did not include cleaning the drain in the residents' common showers.

Interview with a representative from the pipe cleaning company on 08/24/18 at 3:01pm revealed:
-They refilled, repaired and replaced water pipes in various areas throughout the building.
-The company did not know of the worms and did not do a treatment for worms or drain flies.

Second interview with the ED on 08/23/18 at 5:40pm revealed:
-She was aware of the worms one week ago.
-A resident told her about the worms in the shower.

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-The co-owner, a family member, called a friend to look at the worms and treat the worms.

Review of the invoice from the co-owner's acquaintance revealed:
-On 08/03/18 he provided treatment for "drain flies."
-He did not specify which shower or showers or drain was treated for drain flies.
-He did not specify the name or the type of treatment method used.
-He noted that he would return in three weeks on 08/26/18 (Sunday).

Attempted interview with the co-owner's acquaintance on 08/24/18 at 4:21pm was not successful.

Interview with the housekeeper on 08/23/18 at 12:25pm revealed:
-She had worked at the facility for almost one month.
-She knew about the worms in the shower since 07/30/18.
-She cleaned the showers at least once per day, but had observed no worms in the shower, mainly because when cleaning she did look at dirt in the bottom of the shower.
-A resident had picked up a worm from the shower with a paper towel and showed it to her last week.
-She did not tell the owner/ED about the worms in the shower.
-She poured baking soda and vinegar down the shower drain to clean it last week.
-She thought her treatment process had worked.
-She cleaned the shower this morning, but did not pay attention if the worms were in the shower.

Observation on 08/23/18 at 12:34pm of the

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residents' common shower near resident room #102 (same shower with identified live worms) revealed:
-There was a black substance around the lower wall of the shower that appeared to be mold.

Interview on 08/23/18 at 4:35pm with the co-owner revealed:
-The co-owner cleaned the shower today after being made aware of the black substance on the shower floor and there was dirt on the shower floor and not mold.
-The caulking between the titles was not clean, but there was no mold in the shower.

Interview with the housekeeper on 08/23/18 at 12:32pm revealed:
-She had worked at the facility for almost one month.
-She cleaned the showers at least once per day.
-She had noticed the mold/dirt in the shower, so she cleaned the shower with bleach, not necessarily on the mold/dirt but to just clean the shower.
-She had not said anything to the ED regarding the mold/dirt in the shower.

Interview with the ED on 08/23/18 at 5:20pm revealed:
-No one had made her aware the shower was not cleaned properly.
-The housekeeper had a cleaning schedule that included the showers.
-The showers were to be cleaned at least once daily.
-She did not observe the shower to see if it was cleaned.
-No one had complained about the shower not being cleaned, so she was not aware the showers were not cleaned properly.

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{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: FOLLOW UP TO TYPE B VIOLATION Based on the findings, the previous Type B Violation was not abated. Based on record reviews and interviews the facility failed to assure 1 of 3 staff sampled (Administrator) had a criminal background check completed upon hire. The findings are: Review of the Administrator's personnel record revealed: -The date of hire was 07/23/2018. -There was no documentation of a consent for a criminal background check. -There was no documentation of a statewide criminal background check was completed. Interview with the Administrator on 08/23/18 at 5:55 pm revealed: -She had turned in paperwork including her fingerprints and a background check to the state office in order to renew her Administrator's license at the beginning of 2018. -She did not know she had to have a separate criminal background check upon hire at the facility. Interview with the Executive Director on 08/23/18	{D 139}		

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{D 139}	Continued From page 6 at 6:00 pm revealed: -She did not complete a criminal background check on the Administrator when she hired her. -She or the business office assistant were responsible for obtaining criminal background checks on all new employees upon hire. -She thought that since the Administrator and had an Administrator's license, she did not need to have a separate background check on file upon hire. -She had completed a drug screening and Health Care Personnel Registry check on 07/30/18 for the Administrator and thought that was all she needed in her personnel record. _____ The facility failed to ensure the Administrator had a criminal background check upon hire. This failure resulted in the facility being unaware of the Administrator's criminal background history which was detrimental to the welfare and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection on 08/23/18 in accordance with G.S. 131D-34 for this violation.	{D 139}		
D 166	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (b) Training shall be provided by a registered nurse and shall include the following: (1) alternatives to physical restraints; (2) types of physical restraints; (3) medical symptoms that warrant physical restraint; (4) negative outcomes from using physical	D 166		

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restraints;
(5) correct application of physical restraints;
(6) monitoring and caring for residents who are restrained; and
(7) the process of reducing restraint time by using alternatives.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide training on physical restraints for 4 of 4 sampled staff (Staff A, Administrator, Staff C, Staff D).

The findings are:

Review of the facility's restraint and restraint training policies revealed:
-Staff were required by policy to receive training on alternatives to restrictive interventions.
-The facility did not practice physical restrictions or manual holds.

1. Review of Staff A, medication aide (MA)/Resident Care Director's (RCD) personnel record revealed:
-Staff A was hired on 08/01/18.
-There was no documentation of restraint training in the personnel record.
-The section for physical restraints on the LHPS skills validation form was marked "NA."

Interview with Staff A on 08/23/18 at 5:17pm revealed:
-She started working at the facility last Friday.
-She had restraint usage training prior to coming to the facility.

Second telephone interview with Staff A on 08/24/18 at 3:48 pm revealed:
-She knew that one resident had full bed rails.

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-The nurse checked her off on restraint usage when she completed her 5 hour medication training.
-She had been instructed not to use restraints unless there was a physician's order and the restraints had to be released every 2 hours.

Refer to interview with the Executive Director (ED) on 08/23/18 at 6:50 pm.

2. Review of the Administrator's personnel record revealed:
-The Administrator was hired on 7/23/18.
-There was no documentation of restraint training in the personnel record.

Interview with the Administrator on 08/23/18 at 1:00 pm revealed:
-The ED was responsible to ensure staff training was completed.
-She had not completed restraint training at the facility because the facility was restraint-free.
-She did not consider the bed rails that one resident had, a restraint because they were not used.
-She had communicated with staff regarding not using the bed rails when the resident was in bed and did not know the bed rails were being used.

Refer to interview with the Executive Director on 08/23/18 at 6:50 pm.

3. Review of Staff C, personal care aide/housekeeper's personnel record revealed:
-Staff C was hired on 7/26/18.
-There was no documentation of restraint training in the personnel record.

Attempted telephone interview with Staff C on 08/23/18 at 6:00 pm was unsuccessful.

