Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060139	A. BUILDING: _____ B. WING _____	R 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey, a follow-up survey, and a complaint investigation on July 30, 2018 to August 2, 2018.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure a housekeeping (HK) storage room, containing hazardous materials, was locked and not accessible to residents. The findings are: Observation during the initial tour on 07/30/18 between 9:25am and 10:20am revealed the HK storage room located on the third floor was unlocked with hazardous chemicals located in the room that were assessable to the residents. Observation of the third floor on 07/30/18 from 9:25am to 10:15 revealed a confused resident wandered the hall looking for his room; he walked by the HK storage room twice, but did not enter.	D 056	Facility educated maint and houskeeping staff that storage rooms doors are to remain locked while not in use. Maint and or designee will observe daily to ensure locking of all hazardous materials to ensure resident safety. maint will provide an audit weekly x 4wks with ongoing monitoring. Audit results will be surrendered to facility administrator for accuracy. 9-17-18	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tiny S Sells — Adm — 9-7-2018

joanne s robinson RN Reviewed and Acknowledged 09-14-18

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D 056	Continued From page 1 Observation of the HK room located on the third floor on 07/30/18 at 10:05am revealed: -The door was unlocked and opened easily by turning the handle. -There was a shelf on the right side of the wall with a clear gallon jug which was approximately ½ full that was labeled industrial disinfectant cleaner; and a white gallon jug which was approximately ¼ full that was labeled industrial carpet cleaner. Interview with the third floor housekeeping staff on 07/30/18 at 10:18am revealed: -She was assigned to clean the third floor. -Her duties included cleaning the resident's rooms and the common area. -Some of the residents on the third floor were confused and would wander the halls. -There was a new resident that never could find his room, she would help him locate his room multiple times during the day. -She had "stocked her cart" downstairs on the first floor where all the chemical and supplies were kept. -She never used the HK storage room located on the third floor and was not sure why it was unlocked. -She did not know the HK storage room that was unlocked on the third floor had hazardous chemicals on the shelf. -She had the key the HK storage room on the third floor and would secure the room by locking the door. Observation on 07/30/18 at 10:20am revealed the housekeeper locked the HK storage room on the third floor. Review of the manufacturer's instructions	D 056		

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D 056	Continued From page 2	D 056		

revealed:
-The gallon of industrial disinfectant cleaner contained butoxythanol which is classified as a hazardous substance.
-There were instructions on the industrial disinfectant cleaner, "Stored locked-up."
-There were instructions on the industrial disinfectant cleaner, "Call poison control, if ingested."
-There were instructions on the industrial carpet cleaner, "May be harmful if swallowed, seek medical attention."
-There were instruction on the industrial carpet cleaner, "Acute health hazards."

Interview with the maintenance director on 07/30/18 at 2:20pm revealed:
-His duties included overseeing the housekeeping department staff.
-There was one housekeeper assigned to each floor.
-He was unsure how the chemicals got into the HK storage room on the third floor.
-"All chemicals are to be kept on the first floor."
-Management staff, housekeepers, and maintenance had keys to the HK storage room on the third floor.
-He did a walkthrough of the facility about two weeks ago and the door to the HK storage room on the third floor had been locked.

Telephone interview with the facility Nurse Practitioner on 7/31/18 at 11:38am revealed:
-She was in the facility weekly to see residents.
-About 50% of the residents on the assisted living side had a diagnoses of dementia or they were confused.

Interview on 07/31/18 at 3:30pm with the Administrator revealed:

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D 056	Continued From page 3 -The HK storage room on the third floor should have been closed and locked. -He did not know there were hazardous chemicals in the HK storage room on the third floor. -The maintenance director was to oversee the housekeeping staff. -All the facility cleaning chemicals should be secured on the first floor.	D 056		
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 maintain the walls, ceilings, and floor coverings kept clean and good repair in the hallways on 2nd and 3rd floor, carpeting in multi-media room, cracks in main dining room floor, and bathroom floors in the hallway of the 3rd floor. The findings are: 1. Observation of assisted living (AL) and memory care (MCU) on 07/30/18 between 9:30am and 11:30am during the initial tour revealed: -All carpets in the hallways on 2nd and 3rd floors	D 074	Facilities Maint director resigned 2/18 facility hired maint tech 2/18 who resigned 5/18, facility hired new maint tech 5/18 and 2nd maint tech 8/18, who are currently performing routine maint, work orders, any large repairs will be submitted to corp office for approval, adm does not have capability to authorize large repairs of facility nor provide payments. Facilities maint will perform routine inspections and report to adm for repair needs	

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D 074	Continued From page 4	D 074		

in the AL had dark black stains, and were worn.
-The carpeting was worn with dark, black stains and there was debris and trash on the floor of the multi-media room AL.
-The bathroom floors in the hallways of 3rd floor AL had brown dirt with sticky surfaces, and dark black grime and build up along the baseboards.
-The walls in rooms 119,127, 206, 300, and 307 AL were soiled with brown stains, and black dirt and grime was collecting along the baseboards and wall joints.
-There were water stains on the ceilings in the AL staff bathrooms on 2nd and 3rd floor, the 3rd floor hopper room, in the stairwells leading from the 2nd and 3rd floor stairwells, MCU nourishment area, and the resident tub room.
-The craft room AL activity room, and the MCU floors had slippery grease residue which increased risk for falls.

Interview with Housekeeping Supervisor on 08/01/18 at 2:00pm revealed:
-She did not know the floors had greasy residue which made them slippery.
-She would have to look at what product the staff was using to clean the floors and change the product.
-Housekeeping staff were to clean all resident common areas and this included vacuuming, cleaning baseboards, wall joints, and surfaces daily.
-The carpeting had been professionally cleaned in the past months but the stains and the odor remained.

Refer to interview with Administrator on 08/01/18 at 4:00pm.

2. Observation of AL on 07/30/18 between 9:30am and 11:30am during the initial tour

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D 074	Continued From page 5	D 074		

revealed:
-Flooring in AL main dining room had cracks approximately 1/8 inch wide and when chairs were pushed away from tables they would get caught preventing the chair from moving safely and smoothly out.
-The baseboards were peeling away in rooms, 119, 206, 300, and 307 leaving cracks between the walls and boards.
-In room 206 the wall was damaged and had chipped and cracked pieces of drywall approximately 8 inches wide and 4 inches long.

Interview with the Maintenance Manager on 08/01/18 at 2:25pm revealed:
-He had not noticed all of the necessary repairs to the floors and carpeting in the dining room, resident rooms, and hallways.
-He had not routinely inspected the facility to notice necessary repairs, but received notification from staff and residents about items he had addressed.
-The floors in the resident's room were under contract to be replaced with wood flooring and they had begun repairs on 07/31/18.
-When additional approvals for the cost of repairs to the facility floors, ceilings, and walls from management these repairs would be completed.
-All requests for money to repair the facility had come from the corporate office and owner of the building after they were submitted to the Administrator.

Refer to interview with Administrator on 08/01/18 at 4:00pm.

2. Observations during the facility tour on 08/01/18 between 9:30am and 2:30pm at various intervals revealed:
-Room 307 had an area approximately 18 inches

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D 074	Continued From page 6	D 074		

wide and 2 inches long of frayed carpeting exposed the floor in front of resident's recliner.
-There was a very strong urine smell, and large areas of stains between recliner and bed.

Interview with the resident in room 307 on 07/30/18 at 10:00am revealed:
-The strong smell of urine was bothersome to him.
-He could not recall the last time the carpet had been cleaned by a professional cleaning company.
-The frayed carpeting had begun to prevent him from easily moving his walker after standing up in front of his recliner.
-The housekeeper had not cleaned his room since before the weekend.
-He had never seen housekeeping wash the walls or baseboards in his room.
-The housekeeper had vacuumed his room once a week.
-He had requested room fresheners and he was waiting for his family member to bring him some.

Interview with Housekeeping Supervisor on 08/01/18 at 2:10pm revealed:
-Housekeeping staff assigned to 2nd and 3rd floor were to clean all resident rooms and this included vacuuming, cleaning baseboards, wall joints, and surfaces daily.
-The carpeting had been professionally cleaned in the past months but the stains and the odor remained.

Interview with Administrator on 08/01/18 at 4:00pm revealed:
-Housekeepers were expected to complete all assignments given by the housekeeping supervisor for each assigned floor.
-All of the staff was responsible for ensuring all

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D 074	Continued From page 7 resident areas were clean and in good repair. -All of the furnishings and floors in poor repair was reported to him so they were replaced or repaired. -He was aware that the carpeting in the facility needed to be replaced and odors remained after professional cleanings done in the past months. -He was aware additional floors and building repairs needed to be addressed. -Request for outside of facility contractors to perform repairs had been submitted to corporate, and when they had been approved the work on repairs would take place.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the chairs in hallways on the 2nd and 3rd floors, table and chairs in the multimedia room on the 3rd floor, shower chairs, benches and chairs on the patio of the memory care unit (MCU), were kept clean and in good repair. The findings are: Observation of the chairs in the hallways on the 2nd and 3rd floors on 07/31/18 at 9:15am revealed dark brown stains on the seats and arms of the chairs.	D 076	Facility has removed and or replaced items that could be considered hazardous or unsafe, facility has intructed housekeeping to clean general items during their daily routine. Facility maint will routinley inspect along with administrator for cleanliness fo facility and or equipment Facility also has professional furniture and carpet cleaners routinely clean carpets and furniture, and treat for odors and stains, with the application of protectant, last professional cleaning 6/15/18 per invoice Facility also has carpet cleaning machine that is used routinely and during emergiencies	

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D 076	Continued From page 8 Observation of the multi-media room on the 3rd floor on 07/30/18 at 9:15am and again on 07/31/18 at 8:00am revealed the table had a sticky surface with food crumbs and had a sticky grime build up around the edges. Observation of the benches and chairs on the patio of the MCU on 08/01/18 at 10:00am revealed wood splintering edges, and broken slats in the bottom of the chairs. Interview with 3 residents on the 2nd and the 3rd floor on 08/01/18 at 4:00pm revealed: -They had never seen the chairs or the multi-media room cleaned. -Residents had urinated their pants while sitting in the chairs in the hallways and they no longer desired to sit in them. -The staff told them they could sit on the chairs they had put absorbent pads on them so they did not sit on a urine soaked surface. Interview with a personal care aide on the 3rd floor 08/01/18 at 3:30pm revealed: -The resident's had soiled the chairs. -The staff had placed absorbent incontinence pads on the chairs to comfort the resident's concerns in regards to sitting on urine soaked seats. -She had not seen the chairs cleaned since she began working at the facility in October 2017. Interview with the Housekeeping Supervisor on 08/01/18 at 2:00pm revealed: -She had not instructed the personal care staff to place absorbent pads on the chairs. -She did not know the last time the chairs on the hallways had been cleaned. -The housekeeping staff assigned to the 2nd and 3rd floor were to clean all of the resident common	D 076		

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D 076	Continued From page 9 areas, and this included chairs and table surfaces. Interview with the Maintenance Manager on 08/01/18 at 2:15pm revealed: -He was not aware the chairs on the patio of the MCU needed repairs. -He had not routinely walked through the facility to inspect all of the areas for needed repairs. -When the staff had reported broken furnishings he had addressed repairs reported to him. Interview with Administrator on 08/01/18 at 4:00pm revealed: -He was ultimately responsible for all if the day to day cleanliness of the facility. -The housekeepers were expected to complete all assignments given by the housekeeping supervisor for each assigned floor. -The chairs had not been professionally cleaned since he had become administrator. -All of the staff was responsible for ensuring all resident areas were kept clean. -He expected the Maintenance Manager to repair broken furnishings, or bring it to his attention. -All furnishing that were in poor repair were to be reported to him so they could be replaced.	D 076		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or	D 077		

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D 077	Continued From page 10 above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the North Carolina Division of Environmental Health sanitation score remained 85 or above at all times. The findings are: Review of the local health inspection sanitation report for the facility dated 08/01/18 revealed the score documented was 84.5. Observations during the facility tour on 07/30/18 between 9:50am and 11:00am revealed: -In room 307 there was one resident who resided in the room. -In room 307 there was an area approximately 18 inches wide and 2 inches long of frayed carpeting exposing flooring in front of resident's recliner, very strong urine smell, and large areas of dark staining between recliner and bed. Interview with the resident in room 307 on 07/30/18 at 10:00am revealed: -The strong smell of urine was bothersome to him. -He could not recall the last time the carpet had been cleaned by a professional cleaning company. -The frayed carpeting had begun to prevent him from easily moving his walker after standing up in front of his recliner. -The housekeeper had not cleaned his room since before the weekend.	D 077	Facility has addressed issues, regarding health dept report resulting in score of 84.5 and has requested re-inspection of facility by health dept, facility is awaiting there return. Facility will continue to maintain facilty issues and address them timely in order to maintain compliance with rule, major repairs will be submitted to corp for repair Facility was and is in process of having room carpeting repaired or replaced, it has been and will continue to be in process.	

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D 077	Continued From page 11	D 077		

-He had never seen housekeeping wash the walls or baseboards in his room.
-The housekeeper had vacuumed his room once a week.
-He had requested room fresheners and he was waiting for his family member to bring him some.

Observations during the facility tour on 08/01/18 between 9:30am and 2:30pm revealed in the craft room, activity room, and memory care unit the floors had a slippery residue.

Interview with Activities Director on 08/01/18 at 2:00pm revealed:
-The housekeeper had swept and mopped the activity room when it was needed.
-The housekeeper had not swept and mopped the room daily.
-When a large spill occurred the staff had cleaned the floor.
-She had not realized the floor had a slippery surface that created a hazard for falls.

Interview with the medication aide (MA) in the memory care unit (MCU) on 08/01/18 at 10:00am revealed:
-The floor had recently acquired a slippery surface in the nourishment area.
-She was concerned a MCU resident could fall when walking on the floor.
-Housekeeping had not routinely cleaned the floor or the rooms in the MCU.
-The staff had often took it upon themselves to clean up the MCU, but had not performed any of the major cleaning tasks of washing walls, and mopping the floors.
-She had not seen the Administrator or the administrative staff visit the MCU in the past two days.

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REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 077	Continued From page 12 Interview with Housekeeping Supervisor on 08/01/18 at 2:00pm revealed: -She did not know the floors had greasy residue which made them slippery. -She would have to look at what product the staff was using to clean the floors and change the product. -She had not routinely visited all areas assigned to housekeeping staff because she had the first floor assigned to her to perform housekeeping tasks on that floor. -There was two additional housekeepers on staff she supervised, one was assigned to the 2nd and 3rd floors each daily. -The housekeeping staff assigned to 2nd and 3rd floor were to clean all resident common areas and this included vacuuming, cleaning baseboards, wall joints, and surfaces daily. -The carpeting had been professionally cleaned in the past months but the stains and the odor remained. Observations during the facility tour on 08/01/18 between 9:30am and 2:30pm revealed: -In rooms 119, 206, 301, and 307 all had dirt and grime collecting along baseboards and wall joints. -In room 206 there was leaking pipes under the kitchen hand sink. -In room 127 the bathroom needed re-caulking around the hand sink and the tub. Interview with Maintenance Manager on 08/01/18 at 2:15pm revealed: -He had noticed the necessary repairs to the floors and carpeting in the facility that were needed. -He had not routinely inspected the facility to address the minor repairs. -All of the repairs to the facility were required to be contracted, this required a request be made	D 077		

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D 077	Continued From page 13 through the Administrator for corporate approval. -The floors in the resident's rooms 119, 206, 301, and 307 were under contract to be replaced with wood flooring. -The contractors had begun repairs on 07/31/18 to the facility on the 3rd floor to the resident's rooms removing carpets and placing them with the wood floors. Observations during facility tour on 08/01/18 between 9:30am and 2:30pm revealed in room 229 cat hairballs that had been regurgitated by resident's cat laid in a large area on the window sill of the resident's bedroom beside her bed. Interview with the resident in room 229 on 08/01/18 at 11:00am revealed: -The cat resided with her and occasionally had accidents on the bed and coughed up hairballs all of the time. -"What you see on the window sill is hairballs not cat feces, he can't help himself". -She had done her best to clean up after the cat, but she could not reach the window sill. Observations during facility tour on 07/30/18 between 9:45am and 11:00am revealed: -In room 301 there was a strong odor of cat urine and feces. -Cat feces and urine stains covered the resident's bathroom floor. -The resident in room 301 was wheelchair bound with bilateral amputation of lower extremities at the knee. -The resident in 301 required assistance with all housekeeping tasks. -The resident in room 301 was not able to use his bathroom or shower because the cat was confined inside.	D 077	Residents with pets sign agreement that they will maintain or contract someone to maintain pet areas, also stated in house policy that pet owner is ultimately responsible for the care and cleanliness of pet areas, if unable to maintain\ facility will clean areas at resident expense or have pet removed\ per policy. All pet areas have been cleaned by facility staff and they will continue to monitor and clean as necessary.	

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D 077	Continued From page 14 Interview with the Resident in room 301 on 07/30/18 at 9:56am revealed: -He had gotten the cat around the first of the year. -The cat was always kept in his bathroom. -He hired a person that came to the facility to clean the litter box and attend to the cat's needs. -He never used the toilet or shower in the bathroom because he wore depends and was incontinent with bladder and bowel and he -The cat had gotten out of his room a couple of times and staff had to retrieve it for him. Interview with the Housekeeping Supervisor on 08/01/18 between 9:30am and 2:30pm revealed: -"That cat gets out of the resident's room and has bitten staff when they had attempted to place him in the resident's room." -The housekeeping staff had not cleaned up after the cat because they were fearful the cat would bite them, or escape the resident's room. -The housekeeping staff assigned to the second floor was assigned to cleaning the hopper. Review of the facility's current Environmental Health Inspection report dated 08/01/18 revealed: -"Observed hallways on one side of building on third and second floors with lighting measuring 0.3 FC at 30 inches above the floor. Lighting is not sufficient for residents and staff to see where they are going. Lights are currently on a timer. Lighting is to be at least 10 FC 30 inches above the floor at all times. **All areas shall have sufficient illumination. Maintain 10 foot candles of light at 30 inches above the floor in all areas other than food service areas." Observations during facility tour on 08/01/18 between 9:30am and 2:30pm at various intervals	D 077		

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D 077	Continued From page 15	D 077		

revealed:
-The back hallways on the 2nd and 3rd floor of the building were dim at all times.
-Staff attempted to work in the hallways administering medications and providing resident care.
-Residents ambulating with wheelchairs and walkers with limited light that created fall hazards or injury.