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D 166	Continued From page 9 Refer to interview with the Executive Director (ED) on 08/23/18 at 6:50 pm. D. Review of Staff D, medication aide's personnel record revealed: -Staff D was hired on 01/31/18. -There was documentation of training for wrist restraints, gerichair with tabletop, and documentation on the LHPS skills validation in the personnel record dated 2/12/18. -There was no documentation of restraint training involving bed rails in the personnel record. Attempted telephone interview on 08/23/18 at 6:15 pm with Staff D was not successful. Observation of a resident's bed on 08/22/18 at 10:20 am revealed the resident had a hospital bed with two full length bed rails. Observation of the resident on 08/22/18 at 2:20pm revealed: -The resident was in bed and both the bed rails were raised in the up position. -The resident could not physically maneuver the bed rails to get himself out of the bed. Refer to interview with the Executive Director (ED) on 08/23/18 at 6:50 pm. _____ Interview on 8/23/18 at 6:50 pm with the Executive Director revealed: -She was responsible to ensure staff training was completed. -The staff had not received "Specific restraint training". -When the staff had their orientation, alternatives to restraint usage and the facility's physical restraint policy was reviewed with staff as part of	D 166		

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D 166	Continued From page 10 the orientation package. -There was a resident with an order for full bed rails. -They did not consider the bed rails a restraint because the bed rails were not used. -The ED had not observed the resident in bed during the day. -The ED had communicated with staff regarding not using the bed rails when the resident was in bed and did not know the bed rails were being used. Review of the facility's employee orientation training packet revealed the facility was a restraint-free facility and there was no training information related to the use of restraints.	D 166		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure that the	D 238		

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information provided on the current FL2s including the residents' diet orders had been clarified by a prescribing practitioner for 3 of 5 sampled (Resident #2, Resident #5, and Resident #6).

The findings are :

1. Review of Resident #2's current FL-2 dated 10/30/17 revealed diagnoses included type II diabetes.
-A physician's order for metformin 1000mg twice daily (used to control diabetes) and fingerstick blood sugars once a week on Monday.
-There was no diet order on the FL2.

Review of Resident #2's record revealed a diet order dated 11/22/17 for a no concentrated sweets (NCS) diet.

Review of hospital discharge summary orders dated 08/21/18 (electronically signed by a physician) revealed a physician's order for "consistent carbohydrate meals."

Review of the therapeutic diet list posted in the kitchen revealed Resident #2 was to be served a diabetic diet.

Review of the therapeutic diet menus revealed there was a No Concentrated Sweets (NCS) diet menu for all meals, but no consistent carbohydrate diet menu.

Observation of the lunch meal service on 08/22/18 at 12:15pm revealed:
-Resident #2 was served unsweetened tea, coffee, water, rice with beans, turnip greens, yellow cake topped with strawberries, and a corn muffin.

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D 238	Continued From page 12 -The resident ate 100% of the meal. Review of the yellow cake mix revealed sugar was the first ingredient and there were 20 grams of sugar per serving. Review of Resident #2's 2018 electronic medication administration record (eMAR) revealed the resident's blood sugars ranged as follows: June 2018, 97-202; July 2018, 104-150; August 2018, 118-191. Interview with the food service manager (FSM) on 08/22/18 at 12:25pm revealed: -She thought Resident #2 was on a regular diet. -If a resident's diet order changed, then management should have provided her with a new diet order. -The facility had NCS diet menus that was used for all diabetics. Interview with Resident #2 on 08/22/18 at 1:30pm revealed: -She was a diabetic, took medications to control her diabetes and had her blood sugar checked once a week on Mondays. -To her knowledge she should be on a diabetic diet. -At meal time all residents got the same dessert. -She was served the same meal and dessert as other residents. -The facility had sugar-free snack items that she had observed served to other residents. Refer to interview with the FSM on 08/22/18 at 12:25pm. Refer to interview with the dietitian on 08/22/18 at 2:52pm.	D 238		

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D 238	Continued From page 13 Refer to interview with the Executive Director (ED) on 08/23/18 at 1:58pm. 2. Review of Resident #5's current FL2 dated 08/09/18 revealed: -There were no diagnoses, no medications and no treatments ordered on the FL2. Review of Resident #5's record revealed a previous FL2 dated 02/26/18 revealed: -Diagnoses included insulin dependent diabetes mellitus. -A physician's order for detemir (used to control diabetes) 50 units twice daily and lispro (used to control diabetes) 6 up to units with meals. -A physician's order for a diabetic diet. Review of the therapeutic diet list posted in the kitchen revealed Resident #5 was to be served a diabetic diet. Review of the No Concentrated Sweets (NCS) diet menu for the lunch meal 08/22/18 revealed residents were to be served: rice and bean 1-2 cups, corn bread 4 ounces, steamed greens ½ cup, strawberry short cakes 1 each, and beverages of choice. Observation of the lunch meal service on 08/22/18 at 12:15pm revealed: -Resident #5 was served unsweetened tea, coffee, water, rice with beans, turnip greens, brownie topped with strawberries, and a corn muffin. -The resident ate 100% of the meal. Review of the gluten-free brownie mix revealed sugar was the first ingredient and there were 18 grams of sugar per serving.	D 238		

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

(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 238	Continued From page 14 Interview with Resident #5 on 08/23/18 at 10:38am revealed: -He was a diabetic and should be on a diabetic diet. -His meals were always the same as other residents. -He received the brownie, but it did not taste sugar-free. -Sometimes there were sugar-free items offered for snacks, but meals were always the same for all residents. Refer to interview with the FSM on 08/22/18 at 12:25pm. Refer to interview with the dietitian on 08/22/18 at 2:52pm. Refer to interview with the ED on 08/23/18 at 1:58pm 3. Review of Resident #6's current FL2 dated 02/01/18 revealed: -Diagnoses included type II diabetes. -A physician order for Novolog 22 units (used to control diabetes) at breakfast and 20 units at supper and metformin (used to control diabetes) 1,000mg twice daily. -There were no diet orders documented on the FL2. Review of Resident #6's record revealed: -A signed physician diet order dated 03/07/18 with options to specify a specific diet. -The diet options listed on the form were regular, no added salt, diet textures listed were mechanical soft and pureed diets. -There was no option for No Concentrated Sweets (NCS) diet on the diet order sheet. -The physician that completed the form was to	D 238		

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D 238	Continued From page 15	D 238		

put a mark "X" on the line next to the diet option ordered.
-The physician that signed the form did not put an "X" on the required line for a specific diet, but circled the word "diabetic" in the wording of another diet option.
-There was no documentation the facility had clarified the diet order.

Review of the therapeutic diet list posted in the kitchen revealed Resident #6 was to be served a diabetic diet.

Observation of the lunch meal service on 08/22/18 at 12:15pm revealed:
-Resident #6 was served unsweetened tea, coffee, water, rice with beans, turnip greens, brownie topped with strawberries, and a corn muffin.
-The resident ate 100% of the meal.

Review of the gluten-free brownie mix revealed sugar was the first ingredient and there were 18 grams of sugar per serving

Interview with Resident #6 on 08/23/18 at 10:40am revealed:
-He was a diabetic.
-He thought that he was on a sugar-free diet.
-He had always received the same dessert as other residents in the facility.
-He did not know if the brownie served with the lunch meal on 08/22/18 was sugar-free.

Attempted interview on 08/24/18 at 2:33pm with Resident #6's physician was not successful.

Interview with the FSM on 08/22/18 at 12:25pm revealed:
-She created the diet list posted on the wall.

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D 238	Continued From page 16 -She served residents how she knew they liked their meals. -If she knew a resident did not like sugar-free dessert she did not give them a sugar-free dessert. -Today, she served diabetic residents a "gluten free" brownie instead of the yellow cake. -She had only one box of the gluten-free mix and had thrown the box away in the dumpster and could not retrieve the box. -She thought gluten-free desserts were sugar-free and sufficient to give to diabetic residents. -She did not read the nutrition label to identify the sugar content. Interview with the facility's contracted dietitian on 08/22/18 at 2:52pm revealed: -She prepared the facility menus. -She had not visited the facility to ensure staff served the meals as planned. -She thought that when preparing strawberry short cake, everyone used angel food cake mix, which was appropriate for diabetics. -She did not tell the facility to use gluten-free desserts for diabetics. -She would do more educating with the facility to ensure the meals were served as planned. Interview with the ED on 08/23/18 at 1:58pm revealed: -She did not observe every meal to ensure therapeutic diets were served as ordered. -She purchased the food and thought the facility had appropriate desserts for diabetics. Refer to interview with the FSM on 08/22/18 at 12:25pm. Refer to interview with the dietitian on 08/22/18 at	D 238		

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D 238	Continued From page 17 2:52pm. Refer to interview with the ED on 08/23/18 at 1:58pm. Interview with the FSM on 08/22/18 at 12:25pm revealed: -All diabetic residents were served a NCS diet. -She considered a "diabetic diet" the same as an NCS diet. -She was not responsible for clarifying diet orders. -She created the diet list posted on the wall. -She served residents how she knew they liked their meals. -If she knew a resident did not like sugar-free dessert she did not give them a sugar-free dessert. -Today, she served diabetic residents a "gluten free" brownie instead of the yellow date. -She had only one box of the brand named gluten-free mix and had thrown the box away in the dumpster and could not retrieve the box. -She thought gluten-free desserts were sugar-free and sufficient to give to diabetic residents. -She did not read the nutrition label to identify the sugar content. Interview with the facility's contract dietitian on 08/22/18 at 2:52pm revealed: -She prepared the facility's menus. -She had not visited the facility to ensure staff served the meals as planned. -The NCS menu was for all diabetic residents. -If the resident was ordered a "diabetic diet" the NCS menu is the same. -She thought that when preparing strawberry short cake, everyone used angel food cake, which is appropriate for diabetics.	D 238		

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D 238	Continued From page 18 -She did not tell the facility to use gluten-free desserts for diabetics. -She would do more educating with the facility to ensure the meals were served as planned. Interview with the ED on 08/23/18 at 1:58pm revealed: -She did not observe every meal to ensure therapeutic diets were served as ordered. -She considered NCS and diabetic diet to be the same diet and had not clarified diabetic diet orders. -She was in the process of getting all diabetic residents diet changed to NCS diet. -She purchased the food and thought the facility had appropriate desserts for diabetics. -She had not clarified any diet orders.	D 238		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 5 sampled residents (Residents #1 and #2) with aggressive behaviors, medication refusals and medications not available (#1) and orders for duplicate medications (#2). The findings are:	{D 273}		

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{D 273}	Continued From page 19 1. Review of Resident #2's current FL-2 dated 10/30/17 revealed diagnoses included an unspecified fracture of the upper left humerus, difficulty walking, and muscle weakness. Review of Resident #2's signed provider's orders dated 02/21/18 revealed diagnoses included type 2 diabetes mellitus with neuropathy, myasthenia gravis, anxiety, Chronic Obstructive Pulmonary Disease (COPD), epilepsy, and hypertension. Review of Resident #2's primary care provider's (PCP) orders dated 06/04/18 revealed an order for nortriptyline HCl 10 mg (used to treat depression) take 1 capsule three times a day, to help with nerve pain in her feet and legs. Review of Resident #2's mental health provider's order dated 06/12/18 revealed an order for amitriptyline 25 mg (used to treat depression) take 1 capsule every night at bedtime for sleep. Review of Resident #2's record revealed: -A medication clarification request dated 08/07/18 from Resident #2's PCP requesting the facility to verify with Resident #2's mental health provider that the resident needed both nortriptyline and amitriptyline. -There was no documentation or fax confirmation the medication clarification had been sent to the mental health provider. Review of Resident #2's August 2018 electronic medication administration record (eMAR) revealed: -There was an entry for nortriptyline 10 mg give 1 capsule three times a day. -Nortriptyline was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm from 08/01/18	{D 273}		

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{D 273}	Continued From page 20	{D 273}		

through 08/17/18, except for a missed dose at 2:00 pm on 08/08/18 and 08/10/18.
Nortriptyline was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm on 08/22/18.
-There was an entry for amitriptyline 25 mg give 1 capsule every night at bedtime.
-Amitriptyline was documented as administered at 8:00 pm from 08/01/18 through 08/16/18, 08/21/18, and 08/22/18.
-Based on the August 2018 eMAR review, nortriptyline and amitriptyline were both documented as administered from 08/01/18 to 08/16/18.

Review of Resident #2's July 2018 eMAR revealed:
-There was an entry for nortriptyline 10 mg give 1 capsule three times a day.
-Nortriptyline was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm from 07/04/18 through 07/30/18, except for a missed dose at 2:00 pm on 07/07/18.
-There was an entry for amitriptyline 25 mg give 1 capsule every night at bedtime.
-Amitriptyline was documented as administered at 8:00 pm from 07/01/18 through 07/31/18, except for 8:00 pm on 07/02/18.
-Based on the July 2018 eMAR review, nortriptyline and amitriptyline were both documented as administered from 07/01/18 to 07/30/18.

Review of Resident #2's June 2018 eMAR) revealed:
-There was an entry for nortriptyline 10 mg give 1 capsule three times a day, beginning on 06/04/18 at 2:00 pm.
-Nortriptyline was documented as administered at 8:00 am, 2:00 pm, and 8:00 pm from 06/04/18 through 06/29/18, except for a missed dose at

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{D 273}	Continued From page 21 2:00 pm on 06/12/18. -There was an entry for amitriptyline 25 mg give 1 capsule every night at bedtime, beginning on 06/13/18. -Amitriptyline was documented as administered at 8:00 pm from 06/13/18 through 06/30/18. -Based on the June 2018 eMAR review, nortriptyline and amitriptyline were both documented as administered from 06/13/18 to 06/30/18. Observation on 08/23/18 at 4:00 pm of the medications on hand for Resident #2 revealed: -There were 51 capsules of nortriptyline 10 mg available for administration. -There were 26 capsules of amitriptyline 25 mg available for administration. Interview on 08/22/2018 at 10:00 am with Resident #2 revealed: -She had just returned to the facility from a hospitalization due to a foot injury. -She took nortriptyline three times a day and amitriptyline at bedtime to help her sleep. -She did not know what she took nortriptyline for. -She did not know these medicines were related. -The medicines were prescribed by different physicians. -She had recently switched primary care providers but was unsure exactly when. Interview on 08/23/18 at 5:31 pm with the Executive Director (ED) revealed: -She did not know who wrote the order to verify with Resident #2's mental health provider regarding orders for both nortriptyline and amitriptyline. -The MAs were responsible for clarifying any medication orders. -The medication order should have been faxed to	{D 273}		