Interview with three different residents on 3rd floor on 08/01/18 between 4:00pm and 4:45pm revealed:
-They felt it was too dark to see down the hallway and recognize where and how far they would need to travel to exit the floor or find their room.
-The hallway had been dark for an extended period of time and sometimes there was not any light at all.

Interview with the medication aide (MA) on 3rd floor on 07/30/18 at 10am revealed:
-He felt there was inadequate lighting on the back hallway of the 3rd floor.
-He had to place the medication cart on the front hallway in order to see medication labels and items on the cart.

Observations during facility tour on 08/01/18 between 9:30am and 2:30pm revealed:
-No liquid soap and disposable towels available at hand washing sinks in hopper room on second floor, second floor tub room, and memory care unit kitchen area.
-Staff used the second floor hopper room to dispose of trash wearing gloves and removed gloves exiting the hopper room without washing his hands.

Interview with personal care aide on second floor

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D 077	Continued From page 16 on 08/01/18 at 11:30am revealed: -He had not washed his hands in the hopper room because there was not any soap and towels available. -He had to return a resident's room and washed his hands there. Interview with the Administrator on 08/01/18 at 3:45pm revealed: -He expected the staff to follow appropriate hand washing. -He expected plenty of liquid soap and disposable towels were available and had not been restocked by housekeeping. -He was surprised the personal care aide had been reluctant to wash his hands because he was a good worker. Interview with the Housekeeping supervisor on 08/01/18 at 2:00pm revealed: -She supervised two other housekeepers. -Each housekeeper was responsible for each floor of the building. -Each housekeeper vacuumed, dusted, mopped and cleaned each room on their assigned floor daily as needed. -She could not recall the last time any professional deep carpeting cleaning had been done. Interview with the Maintenance Manager on 08/01/18 at 2:20pm revealed: -He had made repairs prioritizing them according to the severity of impact they had made on the resident. -He had submitted the work order request for remodeling of resident rooms throughout the building and these work orders had begun to be completed.	D 077		

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D 077	Continued From page 17 Interview with the Assistant Administrator on 08/01/18 at 4:00pm revealed: -She knew the facility county health sanitation score was 84.5. -She expected housekeeping and/or maintenance to report the areas of concern to her or the Administrator; and those areas of concern should be addressed by housekeeping and maintenance. -She chose to make no further comment to the survey team. Interview with the Administrator on 08/02/18 at 10:00am revealed: -He was not aware of the county health sanitation score of 84.5. -He was did not know the report had been signed by the Assistant Administrator. -The areas of concern on the report should have been addressed and reported to him by housekeeping and maintenance.	D 077		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 079	All pet areas have been cleaned and decluttered by facility, Facility staff will continue to monitor pet areas for cleanliness and maintain if resident is unable to, or provide pet care.Facility adm has met with residents and spoken to their POA about pet care and pet policy, and they have been informed that if care cannot be provided the pet may have to be relaocated.	

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D 079	Continued From page 18	D 079		

review the facility failed to maintain the facility in a clean and orderly manner, free of all obstructions and hazards due to unsanitary pet conditions for 2 of 2 residents (Resident #10 and #14) with pet cats.

Findings:

1. Observation of Resident #10's room on 07/30/18 at 9:54am revealed:
-There was a strong odor of cat urine and cat feces when opening the door to Resident #10's bathroom.
- The resident's pet cat was confined in the resident's bathroom with the bathroom door closed.
-The cat's litter box was in the bathroom placed on the floor of the shower and contained cat feces and urine.
-The shower floor and the bathroom floor had clumps of wet litter scattered about in the bathroom.
-The bathroom floor was covered in cat urine and old dried cat feces.
-The cat's bed on the bathroom floor was also stained and dirty.

Interview with Resident #10 on 07/30/18 at 9:56am revealed:
-He had gotten the cat around the first of the year.
-The cat was always kept in his bathroom.
-He hired a person that came to the facility to clean the litter box and attend to the cat's needs.
-He never used the toilet or shower in the bathroom because he wore depends and was incontinent with bladder and bowel and only took bed baths.
-The cat had gotten out of his room a couple of times and staff had to retrieve it for him.

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D 079	Continued From page 19 Review of Resident #10's record on 8/2/18 at 9:00am revealed there was no documentation the facility had spoken to Resident #10 about the problems or unsanitary conditions involving the resident's pet cat or the condition of Resident #10's bathroom. Review of the facility's most recent health inspection report dated 08/01/18 revealed: -There was documentation on the report a cat was living in the resident bathroom. -There was documentation there were cat feces and urine covering bathroom floor and shower. -There was documentation there was a strong odor of cat feces and urine present. -There was documentation the bathroom was unusable by resident. -There was documentation, "If the hired cat keeper cannot keep bathroom clean at all times, it is the responsibility of management to ensure area stays clean." Interview with the Administrator on 08/01/18 at 2:00pm revealed: -Resident #10 was approved to have a cat as a pet. -He had paperwork that reflected the vaccinations for Resident #10's cat which was valid and current. -He was not aware of the unsanitary pet condition on the third floor in Resident #10's bathroom. -He had not spoken to Resident #10 in regard to problems or unsanitary conditions involving the resident's pet cat. -"It is not the facility's responsibility to clean or take care of a resident's pet." Refer to review of the facility's pet policy on 08/02/18 at 11:30am.	D 079		

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D 079	Continued From page 20 2. Interview with Resident #14 on 08/01/18 at 2:15pm revealed: -She had a cat that lived with her at the facility in her room. -No one in management at the facility had asked her for the cat's vaccination records. -She had paperwork for the cat which showed it received a rabies 3 year shot on 09/06/14 and was due again on 09/05/17. -She did not realize the rabies shot was overdue. -She would work on getting an up to date rabies shot for the cat immediately. -She hired an outside agency staff person to come once a week to clean the cat's litter box. Interview with the local health inspector on 08/01/18 at 1:00pm revealed: -She had completed a health inspection of the facility on 08/01/18. -She observed on the bed covering in Resident #14's bedroom cat feces, and several hairballs on the bedroom window sill. Observation of Resident #14's Room on 08/01/18 at 2:15pm revealed: -The room did not contain any odors from the cat. -The pet cat was not visible. Review of the facility's most recent health inspection report dated 08/01/18 revealed there was documentation on the bed covering in Resident #14's bedroom cat feces, and several hairballs were on the bedroom window sill. Interview with the Administrator on 08/01/18 at 2:00pm revealed: -Resident #14 was approved to have a cat as a pet. -The vaccination paperwork for Resident #14's	D 079		

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D 079	Continued From page 21 cat was unclear due to the name not being the same as the name of the cat currently living in the facility on the second floor with Resident #14. -"It is not the facility's responsibility to clean or take care of a resident's pet." Refer to review of the facility's pet policy on 08/02/18 at 11:30am. _____ Review of the facility's pet policy on 08/02/18 at 11:30am stated: -"Pets were permitted at the facility with prior approval of the Executive Director." -"Residents may keep pets so long as the resident, a family member, or a friend can care for them responsibly and maintain the apartment unit and the pet's environment in a clean and sanitary condition." -"Care and maintenance of the pet was the responsibility of the resident." -"If problems occur involving the pet (i.e. noise, odor, confinement) the following procedures will be followed: -Step 1: Someone from management will discuss the problem with the resident, giving an explanation of its effect on other residents and a time frame for rectifying the situation. This will be documented on the Incident Report form and filed in the resident's record. -Step 2: If the problem continues, the Executive Director will give the explanation to the resident in writing. Together, they will establish a plan of action and a target date. The resident will sign the form as concurring with the plan and the date for resolution of the problem. -Step 3: If the problem remains unresolved by the target date, the pet will be removed to another location."	D 079		

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D 080	Continued From page 22	D 080		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure all residents had a readily accessible supply of pillow cases, and bed sheets for use at all times. The findings are: Interview with the Administrator on 07/30/18 at 9:45am revealed the current census was 36 assisted living(AL) residents, and 15 memory care unit(MCU) residents. 1. Observation on 7/30/18 at 9:47am of rooms 301, and 307 revealed soiled bed sheets and pillows on residents beds with urine odor. Observation on 7/30/18 at 9:51am of the facility revealed no supply of additional sheets and pillow cases in the laundry room on second floor to replace resident's soiled ones. Interview with a personal care aide (PCA) on third floor of assistant living area on 07/30/18 at 9:55am revealed: -She had changed linens for residents on third floor and deposited them in laundry room for	D 080	Facility has ordered backup supply of linens, towels washcloths, sheets, pillow cases and necessary items to satisfy rule areas, facilty also maintains resident agreement/contract that all residents shall provide their own items, in case of urgency facility will provide and notify resident and or POA of needs.	

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D 080	Continued From page 23	D 080		

cleaning on an as needed basis.
-When a resident's sheets and pillow cases were clean they would place them on a resident's bed.
-If the residents had additional clean sheets and pillow cases she had put them on the resident's bed to replace the soiled ones.
-If the residents did not have additional clean sheets and pillow cases the resident's bed would be left without them until the soiled ones had been laundered.

Interview with laundry staff responsible for laundry in the assisted living(AL) on 08/01/18 at 11am revealed:
-She did not work every day and she attempted to catch up on dirty linens every time she worked.
-She did the laundry for the residents in the AL.
-She had plenty of detergent to wash the laundry, and she had not ran out of supply.
-The PCAs would bring the laundry to the laundry room for each resident and return them to the resident's room.
-She was not aware the residents did not have enough clean sheets and pillow cases.

Refer to interview with Administrator on 08/02/18 at 4:00pm.

2. Observation of memory care unit(MCU) on 07/30/18 between 9:30am and 11:00am revealed:
-There was overflowing laundry in the MCU rooms #113,#117,#122, and #123.
-The resident's laundry and personal care was provided according to an assignment roster.
-These assignments were kept in a binder in the kitchen area of the MCU.

Review of the MCU shift assignment binder revealed each shift had been assigned residents to provide personal care and complete their

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D 080	Continued From page 24 laundry. Interview with a PCA on the MCU on 07/30/18 between 9:30 and 11:00am revealed: -Each shift had an assignment which included the resident they are to provide care, their shower day, and their laundry day. -The staff on first shift had not been completing the laundry assignment. -The staff was not washing, drying, folding and return laundry to residents room according to the shift assignment. -She did not know why the other shift's had not completed their assignments. -She had reported her observations to the administrative staff. -Some of the family members of MCU residents had recently taken responsibility for resident's laundry because their laundry was left in the resident's rooms. Interview with the Administrator on 08/02/18 at 4:00pm revealed: -All laundry was placed in the laundry by the PCAs when it was soiled, laundered and returned to the residents rooms. -He was not aware laundry had piled up in the resident's rooms and not cleaned. -He had not received any complaints from staff or resident's family members. -He was aware of the assignment of the PCA duties in the MCU, but was not aware the staff was not completing their assignments to do the resident's laundry. -The facility did not supply any additional sheets and pillow cases when the resident's personal supply was soiled and not laundered.	D 080		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 105	Continued From page 25	D 105		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to assure the fire alarm switch and electrical equipment (room 124) were maintained in safe and operating condition in the memory care unit where twenty residents who were intermittently or constantly disoriented resided, and a wall unit airconditioner's front cover was off exposing wiring in room 303, and insufficient lighting and a flickering hallway light at the entrance to the elevator on the third floor on the assisted living unit. The findings are: Interview with the Administrator on 07/30/18 at 9:45am revealed the current census was 36 residents on the assisted living (AL), and 15 residents on the memory care unit (MCU). 1. Observation of the emergency fire pull station located in MCU on 07/30/18 at 10:42am revealed: -The emergency fire alarm station had been removed from the wall and the electrical wires were exposed but capped. -There was no other fire alarm station in the MCU to pull and alert in case of fire on the MCU. -The residents in MCU had access to the exposed electrical wire that were within arm reach from a standing position.	D 105	Fire alarm was removed by fire/lifesafety as required by law and wired off safely, several other pull station alarms in MC unit were available and operational, part was ordered by life/fire safety repair and replaced. Room 124 as laid out was actually a cablevision cover plate where no electricity is available was identified and replaced. Room 303 is currently under renovation and necessary locks and parts have been ordered for replacement. Facility will perform and audit of residents rooms for hazards and will repair or replace immediately. Audits will be performed weekly x 4 wks with ongoing monitoring DOC 9/17/18	

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D 105	Continued From page 26 Interview with a medication aide (MA) on 08/01/18 at 10:42am revealed: -She was aware the emergency fire pull station was removed and the wires were capped off. -She did not know how long the emergency fire pull station was "out of service". -She had notified the Maintenance Manager was aware it was broken and a part was ordered. Telephone interview with a fire equipment company representative on 08/01/18 at 4:43pm revealed: -He was called to the facility on 07/30/18 and removed the emergency fire pull station in the MCU. -The emergency fire pull station was not working and by law it was removed. -He ordered part for the emergency fire pull station on 08/01/18 and was to be delivered to the warehouse by Friday (08/03/18). Interview with the Administrator on 08/01/18 at 11:33am revealed: -The emergency fire pull station produced "false alarms" for about a week that become more frequent over time. He called the fire equipment company to come and look at it on 07/30/18. -The fire equipment company sent out a representative on 07/30/18 and the pull station was removed according to law. -The law required a emergency fire pull station to be removed, capped off and fixed before replacing due to the false alarms triggered through the system. -The parts were ordered today 08/01/18 and would be here on 08/03/18. -The staff in MCU were to use the closest pull alarm outside of the MCU in the case of a fire until this pull alarm was repaired.	D 105		

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D 105	Continued From page 27 Refer to interview with Maintenance Manager on 08/01/18 between 9:00am and 2:30pm. Refer to interview with Administrator on 08/02/18 at 4:00pm. 2. Observation of resident room 124 in the MCU on 08/01/18 at 10:11am revealed: -A resident was laying in the bed andan his bed was pushed up against the wall. -There was an electrical outlet on the wall above the center of the bed that was easily accessible to the resident. -The electrical outlet cover was broken on the top portion with jagged rough edges and exposed the electric box behind it. -The electrical outlet had an exposed area that allowed access to live electricity and potentially could cause shock with attempted use of the outlet. Interview with the sitter hired by the family of the resident in room 124 on 08/01/18 at 10:11am revealed: -He had noticed the electrical outlet was broken months ago. -He told a medication aide months ago when he noticed the electrical outlet was broken. -He did not know how the electrical outlet was broken. Interview with maintenance manager on 08/01/18 between 9:00am and 2:30pm revealed he did not know the electrical outlet in room 124 was broken. Refer to interview with Maintenance Manager on 08/01/18 between 9:00am and 2:30pm. Refer to interview with Administrator on 08/02/18	D 105		

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D 105	Continued From page 28 at 4:00pm. 3. Observation of room 303, on the AL unit, on 07/30/18 between 9:25am and 10:15am revealed: -The door to room 303 was open and there were no resident residing in the room. -There was no door knob on the door. -The air conditioner unit was on the back wall area with the front cover propped in front of the air conditioner unit. -The wiring was exposed on the left side near the bottom of the air conditioner vent. -The electrical cord was exposed laying in front of the air conditioner. Observation on the 3rd floor on 07/30/18 from 9:25am to 10:15am revealed a confused resident wandered the halls looking for his room attempting to enter rooms to find his own room. Interview with the third floor housekeeping staff on 07/30/18 at 10:18am revealed some of the residents on the third floor were confused and would wander the halls. Telephone interview with the facility Nurse Practitioner on 7/31/18 at 11:38am revealed about 50% of the residents on the assisted living side (third floor) had a diagnoses of dementia or they were confused. Refer to interview with Maintenance Manager on 08/01/18 between 9:00am and 2:30pm. Refer to interview with Administrator on 08/02/18 at 4:00pm. 4. Observation of hallways on one side of building on third and second floors on 07/30/18 at 10:00am revealed:	D 105		

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D 105	Continued From page 29 -There was insufficient lighting and a flickering hallway light at entrance to the elevator on the third floor which impeded residents and staff to see where they are going. -Staff attempted to work in the hallways administering medication and provided resident care. Interview with three different residents on 3rd floor on 08/01/18 between 9:00am and 2:30pm revealed: -They felt it was too dark to see down the hallway, recognize how far they would need to travel to exit the floor or find their room. -The hallway had been dark for an extended period of time and sometimes there was not any light at all. -One resident stated "I have cataracts and wear glasses that limit my vision, it is worse when there is not enough light." Interview with the medication aide(MA) on 3rd floor on 07/30/18 at 10am revealed: -He felt there was inadequate lighting on the back hallway of the 3rd floor. -He had to place the medication cart on the front hallway in order to see medication labels and items on the cart. Interview with maintenance manager on 08/01/18 at 2:30pm revealed he did not know the lighting in the hallways was inadequate. Refer to interview with Maintenance Manager on 08/01/18 between 9:00am and 2:30pm. Refer to interview with Administrator on 08/02/18 at 4:00pm. Interview with maintenance manager on 08/01/18	D 105		

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D 105	Continued From page 30 between 9:00am and 2:30pm revealed: -He had worked at the facility for 3 months.. -When staff reported things the were in need of repair, he repaired them. -He had not heard about any of the repairs needed. -He did not routinely walk through the facility to inspect for necessary repairs. Interview with the Administrator on 08/02/18 at 4:00pm revealed: -He was ultimately responsible for all of the day to day operations of the facility and keeping it free of fire and electrical safety hazards. -When he was made aware of areas of concern he would visit that area of the facility. -He did not make routine rounds visiting each area of the facility to perform inspections. -He expected that staff and the Maintenance Manager would report necessary repairs needed to maintain electrical and fire safety in the building. -He would ensure necessary tools and parts needed for repairs were available if he was made aware of them.	D 105		
D 169	10A NCAC 13F .0509 Food Service Orientation 10A NCAC 13F .0509 Food Service Orientation The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. Registered dietitians are exempt from this orientation. The orientation program is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing	D 169	All employees that prepare or handle food is given the food service orientation as laid out by DHHS upon hire. Audit of employees performed that were in question revealed food service orientation had been completed, facility will ensure that all food handlers are given food service orientation upon hire, audit will be performed on current employees, for assurance that \they have been given the required orientation/traning. DOC-9-17-18	