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{D 273}	Continued From page 22 the mental health provider by the RCD and a fax confirmation would have been stapled to the order, and distributed with the order clarification to the MAs and placed in the resident's record. -The medication aides (MA) would have more information regarding orders in the resident records. Telephone interview on 08/23/18 at 5:45 pm with a first shift MA revealed: -She remembered seeing the physician clarification request note from Resident #2's PCP on 08/07/18. -The MAs were responsible for contacting the physician for medication order clarifcations. -She did not know if the clarification order had been sent to the mental health provider or not. -A fax confirmation should have been received if the clarification was sent to the mental health provider. -She did not know if there had been a response from the resident's mental health provider. -Resident #2 went out of the facility for her mental health appointments once a month. -She knew the resident had both nortriptyline and amitriptyline prescribed and on her eMAR. -She had been documenting administration of both nortriptyline and amitriptyline to Resident #2 on the eMAR. Telephone interview on 08/23/18 at 5:52 pm with the Resident Care Director (RCD) revealed: -She did not know about the request for medication clarification. -A fax confirmation should have been received if the clarification was sent to the mental health provider. -The fax confirmation would have been stapled to the order ,and distributed with the order clarification to the MAs and placed in the	{D 273}		

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{D 273}	Continued From page 23 resident's record. -Resident #2 had last seen her mental health provider on 08/08/18. -She did not know which provider wrote the clarification request. Telephone interview on 08/24/18 at 4:43 pm with Resident #2's mental health provider revealed: -She did not know about the medication clarification form requesting to verify that Resident #2 needed both nortriptyline and amitriptyline. -The facility had not contacted her regarding the clarification request until that afternoon. -She did not know that Resident #2 had been prescribed nortriptyline by her PCP. -She would not have prescribed amitriptyline if she had known the resident was already receiving nortriptyline. -She did not typically receive a copy of the resident's eMAR or provider orders when she came to the office for her appointments. -Since the medications were in the same class, it was dangerous to take both together. Complications could include cardiac issues and overdose. -Her expectation was for the facility to coordinate care between mental health and primary care if either provider had questions or concerns. 2. Review of Resident #1's current FL2 dated 06/04/18 revealed diagnoses included dementia, depression, hypertension, chronic headaches, and neck and knee pain. Review of Resident #1's Resident Register revealed an admission date of 06/04/18. Review of Resident #1's Care Plan dated	{D 273}		

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{D 273}	Continued From page 24 06/04/18 revealed: -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. Supervision was required when eating. -There was no documentation that care planned the resident's behaviors. a. Review of Resident #1's nurse notes revealed: -On 06/23/18 (no time documented), Resident #1 had moments of aggression and agitation, and smacked the medication aide's (MA) hand away when trying to help him up. -On 07/14/18 (no time documented), Resident #1 was "a little combative this A.M." 07/17/18 11pm to 7:00am, Resident #1 was combative. -On 07/20/18 (no time documented), Resident #1 was very combative today, but better after lunch. -On 07/21/18 7:00pm to 7:00am, Resident #1 was very combative. -On 07/22/18 7:00pm to 7:00am, Resident #1 was very combative. -On 06/23/18 (no time documented), Resident #1 had been agitated today. -On 07/23/18 at 6:15pm to 11:00pm, Resident #1 was very combative. -On 07/24/18 (no time documented), a female resident said Resident #1 was very flirty with her, and a male resident said Resident #1 was picking on him. -Several residents male and female were complaining about Resident #1's behavior to them. -On 07/24/18 10:45pm to 7:00am, Resident #1 was combative, and grabbing the MA's bottom and breast. -On 07/25/18 at 7:30am, the MA and personal care aide (PCA) were getting Resident #1 out of bed, the resident hit the MA in the face causing a	{D 273}		

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{D 273}	Continued From page 25 cut on the bridge of the nose and causing a nose bleed and punched the PCA in the chest. -On 07/25/18 at 10:00pm to 7:00am, Resident #1 was very combative and the MA had to block his hits while trying to change the resident's soiled incontinent brief. -On 07/27/18 (no time documented) Resident #1 was combative. -On 07/31/18 at 4:00am, Resident #1 became combative because the resident was wet and needed incontinence care. -On 08/04/18 third shift, Resident #1 was combative. -There was no documentation Resident #1's primary care provider (PCP) was notified of the resident's behaviors. Interview on 08/23/18 at 11:20am with Resident #1's Power of Attorney (POA) revealed: -Two weeks ago the facility staff told her that Resident #1 was very aggressive, and he "acted out," but did not explain how the resident acted out. -She thought maybe the resident's medications were not right because Resident #1 "did not act like this at the previous facility." -She was in the process of looking for placement at a skilled nursing facility for Resident #1 near her home. -Prior to the phone call two weeks ago, no one at the facility had said anything to her regarding Resident #1's behaviors. -She had not contacted the physician regarding Resident #1 because the resident had an upcoming appointment. -She was told when Resident #1's had his appointment to make the physician aware of the behaviors. -She did not know if she needed to contact the physician regarding the behaviors.	{D 273}		

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{D 273}	Continued From page 26 -No one at the facility told her that she needed to contact the physician prior to the appointment regarding Resident #1's behaviors. -The appointment was a follow-up missed appointment, but was mainly to get an assessment to move Resident #1 to a facility closer to family. Interview on 08/22/18 to 4:38pm and 08/23/18 at 3:52pm with a nurse at Resident #1's PCP's office revealed: -There was no documentation regarding Resident #1's behaviors. -The PCP had seen Resident #1 on 06/20/18 and there was no documentation regarding the resident's behaviors. -The PCP noted the resident had "serve dementia," but there was nothing regarding behaviors. -The PCP did want to be notified if the resident had behavior problems and was combative. -The resident may need additional treatments, medication adjustment or even referral to a specialist. -Without seeing the resident or anyone communicating to the PCP concerning the resident's behavior there was no way to determine what was going on with Resident #1. Interview with a PCA/van driver on 08/24/18 at 1:33pm revealed: -Resident #1 was always combative, fighting and punching staff when staff tried to provide incontinent care. -A month or more ago she had made management aware of Resident #1's behaviors, but did not know what was done because Resident #1 was still feeling on staff buttocks, thighs and breast, he was aggressive and hit staff.	{D 273}		

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{D 273}	Continued From page 27 -Management that she made aware of Resident #1's behaviors was the owner/Executive Director (ED), Administrator and the office personal. -The MAs were to tell management when there was a problem and management were to contact the resident's PCP. Interview with a second MA on 08/24/18 at 12:42pm revealed: -Resident #1 was combative with episodes of physical fighting, mostly with staff. -The facility's protocol was to notify the physician for aggressive behaviors. -Several times over the past month she had reported Resident #1's behaviors to management (ED and Administrator). -Management was supposed to contact Resident #1's PCP. -She did not know if the PCP had been notified. Based on record review, observation and attempted interview on 08/22/18 it was determined that Resident #1 was not interviewable. b. Review of Resident #1's current FL2 dated 06/04/18 revealed a physician's order for aluminum hydroxide gel (lowers acid in the stomach) sus320/5ML 20ml every four hours. Review of Resident #1's June 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for aluminum hydroxide gel 20 ML every four hours at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -Documentation aluminum hydroxide gel had been administered 65 times from 06/05/18 through 06/30/18. -Documentation Resident #1 refused the	{D 273}		

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{D 273}	Continued From page 28	{D 273}		

medication or the medication was not available 36 times from 06/05/18 through 06/30/18.
-According to the eMAR for June 2018, aluminum hydroxide gel should have been administered 100 times.
-There was no documentation that contact was made with Resident #1's PCP to inform the medication was not administered due to Resident #1's refusal or the medication was available.

Review of Resident #1's July 2018 eMAR revealed:
-There were two eMARs for July 2018.
-One eMAR had an entry for aluminum hydroxide gel 20 ML every four hours daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-A second eMAR had an entry for aluminum hydroxide gel 20 ML every four hours at 2:00am, 6:00am, 10:00am, 2:00pm, 6:00pm and 10:00pm.
-Documentation Resident #1 refused the medication or the medication was not available 24 times from 07/01/18 through 07/31/18.
-According to the eMAR for July 2018, aluminum hydroxide gel should have been administered 142 times.
-There was no documentation that contact was made with Resident #1's PCP to inform the medication was not administered due to Resident #1's refusal or the medication was available.

Review of Resident #1's August 2018 eMAR revealed:
-An entry for aluminum hydroxide gel 20 ML every four hours daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Documentation aluminum hydroxide gel had been administered 114 times from 08/01/18 through 08/22/18.
-Documentation Resident #1 refused the medication or the medication was not available

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{D 273}	Continued From page 29 22 times 08/01/18 through 08/22/18. -According to the eMAR for August 2018, aluminum hydroxide gel should have been administered 129 times. -There was no documentation that contact was made with Resident #1's PCP to inform the medication was not administered due to Resident #1's refusal or the medication was available. Interview on 08/22/18 to 4:38pm with Resident #1's PCP revealed: -There was no documentation regarding Resident #1's refusal of the antacid. -There was no documentation the medication was not available. -The PCP did not intend for staff to wake the resident up from 12:00am to 6:00am to administer the antacid. -If the resident was already awake and needed the medication that was different. -The facility should have contacted the PCP if they did not understand how to administer the medication . -The PCP definitely wanted to know if the resident was refusing or if there was a problem administering the medication. Interview a second shift medication aide (MA) on 08/23/18 at 5:53pm revealed: -She did not contact Resident #1's physician because that was done by management. -She had not reported to management that Resident #1 refused or was not administered aluminum hydroxide gel because it had only happened a couple of times on her shift. Interview with the Administrator and Executive Director (ED) on 08/23/18 at 1:20pm. -They did not know Resident #1 refused his medications or for whatever reasons the	{D 273}		

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{D 273}	Continued From page 30 medication was not available. -The facility had a medication refusal policy that required staff to contact the resident's physician after "so many hours" refusing the medication back-to-back. -Depending on why the medication was not available that would not necessarily require them to contact the physician. Interview on 08/23/18 at 9:53am with a pharmacist at the contracted pharmacy revealed: -The pharmacy did not have any new orders for Resident #1's aluminum hydroxide gel, but took the medication from the previous eMAR system. -The pharmacy changed the medication administration times to every six hours around the clock, but did not contact the resident's physician. Attempted interview on 08/23/18 at 5:16pm and 08/23/18 at 10:43am with a first shift MA was not successful. Based on record review, observation, and attempted interview on 08/22/18, it was determined Resident #1 was not interviewable. Review of the facility's medication refusal policy revealed: -If medications are routinely refused or in the judgment of the nurse, a significant number of times the administrator in charge shall be notified. -The Administrator-in-Charge shall request the assistance of the family, the social services worker, etc. in getting the resident to accept the medication. -If the Administrator-in-Charge is unsuccessful in getting the resident to accept the medication for 48 hours, the physician shall be contacted and asked to discontinue the order.	{D 273}		

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{D 273}	Continued From page 31 The facility failed to assure referral and follow-up for medication clarification by not notifying the mental health provider resulting in Resident #2 receiving two antidepressant medications with possible side effects of drowsiness, irregular heart beat, confusion and memory problems; and not notifying Resident #1's physician of aggressive and inappropriate behaviors resulting in substantial risk of neglect and physical harm, residents feeling unsafe and uncomfortable in their living environment and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on 08/23/18 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018.	{D 273}		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop a program of age appropriate	D 315		

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activities and to seek the residents input for activities designed to promote the residents' active involvement for all 12 residents residing in the facility.

The findings are:

Review during the initial tour of the facility on 08/22/18 at 10:40am of the facility's August 2018 activity calendar revealed:
-"Conversation & coffee" was offered daily at 8:30am from 08/01/18 through 08/31/18.
-"Daily Devotional" was offered daily at 9:30am (no end time) from 08/01/18 through 08/31/18.
-Other activities were board games, bible study, bingo, devotion on Sundays, nails and crafts.

Confidential interviews with nine residents revealed:
-There were no activities done at the facility.
-It had been a month since they played a game.
-Yesterday they played a game and that was because the "surveyors" were at the facility.
-They did not ever go anywhere, and "it gets to us, we feel like we are in a [expletive] adult day care."
-Five residents participated in devotion, which was done daily.
-Some residents did not consider devotion an activity because they did not attend devotion.
-The facility did not ask them their opinion for simple activities like movies.
-The facility had showed one movie since May 2018 and it was a movie for young children called "finding ..."
-In May 2018, after residents complained about not going out and they were taken to a park.
-The facility staff did not plan any outside activities for the park.
-The residents did at the park what they did every

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day at the facility, they sat and looked at each other and smoked cigarettes until they left the park.
-The management (Owner/Executive Director/ED and Administrator) had not asked the residents what they wanted to do for activities.
-The residents would like to be asked their opinion for some different types activities or at least be asked what they wanted to do.

Interview with the Executive Director (ED) on 08/23/18 at 1:00pm revealed:
-She recently hired an Activity Director.
-The Activity Director had not started to work yet, but staff were to assist the residents with activities.
-She did not seek the residents input when planning activities.
-An outside consultant created the activity calendar and planned the activities for the residents.
-The facility staff provided activities like singing, church and bingo.
-The residents went on an outing at least monthly.
-Devotion and coffee was an activity that was offered daily.
-The residents had complained about activities, mainly because they did not like the prizes that were given out, so she recently bought better prizes.
-The Administrator was trying to set up some free activities with the community, but currently did not have anything available for the residents to participate in.

Interview with the Administrator on 08/23/18 1:25pm revealed:
-She had tried to seek local out free events for the residents, but there were not any in the area.

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D 315	Continued From page 34 -Residents had planned activities daily on the calendar. -She observed the daily devotion. -The residents had not discussed with her their discontentment of the activities. -She did not prepare the activity calendar and did not ensure activities were implemented. Interview a personal care aide (PCA) on 08/12/18 at 4:50pm revealed: -She took residents on outings maybe at least monthly when they got paid. -She thought the last time that she took residents out was the first week in August 2018. -She mostly took the resident's to the local store to shop for personal items. -There was a transportation issue and all the resident could not fit in one vehicle. -She sometimes made two trips or was given a list to shop for residents that did not go out.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record	D 338		

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reviews, the facility neglected to assure residents' rights were maintained and residents were safe and free from being inappropriately touched by a resident (Resident #1) on the buttocks, arms, back and thighs, hitting residents, exposing himself in front of residents, threatening other male residents, and who wandered in residents' rooms taking personal items.

The findings are:

1. Observation during the initial tour of the facility on 08/22/18 at 9:45am revealed twelve residents currently resided at the facility.

Review of Resident #1's current FL2 dated 06/04/18 revealed diagnoses included dementia, depression, hypertension, chronic headaches, and neck and knee pain.