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D 169	Continued From page 31 from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to assure the staff person in charge of the preparation and serving of food (the Assistant Administrator) had completed a food service orientation program established by the Department or an equivalent with 30 days of hire for those staff hired on or after July 2, 2004. The findings are: Observation of the kitchen on 07/30/18 at 11am revealed: -The kitchen and dining area were staffed with a cook, two dietary aides, and one food server. -The cook was responsible for the supervision of the staff, ensuring therapeutic diets were served, and maintaining daily food services. Interview with the cook on 07/30/18 at 11:00am revealed: -She received staff schedules and menus to the kitchen from the assistant administrator. -She did not know a food service orientation program was required to be completed by staff in charge of food service. -She had attempted to complete her food safe serve certification and failed. -She had not completed the food service orientation program. -Two of the kitchen staff had completed their food safe service certification and they were not working first shift. Interview with the Assistant Administrator on 07/31/18 at 9:15am revealed:	D 169		

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D 169	Continued From page 32 -She was hired 08/12/15 as a MA and in October 2017 she had been promoted to Assistant Administrator. -She was in charge of food service, the menus and ordered all the food for the facility. -The facility had requested an approval to hire a dietary manager over a month ago but corporate had not approved the hire. -She had not completed the food service orientation training. -She would make sure she completed the food service orientation training as soon as possible.	D 169		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to tested for tuberculosis (TB) disease for 1 of 7 residents (Resident #3) in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205. The findings are:	D 234	Facility observed the transposition of dates or error in dates, given vs read, the resident in question has been retested with neg results, the facility will audit resident charts to ensure all testing is within compliance per regualtions. Facility will continue to test all new admissions with two step procedure being performed by a nurse. DOC 9-17-18	

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D 234	Continued From page 33 Review of Resident #3's FL-2 dated 07/04/18 revealed diagnoses included weakness, urinary tract infection, anxiety, depression, chronic pain, abnormalities of gait and mobility, and decreased white blood cell count. Review of Resident #3's record revealed she was admitted to the facility on 12/12/16. Review of Resident #3's form for Tuberculin Skin Test (TST)/Documentation of Two-Step revealed: -There was documentation she received the first TST on 10/16/18 and read on 10/18/17, (one year apart) -There was documentation she received the second TST on 11/12/17 and read on 10/04/17. (Second step TST read prior to the first step administered) Interview with Resident #3 on 07/31/18 at 11:58am revealed: -She recalled having a TST, but she could not remember having a TST in this facility. -She had a TST prior to moving into a different facility. Interview with the Administrator on 07/31/18 at 12:30pm revealed: -He had started working as the Administrator on 10/30/17. -He did not know why the TST was documented with "the strange dates". -A nurse should know how to properly document TSTs.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and	D 270		

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D 270	Continued From page 34 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 adequate supervision for 4 of 8 sampled residents (#13, #1, #11, and #12), related to the elopement (Resident #13), a fall with injury and multiple falls (Resident #1 and #12) and aggressive behaviors (Resident #11). The findings are: 1. Review on Resident #13's current FL2 dated 06/01/18 revealed: -Diagnoses included Alzheimer's disease, congestive heart failure and acute respiratory failure. -He required assistance with personal care, "total care". -He required a Hoyer lift for transfers and was non ambulatory. -There was documentation his speech was occasionally garbled. -There was documentation he was a high fall risk. Review of Resident #13's Resident Register revealed an admission date of 08/25/16. Review of an Incident Report dated 12/30/17 at 5:30pm for Resident #13 revealed: -There was documentation of an occurrence as a	D 270	Staff have been informed to monitor residents especially identify residents that are high fall risk with history and to provide interventions with PCP assistance, Facility will educate staff regarding elopement of residents or missing residents procedure and policy. This administrator was unaware of elopements that occured as he was not the administrator until feb of 2018. The facility also has LEAF program that education is given to every employee upon hire regarding fall risk patients, facility will continue to educate employees Facility. Facility has developed house policy directly relating to behaviors, staff to be educated regarding policy 9-1-2018 DOC	

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D 270	Continued From page 35	D 270		

"missing person."
-There was documentation the description of the occurrence was follows: Resident [#13] was in the dining room and came to the front desk wanting to go outside.
-The Receptionist went to check on Resident [#13] and he was not there. The "Facility went into a code silver" (a missing person alert).
-Resident #13 was found "sitting in a wheelchair at the gas station."
-The family had been notified at 6:59pm and the Administrator was notified at 5:15pm.
-Resident #13 was placed on "Alert Charting" at 6:30pm.
-Resident #13 was "on hourly watch" until 01/02/18.
-There was no documentation of the time Resident #13 had been located, or of his condition when he had returned.
-There was no documentation Resident #13 had been assessed when he was returned to the facility.
-The Incident Report was signed by a medication aide (MA) on 12/30/18, and the Administrator had signed and dated on 01/02/18.

Review of the facility sign-out book for the month of December 2017 revealed there was no documentation Resident #13 had signed out on 12/30/17.

Attempted to obtain Progress Notes for the month of December 2017 for Resident #13 three times on 07/31/18 at 9:15am, 11:47am, and on 08/01/18 at 3:52pm were unsuccessful.

Interview with a MA on 07/31/18 at 10:40am revealed:
-She worked on 12/31/17 when Resident #13 had eloped.

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D 270	Continued From page 36	D 270		

-Resident #13 was found at a gas station sitting in his wheelchair.
-"It's probably about 1/4 of a mile from the facility."
-The Resident [#13] had to propel his wheelchair up a sidewalk in front of the facility and then cross over a two lane main road.
-"There is always traffic on the road because we are 2 blocks from the hospital."
-The staff called a silver alert and everyone went to look for [Resident #13].
-A code silver alert means a "missing person."
-The staff person who found him did not work at the facility anymore.
-She was unsure exactly how long Resident #13 had been missing, "I don't think it was long though."
-Resident #13 was never sent to the emergency department (ED) for an evaluation on 07/30/17 after he was brought back to the facility.

Interview with Resident #13's physician on 08/01/13 at 9:20am revealed:
-He was not aware Resident #13 had eloped on 12/30/17 or that the facility had issued a code silver to find the Resident #13.
-He did not know Resident #13 was found at a gas station approximately ¼ mile away from the facility sitting in his wheelchair.
-He knew the road Resident #13 crossed in his wheelchair was near the hospital and was heavily traveled.
-"This was something you would not forget."

Telephone interview with Resident #13's guardian on 08/01/18 at 3:30pm revealed:
-She or another family member would visit Resident #13 two or three times weekly.
-She had been disappointed in the care and treatment of Resident #13 while in the facility.

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D 270	Continued From page 37 -There was no communication with the staff in regards to Resident #13's needs and care. -She did not know Resident #13 had eloped from the facility on 12/30/17 or Resident #13 was found at a gas station sitting in his wheelchair. -The facility staff never informed her in regards to Resident #13 leaving the facility on 12/30/17 or when Resident #13 had been found. "I would remember something like that." Interview with the Assistant Administrator on 08/02/18 at 10:30am revealed: -She had known Resident #13 had eloped on 12/30/17 and had went to look for Resident #13 after the code silver was initiated. -A code silver was called when a resident was missing, all staff were to search for the resident. -The staff person who found Resident #13 no longer worked at the facility. -"I do not think he crossed the road to the gas station. He was just sitting on the side of the road in his wheelchair." Interview with the front desk receptionist on 08/02/18 at 10:40am revealed: -She was working on 12/30/17 when Resident #13 had eloped. -Resident #13 wanted to go outside and smoke. -After a while she went to look for Resident #13, and "he was gone." -She thought it was about 5 minutes Resident #13 was outside smoking. -Resident #13 was in his wheelchair but she could not find him on the premises in front of the facility. -She called the MA and told her Resident #13 was missing, and she would "call a code silver", which means a missing person. -"Everyone went to look for [Resident #13], checking the building and outside areas".	D 270		

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-We sent a staff person in her car to look for Resident #13.
-A man was walking up the sidewalk toward the facility and asked if we were looking for someone, as he had seen a man pushing a wheelchair on the sidewalk headed for the main road.
-The staff person found Resident #13 at a gas station about ¼ mile from the facility sitting in his wheelchair.
-The road Resident #13 crossed was busy and heavily traveled and the facility was located about two blocks from the hospital.

Interview with the Administrator on 08/02/18 at 11:42am revealed:
-He had worked as the Administrator since 10/30/17.
-He was responsible for the day to day operations in the facility.
-He did not know Resident #13 had eloped on 12/30/17.
-He did not know the facility had called a code silver to search for Resident #13.
-He did not know Resident #13 had crossed over a heavily traveled road, and was found by staff at a gas station sitting in his wheelchair.

Review of the facility Missing Resident Policy posted at the nurses station on the second floor revealed:
-"In the event a resident was noted to be missing, the building and surroundings ground would be searched."
-"The supervisor in-charge would also immediately notify the Administrator or Resident Care Director."
-"If the resident was not located, staff contacted any known family or friends to attempt to locate the resident."
-"Staff also contacted all local hospital ED's to

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D 270	Continued From page 39 see if the resident resident could be located." -"If the resident was not found after 30 minutes, the facility contacted the local police department and filed a missing person's report." -"Department of Social Services (DSS) would be contacted." -"When the resident was located, he/she would be thoroughly assessed by the community physician or taken to the local ED." -"An Accident/Incident Report would be completed and sent to DSS." -"The resident's family would be notified of the incident. Refer to review of the Policy and Procedure handbook. 2. Review of Resident #1's current FL2 dated 03/15/18 revealed: -Diagnoses included dementia, hypertension and cervical spine disease. -There was documentation she required assistance with bathing, dressing and was non-ambulatory. -There was documentation she was incontinent of bowel and bladder. Review of Resident #1's Resident Register revealed an admission date of 03/19/18. Review of Resident #1's Care Plan dated 04/18/18 revealed: -The resident ambulated with the aid of a wheelchair. -The resident transferred with a sliding board and was assisted by 1 or more staff persons. -The resident was fully dependent on staff for	D 270		

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D 270	Continued From page 40 toileting, ambulation, dressing, personal hygiene and transferring. Review of the Licensed Health Professional Support (LHPS) for Resident #1dated 05/21/18 revealed: -Resident #1 was unable to ambulate without the assistance of a staff person. -The resident transferred with the assistance of 1 or more staff persons. -The resident was incontinent of bowel and bladder. -Resident #1 was fully dependent on staff for toileting, ambulation, dressing, personal hygiene and transferring. Review of the Incident Reports for Resident #1 revealed: -There was an Incident Report completed by the staff on 04/17/18 at 11:45am. The report documented the resident slid from her wheelchair to the floor in an attempt to stand up and walk. A skin tear to the right hand, index finger, was noted. The report documented the resident would be placed on hourly checks for an indeterminate period of time. -There was an Incident Report completed by the staff on 04/21/18 at 7:15am. The report documented there was an unwitnessed fall in the common area where the resident was observed by the staff on her back. 911 was called and the resident was taken to the emergency department (ED) for assessment. The report documented the resident would be placed on hourly checks for an indeterminate period of time. -There was an Incident Report completed by the staff on 04/21/18 at 3:50pm. The report documented the resident had a witnessed fall in the common area with a skin tear on her right upper arm and right cheek. The report	D 270		

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documented the resident would be placed on 15 minute checks for an indeterminate period of time.
-There was an Incident Report completed by the staff on 04/22/18 at 12:15pm. The report documented an unwitnessed fall in the common area with a quarter size skin tear (location of the skin tear was not documented) and the resident complained of pain to the neck and back. 911 was called and the resident was taken to the ED for evaluation. The report also documented the resident would have an alarm on her person and have hourly checks for an indeterminate period of time.
-There was an Incident Report completed by the staff on 06/24/18 at 6:00am. The report documented an unwitnessed fall in the resident's bedroom. The resident was found on her right side, on the floor, parallel to the side of the bed and bleeding profusely. 911 was called and the resident was taken to the ED for evaluation. The report documented the resident would have increased checks by staff, increased supervision by staff, use of a bed rail, fall mat, personal alarm and bed wedge. No time frame was listed for the implementation of these interventions.

Review of the Memory Care Binder, "Hot Box Protocol", revealed:
-Medication aides (MAs) were responsible for all 72 hour and Hot Box Protocol charting.
-Hot Box charting included any resident with a change in cognitive and health status, antibiotic therapy, falls, admissions, re-admissions and skin impairments.
-Documentation should be entered daily into "Quick Mar" (the electronic medication administration system), under chart notes, for the required time frame.
-There were no guidelines listed for the "required

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time" for each Hot Box category.
-The personal care assistants (PCAs) did not participate in the review of the "Hot Box" or the documentation.

Review of the Memory Care binder for hourly check documentation revealed:
-Resident #1 had two 1 Hour Check forms with handwritten entries by the staff.
-On 06/25/18-06/26/18 staff had documented hourly checks from 11:00am on 06/25/18 to 6:00am on 06/26/18.
-On 06/26/18-06/27/18 staff had documented hourly checks from 7:00am on 06/26/18 to 7:00am on 06/27/18.
-No further documentation of hourly checks for Resident #1 were in the binder.

Review of Resident #1's Record revealed:
- There was no documentation of an order from the physician for a chair alarm.
-There was no documentation of hourly observation as noted in the Incident Reports of 4/17/18, 4/21/18 and 4/22/18.

Review of the hospital discharge summary dated 04/21/18 revealed:
-Resident #1 was transported to the ED by the Medics on 04/21/18 at 7:17am.
-The resident was found lying on the floor at the facility in no apparent distress.
-The staff reported she attempted to stand from a sitting position in her wheelchair and fell.
-The resident has a hematoma on her left forehead.

Review of the hospital discharge summary dated 04/22/18 revealed
-Resident #1 was transported to the ED by the Medics on 04/22/18 at 12:29pm.

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D 270	Continued From page 43 -The resident was found lying on the floor at the facility in no apparent distress. -She had an unwitnessed fall from her wheelchair. -The staff reported the resident has had an increasing number of falls over the past few days. -The resident had a hematoma from a previous fall, bruising on her right neck and and an abrasion on her right elbow. -The hospital discharge recommendation, electronically signed, was to check the resident's orthostatic vital signs and be closely supervised by the staff. Review of the hospital discharge summary dated 06/24/18 revealed: -Resident #1 was transported to the ED by the Medics on 06/24/18 at 6:25am. -The resident was found lying on the bedroom floor, between the bed and a Hoyer lift, bleeding from the face and forehead. -The staff reported to the Medics the resident was being assisted in a transfer with the Hoyer lift, fell, and hit her head on the metal hook of the lift. -There appeared to be a 6cm laceration on the center of her forehead, bruising and discoloration around her eyes, and she complained of neck and back pain. -Hospital discharge notes on 06/24/18 documented initial reports to the Medics and the hospital were the resident fell while being transferred from the bed in her Hoyer lift. The Hoyer lift hook caught the resident's forehead. -Upon further contact with the facility, the staff reported the resident rolled out of the bed and hit her head on the base of the Hoyer lift. -The resident sustained a 5cm laceration with missing tissue from the middle of the wound. -The injuries were not consistent with the reports from the facility.	D 270		

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D 270	Continued From page 44 Review of the electronic administration records (eMAR) revealed: -There was no entry on the May 2018 eMAR to check Resident #1's orthostatic vital signs. -There was no entry on the June 2018 eMAR to check Resident #1's orthostatic vital signs. -There was no entry on the July 2018 eMAR to check Resident #1's orthostatic vital signs. Review of Resident #1's record revealed there was no documentation the primary care physician (PCP) was notified of the recommendation by the hospitalist to check the resident's orthostatic vital signs due to falls. Telephone interview with a third shift medication aide (MA) on 08/02/18 at 9:45am revealed: -She was completing her rounds at 5:15am on 06/24/18 and found Resident #1 face down on the floor. -The resident's bed was not in the low position and the Hoyer lift was parallel to the bed. -The bed alarm was attached to the nightgown of the resident and there was a pool of blood on her and the Hoyer lift. -The resident did not have a bed wedge at this time. -Pressure was applied to the head wound and 911 was called. -She did not know who left the Hoyer lift next to the bed. She was not sure if she observed the Hoyer lift next to the bed, earlier in the evening. -The Hoyer lifts were left in the resident's bathroom when not in use. -She completed her rounds every 30 minutes. At 4:45am the resident was in her bed sleeping. -The PCAs working with the MA during the shift were from an agency. -She reported the facility was shorthanded,	D 270		

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D 270	Continued From page 45 especially on the weekends, and had employed several agency staff persons. Observation on 07/31/18 at 8:20am revealed: -There was a fall mat next to Resident #1's bed. -The Hoyer lift was in the resident's bathroom. -There was a chair alarm on her wheelchair. -Resident #1 is not on increased checks at this time. Interview with the Memory Care Manager (MCM) on 08/01/18 at 7:30am revealed: -She did not know where the recent documentation for the hourly and 15 minute checks for the "Hot Box" residents were. -They should have been kept in the Memory Care binder for "Hot Box" concerns. -The medication aides (MAs) were responsible for documenting hourly checks if a resident fell frequently, or had changes in their behavior. -She did not know when hourly checks were initiated if a resident exhibited a change in behavior. -She did not know if the Fall Policy stated the criteria for placing a resident on hourly observation. -She did not know what guidelines dictated when a resident would be observed by the staff every 15 minutes. -"15 minute checks (of a resident) happened when they fell many times." -Residents were brought to the common area in the morning and observed by the staff during the day. -She knew the residents who fell frequently, and she instructed the staff to bring those residents to the common area for observation. -She did not document observations on an hourly sheet since she was not an MA. -It was the responsibility of the MA to	D 270		

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communicate to herself and the staff the residents who were listed in the "Hot Box" documentation so proper care and supervision could be provided by the PCAs.
-Some MAs were better than others communicating information depending on the shift.
-Agency staff did not always get report from the previous shift, when they arrived for their shift.