Review of Resident #1's Resident Register revealed an admission date of 06/04/18.

Review of Resident #1's nurses' notes revealed:
-An entry on 07/24/18 (no time documented), a female resident said Resident #1 was very flirty with her, and a male resident said Resident #1 was picking on him.
-Several residents male and female were complaining about Resident #1's behavior.

Confidential interviews with nine residents revealed:
-Six female residents said Resident #1 touched them several times on their buttocks, rubbed their back, neck and arms, which made them uncomfortable.
-Resident #1 pulled this "private" out of this pants and urinated in front of other residents.
-Resident #1 masturbated in the common area,

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and outside on the patio in front of all the residents.
-The female residents expressed they did not feel comfortable around Resident #1, "he is terrible," "I am afraid at night because he can open the bedroom doors."
-Three female residents said Resident #1 was "hanzie," meaning he always touched the females inappropriately.
-Management and facility staff acted as if it was "okay" for Resident #1 to fondle female residents, because all the staff said was "he don't know better."
-They (residents) told staff all the time about Resident #1 and nothing was done.
-A month ago, they told the owner/Executive Director and was told "he did not know any better."
-The female residents were very uncomfortable around Resident #1, he had no regard for others and "whipped it out (his private body part) all the time."
-The residents were upset and expressed their discontentment with management because Resident #1 was allowed to touch the female residents and it made them feel unsafe.

Continued interview with nine residents validated one month ago management had a meeting with the residents and they voiced concerns regarding Resident #1, but all nine residents stated nothing had been done to stop Resident #1.
-Management (Owner/ED and Administrator) told them "we gonna handle it," "as far as we are concerned they (management) are not handling it."
-They (residents) would get in trouble with management if they said something to staff about how they disliked the things that Resident #1 did.
-They would "get in trouble" with management if

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they were talking about Resident #1 among themselves.
-Management would tell them not to talk about Resident #1 because he could not help what he was doing.
-Resident #1 often put his fist up at the male residents as to initiate a fight, Resident #1 was allowed to fight and beat up staff and all management did was to say, "he could not help what he was doing."
-One male resident said Resident #1 always took a fork from the table and holding the fork in his fist like it was a knife with the prongs pointed at him.
-Resident #1 pointed the fork at him as if he wanted to stab him with the fork.
-He did not sit near Resident #1, but was uncomfortable around Resident #1.
-Two male residents said they had observed Resident #1 displaying his private body parts and did not appreciate seeing those parts of the resident's body.
-One male resident said he had seen Resident #1 come in the room and take stuff.
-Last week he observed Resident #1 in his room, near his roommate's bed, but he did not know what Resident #1 was doing.
-Using his hands he waved at Resident #1 to get out of the room, and Resident #1 eventually left the room.
-A couple of days later his roommate's glasses were missing.
-They told staff and Resident #1's room was searched and the glasses were found in Resident #1's room.
-Staff gave the glasses back to his roommate.
-All nine residents felt it did not do any good to tell staff when Resident #1 was taking thing from their rooms, fondling them, urinating in front of them or playing with his private body parts in front

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of them.
-Staff did not do anything, and Resident #1 continued to do the same things over and over.

One resident said Resident #1 hit her several times and even hit her in the face.
-The last time Resident #1 hit her in the face was two weeks ago.
-One week ago Resident #1 touched her on the buttocks.
-She did not tell facility staff when Resident #1 touched or hit her because staff did not do anything.
-Staff did not do anything because Resident #1 spoke Spanish and did not understand the English language and staff were unable to communicate with Resident #1.
-Some nights Resident #1 watched her to see when she laid down in the bed, and he wheeled himself to the door and opened the door to come inside her room.
-She yelled at him to get out of her room and close the door.
-She told the MA on duty, but he still comes to her room door at night.
-She felt facility staff did not do anything about Resident #1 because of the language barrier.
-Every day Resident #1 called the residents "puta", which is "bitch," she knows because she looked the word up, also the van driver spoke Spanish and validated the meaning of the word.

A second female resident stated one month and half ago she woke up and Resident #1 was in her room rubbing her leg.
-Resident #1 was in a wheelchair so she pushed him out of her room.
-Resident #1 smacked her on the arm and she did not tell staff because no staff were present.
-There was only one staff person on duty and that

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staff was in a resident's room helping the resident.
-Resident #1 went into other residents' rooms and took things.
-She had observed Resident #1 masturbating in the common area in front of everyone.
-Resident #1 was "very nasty" he urinated outside on the deck in front of all the residents outside, and peed in the common living area by the medication cart.

A third female said Resident #1 touched her on the buttocks and she smacked his hand.
-One day she was in the common living area and had fallen asleep and was awaken by Resident #1 grabbing her leg and shaking it back and forth.
-She yelled at him to get away from her.
-On Tuesday (08/21/18), this week she was walking down the hallway and observed Resident #1 with his disposable brief off and masturbating in the drawer.
-Resident #1 was in his bedroom, but the door was wide open and there was no privacy so anyone could see the resident.

Interview with a staff member revealed:
-On Tuesday (08/21/18), staff and a female resident were walking down the hallway past Resident #1's room, and the door was wide open.
-The resident had his pants open and his incontinent brief was off.
-Resident #1 was masturbating in the drawer, and could easily be seen from the doorway when walking past the room.
-Staff told the MA on duty.
-Since Resident #1 moved into the facility in June 2018, she had observed the resident on several occasions rub his hands up and down and across female residents' arms and back.
-The female residents said they were

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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uncomfortable and wanted to punch Resident #1.
-Three weeks ago she observed Resident #1 rubbing his hand cross another female resident's back.
-The resident was very upset and said it made her feel uncomfortable.
-Staff did not report to the MA because the MA was in the room when it happened.
-Recently, (within the past week or two) she observed Resident #1 reaching up toward another female resident's breast.
-Staff yelled for the resident to stop and he did.
-Resident #1 liked to touch the female residents and the residents often complained they were uncomfortable around him and wanted him to leave.
-Staff did not know if all the staff had a meeting regarding Resident #1's advances toward the female residents.
-No other staff had mentioned anything to staff regarding monitoring Resident #1 more often because the resident still wandered all over the facility throughout the day.

Interview on 08/23/18 at 11:20am with Resident #1's Power of Attorney (POA) revealed two weeks ago staff told her that Resident #1 was very aggressive, and he "acted out," they did not explain how the resident acted out.

Interview with a personal care aid (PCA) on 08/23/18 at 4:50 pm revealed:
-Resident #1 was aggressive "from day one."
-About one month ago a female resident verbally told her that Resident #1 had touched her arm in a way that was uncomfortable to her.
-She reported what the resident told her to management.
-Shortly after Resident #1 was admitted to the facility he hit his roommate.

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-She thought Resident #1 hit his roommate because he did not want a roommate.
-Resident #1's roommate had dementia and was often forgetful, so the resident did not say much.

Interview with a second MA on 08/24/18 at 12:42pm revealed:
-She knew Resident #1 rubbed the upper thighs, buttocks and breasts of female staff and residents.
-She had seen the resident rub female residents on their arms, which made the residents uncomfortable.
-She had also seen Resident #1 go by the male residents and put his fist up like he wanted to fight.
-She could not recall the exactly, but thought two weeks ago she was told to "keep an eye on Resident #1", and if he tried anything staff were to redirect him.
-Recently, she had not observed the resident try anything when she worked.

Interview with a PCA/van driver on 08/24/18 at 1:33 pm revealed:
-She worked three days per week, sometimes as the van driver or as a PCA.
-Resident #1 spoke Spanish and she sometimes communicated with Resident #1.
-She had observed Resident #1 liked to touch females because he had tried to inappropriately touch her thighs when providing incontinent care.
-She told him in Spanish not to do that and he would say "okay," if the resident was not fighting or hitting staff he would try to touch the female staff.
-She believed Resident #1's dementia was to blame for some of the inappropriate touching and rubbing.
-Resident #1 wore disposable briefs for

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incontinence and on several occasions she had observed Resident #1 take his private part out in the public areas.
-She assumed the resident took his privates out because he had to use the bathroom, so she usually took the resident to his room to replace the disposable brief.

Interview with a third MA on 08/24/18 at 3:53pm revealed:
-She worked at the facility since April 2018 as a MA.
-Less than one month ago Resident #1 and another resident "got into it".
-She took it upon herself to watch Resident #1, she "kept a close eye" on him because the other residents complained that he came into their rooms.
-She had not observed Resident #1 touching other female residents, but one time Resident #1 put his hand between her legs and rubbed up and down on her leg.
-She told the resident that was not allowed and he stopped.
-She thought part of the problem was Resident #1 spoke Spanish and no staff could communicate with him other than no or stop.
-Some things he understood, but there was a language barrier problem.
-Also, Resident #1 had dementia and that may be a problem with his wanting to touch females.

Based on record review, observation, and attempted interview on 08/22/18 at 11:48am, it was determined that Resident #1 was not interviewable.

Based on record review, observation, and attempted interview on 08/23/18 at 7:10pm, it was determined that Resident #1's roommate was not

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D 338	Continued From page 43 interviewable. Interview with the Executive Director (ED) on 08/23/18 at 1:00 pm and 5:50 pm revealed: -She had a lot of complaints regarding Resident #1, but had not witnessed any incidents. -She visited the facility daily, but her office was in a separate building and she did not spend 100% of her time in the facility. -She often watched the inside of the facility via camera, but was only able to see inside common areas. -In July, 2018 (unable to recall the exact date) she and the Administrator had a resident council meeting with the residents to find out about "the problem." -She and the Administrator educated residents to move away from Resident #1, and to tell staff when he bothered them. -She told staff to document incidents with Resident #1, she had not gotten any reports regarding Resident #1 since the meeting. -She thought the facility could meet Resident #1's needs and she did not see a safety issue providing care. -Two hour rounds were regular rounds for staff to check on all residents. -On 07/27/18, she instructed staff to "keep an eye" on Resident #1 because there were so many complaints regarding the resident. -The staff were to identify the resident's whereabouts and know where he was at all times. -She did not document her instructions to staff and she did not require staff to document their "keeping an eye" on Resident #1. -No staff had reported any incidents since the meeting in July, therefore she thought no incidents had occurred with Resident #1. The facility neglected to ensure residents' rights	D 338		

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D 338	Continued From page 44 were maintained and were free from inappropriate touching, hitting other residents,exposing himself in front of other residents, threatening other male residents; wandered into other residents' rooms taking personal items by Resident #1. The facility's neglect resulted in residents feeling unsafe and uncomfortable in their living environment and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on 08/23/18 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018.	D 338		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide	D 482		

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D 482	Continued From page 45 safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process and after alternatives had been tried and documented in the resident's record for 1 of 1 sampled residents (Resident #1) who had full bed rails.	D 482		

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D 482	Continued From page 46 The findings are: Review of Resident #1's current FL2 dated 06/04/18 revealed: -Diagnoses included dementia, depression, hypertension, chronic headaches, and neck and knee pain. -A physician's order for a hospital bed with bed rails. Review of Resident #1's Resident Register revealed an admission date of 06/04/18. Review of Resident #1's Care Plan dated 06/04/18 revealed the resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. Supervision was required when eating. -There was no documentation that addressed a care plan for the full bed rails. Observation of Resident #1's bed on 08/22/18 at 10:20am revealed the resident had a hospital bed with two full length bed rails. Review of the facility's video camera footage on 08/23/18 at 1:38pm revealed: -On 08/22/18 at 1:26pm two staff (medication aide/MA and Resident Care Director/RCD) took Resident #1 to his room. -The MA left the room at 1:43pm and shortly after the RCD left the room. Observation of Resident #1 on 08/22/18 at 2:20pm revealed: -Resident #1 was in bed and both the bed rails were raised. -The resident was in bed for more than two hours. -Resident #1 could not physically maneuver the	D 482		

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bed rails to get himself out of the bed.

Interview on 08/22/18 to 4:38pm with a nurse at Resident #1's primary care provider's (PCP) office revealed:
-The PCP ordered a hospital bed with bed rails, but she did not see any documentation why the bed rails were ordered.
-The PCP did not know that side rails were considered a restraint.
-The facility did not make the PCP aware that side rails were not allowed at the facility or that he needed to revise the order for restraint usage.

Interview on 08/22/18 at 4:22pm with Resident #1's Power of Attorney (POA) revealed:
-Resident #1's PCP recommended the hospital bed with bed rails because the resident previously fell out of bed.
-Resident #1 had dementia and often tried to get out of bed.
-Resident #1 would try to get up and he would get "dizzy" and fall to the floor.
-Resident #1 was not able to ambulate safely by himself.
-She was sure Resident #1 could not get out of bed when the side rails were up.
-The side rails were used to keep Resident #1 from getting out of bed.

Interview with the Resident Care Director (RCD) on 08/23/18 at 5:17pm revealed:
-She was sure Resident #1 had an order for side rails.
-She was aware the side rails were a restraint and thought they were okay if the resident had an order.
-The order did not specifically state put the full bed rails up when the resident was in bed, but she had worked in other facilities and that was

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process when a resident had bed rails.
-Yesterday, she helped the medication aide (MA) put Resident #1 to bed and the bed rails were raised.
-The bed rails on Resident #1's were full bed rails and were usually up when the resident was in bed.
-Resident #1 could not get out of the bed when the bed rails were up.
-Resident #1 could not physically let the side rails down.
-She had restraint usage training prior to coming to the facility.

Interview with a personal care aide (PCA)/van driver on 08/24/18 at 1:33pm revealed:
-She worked three days per week, sometimes as the van driver or as a PCA.
-When she assisted with putting Resident #1 to bed, the bed rails were always put up for safety.
-Resident #1 would try to get up out of the bed and if the bed rails were not up the resident would fall to the floor.
-Staff usually put Resident #1 in bed around 8:00pm, the resident was gotten up out of bed around 6:45am, and the side rails stayed up the entire time the resident was in bed.
-There was no call bell system in the facility for Resident #1 to call for assistance when in bed.
-Staff were required to do rounds and check the residents every two hours, however she sometimes checked more often than two hours.
-When the bed rails were up Resident #1 could not get out of bed, and that was why staff put the bed rails up.
-She had not received restraint usage training and did not know Resident #1's bed rails were considered a restraint.