Telephone interview with the third shift PCA on 08/02/18 at 9:55am revealed:
-She was working on 06/24/18 when the accident occurred.
-She responded for assistance when the MA called for help and stayed with the resident while the MA called 911.
-The Hoyer lift was parallel to the bed and the resident was on her right side.
-The resident fell out of her bed and hit her head on the base of the Hoyer lift.
-She did not witness the fall.
-Resident #1 did not have any previous falls on her shift.
-Resident #1 was not on any increased checks for supervision at the time of the accident.
-She did not know who left the Hoyer lift next to the bed.
-She worked for an agency and had been assigned to this facility previously.

Telephone interview with first shift PCA on 08/02/18 revealed:
-She was sent by the agency to work first shift at the facility for the first time, on 06/24/18.
-She arrived shortly before 7:00am and requested a report from the PCAs on the previous shift.
-The PCAs did not give her report and walked away.
-After stating she could not give proper care to

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the residents without a report, the MA acclimated her to the unit and informed her there had been an accident.
-She did not get a report on the specifics of the accident.
-She received no information on increased supervision for residents having falls.
-She did not feel she was given the information necessary from the staff to complete her assignment well.
-Resident #1 had not returned prior to her shift ending.
-She has not been back to the facility since 06/24/18.

Telephone interview with the power of attorney (POA) on 08/01/18 at 5:07pm revealed:
-She received conflicting reports from the facility and the hospital on the day Resident #1 fell (06/24/18).
-Routinely, the staff would be getting Resident #1 out of bed at 6:00am.
-The staff brought the Hoyer lift out of the bathroom when it was needed for transfers.
-There was no other furniture in the resident's room that could cause those injuries.
-She reported the facility was always short staffed and could not provide the supervision for the memory care residents they required.
-On the weekends the Memory Care unit was almost completely staffed by agency personnel who did not know the residents or their needs.
-She had asked the staff to transfer Resident #1 from her wheelchair to another chair during the day for comfort.
-The staff kept Resident #1 in her previous, very uncomfortable, wheelchair all day and evening. She has low back and hip pain and the POA believed she tried to transfer herself to get relief from the pain, resulting in her earlier falls.

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D 270	Continued From page 48 -The falls outside the resident's room declined when a wheelchair more suited to the resident's physical needs was ordered and arrived. -The family member does not believe the decrease in falls during the day was due to increased supervision by the staff. -When she visited her loved one, she observed staff socializing and eating-not attending in a timely manner, or anticipating, the resident's needs. Interview with the nurse practitioner (NP) on 08/01/18 at 10:40am revealed: -Resident #1's family member had spoken to her regarding concerns the staff could not provide the proper supervision for her family member and others in the Memory Care unit. -The NP's recommendation, for this resident's medical needs to be sufficiently met, was in a skilled nursing facility. -The NP documented this on her progress notes and recommendations to the facility in June 2018 and July 2018. -The NP did not speak to the family regarding this recommendation. -She was not contacted by the facility for a conference to discuss long term planning for Resident #1. Interview with a personal care assistant (PCA) on 08/01/18 at 7:40am revealed: -She was an agency PCA who had worked at the facility for "about a month." -She did not know about the Fall Protocol for the residents. -She did not know if there was a policy on the protocol for staff when residents exhibited aggressive behavior. -She did not document hourly or quarterly checks on any residents.	D 270		

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D 270	Continued From page 49 -She did not check the Memory Care binder for information on residents with special needs and care issues. -The staff tried to keep all the residents in the common area to observe them, unless the resident was napping. -She did not always get report on the residents from the third shift. -She was not always aware of residents on hourly observation because the MAs document those checks. Interview with a MA on 08/01/18 at 7:55am revealed: -The MAs were supposed to read the documentation for the residents in the "Hot Box" section of the Memory Care binder. This was to be done each shift. -The MAs were supposed to document hourly checks on the residents who were fall risks, had falls or changes in behavior. -She thought the documentation for a Hot Box resident was for 3 days but she was not sure. -She did not know why there was not documentation for hourly checks on Resident #1, Resident #11 or Resident #13, who had several falls or changes in behavior. -She did not know exactly when a resident went from hourly checks to 15 minute checks. -She thought 15 minute checks were initiated after several falls. -The facility nurse in Memory Care had instructed the MAs to document in the Hot Box. Telephone interview with an agency PCA on 08/02/18 at 10:10am revealed: -He had worked the morning of 06/24/18 on the first shift in the Memory Care unit. -Resident #1 had already been sent to the hospital when he arrived for work.	D 270		

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D 270	Continued From page 50 -He knew the resident had sustained an injury during a transfer, but he did not know the details. Interview on 08/02/18 at 11:42am with the Administrator revealed: -He had worked as the Administrator since 10/30/17. -He was responsible for the day to day operation of the facility. -He had conducted in service training on the proper technique for transfers using a Hoyer lift. -He could not substantiate the in service training with documentation. -The facility nurse in the Memory Care unit had oversight on the implementation of fall protocol and supervision of residents. -He did not know there were contrary statements regarding Resident #1's fall on 06/24/18. -He was informed of the incident that morning and was told she had rolled out of bed and hit her forehead on the base of the Hoyer lift. -The facility nurse for Memory Care is responsible for the Incident Reports and follow up. Based on observation, interviews and record reviews it was determined Resident #1 was not interviewable. Refer to the Policy and Procedure handbook. 3. Review of Resident #11's current FL2 dated 04/30/18 revealed: -Diagnoses included advanced dementia, type 2 diabetes mellitus, stage 3 chronic kidney disease. -Medications included clonidine, divalproex sodium, lorazepam and trazadone for behaviors; mirtazapine for sleep disturbances; and furosemide for fluid retention. Review of Resident #11's Resident Register	D 270		

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revealed:
-He was admitted to the Assisted Living community on 08/10/16.
-He was admitted to the Memory Care unit on 09/10/17.

Review of Resident #11's Progress Notes revealed the following documentation:
-On 08/31/17, the resident broke through the front door of the main entrance to the facility, screaming and cursing, and went towards the road. There was no documentation any interventions were put in place.
-On 09/07/17, the resident kicked a staff person and the front door at the main entrance, damaging the door, yelling and screaming. The resident was transported to the emergency department (ED) for evaluation.
-On 09/08/17, the social worker from the hospital advised placement in the Memory Care unit upon the resident's return to the facility.
-On 09/10/17, Resident #11 was returned to the facility and admitted to the Memory Care unit. There was no documentation any interventions were put in place.
-On 10/05/17, Resident #11 was physically aggressive toward another resident and the staff person who attempted to intervene. There was no documentation any interventions were put in place.
-On 10/05/17, the staff called the Veteran's Administration (VA) to schedule an appointment with a mental health provider. There was no further documentation an appointment was confirmed or attended.
-On 10/05/17, there was an appointment for the resident to see his primary care physician (PCP). There was no documentation the resident attended this appointment.
-On 10/05/17, Resident #11 threatened to "kill" a

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male staff person who intervened between this resident and his aggression toward another resident. There was no documentation any interventions were put in place.
-On 10/10/17, he grabbed a female resident aggressively by the wrist. There was no documentation any interventions were put in place.
-On 10/10/17, Resident #11 became agitated and was banging on the dining room table during mealtime. The residents were removed from his dining table. There was no documentation any interventions were put in place.
-On 10/30/17, the resident was observed engaged in inappropriate sexual behavior with another resident.
-On 11/03/17, the resident was aggressive toward a staff person. There was no documentation any interventions were put in place.
-On 11/11/17, the staff had been reminded to chart on the resident's aggressive behavior due to its frequency.
-On 12/01/17, the resident was physically combative towards staff during personal care. There was no documentation any interventions were put in place.
-On 12/12/17, Resident #11 hit another resident. It took 3 staff persons to remove him from the female victim. There was no documentation any interventions were put in place.
-On 12/14/17, the resident flipped a table over in the common area to reach another resident. There was no documentation any interventions were put in place.
-On 12/19/17, Resident #11 lunged forward to reach a wheelchair bound resident in the common area, in a hostile manner. There was no documentation any interventions were put in place.
-On 01/21/18, the resident was combative with

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the staff. There was no documentation any interventions were put in place.
-On 02/01/18, the resident was combative with the staff during rounds. There was no documentation any interventions were put in place.
-On 02/08/18, the resident was acting out sexually towards the staff during care, attempting to kiss the staff and masturbate.
-On 02/09/18, the resident was acting out sexually toward the staff.
-On 02/20/18, the resident showed aggressive behavior toward another resident. There was no documentation any interventions were put in place.
-On 02/21/18, the resident was acting out sexually towards the staff during personal care.
-On 02/28/18, the resident was physically aggressive towards the staff during personal care. There was no documentation any interventions were put in place.
-On 03/05/18, the resident was very angry and tried to hit another resident while cursing at her. There was no documentation that any interventions were put in place.
-On 03/06/18, Resident #11 grabbed the wrist of another resident while cursing at them. There was no documentation that any interventions were put in place.
-On 03/06/18, the resident was noted as having increased agitation, aggressive behavior and inappropriate sexual behavior. There was no documentation any interventions were put in place.
-Progress Notes from April 2018 were missing from Resident #11's record.
-On 05/15/18, Resident #11 refused to leave a resident's room, pulling pictures from the wall and was aggressive. The resident was resting in their room. There was no documentation any

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interventions were put in place.
-Progress Notes from June 2018 were missing from Resident #11's record.
-On 07/07/18, the resident was sent to the hospital for aggressiveness toward staff. No interventions prior to the 911 call were noted.

Review of the Resident #11's record revealed:
-There was documentation an Incident Report was sent to the PCP on 10/10/17.
-There was documentation an Incident Report was sent to the PCP on 03/06/18.
-There was a Progress Note on 10/05/17 staff called the VA regarding an appointment to be scheduled for the mental health physician.
-There was a Progress Note on 10/10/17 the PCP was notified of Resident #11's behaviors that day. No recommendation was documented.
-There was a Progress Note on 10/30/17 the PCP was contacted regarding Resident #11's behaviors. There were no recommendations noted from the PCP.
-No additional documentation was found in the record regarding the resident's behavior or interventions implemented by the facility staff..

Interview with the Memory Care Manager (MCM) on 07/30/18 at 10:47 revealed:
-She had been employed for several years at this facility and had been employed previously out of state in a Special Care unit.
-She did not know if there was a facility written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-She had not received any formal training, she could recall, regarding resident aggression or assault.
-In her experience, most resident's behavior was related to the approach of the staff to the

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resident.
-When a resident was agitated, she re-approached the resident and attempted to discover the cause of their agitation. "I don't usually have any behavior problems when I am working."
-She knew Resident #11 had periods of agitation and aggression, but she would speak with him quietly and he would usually calm down.

Interview with the first shift medication aide (MA) on 07/31/18 at 12:00pm revealed:
-She had been a full time employee at the facility for several years and worked first shift as an MA in the Memory Care unit.
-She did not know if there was a written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-She had not received any formal training regarding agitated or aggressive residents that she could remember.
-She would attempt to re-approach the resident if they were agitated and determine the cause of the agitation.
-She would administer an as needed (PRN) medication if the resident continued to be agitated or aggressive.
-She did not remember who instructed her to re-approach an agitated or aggressive resident and administer a prn medications if necessary. It may have been the registered nurse who administered the medication skills checklist.
-If the resident attempted to become physical with another resident, she sent the target resident to their room and tried to calm the agitated resident.
-If the resident continued to escalate, and a PRN medication was not able to be administered or was ineffective, she would call her supervisor.
-If a supervisor was unavailable, she would call

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D 270	Continued From page 56 911 and send the resident to the emergency department of the hospital. Interview with the Memory Care Manager (MCM) on 08/01/18 at 7:30am revealed: -She did not know where the recent documentation for the hourly and 15 minute checks for the "Hot Box" residents were. -They should have been kept in the Memory Care binder for "Hot Box" concerns. -The medication aides (MAs) were responsible for documenting hourly checks if a resident fell frequently, or had changes in their behavior. -She did not know when hourly checks were initiated if a resident exhibited a change in behavior. -She did not know if the Fall Policy stated the criteria for placing a resident on hourly observation. -She did not know what guidelines dictated when a resident would be observed by the staff every 15 minutes. -"15 minute checks (of a resident) happened when they fell many times." -Residents were brought to the common area in the morning and observed by the staff during the day. -She knew the residents who fell frequently, and she instructed the staff to bring those residents to the common area for observation. -She did not document observations on an hourly sheet since she was not an MA. -It was the responsibility of the MA to communicate to herself and the staff the residents who were listed in the "Hot Box" documentation so proper care and supervision could be provided by the PCAs. -Some MAs were better than others communicating information depending on the shift.	D 270		

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D 270	Continued From page 57 -Agency staff did not always get report from the previous shift, when they arrived for their shift. Interview with the Administrator on 08/02/18 at 10:15am revealed: -The resident was placed in the Memory Care unit due to his dementia. -The hospital social worker recommended this placement when the resident wandered out the front door to the parking lot. -The Memory Care staff knew when a resident becomes agitated or aggressive, they should re-direct them, re-approach the resident after a short while, request a prn medication or send them to the ED if the resident continues to escalate. -He did not know Resident #11 had 29 documented incidents of aggressive behavior, some of which involved other residents and staff. -He did not know only 2 incident reports were documented regarding these behaviors. -He did not know the PCP was not contacted after each incident. -He did not have a written policy and procedure for the management of behaviors to aid the staff in the event of physical aggression or assault by a resident. Interview with the facility nurse for the Memory Care unit on 08/03/18 at 3:01pm revealed: -Incidents with the residents were documented on a facility form titled Occurrence Report and Investigation. -These reports were completed by the staff person witnessing the incident. -The report should be completed before the staff person finished their shift. -The report included the type of occurrence, the nature of the injury, the description of the occurrence, who was notified and the	D 270		

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interventions to be taken.
-This report was to be submitted to the facility nurse or the Administrator before the end of the staff person's shift.
-She did not know these reports were not completed for all Resident #11's incidents.
-She thought the administrator kept all the Incident Reports.
-She did not know if there was a written policy and procedure for the management of behaviors to aid the staff in the event of physical aggression or assault by a resident.

Interview with a personal care assistant (PCA) on 08/01/18 at 7:40am revealed:
-She was an agency PCA who had worked at the facility for "about a month."
-She did not know about the Fall Protocol for the residents.
-She did not know if there was a policy on the protocol for staff when residents exhibited aggressive behavior.
-She did not document hourly or quarterly checks on any residents.
-She did not check the Memory Care binder for information on residents with special needs and care issues.
-The staff tried to keep all the residents in the common area to observe them, unless the resident was napping.
-She did not always get report on the residents from third shift.
-She was not always aware of residents on hourly observation because the MAs document those checks.

Interview with a MA on 08/01/18 at 7:55am revealed:
-The MAs were supposed to read the documentation for the residents in the "Hot Box"

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section of the Memory Care binder. This was to be done each shift.
-The MAs were supposed to document hourly checks on residents who were fall risks, had falls or changes in behavior.
-She thought the documentation for a Hot Box resident was for 3 days but she was not sure.
-She did not know why there was not documentation for hourly checks on Resident #1, Resident #11 or Resident #13, who had several falls or changes in behavior.
-She did not know exactly when a resident went from hourly checks to 15 minute checks.
-She thought 15 minute checks were initiated after several falls.
-The facility nurse in Memory Care had instructed the MAs to document in the Hot Box.

Review of the documentation for Accident and Incident reports revealed:
-Several of the incidents documented in the Progress notes regarding Resident #11 were not documented on an Accident and Incident report form.
-There was no documentation the incidents were investigated.
-There was no documentation Resident #11 or the residents and staff he was physically aggressive with, were assessed by the nursing staff.
-There was no documentation the appropriate incidents had been reported to the Adult Home Specialist.

Attempted telephone interview with the responsible party, on 08/02/18 at 1:04pm, was unsuccessful.

Attempted telephone interview with the PCP, on 08/02/18 at 1:15pm, was unsuccessful.

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D 270	Continued From page 60 Refer to the Policy and Procedure handbook. 4. Review of Resident #12's FL2 dated 05/16/18 revealed: -Unspecified dementia without behaviors, Parkinson disease, diabetes, hypertension and edema in the lower extremities. -There was documentation the resident was ambulatory, needed assistance in dressing and was incontinent of bowel and bladder. Review of Resident #12's Resident Register revealed an admission date, to the Memory Care unit, of 04/04/18. Review of the Incident Reports for Resident #12 revealed: -There was an Incident Report competed by the staff on 05/20/18 at 8:40am. The resident was observed on the floor in his bedroom. He complained of right arm and bilateral leg pain. The report documented the resident would be placed on hourly checks for an indeterminate period of time. -There was an Incident Report completed by the staff on 05/24/18 at 10:00am. The resident was observed on the floor in his bedroom. The report documented the resident would be placed on hourly checks for an indeterminate period of time. -There was an Incident Report completed by the staff on 05/25/18 at 10:41am. The resident was observed on the floor in his bedroom. The report documented the resident would be placed on hourly checks for an indeterminate period of time. -There was an Incident Report completed by the staff on 05/28/18 at 5:45am. The resident was observed on the floor of his bedroom. The report identified bilateral swelling of the lower legs and feet. The report documented the resident would	D 270		

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D 270	Continued From page 61 be placed on hourly checks for an indeterminate amount of time, and should be escorted to the common areas. -There was an Incident Report completed by the staff on 06/04/18 at 12:30pm. The resident was observed on the floor of his bedroom face down, with no visible injuries. The report documented the resident would be placed on hourly checks for an indeterminate amount of time. -There was an Incident Report completed by the staff on 06/06/18 at 3:45am. The resident was observed on the floor of his bedroom next to his bed. There was a half dollar size skin tear on his left upper arm. Interventions documented were to increase supervision, wear shoes and use the rollator while ambulating. There was no follow up documentation on these interventions. -There was an Incident Report completed by the staff on 06/11/18 at 10:30am. The resident was observed on the floor of his bedroom in a sitting position. The report documented the resident would receive a chair alarm. -There was an Incident Report completed by the staff on 06/28/18 at 2:45pm. The report indicated a witnessed fall with no injuries -it was unclear from the report what had occurred. The report documented the resident would continue to be monitored for safety. -There was an Incident Report on 07/07/18 at 4:40pm. The resident was observed lying on his right side on the floor in his bedroom. The resident was sent to the hospital for complaints of shortness of breath. -There was an Incident Report completed by the staff on 07/28/18 at 12:00pm. The resident was observed on the floor in his bedroom multiple times by the staff. The report documented the staff would continue hourly checks for an indeterminate amount of time. No other interventions were documented.	D 270		

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D 270	Continued From page 62 Review of the facility Progress Notes for Resident #12 revealed: -On 05/26/18 the resident was sent to the emergency department (ED) for a fall with complaints of pain in his back. -On 05/28/18 the resident was sent to the ED for "several" falls. No interventions were noted in the Progress Notes. -On 05/30/18 the resident was found on his knees in the bedroom. No interventions were noted in the Progress Notes. -On 05/30/18 the resident was observed exit seeking from the Memory Care unit. No interventions were noted in the Progress Notes. -On 06/05/18 the resident had an unwitnessed fall in his bedroom. No interventions were noted in the Progress Notes. -On 06/06/18 the resident was observed on the floor in his bedroom and was sent to the ED for behaviors-unspecified. No interventions were noted in the Progress Notes. -On 07/04/18 the resident had an unwitnessed fall and was sent to the ED for evaluation. The resident was diagnosed with a right rib fracture. No interventions were noted in the Progress Notes -On 07/06/18 the resident was observed at the bottom of his bed on the floor in a sitting position. No interventions noted in progress notes. -On 07/07/18 the resident was observed on the floor in his bedroom. No interventions were noted in the Progress Notes. -On 07/15/18 the resident was sent to the ED due to complaints of pain and inability to move. -On 07/16/18 it was documented the resident was on hourly checks for 72 hours and had a bed alarm. -On 07/16/18 the resident was sent to the ED due to complaints of pain and inability to move.	D 270		

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D 270	Continued From page 63 -On 07/26/18 the resident was complaining of pain and the primary care physician (PCP) ordered he be sent to the ED for evaluation. No determination of the location or cause of the pain was noted. -On 07/28/18 the resident was sent to the ED due to falling 5 times before the noon meal. No interventions were noted in the Progress Notes. Review of the Memory Care Binder, "Hot Box Protocol", revealed: -Medication aides (MAs) were responsible for the Hot Box Protocol charting. -Hot Box charting included any resident with a change in cognitive and health status, antibiotic therapy, falls, admissions, re-admissions and skin impairments. -Documentation should be entered daily into "Quick Mar" (the electronic medication administration system), under chart notes, for the required time frame. -There were no guidelines listed for the "required time" for each Hot Box category. -The personal care assistants (PCAs) did not participate in the review of the "Hot Box" or the documentation. Review of the Memory Care binder for Hourly Check documentation revealed: -Resident #1 had two 1 Hour Check forms with handwritten entries by the staff. -On 07/15/18-07/16/18 the staff had documented hourly checks from 7/15 at 8:00am- 7/16 at 12:00pm. -On 07/21/18 the staff had documented hourly checks from 3:00am-10:00pm. -There was no documentation regarding hourly checks performed by the staff as indicated in their Progress notes on 05/20, 05/24,05/28, 06/04, 06/06, 06/28, 07/28.	D 270		

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D 270	Continued From page 64 Interview with the Memory Care Manager (MCM) on 08/01/18 at 7:30am revealed: -She did not know where the recent documentation for the hourly and 15 minute checks for the "Hot Box" residents was. -They should have been kept in the Memory Care binder for "Hot Box" concerns. -The medication aides (MAs) were responsible for documenting hourly checks if a resident fell frequently, or had changes in their behavior. -She did not know when hourly checks were initiated if a resident exhibited a change in behavior. -She did not know if the Fall Policy stated the criteria for placing a resident on hourly observation. -She did not know what guidelines dictated when a resident would be observed by the staff every 15 minutes. -"15 minute checks (of a resident) happened when they fell many times." -Residents were brought to the common area in the morning and observed by the staff during the day. -She knew the residents who fell frequently, and she instructed the staff to bring those residents to the common area for observation. -She did not document observations on an hourly sheet since she was not an MA. -It was the responsibility of the MA to communicate to herself and the staff the residents who were listed in the "Hot Box" documentation so proper care and supervision could be provided by the PCAs. -Some MAs were better than others communicating information depending on the shift. -Agency staff did not always get report from the previous shift, when they arrived for their shift.	D 270		

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D 270	Continued From page 65 Interview with a personal care assistant (PCA) on 08/01/18 at 7:40am revealed: -She was an agency PCA who had worked at the facility for "about a month." -She did not know about the Fall Protocol for the residents. -She did not know if there was a policy on the protocol for staff when residents exhibited aggressive behavior. -She did not document hourly or quarterly checks on any residents. -She did not check the Memory Care binder for information on residents with special needs and care issues. -The staff tried to keep all the residents in the common area to observe them, unless the resident was napping. -She did not always get report on the residents from third shift. -She was not always aware of residents on hourly observation because the MAs document those checks. Interview with a MA on 08/01/18 at 7:55am revealed: -The MAs were supposed to read the documentation for the residents in the "Hot Box" section of the Memory Care binder. This was to be done each shift. -The MAs were supposed to document hourly checks on residents who were fall risks, had falls or changes in behavior. -She thought the documentation for a Hot Box resident was for 3 days but she was not sure. -She did not know why there was not documentation for hourly checks on Resident #1, Resident #11 or Resident #13, who had several falls or changes in behavior. -She did not know exactly when a resident went	D 270		

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from hourly checks to 15 minute checks.
-She thought 15 minute checks were initiated after several falls.
-The facility nurse in Memory Care had instructed the MAs to document in the Hot Box.

Attempted telephone interview with the PCP on 08/02/18 at 12:45pm revealed:
-A message was left regarding the 15 falls the resident had over the past several months and was the PCP informed.
-The PCP returned the call on 08/03/18 at 1:15pm and left a voice message .
-He was informed by the facility regarding most of the resident's falls.
-He was concerned regarding the falls and was not sure if it was a clinical issue or a facility issue.
-The facility had implemented his orders for physical therapy (PT) and occupational therapy (OT).
-The message did not include the date he ordered the PT and OT, or when it was implemented.

Telephone interview with Resident #12's responsible party on 08/02/18 at 2:05pm revealed:
-He knew that Resident #12 fell frequently.
-He believed the resident fell because he would not use his walker.
-He did not know if the facility contacted the family every time the resident fell because there were 2 contact phone numbers.
-He was concerned Resident #12 has had several falls, but was unsure if the facility could be providing more supervision.

Based on observation, interviews and record reviews it was determined Resident #12 was not interviewable

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D 270	Continued From page 67 Refer to the Policy and Procedure handbook. Review of the Policy and Procedure handbook revealed: -There was a facility Accident and Incident Report policy. -There was no policy or procedure for residents exhibiting aggressive behavior. -All accidents and incidents were to be reported in a timely manner, in accordance with the North Carolina state regulations. -All accidents and incidents should be documented and investigated in a timely manner. -Any resident or staff member involved should be assessed by nursing personnel in order to determine further treatment or follow up. -All incidents and accidents should be documented on an Incident Report and employees should complete a Staff Injury report immediately. -Incident Reports should include (but were not limited to): falls, bruises, skin tears, cuts, change in mental status or physical decline. The facility failed to provide adequate supervision for 4 of 8 sampled residents related to: an elopement, (Resident #13) who crossed a heavily traveled road and was found at a gas station approximately 1/4 mile from the facility; a resident with a recent history of falls who was found on the floor with a laceration to her head, bruising to her face and neck pain (Resident #1); a resident with an extensive history of aggressive behaviors to include physical violence and sexual inappropriateness toward other residents (Resident #11), and a resident who had multiple	D 270		

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D 270	Continued From page 68 falls in the facility lacking effective interventions or any interventions which resulted in multiple rib fracures (Resident #12). This failure placed residents at substantial risk of serious harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to assure physician contact for 5 of 5 sampled residents; Resident #5 sustained rib fractures, (Resident #8) an infectious leg wound, (Resident #13) elopement from the facility, (Resident #11) aggressive behavior and (Resident #12) for multiple falls over a 3 month period. The findings are: 1. Review of Resident #5's current FL2 dated	D 273	Facility is providing education to lpn supervisors to follow up daily for any injuries requiring treament other than basic first aid, to ensure that physcian and family/poa have been notified, and to ensure that physcian has been notified that follow-up visit is required LPN's will ensure that doucments have been faxed to PCP with confirmation of fax, documents will be uploaded to Qmar for retention and quick referral and become matter of permanet medical record. DOC 9-1-18 ongoing monitoring	

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D 273	Continued From page 69 07/03/18 revealed: -Diagnoses included dementia, diabetes, and hypertension. -There was documentation Resident #5 was incontinent of bladder and bowel. -Ambulation status was documented as using a wheelchair. Review of Resident #5's Resident Register revealed an admission date of 06/04/09. Review of an Incident Report for Resident #5 dated 07/11/18 at 9:15am revealed: -There was documentation Resident #5 had an unwitnessed fall in her room with no visible injury. -Resident #5 was not sent out to the emergency department (ED) for an evaluation. -There was documentation Resident #5 "does not remember the fall." -There was documentation the physician had been notified via telephone or by fax. -There was no documentation the family or responsible person had been notified. -The Incident Report was signed and dated on 07/11/18 by the medication aide (MA), the facility nurse, and the Administrator. Review of an ED visit note for Resident #5 dated 07/11/18 at 6:11pm revealed: -There was documentation Resident #5 was seen for an evaluation of a status post fall and pain in her right side. -There was documentation the fall had happened around 10:00am on 07/11/18. -There was documentation Resident #5 fell while ambulating with a walker to the bathroom to take a shower. -There was documentation Resident #5 had yellowish bruising to her upper abdomen and some abrasions and a contusion to her posterior	D 273		

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back on the right side.
-There was documentation a cat scan (CT) of the chest was performed on Resident #5 which showed rib fractures 7-11 posterior.

Review of the Resident #5's Progress Notes dated 07/11/18 at 6:08pm revealed:
-An entry by the medication aide (MA) documented Resident [#5] was observed on the floor this morning at around 9:30am.
-The resident was assisted up, there were no visible signs of injury and the resident did not complain of pain.
-At 6:05pm the resident was observed making facial expressions that signified pain and also stated that she was in pain and is developing a bruise on her back.
-The resident was sent out to the ED and the family was notified.

Interview with Resident #5's physician on 08/01/18 at 9:15am revealed:
-He could not recall if the facility had contacted him in regard to Resident #5's fall on 07/11/18.
-If the facility MAs called, the physician ask questions to determine if a resident should be send out for an evaluation to the ED.
-The MA cannot assess a resident and sometimes they tell me "no injury", "I want to be sure the resident is not hurt."
-He did not know Resident #5 fell in her room, was found lying on her back and did not remember the fall.
-The physician was not aware Resident #5 had posterior rib fractures 7-11 until 08/01/18.
-The physician would like to know what was going on with his residents so he could provide the best service and treatment.
-"It is important to know about any issue with my residents."

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-If the facility would have contacted him about the fall he would have sent Resident #5 out to be evaluated after the fall had occurred at 9:15am on 07/11/18.

Interview with Resident #5 on 07/31/18 at 9:00am revealed she could not recall the fall on 07/11/18.

Attempted telephone interview on 07/31/18 at 2:53pm and on 08/01/18 at 9:15am with Resident #5's guardian was unsuccessful.

Interview with the Licensed Practical Nurse (LPN) on the Assisted Living side on 07/31/18 at 11:08am revealed:
-She was working on 07/11/18 the day Resident #5 had fallen.
-The MA had not told her about Resident #5's fall and she did not know until that afternoon when she heard the ambulance arrived to pick up Resident #5.
-If the MA had informed her about the fall, she would had completed an assessment for Resident #5.
-The MAs are responsible for completing the Incident Reports, LPN reviewed and signed the reports, and then the administrator will review and sign.
-"There is a communication problem with the staff and what they can and cannot do."
-She knew Resident #5 had multiple fractured ribs resulting from the fall on 07/11/18 after Resident #5 had returned from the ER.
-She had not called Resident #5's physician concerning the rib fractures.

Interview with the Administrator on 08/01/18 at 5:05pm revealed:
-He knew Resident #5 had fallen on 07/11/18.
-The MA had told him she had fallen with no

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injuries.
-He did not Resident #5 had a diagnosis from the ER visit dated 07/11/18 of posterior rib fractures 7-11.
-He did not know the physician had not known of Resident #5's rib fractures.
-He relied on the MAs to complete the Incident Reports and contact the physician for any issue concerning the residents.

2. Review of Resident #8's current FL2 dated 07/20/18 revealed:
-Diagnoses included dementia, falls, and hypertension.

Review of an Incident Report for Resident #8 dated 07/07/18 at 8:30pm revealed:
-There was documentation Resident #8 had an unwitnessed fall in her room.
-There was documentation Resident #8 had a "deep open face cut, bleeding very very heavy."
-There was documentation first aid was administered, "apply pressure for bleeding, gauze."
-There was documentation of the description of the occurrence, "light puddle of blood bathroom floor, dripping of blood from bathroom into bedroom, found bedroom chair sitting, found by caregiver."
-There was documentation vital signs were obtained and Resident #8 said "she was ok."
-There was documentation Resident #8 was sent to the ED for an evaluation and the family was notified on 07/07/18 at 9:00pm.
-There was no documentation the physician had been notified on the incident.
-The Incident Report was signed by the MA on 07/07/18, the facility nurse on 07/09/18, and the Administrator with no date documented.

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D 273	Continued From page 73 Review of the Progress Notes for Resident #8 dated 07/07/18 at 9:36pm revealed: -It was documented at around 8:25pm [Resident #8] was found in the room sitting in her chair bleeding very badly on her front left leg. -There was an open cut and she was found by the caregiver. -911 contacted and she was taken to the hospital [local]. -Her vitals signs were documented as; blood/pressure 154/86, pulse 79, respirations 72, and temperature 98.0. -The family member was contacted and the resident was alert and oriented. Telephone interview with Resident #8's guardian on 07/31/18 at 9:00am revealed the facility had contacted him on 07/07/18 when Resident #8 had fallen and had a laceration to the left leg. Review of an ED visit note date 07/07/18 at 10:15pm revealed: -There was documentation Resident #8 was seen for a status post fall-laceration to the left leg. -There was documentation a procedure to close the laceration was performed and sutures were placed. -A golf ball size hematoma was noted under the left leg laceration. -There was documentation a dressing was applied and follow up instructions for Resident #8 to see her physician in 2-4 days. Telephone interview with the home health (HH) nurse on 07/31/18 at 9:10am for Resident #8 revealed: -She had started services for dressing changes on 07/10/18 for Resident #8. -Her visits for wound care were for 2 times weekly and as needed.	D 273		

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-She had documentation the NP had ordered doxycycline 100 mg two times daily for 7 days on 07/14/18.
-She and the NP had seen Resident #8 together on 07/18/18 with concerns of infection to the leg wound.
-The sutures had embedded into Resident #8's wound and could not be removed.
-The left leg wound had signs of "redness and swelling down her left leg."
-"The wound appeared to be infected."
-The NP had sent Resident #8 out to the ED on 07/18/18 for an evaluation of the left leg wound.

Review of a hospital discharge dated 07/18/18 for Resident #8 revealed:
-There was documentation Resident #8 was admitted to the hospital for cellulitis of the left lower extremity.
-There was documentation Resident #8 had "impressive cellulitis" to the left leg.
-There was documentation Resident #8 was started on IV antibiotics and had seen wound care for dressing orders.
-There was documentation Resident #8 had returned to the facility on 07/20/18.

Telephone interview with the NP on 07/31/18 at 11:30am revealed:
-The facility contacted her when Resident #8 had fallen on 07/07/18.
-She did not know Resident #8 had returned from the ED with sutures to the left lower leg.
-"The facility is supposed to notify me when a resident returns from the ER or hospital."
-On 07/18/18 the HH nurse was in the facility and approached her in regard to the sutures embedded in Resident #8's leg wound.
-"Resident #8's left leg was swollen, red, and the wound showed signs of infection."

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-Facility staff had not reported any swelling or redness to Resident #8's left leg.
-The HH nurse had attempted to remove the sutures on 07/18/18, but was not able due to Resident #8's swelling and the pain to the leg.
-She attempted to remove the sutures, but [Resident #8] "was in too much pain."
-She had sent Resident #8 to the ED for an evaluation and treatment of the wound on 07/18/18.
-"If the facility does not inform me of resident's changes and condition I cannot treat them."
-"This is a challenging facility, there is no communication with physicians and providers."

Interview with the Administrator on 07/31/18 at 5:50pm revealed:
-He had known Resident #8 had fallen on 07/07/18 and was sent out to the ED for an evaluation of a laceration to the left leg.
-He relied on the MA to contact the physician and family when a resident was sent to the ED or to the hospital.
-He did not know if the MAs had contacted the NP when Resident #8 had returned from the ED on 07/07/18 and reported the sutures.
-He recalled speaking to the NP on 07/10/18 about wound care orders.
-He recalled speaking to the NP on 07/13/18 "she forgot to see Resident #8."
-There was no documentation for review of either conversation with the Administrator or the NP.

3. Review on Resident #13's current FL2 dated 06/01/18 revealed diagnoses included Alzheimer's disease, congestive heart failure and acute respiratory failure.

Review of a facility Incident Report dated 12/30/17 at 5:30pm for Resident #13 revealed:

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-There was documentation Resident #13 was missing from the facility and was found "sitting in a wheelchair at the gas station."
-There was documentation the family had been notified at 6:59pm and the Administrator was notified at 5:15pm.
-There was no documentation the physician had been notified.
-The Incident Report was signed by the MA on 12/30/18, the Administrator had completed and dated on 01/02/18 as well as the nurse.

Interview with a MA on 07/31/18 at 10:40am revealed:
-She had worked on 12/31/17 when Resident #13 had eloped.
-He was found at a gas station sitting in his wheelchair.
-'It's probably about 1/4 of a mile from the facility.
-The staff called a silver alert and everyone went to look for him.
-A silver alert means a "missing person."
-It's the responsibility of the MA who had that assignment to complete an Incident Report and to notify the family and physician.
-The staff person who found him does not work here anymore.