Interview with the dietary aide on 08/24/18 at

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D 482	Continued From page 49 3:21pm revealed: -Resident #1's room was right by the kitchen, she was able to see the resident when he was in bed. -Every morning she observed that Resident #1's side rails were up. -Resident #1 had dementia and could not physically or have cognitive ability to let the bed rails down. -She did not know why the bed rails were up when the resident was in bed, but it was to keep the resident from getting out of bed. Interview with a medication aide (MA) on 08/24/18 at 3:52pm revealed: -Every time Resident #1 was put into the bed the bed rails were put up. -She thought the side rails were part of the "doctor's orders" to keep the resident from falling out of bed. -She had never had restraint usage training before or since she started working at the facility. Interview with the Executive Director (ED) and Administrator on 08/23/18 at 1:00pm revealed: -When Resident #1 was admitted to the facility he had an order for the side rails. -No alternatives had been tried. -They did not consider the side rails a restraint because they were not used. -The ED and Administrator had not observed Resident #1 in bed during the day. -They had communicated with staff regarding not using the side rails when Resident #1 was in bed and did not know the side rails were being used.	D 482		
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:	D912		

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D912	Continued From page 50 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to other staff qualifications. The findings are: Based on record reviews and interviews the facility failed to assure 1 of 3 staff sampled (Administrator) had a criminal background check completed upon hire. [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Unabated 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 that the residents were free of neglect related to resident rights, health care and implementation.	{D914}		

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{D914}	Continued From page 51 The findings are: 1. Based on observations, interviews and record reviews, the facility neglected to assure residents' rights were maintained and residents were safe and free from being inappropriately touched by a resident (Resident #1) on the buttocks, arms, back and thighs, hitting residents, exposing himself in front of other residents, threatening other male residents, and who wandered in residents' rooms taking personal items. [Refer to tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).]. 2. Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 5 sampled residents (Residents #1 and #2) with aggressive behaviors, and medication refusals and medications not available (#1) and orders for duplicate medication (#2). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the Owner/Executive Director (ED) failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to residents' rights, health care, housekeeping and furnishings, other staff qualifications, training on physical restraints, medical examination and implementation, nutrition and food service, activities programs and use of physical restraints and alternatives all of which are the responsibility of the Owner/ED. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A2 Violation).]	{D914}		

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D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Owner/Executive Director (ED) failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to residents' rights, health care, housekeeping and furnishings, other staff qualifications, training on physical restraints, medical examination and implementation, nutrition and food service, activities programs, use of physical restraints and alternatives all of which were the responsibility of the Owner/ED. The finding are: Interview with the Owner/ED on 08/23/18 at 1:00 pm revealed: -She and another family member owned the business. -She recently hired an Administrator and at some point she planned to not be responsible for the total operations of the facility. -Currently, she and the family made decisions together regarding the facility.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080020	A. BUILDING: _____ B. WING _____	R 08/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D980	Continued From page 53 Confidential interviews with nine residents on 08/22/18 and 08/23/18 at various times revealed: -When they referred to "Management" they were referring to the Owner/ED. -The Owner/ED was responsible for the total operations of the facility. -When they complained to staff, the staff told them they would let "management" know their complaints. -They had reported their concerns directly to the Owner/ED and felt their concerns were not taken seriously. Interview with a personal care aid (PCA) on 08/23/18 at 4:50 pm revealed: -The Owner/ED was "management." -When she had a problem she either told the medication aide (MA) or the Owner/ED. -It was her understanding the Owner/ED and a family member owned the business and were responsible for the total operations of the business. Interview with a second MA on 08/24/18 at 12:42pm revealed: -The Owner/ED was the main person in charge of the facility. -If she had problems she reported them to the Owner/ED. Interview with a PCA/van driver on 08/24/18 at 1:33 pm revealed: -She worked three days per week, sometimes as the van driver or as a PCA. -She knew the Owner/ED was responsible for the total operations of the facility because she was the person that hired and fired everyone. -She received instructions from the MA, and now the Administrator, but the Owner/ED was the	D980		

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D980	Continued From page 54 person in control of the business. 1. Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 5 sampled residents (Residents #1 and #2) with aggressive behaviors, and medication refusals and medications not available (#1) and orders for duplicate medication (#2). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 2. Based on observations, interviews and record reviews, the facility neglected to assure residents' rights were maintained and residents were safe and free from being inappropriately touched by a resident (Resident #1) on the buttocks, arms, back and thighs, hitting residents, exposing himself in front of other residents, threatening other male residents, and who wandered in residents' rooms taking personal items. [Refer to tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).]. 3. Based on record reviews and interviews the facility failed to assure 1 of 3 staff sampled (Administrator) had a criminal background check completed upon hire. [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)]. 4. Based on observations and interviews, the facility failed to ensure the shower in the residents' common bathroom was clean and free of drain fly larvae and dirt. [Refer to Tag 0074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings]. 5. Based on record review and interview, the facility failed to provide training on physical restraints for 4 of 4 sampled staff (Staff A,	D980		

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ANGELS AT HEART ASSISTED LIVING	1114 SOUTH MAIN STREET CHINA GROVE, NC 28023

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D980	Continued From page 55 Administrator, Staff C, Staff D). [Refer to Tag 0166 10A NCAC 13F .0506 Training on Physical Restraints]. 6. Based on observation, interview, and record review the facility failed to assure that the information provided on the current FL2's including the residents diet order had been clarified by a prescribing practitioner for 3 of 5 sampled (Resident #2, Resident #5, and Resident #6). [Refer to Tag 0238 10A NCAC 13F .0703(c-4) Tuberculosis Test, Medical Examination and Implementation]. 7. Based on observations and interviews, the facility failed to develop a program of age appropriate activities and to seek the residents input for activities designed to promote the residents' active involvement for all 12 residents residing in the facility.[Refer to Tag 0315 10A NCAC 13F .0905(a)(b) Activities Program]. 8. Based on observation, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process and after alternatives had been tried and documented in the resident's record for 1 of 1 sampled residents (Resident #1) who had full bed rails. [Refer to Tag 0482 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives]. The Owner/ED failed to ensure physician notification of Resident#1's aggressive behaviors, and neglected to assure residents' rights were maintained and residents were safe and free from being inappropriately touched by Resident#1 on the buttocks, arms, back and thighs, hitting residents, exposing himself in front of residents,	D980		

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D980	Continued From page 56 threatening other male residents, and who wandered in residents' rooms taking personal items; medication refusals and medications not available for Resident #1 and duplicate medication orders resulting in Resident #2 being administered two antidepressant medications with possible side effects of drowsiness, irregular heart beat, confusion and memory problems. The Owner/ED failed to ensure the shower in the residents' common bathroom was clean and free of drain fly larvae and dirt, to provide training on physical restraints, diet orders had been clarified by a prescribing practitioner for Residents #2, #5, and #6, develop an program of age appropriate activities and seek residents input for activities designed to promote the residents' active involvement for all 12 residents, assessment for physical restraints used for 1 of 1 sampled resident (#1) who had full bed rails, and the Administrator had a criminal background check upon hire. These failures resulted in substantial risk of neglect and physical harm, residents feeling unsafe and uncomfortable in their living environment and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on 09/17/18 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018	D980		