Interview with Resident #13's physician on 08/01/18 at 9:20am revealed:
-He was not aware Resident #13 had eloped on 12/30/17 and the facility had issued a code silver to find the resident.
-He did not know Resident #13 was found at a gas station approximately ¼ mile away from the facility sitting in his wheelchair.

Telephone interview with Resident #13's guardian on 08/01/18 at 3:30pm revealed:
-She did not know Resident #13 had eloped from

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the facility on 12/30/17 or was found at a gas station sitting in his wheelchair.
-The facility staff never contacted her in regards to Resident #13 leaving the facility on 12/30/17. "I would remember something like that."

Interview with the Administrator on 08/01/18 at 5:05pm and on 08/02/18 at 11:42am revealed:
-He started working as the Administrator on 10/30/18.
-He did not know Resident #13 had eloped on 12/301/8 and a code silver was called by the facility staff.
-He did not know the resident had crossed over a busy heavily traveled road, and was found by staff at a gas station sitting in his wheelchair.
-He relied on the MAs to complete the Incident Reports and to contact the physician for any issue concerning the residents.

4. Review of Resident #11's current FL2 dated 04/30/18 revealed:
-Diagnoses included advanced dementia, type 2 diabetes mellitus and stage 3 chronic kidney disease.
-Medications included clonidine, divalproex sodium, lorazepam and trazadone for behaviors and mirtazapine for sleep disturbances.

Review of Resident #11's Resident Register revealed:
-There was an admission to the assisted living community on 08/10/16.
-There was an admission to the Memory Care unit on 09/10/17.

a. Review of Resident #11's Progress Notes revealed the following documentation:
-On 08/31/17, the resident broke through the front

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door of the main entrance to the facility, screaming and cursing, and went towards the road. There was no documentation the primary care physician (PCP) was notified.
-On 09/07/17, the resident kicked a staff person and the front door at the main entrance, damaging the door, yelling and screaming. The resident was transported to the emergency department for evaluation. There was no documentation the PCP was notified.
-On 09/08/17, the social worker from the hospital advised placement in the Memory Care unit upon resident's return to the facility.
-On 09/10/17, Resident #11 was returned to the facility and admitted to the Memory Care unit.
-On 10/05/17, Resident #11 was physically aggressive toward another resident and the staff person who attempted to intervene. There was no documentation the PCP was notified.
-On 10/05/17, the staff called the Veteran's Administration (VA) to schedule an appointment with a mental health provider. There was no further documentation that an appointment was confirmed or attended.
-On 10/05/17,there was an appointment for the resident to see his PCP. There was no documentation the resident attended this appointment.
-On 10/05/17, Resident #11 threatened to "kill" a male staff person who intervened between this resident and his aggression toward another resident. There was no documentation the PCP was notified.
-On 10/10/17, he grabbed a female resident aggressively by the wrist. There was no documentation the PCP was notified.
-On 11/03/17, the resident was aggressive toward a staff person. There was no documentation the PCP was notified.
-On 11/11/17, the staff had been reminded to

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chart on the resident's aggressive behavior due to its frequency. There was no documentation the PCP was notified.
-On 12/01/17, the resident was physically combative towards staff during personal care. There was no documentation the PCP was notified.
-On 12/12/17, Resident #11 hit another resident. It took 3 staff persons to remove him from the female victim. There was no documentation the PCP was notified.
-On 12/14/17, the resident flipped a table over in the common area to reach another resident. There was no documentation the PCP was notified.
-On 12/19/17, Resident #11 lunged forward to reach a wheelchair bound resident in the common area, in a hostile manner. There was no documentation the PCP was notified.
-On 01/21/18, the resident was combative with staff. There was no documentation the PCP was notified.
-On 02/01/18, the resident was combative with staff during rounds. There was no documentation the PCP was notified.
-On 02/08/18, the resident acted out sexually towards the staff during care. He attempted to kiss the staff and masturbated. There was no documentation the PCP was notified.
-On 02/09/18, the resident acted out sexually toward the staff. There was no documentation the PCP was notified.
-On 02/20/18, the resident showed aggressive behavior toward another resident. There was no documentation the PCP was notified.
-On 02/21/18, the resident was acted out sexually towards the staff during personal care. There was no documentation the PCP was notified.
-On 02/28/18, the resident was physically aggressive towards the staff during personal

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care. There was no documentation the PCP was notified.
-On 03/05/18, Resident #11 was very angry and tried to hit another resident while cursing at her. There was no documentation the PCP was notified.
-On 03/06/18, the resident was noted as having increased agitation, aggressive behavior and inappropriate sexual behavior. There was no documentation the PCP was notified.
-On 05/15/18, Resident #11 refused to leave a resident's room, pulling pictures from the wall and becoming aggressive. The resident was resting in their room at the time. There was no documentation the PCP was notified.
-The Progress Notes for June were not available.
-On 07/07/18, the resident was sent to the hospital for aggressiveness toward staff. No interventions prior to the 911 call were noted. There was no documentation the PCP was notified.

Review of Resident #11's record revealed:
-There was documentation an Incident Report was sent to the PCP on 10/10/17. There were no documented recommendations from the PCP.
-There was a Progress Note on 10/30/17 the PCP was contacted regarding Resident #11's behavior. There were no documented recommendations from the PCP.
-There was documentation an Incident Report was sent to the PCP on 03/06/18. There were no documented recommendations from the PCP.
-23 of 26 incidents regarding Resident #11's behaviors were not documented as reported to the PCP.

Interview with the Memory Care Manager (MCM) on 07/30/18 at 10:47 revealed:
-She had been employed for several years at this

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facility and had been employed previously out of state in a special care unit (SCU)
-She did not know if there was a facility written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-She did not know the policy regarding informing the physician when incidents with a resident occurred.
-She assumed the MA or facility nurse followed up with the appropriate persons.

Interview with the first shift medication aide (MA) on 07/31/18 at 12:00pm revealed:
-She had been a full time employee at the facility for several years and worked first shift as an MA in the Memory Care unit.
-She did not know if there was a facility written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-If the resident was aggressive and continued to escalate, she would administer an as needed (PRN) medication.
-If this was ineffective, she would call her supervisor.
-If a supervisor was unavailable, she would call 911 and the resident would be sent to the emergency department of the hospital.
-If an Incident Report was written for a behavior, there was a section that required the PCP to be notified. That would be faxed to the PCP by the MA completing the report.
-She had never completed an Incident Report for Resident #11.
-He usually 'calmed down' after awhile and we 'kept an eye on him'.
-The facility nurse for Memory Care reviews the Incident Reports.

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D 273	Continued From page 82 Interview with the first shift MA on the Assisted Living unit on 07/31/18 at 3:40pm revealed: -Resident #1 had several aggressive and combative incidents while he was residing in the assisted living community. -He tried to leave the facility several times. -She did not know his recent behaviors in Memory Care since she never worked on that unit. -She had never filled out an Incident Report on Resident #11. -She reported the Incidents to her Supervisor, the facility nurse in the Assisted Living community. Interview with the Administrator on 08/02/18 at 10:15am revealed: -The resident was placed in Memory Care due to his dementia. -The hospital social worker recommended this placement when he wandered out the front door to the parking lot. -The Memory Care staff knew when a resident becomes agitated or aggressive, they should re-direct them, re-approach the resident after a short while, request a prn medication or send them to the ED if the resident continues to escalate. -He did not know Resident #11 had 26 documented incidents of aggressive behavior, some of which involved other residents. -He did not know only 2 Incident Reports were filed regarding these behaviors. -He did not know the PCP was not contacted after 23 of 26 incidents. b. Review of the records from the hospital admission on 01/24/18 revealed: -The facility sent Resident #11 to the ED for hypertension. -The discharge recommendation on 01/24/18 was	D 273		

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a referral for a medication review due to polypharmacy (the concurrent use of multiple medications by a patient).
-The ED hospitalist specifically questioned the need for several medications for behaviors, including seroquel, depakote, mirtazapine, lorazepam and trazadone. He was also concerned regarding the administration of lasix and possible dehydration.

Review of Resident #11's record revealed no documentation the PCP or mental health provider were notified of the hospitalist recommendation, or that a medication review was performed.

Interview with the Administrator on 08/02/18 at 10:15am revealed:
-He did not know there was a medication review recommended from the hospital visit on 01/24/18, that was not referred to the PCP.
-It was the responsibility of the facility nurse in the Memory Care unit to follow up with the Incident Reports, discharge orders and physician recommendations.
-There was no written policy and procedure for the management of behaviors to aid the staff in the event of physical aggression or assault by a resident.

Interview with the facility nurse for the Memory Care unit on 08/03/18 at 3:01pm revealed:
-Incidents with the residents were documented on a facility form titled Occurrence Report and Investigation.
-These reports were completed by the MA on duty.
-The report should be completed before the MA finished their shift.
-The report included the type of occurrence, the nature of the injury, the description of the

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occurrence, who was notified and interventions to be taken.
-There was a section on the report listing the persons to be informed of the incident and by what means.
-The staff person filling out the report, faxed the report to the PCP and called the responsible party.
-This report was to be submitted to the facility nurse and the Administrator before the end of the staff MA's shift.
-She did not know reports were not completed for all Resident #11's incidents.
-She thought the administrator kept the Incident Reports in hid office.

Attempted phone interview with the resident's primary contact on 08/02/18 at 1:04pm was unsuccessful.

Attempted phone interview with the PCP on 08/02/18 at 1:15pm was unsuccessful.

5. Review of Resident #12's FL2 dated 05/16/18 revealed diagnoses included unspecified dementia without behaviors, Parkinson disease, diabetes, hypertension and edema in the lower extremities.

Review of Resident #12's Resident Register revealed an admission date of 04/04/18.

Review of the Incident Reports for Resident #12 revealed:
-The staff reported 10 falls on Incident Reports for Resident # 12.
-The reports were dated 05/20/18, 05/24/18, 05/25/18, 05/28/18, 06/04/18, 06/06/18, 06/11/18, 06/28/18, 07/07/18, 07/28/18.
-On 07/28/18, Resident #12 fell 5 times before

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the noon meal and was sent to the hospital for evaluation.
-The reports documented the PCP was faxed a copy of the Incident Reports for these dates.
-There was no documentation of recommendations from the PCP for any of these falls.

Review of the Progress Notes for Resident #12 revealed:
-There was documentation for 7 falls and 1 incident of exit seeking behavior without corresponding Incident Reports.
-The dates of these incidents were; 05/26/18, 05/30/18, 05/30/18, 06/05/18, 07/04/18, 07/06/18, 07/15/18, 07/16/18.
-There was no documentation the PCP was contacted regarding these falls and incident.
-The physician was not notified of 7 of the 17 falls and 1 incidence of exit seeking behavior.

Attempted phone interview with the PCP on 08/03/18 at 12:45pm revealed:
-A voice message was left on the PCP's cell phone regarding Resident #12's falls and the physician's notification.
-The PCP left a return voice message on 08/03/18 at 1:15pm.
-He was informed by the facility regarding most of the resident's falls.
-He was concerned regarding the falls and was not sure if it was a clinical issue or a facility issue.
-The facility had implemented his orders for physical therapy and occupational therapy (unknown when order was sent or implemented).

Phone Interview with Resident #12's responsible party on 08/02/18 at 2:05pm revealed:
-He knew Resident #12 fell frequently.
-He did not know if the facility contacted the

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D 273	Continued From page 86 family every time the resident fell because there were 2 contact phone numbers. -He was concerned Resident #2 has had several falls, but was unsure if the facility could be providing more supervision. Based on observations, interviews and record reviews it was determined Resident #12 was not interviewable. _____ The failure of the facility to assure timely referral and follow-up for 5 of 5 sampled residents, to meet the acute physical and mental health care needs of the residents which resulted in one resident who sustained rib fractures after a fall not being evaluated by a physician for approximately 8 hours (Resident #5); a resident who had a wound on her leg which became infected and required hospitalization(Resident #8); a resident who had documented violent and sexually inappropriate behaviors for over 10 months which were not effectively reported to the primary care provider which posed physical danger to other residents and who had recommendations from a hospitalist regarding a medication review for polypharmacy to assist in the resident's physical and mental health which also was not reported to the primary care physician (Resident #11); a resident who suffered multiple falls of which only 10 of 17 falls were documented as reported to the primary care physician (Resident #12); and a resident who eloped from the facility, crossed a heavily traveled road and was found at a gas station approximately 1/4 mile from the facility was not reported to the physician (Resident #13). This failure placed residents at substantial risk of serious harm and neglect and constitutes a Type A2 Violation.	D 273		

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D 273	Continued From page 87 The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2018.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure diets were served as ordered for 2 of 10 sampled residents (Resident #4 and #8).who had orders for a mechanical altered diet and low cardiac diet. The findings are: Review of the therapeutic diet menu for lunch on 07/31/18 at 11:00am revealed: -Residents on a cardiac diet were to be served 3 ounces of chicken breast, ½ cup noodles, ½ cup green peas, wheat dinner roll/bread, ½ cup mandarin oranges, 8 ounces of skim milk, and 8 ounce of beverage of choice. -Residents on a mechanical altered diet were to be served an 8 ounce ladle chicken and	D 310	Education given to cooks to follow menu as directed by PCP that no exceptions shall occur unless diet has been changed by PCP. If resident becomes agitated or angry about diet, staff is to notify administration so that meeting with resident and or family/poa can be informed of diet orders by PCP, and PCP can be notified of concerns so that they may also address with resident, family/poa. Random observation of meal times with specific dietary orders will be monitored 2x/week x 4weeks. Request to corp office for hire of dietary manager sent. doc 9-17-18	

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dumplings, ½ cup waxed beans, 1/4 cup of pureed wheat roll, ½ cup mandarin oranges, 8 ounces of skim milk, and 8 ounce beverage of choice.

1. Review of Resident #4's current FL-2 dated 01/23/18 revealed:
-Diagnoses included: cognitive disorder, cerebrovascular accident (CVA), hypertension (HTN), atrial fibrillation (A Fib), and dysphasia.
-Physician ordered Resident#4 diet of heart healthy cardiac diet.

Review of Resident #4 diet order dated 01/23/18 revealed heart healthy cardiac diet.

Observation of the lunch meal on 07/31/18 at 12:20pm revealed:
-The cook served Resident #4 served 8 ounce ladle chicken and dumplings, ½ cup green peas, ½ cup corn, wheat dinner roll/bread, 8 ounce 2% milk, and 8 ounce beverage of choice.
-Resident #4 ate 100% of the meal served.

Interview with Resident #4 on 07/31/18 at 12:15pm revealed:
-He was aware his physician had ordered a cardiac heart healthy diet.
-He was not aware he should not had ate dumplings and drank 2% milk.

Refer to interview with cook on 07/31/18 at 1:30pm

Refer to interview with Assistant Administrator on 07/31/18 at 1:45pm.

Refer to interview with dietician on 08/03/18 at 12:00pm.

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Interview with the Resident #4's physician on 08/03/18 at 1:00pm revealed:
-The resident had been prescribed a cardiac diet to manage his hypertension and A-fib.
-The resident had a history of elevated triglycerides and lipids.
-Her expectation was that the resident remained on a cardiac diet until she decided it was no longer necessary.
-If the resident did not follow this diet it could worsen his heart disease.

2. Review of Resident #8's current FL-2 dated 07/20/18 revealed:
-Diagnoses included dementia, dysphasia, falls, and hypertension.

Review of Resident #8 diet order dated 07/20/18 revealed mechanical altered diet with thin liquids.

Observation of the lunch meal on 07/31/18 at 12:20pm revealed:
-The cook served Resident #8 tossed green leaf salad, 8 ounce ladle chicken and dumplings, ½ cup green peas, ½ cup corn, wheat dinner roll/bread, ½ cup mandarin oranges, 8 ounce 2% milk, and 8 ounce beverage of choice.
-Resident #8 ate 100% of the meal served.

Interview with the dietary aide on 07/31/18 at 1:30pm revealed:
-She had worked at the facility for one year.
-She was aware that Resident #8 was on a mechanical altered diet.
-She was instructed by the cook to serve diets prepared by the cook.
-She was aware tossed salad was not listed on the mechanical altered diet.
-Resident #8 had requested tossed salad at most of her meals and had become very upset when

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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she had not been served a tossed salad.
-Every staff member was aware that Resident #8 was to get a tossed salad although it was not part of her diet.

Interview with the cook on 07/31/18 at 1:30pm revealed:
-She had used the day at a glance for week 1 and day 3 spreadsheet provided to the kitchen by the assistant administrator to reference therapeutic diets that the facility had acquired from U.S. Food Services.
-She had not used the new menu.
-She had referred to therapeutic diet orders for each resident in physician's order book kept in the kitchen.
-She was not aware of the modifications from regular diet to cardiac and mechanical altered diets served.
-She had never met the dietician.
-When a resident had requested items that were contraindicated to the resident's diet she made the Assistant Administrator aware.

Interview with the dietician on 08/03/18 at 12:00pm revealed:
-She worked for the company who reviewed therapeutic diet menus for the facility.
-The therapeutic diets menus were to be served as directed with appropriate modifications indicated.
-A tossed salad was not an appropriate substitution for mechanical altered diet.

Interview with Resident #8 physician on 08/02/18 at 2:00pm was unsuccessful.

Interview with Assistant Administrator on 07/31/18 at 1:45pm revealed:
-She was responsible for printing menus from

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D 310	Continued From page 91 U.S. Foods website and providing them to the kitchen staff. -The facility had not hired a dietary manager because the corporate office had not approved their request 3 months ago. -She did not know modifications for therapeutic diets had not been addressed. -She did not know a tossed salad was contraindicated for residents on a mechanical altered diet. Interview with the Administrator on 08/01/18 at 9:15am revealed: -He was comfortable with his knowledge of therapeutic diets and depended on his assistant to manage them. -He was not aware of appropriate modifications to the mechanical altered diet or the cardiac diet. -He had not met the dietician who had created the diet menu. -He was planning to ensure one of his staff to obtain appropriate education of therapeutic diets to avoid any future errors.	D 310		
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.	D 358		

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D 358	Continued From page 92 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were available and administered as ordered by physician for 2 of 6 residents (Residents #4) with orders for Finasteride 5mg, Atorvastatin Calcium 80mg, Melatonin 5mg, and Tramadol 50mg, and (Resident #1) orders for Clobetasol 0.05% cream and Tramadol 50mg. The findings are: 1. Review of Resident #4's current FL-2 dated 01/23/18 revealed: -Diagnoses included: cognitive disorder, cerebrovascular accident (CVA), hypertension (HTN), atrial fibrillation (A Fib), benign prostatic hyperplasia (BPH), anxiety, depression and dysphasia. -It was documented in the medication section "see attached list". Review of the physician signed attached list that was faxed to the facility on 01/24/18 revealed: -The medications orders included the following: -Finasteride 5mg (a medication used to treat enlarged prostate) 1 tablet each night at bedtime. -Atorvastatin 80mg (a medication used for cardiovascular disease) 1 tablet each night at bedtime. -Melatonin 5mg (a supplement used to aid sleep) 1 tablet each night at bedtime. Review of Resident #4's record revealed: -A physician orders dated 02/23/18 for Tramadol 50mg (a medication used to treat pain) three times a daily. -There were no other orders to discontinue any other medications.	D 358	Facility has educated lpn supervisors and medication staff of various ways to order meds from pharmacy to ensure all residents have medications available. Facility also has all residents/poa sign agreement that if they elect to use outside pharmacy and do not provide meds in a timely manner, that meds will be ordered from house pharmacy at their expense. Facility will pull medication stickers and fax to pharmacy with documentation maintained within facility. Supervisors will contiune to audit carts vs mars on a weekly basis with documentation of audits. Ongoing monitoring will continue with supervisors performing comparison of delivery manifest from pharmacy vs meds ordered daily Audit to be performed 1xwk x 4wks and surrendered to adm doc 9-17-18	

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D 358	Continued From page 93 a. Review of Resident #4's May 2018 electronic Medication Administration Records (eMAR) revealed: -There was an entry for Melatonin 5mg scheduled for administration at 9:00pm every evening. -From 05/20/18 through 05/31/18 it was documented Melatonin 5mg was not administered on 10 occasions "medication unavailable- ordered from pharmacy". Review of Resident #4's June 2018 eMAR revealed: -There was an entry for Melatonin 5mg take one tablet at 9:00pm every evening. -From 06/01/18 through 06/12/18 it was documented Melatonin 5mg was not administered each date as "medication unavailable- ordered from pharmacy". Interview on 08/02/18 at 9:45am with the facility pharmacy regarding Resident #4's medication revealed: -The facility pharmacy dispensed 30 tablets of Melatonin 5 mg on 04/02/18 and 07/31/18. -There was no documentation a refill was requested for the Melatonin 5mg in May2018 or June 2018. -The facility had the ability to request refills on medications three different ways. One was to pull the sticker from the medication and fax the request. The second was to call the pharmacy and the third was to use the eMAR reorder button on the computer system. Refer to telephone interview on 08/02/18 at 11:10am with Responsible Party for Resident #4. Refer to interview on 08/02/18 at 11:40am with the facility nurse for the Assisted Living side of the facility.	D 358		

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D 358	Continued From page 94 Refer to interview on 07/31/18 at 9:50am with a medication aide (MA). Refer to review of the facility's medication ordering policy on 08/02/18 at 12:30pm. b. Review of Resident # 4's June 2018 eMAR revealed: -There was an entry for Atorvastatin Calcium 80mg take one tablet at 9:00pm every evening at bedtime. -From 06/03/18 through 06/12/18 it was documented Atorvastatin Calcium 80mg was not administered on 9 occasions "medication unavailable- ordered from pharmacy." Interview on 08/02/18 at 9:45am with the facility pharmacy regarding Resident #4's medication revealed the facility pharmacy never completed a fill for the Atorvastatin Calcium 80mg but could tell from their computer system that the last refill on that medication was done by an outside pharmacy on 06/13/18. Interview on 08/02/18 at 11:20am with the outside pharmacy that filled Resident #4's medications revealed: -The Atorvastatin Calcium 80mg medication was filled on 03/23/18 and 30 tablets were dispensed. -The next refill order they received was on 06/13/18 and 30 tablets were dispensed. Refer to telephone interview on 08/02/18 at 11:10am with Responsible Party for Resident #4. Refer to interview on 08/02/18 at 11:40am with the facility nurse for the Assisted Living side of the facility.	D 358		

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D 358	Continued From page 95 Refer to interview on 07/31/18 at 9:50am with a medication aide (MA). Refer to review of the facility's medication ordering policy on 08/02/18 at 12:30pm. c. Review of Resident # 4's June 2018 eMAR revealed: -There was an entry for Finasteride 5mg take one tablet at 9:00pm each night at bedtime. -From 06/12/18 through 06/26/18 it was documented Finasteride 5mg was not administered on 8 occasions "medication unavailable- ordered from pharmacy." Interview on 08/02/18 at 11:20am with the outside pharmacy that filled Resident #4's medications revealed: -The Finasteride was filled on 04/30/18 for a quantity of 90 tablets that were dispensed. -There was no other request made to refill the Finasteride 5mg at their pharmacy since that date. Interview on 08/02/18 at 9:45am with the facility pharmacy regarding Resident #4's medication revealed: -A request from the facility for a refill of the Finasteride was received on 06/23/18, but the pharmacy was unable to complete the request due to insurance denial since the medication was filled on 04/30/18 at an outside pharmacy. -The pharmacy documented a call to the facility on 06/23/18 letting them know why the requested medication could not be sent over. -The pharmacy was able to do an emergency fill of Finasteride 5mg on 06/27/18 for 12 tablets. -The facility requested a refill of Finasteride on 07/07/18 and the pharmacy completed it on 07/09/18 dispensing 30 tablets.	D 358		

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D 358	Continued From page 96 Interview on 08/02/18 at 11:40am with the facility nurse for the facility revealed she was not aware that Resident #4 had missed dosages of his medications and medications had not been administered to the Resident as ordered. Interview on 08/01/18 at 11:00am with Resident #4's Nurse Practitioner revealed: -She was not aware that Resident #4 had missed doses of his prescribed medications. -She was not concern about Resident #4 missing some medications but the Finasteride would be detrimental to his health" he could retain urine." Refer to interview on 07/31/18 at 9:50am with a medication aide (MA). Refer to review of the facility's medication ordering policy on 08/02/18 at 12:30pm. d. Review of Resident #4's record revealed: -A physician order dated 02/23/18 for Tramadol 50mg (a medication used to treat pain), by mouth three times a day. Review of Resident # 4's June 2018 eMAR revealed: -There was an entry for Tramadol 50mg scheduled three times daily at 8:00am, 2:00pm, and at 8:00pm. -From 06/07/18 through 06/12/18 it was documented tramadol 50mg was not administered on 11 occasions as "medication unavailable- ordered from pharmacy." Interview on 08/02/18 at 11:20am with the outside pharmacy that filled Resident #4's medications revealed the Tramadol was filled on 06/08/18 for 90 tablets dispensed that would last 30 days with	D 358		

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D 358	Continued From page 97 no other requested refill after that date. Interview on 08/02/18 at 9:45am with the facility pharmacy regarding Resident #4's medication revealed: -The facility pharmacy dispensed Tramadol 50mg on 03/01/18 for a quantity of 90 pills that would last for 30 days and again on 3/26/18 for 90 pills that lasted 30 days. -On 04/28/18, the pharmacy dispensed Tramadol 50mg 90 pills for a 30 day supply. -The facility requested a refill on Tramadol 50mg on 06/07/18, but the pharmacy was unable to fill the request due to needing a new physician written hard script. -A hard script for Tramadol 50mg was received in the pharmacy on 06/14/18, but when the facility pharmacy tried to fill the order it was rejected in the system because the medication was filled at an outside pharmacy on 06/08/18. -The pharmacy dispensed Tramadol 50mg on 07/18/18 for 90 tablets using the written script dated 6/14/18. -The facility pharmacy had another hard script for Tramadol 50mg written on 07/18/18 but has had no request from the facility to fill it. -The facility pharmacy stated the facility had the ability to request refills on medications three different ways. One way was to pull the sticker from the medication and fax the request. The second way was to call the pharmacy and the third was to use the QMAR reorder button on the computer system. Interview on 08/01/18 at 11:00am with Resident #4's Nurse Practitioner revealed she was not overly concerned about Resident #4 missing some of his medications but the Tramadol would indicate the "staff was ignoring his pain."	D 358		

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D 358	Continued From page 98 Telephone interview on 08/02/18 at 11:10am with Responsible Party for Resident #4 revealed: -The facility contacted her on three different occasions requesting she deliver medication to the facility for her spouse. -She was unable to recall the dates of the request and the type of medications. Interview on 08/02/18 at 11:40am with the facility nurse for the Assisted Living side of the facility revealed: -The Medication Aides (MA) re-ordered medications by faxing the requested refill to the pharmacy or by calling the pharmacy to request the refill. -She stated using the QMAR button on the computer was not preferred because it proved to not be a reliable way to re-order medications. -The facility medication carts were audited every week by the facility nurse who was also able to request refills of medications. Interview on 08/01/18 at 11:00am with Resident #4's Nurse Practitioner revealed her preference was to be notified as soon as possible when a resident missed doses of medications. Interview on 07/31/18 at 9:50am with a medication aide (MA) revealed: -The facility policy was "if a resident missed 3 doses of medication we were to notify the Administrator." -The Administrator should call the physician or the nurse practitioner. -If the residents missed an antibiotic the MAs were to call the physician immediately. Review of the facility's medication ordering policy on 08/02/18 at 12:30pm revealed: -"All staff who assist with medications must be	D 358		

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aware when a resident is getting low on medications and know the procedure to order medications."
-"Each facility has an assigned staff member responsible for ordering medications on a regular basis, but there may be instances when it is necessary for another staff to place an order. If someone other than the assigned staff orders medications, it is important to leave clear notes in the communication log."

2. Review of Resident #1's current FL2 dated 03/15/18 revealed diagnoses included dementia, Bullous pemphigoid, hypertension and cervical spine disease.

Review of Resident #1's Resident Register revealed an admission date of 03/19/18.

a. Review of a Physician's order dated 04/14/18 revealed there was an order for Clobetasol 0.05% ointment, apply topically to blisters twice a day for one week, start date 03/23/18.

Review of Resident #1's April 2018 electronic medication record (eMAR) revealed there was an entry for Clobetasol Propionate 0.05% ointment, apply to blisters twice a day for one week, documented as administered twice a day from 04/01-04/30.

Review of Resident #1's May 2018 eMAR revealed there was an entry for Clobetasol Propionate 0.05% cream apply to blisters twice a day for one week, documented as administered twice a day from 05/01-05/31.

Review of Resident #1's June 2018 MAR revealed there was an entry for Clobetasol Propionate 0.05% cream apply to blisters twice a

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D 358	Continued From page 100 day for one week, documented as administered twice a day from 06/01-06/30. Review of Resident #1's July 2018 eMAR revealed there was an entry for Clobetasol Propionate 0.05% ointment apply to blisters twice a day for one week, documented as administered twice a day from 07/01-07/31. Observation of the medication on hand in the Memory Care unit on 08/01/18 at 3:52pm revealed: -There was a tube of Clobetasol Propionate 0.05% ointment labeled with Resident #1's name, 60 grams per week. -The directions on the medication label read 'apply topically to blisters twice a day for one week'. -The medication was dispensed on 01/11/2018. -There was one quarter of the ointment remaining in the tube of Clobetasol in the medication cart. Interview with the second shift medication aid (MA) in the Memory Care unit on 08/01/18 at 4:10pm revealed: -She worked as needed in the facility for the past year. -She had signed for administering the Clobetasol ointment for Resident #1. -She did not notice the order had expired. -If she had noticed, she would have alerted her supervisor and removed the cream from the cart. Interview with the power of attorney for Resident #1 on 08/01/18 at 5:10pm revealed: -The Clobetasol cream was prescribed by her previous physician for skin eruptions due to the resident's chronic skin condition. -The Clobetasol had been very successful in the treatment of skin flare ups.	D 358		

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D 358	Continued From page 101 -She had filled the prescription from an outside pharmacy in January (01/11/18) to have on hand when Resident #1 had skin eruptions. -She brought the tube of Clobetasol to the facility in March 2018 when it was prescribed for Resident #1 for one week. Interview with the Administrator on 08/02/18 at 10:25am revealed: -The MAs should be reading the entire medication entry on the eMAR and the label on the medication before administration. -The facility nurse for the Memory Care unit conducted cart audits monthly. -He did not know why this was not discovered during a monthly cart audit. -He did not know why the MAs did not question this entry and clarify with their supervisor. b. Review of a Physician's orders dated 04/14/18 revealed: -There was an order for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours as needed (PRN) for moderate pain. -There was an order for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for severe pain. Review of Resident #1's April 2018 eMAR revealed: -There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for moderate pain. -There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for severe pain. Review of Resident #1's May 2018 eMAR revealed: -There was an entry for Tramadol HCl 50mg	D 358		

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tablets, take 1 tablet by mouth every 6 hours PRN for moderate pain.
-There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for severe pain.

Review of Resident #1's June 2018 eMAR revealed:
-There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for moderate pain.
-There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for severe pain.

Review of Resident #1's July 2018 eMAR revealed:
-There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for moderate pain.
-There was an entry for Tramadol HCl 50mg tablets, take 1 tablet by mouth every 6 hours PRN for severe pain.

Observation of the medication on hand in the Memory Care unit on 08/01/18 at 3:52pm revealed:
-There was a bottle of Tramadol 50mg in the cart labeled with Resident #1's name.
-The directions on the medication label were to "Take 1 or 2 tablets every six hours as needed for pain".
-The medicine bottle was taped shut.
-The dispense date on the bottle was 11/09/17.
-270 pills were dispensed-approximately half remained in the bottle.

Interview with the second shift medication aid (MA) in the Memory Care unit on 08/01/18 at 4:10pm revealed:

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D 358	Continued From page 103 -She worked as needed in the facility for the past year. -She had not reviewed the label on the Tramadol bottle since she had never administered the Tramadol 50mg to Resident #1. -If she had noticed, she would have alerted her supervisor and obtained a "change of direction" sticker to apply to the bottle. Interview with the Administrator on 08/02/18 at 10:25am revealed: -The MAs should be reading the entire medication entry on the eMAR and the label on the medication before administration. -The facility nurse for the Memory Care unit conducted cart audits monthly. -He did not know why these medication errors were not discovered during a monthly cart audit. -He did not know why the MAs did not question the Clobetasol order and the Tramadol order and clarify with their supervisor. Attempted telephone interview with the prescribing physician on 08/02/18 at 10:55am was unsuccessful	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and	D 375	facility will allow any resident who meets the requirements of self administration of meds, with physcian orders and nurse evaulation for competency and safety, facility will routinely inspect resident rooms for medications that may have been brought in by family or resident that do not meet requirements. Facility will also inform family members via in-person or newsletter this will also include residents. The facility will follow house policy as written. doc 9-17-18	

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D 375	Continued From page 104 (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews the facility failed to assure 1 of 5 sampled residents (Resident #3) had medications properly labeled in her room and 1 of 3 sampled residents had orders to self-administer medications (Resident #7). The findings are: Review of Resident #3's FL-2 dated 07/04/18 revealed: -Diagnoses included weakness, urinary tract infection, anxiety; depression, chronic pain, abnormalities of gait and mobility, and decreased white blood cell count. -There were no orders on the FL-2 for Resident #3 to self-administer her medications. Review of Resident #3's physician's orders dated 07/04/18 revealed: -Diagnoses included weakness, urinary tract infection, abnormalities of gait and mobility, muscle weakness (generalized) difficulty in walking, transient cerebral ischemic attack, and decreased white blood cell count. -Notations: "Patient may self-administrate all meds except for narcotics." Interview with Resident #3 on 07/31/18 at 11:58am revealed: -She had been a resident of the facility since 12/12/16.	D 375		

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D 375	Continued From page 105 -She self-administered all of her medications except the narcotics. -She self-administered all her medications until the doctor stopped her from administering her narcotics last summer. -She kept her medications in her room in red box provided by the facility. -The facility kept her narcotics. Observation of Resident #3's medications on 07/31/18 at 11:58am revealed she had a medication bottle labeled Alprazolam 2mg 1 pill by mouth 4-times per day sitting on a bedside table filled with white oval shaped pills with red lettering that said Tylenol. Interview with the Licensed Practical Nurse, LPN, for assisted living on 08/01/18 at 9:15am revealed: -Resident #3 had a physician order to self-administer all of her medications except the narcotics. -The facility did not order medications for Resident #3. -She met with Resident #3 last month to discuss her medications. -At that time, Resident #3 could not tell her how much or what medications she was taking. -She left the nurse practitioner a note to assess Resident #3's concerning her medications to determine if Resident #3 could continue administer her own medications. -She did not document the conversation with Resident #3 regarding her medications. -The Administrator gave her a form, "Medication Self-Administration Assessment," on 07/31/18 to assess residents who self-administer their medications. -This was the first time she had ever seen this form.	D 375		

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-She thought all that was needed for a resident to self-administer medications was an order from the resident's physician.
-She was not aware of the facility's policy and procedure for self-administration until 07/31/18.

Interview with the Nurse Practitioner (NP) on 08/01/18 at 11:40am revealed:
-She was not aware of any resident in the facility who had the mental ability to self-administer medications.
-She was unaware that Resident #3 had self-administered her own medications.
-She was not aware Resident #3 had a medication bottle labeled Alprazolam 2mg 1 pill by mouth 4-times per day sitting on a bedside table filled with white oval shaped pills with red lettering that said Tylenol.
-She "could have signed" the six month subsequent orders on 07/04/18 for Resident #3 to self-administer all of medications except for the narcotics.
-She felt that Resident #3 was orientated enough, but not psychological enough to self-administer her medications.
-Because of Resident #3's depression and anxiety, she would not want Resident #3 to self-administer her medications.
-She had concerns about the recent changes in Resident #3's psychological state over the last few weeks.
-She had received a note from the LPN on the assisted living side on 08/01/18 to evaluate Resident #3 to determine if she was capable to administer her own medications.

Confidential interview with a medication aide (MA) revealed:
-The facility's staff received an order today from the NP to administer all of Resident #3's

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medication.
-She thought Resident #3's mental health ability had declined over the last couple of weeks, but she never reported the concern to LPN or documented the concern.
-She was unaware of the policy for residents to administer their own medications.

Refer to review of the facility's Self-Administration of Medications by Resident policy and procedures.

2. Review of Resident #7 FL-2 dated 11/28/17 revealed diagnosis included dementia, lymphedemia, coronary arteriosclerosis, diabetes mellitus, neuropathy, atrial fibrillation, edema, cardiovascular accident, venous thrombosis, and embolism.

Review of Resident #7 physician orders on 08/02/18 at 10:55am revealed no order to self-administer medications.

Observation of Resident #7 in his room on 07/30/18 at 9:45am revealed Resident #7 had the following medications on his bedside table: Zinc Oxide ointment, and Nasal Decongestant spray.

Interview Resident #7 on 07/30/18 at 9:45am revealed:
-The resident used these medications independently when ever he needed them.
-He used the Zinc Oxide when he had a rash on his legs, and Nasal Decongestant spray when his nose was congested.
-Staff was aware he had them because on many occasions they had been in his room.

Interview with Nurse Supervisor on 08/02/18 at

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D 375	Continued From page 108 12:00pm revealed: -Resident #7 had no physician's order to self-administer his medications. -She was not aware Resident #7 self-administered his medications. -There were no residents on the assisted living 3rd floor that should have self-administered medications. -Resident #7's family member had brought those medications to him. -She had not checked his room for medications. Interview with Resident #7's physician on 08/02/18 at 12:30 was unsuccessful. Refer to review of the facility's Self-Administration of Medications by Resident policy and procedures. _____ Review of the facility's Self-Administration of Medications by Resident policy and procedures revealed: -The facility shall permit residents who are competent and physical able to self-administer their medications if the following are met: 1. The self-administration is ordered by physician or other authorized prescriber and documented in the resident's medical record. 2. Specific instructions for administration of prescription medications are printed on the medication label. Procedure as follows: A.Residents who request approval to self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent. B.The interdisciplinary will assess the resident's cognitive, physical and visual ability to carry out	D 375		

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D 375	Continued From page 109 this responsibility. If the team determines that the resident is competent, the attending physician shall be contacted to request a specific order for self-administration of the medication. C.If the resident demonstrates the ability to self-administer medications, a further assessment of the safety of the bedside medication storage shall be done. Beside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or who room with residents who self-administer. D.The interdisciplinary team shall re-assess the resident's ability to self-administer every three months. If the self-administration privileges are withdrawn, the medications of the resident shall be stored in the med-cart or in the med-room. E.The facility's staff are not required to document when a resident self-administers medications stored at bedside shall be secure from other residents. Lockable drawers or cabinets are not required. The medications provided to the residents for bedside storage are kept in the containers dispensed by the provider pharmacy. F.If self-administration privileges are withdrawn, the physician shall be notified and the pharmacist asked to update the prescription records.	D 375		
D 448	10A NCAC 13F .1211 Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following: (1) ordering, receiving, storage, discontinuation,	D 448	The facility has obtained written polices with regards to 10A NCAC 13F.1211, facilty will place house policies available for use in nursing areas, management staff, all staff will be informed of location and use of polices. doc 9-10-18	

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D 448	Continued From page 110 disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications; (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse; (3) accident, fire safety and emergency procedures; (4) infection control; (5) refunds; (6) missing resident; (7) identification and supervision of wandering residents; (8) management of physical aggression or assault by a resident; (9) handling of resident grievances; (10) visitation in the facility by guests; and (11) smoking and alcohol use. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to develop and implement a written policy and procedure for the management of physical aggression or assault by a resident, and the facility did not have a policy for infection control related to contact isolation in regard to the scabies infection control. The findings are: A. Interview with the Memory Care Manager	D 448	Facilty has developed behavioral policy and is educating staff with policy with distribution of policy. Facility does have policy regarding contact precautions not specfic to scabies however has developed, with education to staff being presented. Ongoing education will be provided and education will be given to new employees upon hire regarding behaviors and infection control. DOC 9/10/2018	

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D 448	Continued From page 111 (MCM) on 07/30/18 at 10:47 revealed: -She had been employed for several years at the facility, and had been employed previously out of state in a Special Care unit. -She did not know if there was a written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff. -She had not received any formal training, that she could remember, regarding resident aggression or assault. -In her experience, most resident's agitated or aggressive behavior was related to the staff having approached the resident incorrectly. -When a resident was agitated, she re-approached the resident and attempted to discover the cause of their agitation. "I don't usually have any behavior problems when I am working." Interview with the first shift medication aide (MA) on 07/31/18 at 12:00pm revealed: -She had been a full time employee at the facility for several years and worked first shift as a MA in the Memory Care unit. -She did not know if there was a facility written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff. -She had not received any formal training regarding agitated or aggressive residents that she could remember. -She attempted to re-approach the resident if they were agitated, and administer an as needed (PRN) medication if the resident was not combative. -She does not remember who instructed her to re-approach an agitated or aggressive resident and administer a PRN medication if necessary. It may have been the registered nurse who	D 448		

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administered the medication skills checklist.
-If the resident attempted to become physical with another resident, she sent the target resident to their room and tried to calm the agitated resident.
-If the resident continued to escalate, and a prn was not able to be administered, she would call her supervisor.
-If a supervisor was unavailable, she would call 911 and send the resident to the emergency department (ED) of the hospital.

Interview with the second shift MA on 07/31/18 at 4:11pm revealed:
-She worked PRN on second shift administering medications and delivering resident care.
-She did not know if there was a written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-She had not received any formal training on the management of aggressive residents from her supervisor.
-She knew some of the residents would get agitated, and occasionally aggressive, but she was usually able to calm them down by speaking with them or giving them a PRN medication.
-She sent residents to the ED if they continued to be aggressive or assaultive, per her supervisor's directive.

Interview with an agency personal care aide (PCA) on 08/01/18 at 12:30pm revealed:
-She had been assigned to this facility part time through her agency for the past month.
-She had not received any training in the management of a resident exhibiting aggressive behavior toward another resident or staff.
-She did not know if there was a written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward

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another resident or staff.
-If she encountered any behaviors she requested the assistance of the MCM or MA.

Interview with the Administrator on 08/02/18 at 10:15am revealed:
-There was no written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-The staff knew to redirect the resident, administer PRN medication, re-approach the resident and call 911 when residents were agitated to the point of aggression.
-There was no formal training offered to staff upon hire regarding aggressive behaviors, or assault to another resident or staff member.
-He had conducted in service training for the staff regarding behaviors periodically.
-He was unable to produce documentation of any in service training to the staff regarding resident behaviors.

Interview with the facility nurse for the Memory Care unit on 08/02/18 at 3:01pm revealed:
-She did not know of a written policy and procedure for staff guidance in the event of a resident exhibiting aggressive behavior toward another resident or staff.
-Residents with any acute issues were to be identified in the "Hot Box".
-The "Hot Box" was a 3 ring binder. The MA's were to reference the binder on each shift to alert the staff to resident's with acute issues, and to document on those residents with a change in cognitive or health status, antibiotic therapy, falls, admissions, re-admissions and skin impairments.
-She encouraged the staff to redirect the resident if agitated or aggressive, administer PRN medications, and contact 911 if necessary.

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D 448	Continued From page 114 -She believed this had been discussed in one of their management meetings with the Administrator, but was unable to recall when. -She was responsible for the clinical staffing in the Memory Care unit. Review of the Progress Notes for Resident #11 revealed: -There were 14 documented incidents of aggressive behavior toward staff or residents, in the past 6 months. -There were no documented interventions implemented by the facility to decrease agitation or behaviors. Attempted phone interview with resident's family member, the primary contact, on 08/02/18 at 1:04pm was unsuccessful. Attempted phone interview with the PCP on 08/02/18 at 1:15pm was unsuccessful. B. Review of Resident #10's FL 2 dated 07/05/18 revealed diagnoses included dementia, agitation, anxiety, malnutrition and hypertension. Review of a Hospice order dated 07/24/18 revealed: -Resident #10 was to be on contact isolation until scabies was ruled out. -An referral order for Resident #10 to see a dermatologist for a rash. Review of Resident #10's physician order dated 07/26/18 revealed an order for permethrin 5% topical cream 120 grams, apply to skin (head to toe) and leave on overnight. Wash off in the morning and repeat in one week. Interview with resident #10's Hospice Nurse on 08/01/18 at 4:00pm revealed:	D 448		

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D 448	Continued From page 115 -She placed Resident #10 on contact precautions for scabies on 07/24/18 to rule out scabies until after Resident #10 saw the dermatologist. -Resident #10 was seen at the Dermatologist on 07/26/18 and a skin scraping was done and was sent to the lab to rule out scabies. -After she talked with the dermatologist about Resident #10 she wrote an order for permethrin 5% topical cream 120 grams, apply to skin (head to toe) and leave on overnight. Wash off in the morning and repeat in one week. -She provided education to the staff at the facility on 07/26/18 via phone and at the facility on 07/27/18 for scabies contact isolation precautions. -The contact isolation instructions included; anyone having contact with Resident #10 was to wear an isolation gown, gloves and shoe covers, hand washing after contact with Resident #10, linens were to be placed in a plastic bag and taken to the laundry room and washed in hot water immediately and separate from any other residents linen, and the trash was to be placed in a plastic bag and disposed of in the trash and housekeeping should wear an isolation gown and gloves to clean the room and laundry. -She expected the staff to call her with any concerns related to Resident #10's condition including the scabies. Interview with the Administrator on 08/01/18 at 4:58pm revealed: -The facility did not have a policy for contact isolation. -The facility used the Center for Disease Control (CDC) guidelines for scabies infection control. -That included the used of personal protective equipment and isolation. Interview with a medication aide (MA) on	D 448		

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D 448	Continued From page 116 07/30/18 at 10:28am revealed: -Resident #10 was on contact isolation for scabies. -She wore a gown and gloves every time she entered Resident #10's room. -She would wear shoe covers but there were none at this facility. -There was not a contact isolation policy at the facility. -She used training from another facility on contact isolation. Observation of isolation cart on 07/31/18 at 10:30am revealed 2 isolation gowns and a partially used box of gloves. Observation of Resident #10's caregiver on 07/31/18 at 10:30am revealed: -The caregiver was leaving Resident #10's room with soiled bed linens. -The caregiver did not have on a yellow isolation gown or gloves. -The linens were not in a bag. -The caregiver took the bed linens to the laundry room and dropped off the bed linens. -The caregiver returned to Resident #10's room to help with the medications. Interview with a housekeeper on 07/31/18 at 10:55am revealed: -She did not know about an infection control policy at the facility. -She preformed her job based on other jobs with infection control. Interview with Resident #10's caregiver on 07/31/18 at 11:08am revealed: -No one educated him on contact isolation precautions. -He took out the trash if the housekeeper did not	D 448		

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REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

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D 448	Continued From page 117 get it. He took the trash to the end of the hall to the dirty utility room. -He took the soiled linens and clothes to the laundry room and dropped them off. He did not take the linens in a bag and he carried them to the laundry room after removing them from the bed. Interview with the Administrator on 08/01/18 at 11:33am revealed: -The facility did not have a "contact isolation policy" for scabies. -He expected the staff to wear a gown, gloves and shoe covers upon entering the resident's room. -A cart was placed outside of Resident #10's room on 07/26/18 with all of the isolations supplies on it. -All staff and visitors entering into Resident #10's room were to wear a gown gloves and shoe covers and to remove them and place in a plastic bag before exiting the room. -All of Resident #10's laundry was to be placed in a plastic bag and to be washed immediately after being removed from Resident #10's room in hot water and separate from other resident's laundry. -All of the trash was to be removed from Resident #10' room in a double plastic bad and taken to the dumpster. _____ The facility failed to develop and implement a written policy and procedure for the management of behaviors to aid the staff in the event of physical aggression or assault by a resident (Resident #11) with 14 documented incidents of aggressive behavior toward residents and for infection control related to contact isolation in regards to a resident who had orders for contact	D 448		

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D 448	Continued From page 118 isolation and a potential diagnosis of scabies (Resident #10) which put other residents at risk for contracting a highly contagious skin disease. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2018.	D 448		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observation, facility policy/documentation and interviews, the facility failed to report accidents/incidents to the county department of social services for 7 out of 12 (Resident #1, #5, #6, #8, #11, #12, #13).	D 451	plan of protection provided at time of citation. Community will notify DSS of any accident or injury requiring referral for medical treatment or hospitalization other than basic first aid. RCC and lpn's will ensure that incident reports are sent to DSS within a timely manner, audits will be performed monthly x 2months. Audit results will be presented to DON/ Administrator for review of accuracy and quality. Community will maintain receipt of fax transmissions. DOC 9/117/18	

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D 451	Continued From page 119 Findings: 1. Review on Resident #13's current FL2 dated 06/01/18 revealed diagnosis included Alzheimer's disease, congested heart failure and acute respiratory failure. Review of Resident #13's resident register revealed an admission date of 08/25/16. Review of a facility incident report dated 12/30/17 at 5:30pm for Resident #13 revealed: -There was documentation of an occurrence as a "missing person." -There was documentation the "Facility went into a code silver." -There was documentation Resident #13 was found "sitting in a wheelchair at the gas station." -There was documentation the family had been notified at 6:59pm and the Administrator was notified at 5:15pm were contacted. -There was no documentation the county Department of Social Services (DSS) were notified of Resident #13 elopement. -The incident report was signed by the MA on 12/30/18, and the Administrator had signed and dated on 01/02/18. Review of the facility sign-out book for the month of December 2017 revealed there was no documentation Resident #13 had signed out on 12/30/17. Interview with the Assistant Administrator on 08/02/18 at 10:30am revealed: -She had known Resident #13 had eloped on 12/30/17 and had went to look for Resident #13 after the code silver was called. -She was not aware the incident report was not faxed to the county DSS.	D 451		

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D 451	Continued From page 120 Interview with the Administrator on 08/02/18 at 11:42am revealed: -He did not know Resident #13 had eloped on 12/30/17. -He did not know why the incident report was not faxed to the county DSS. Review of the facility missing resident policy posted at the nurses station on the second floor revealed the procedure included; "Accident/incident report will be completed and sent to DSS." Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm. Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm. Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm. Refer to interview with the Administrator on 07/31/18 at 5:15pm. Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm. Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm. 2. Review of Resident #5's current FL2 dated 07/03/18 revealed diagnoses included dementia, diabetes, and hypertension. Review of an incident report for Resident #5 dated 07/11/18 at 9:15am revealed:	D 451		

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D 451	Continued From page 121 -There was documentation Resident #5 had an unwitnessed fall in her room with no visible injury. -There was documentation Resident #5 was not sent out to the ER for an evaluation. -The incident report was signed and dated on 07/11/18 by the medication aide (MA), the facility nurse, and the Administrator. Review of an Emergency Room (ER) visit note for Resident #5 dated 07/11/18 at 6:11pm revealed: -There was documentation Resident #5 was seen for an evaluation of a status post fall and pain in her right side. -There was documentation a CT of the chest was performed on Resident #5 which showed rib fractures 7-11 posterior. Review of Resident #5's record revealed there was no documentation the county DSS was notified of Resident #5 fall on 07/11/18 resulting in an ER visit for a diagnosis of multiple rib fractures. Interview with the Administrator on 08/01/18 at 5:05pm revealed: -He was not aware Resident #5 had a diagnosis from the ER visit dated 07/11/18 of posterior rib fractures 7-11. -He relied on the MAs to complete an incident report and document all parties notified. Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm. Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm. Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm.	D 451		

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D 451	Continued From page 122 Refer to interview with the Administrator on 07/31/18 at 5:15pm. Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm. Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm. 3. Review of Resident #8's current FL2 dated 07/20/18 revealed diagnoses included dementia, falls, and hypertension. Review of an incident report for Resident #8 dated 07/07/18 at 8:30pm revealed: -There was documentation Resident #8 had an unwitnessed fall in her room. -There was documentation Resident #8 had a "deep open face cut, bleeding very very heavy." -There was documentation Resident #8 was sent to the ER for an evaluation and the family was notified on 07/07/18 at 9:00pm. -There was no documentation the county Department of Social Services (DSS) were notified of Resident #8's fall resulting in an injury(laceration) and an ER visit. -The incident report was signed by the MA on 07/07/18, facility nurse on 07/09/18, and the Administrator with no date documented. Review of the progress notes for Resident #8 dated 07/0718 at 9:36pm revealed there was no documentation the incident report had been faxed to DSS. Review of an ER visit note date 07/07/18 at 10:15pm revealed: -There was documentation Resident #8 was seen	D 451		

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D 451	Continued From page 123	D 451		

for a status post fall-laceration to the left leg.
-There was documentation a procedure to close the laceration was performed and sutures were placed, a golf ball size hematoma was noted under the left leg laceration.

Interview with the Administrator on 07/31/18 at 5:50pm revealed:
-He had known Resident #8 had fallen on 07/07/18 and was sent out to the ER for an evaluation of a laceration to the left leg.
-He relied on the MA to complete the incident report for all injuries.

Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm.

Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm.

Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm.

Refer to interview with the Administrator on 07/31/18 at 5:15pm.

Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm.

Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm.
4. Review of Resident #11's current FL2 dated 04/30/18 revealed diagnoses included advanced dementia, type 2 diabetes mellitus, stage 3 chronic kidney disease.

Review of Resident #11's Progress Notes revealed:

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D 451	Continued From page 124 -On 09/07/17, Resident #11 kicked a staff person, and the front door at the main entrance to the facility, yelling and screaming, damaging the door. -The resident was transported to the Emergency Department (ED) for evaluation. -There was no documentation that an Incident Report, per facility policy, was completed for the incident on 09/07/17. -There was no documentation the county Department of Social Services (DSS) were notified Resident #11 was sent to the ED for aggressive, violent behavior. Review of Resident #11's record revealed: -There was a hospital discharge summary documenting Resident #11 was seen in the ED for a psychiatric evaluation due to bouts of aggressive behavior on 07/06/18. -There was no documentation the county Department of Social Services (DSS) were notified of Resident #11's ED visits. -There was no documentation that an Incident Report had been completed, per facility policy, for hospital visits on 09/07/17 and 07/06/18 for aggressive behaviors toward residents and staff. Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm. Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm. Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm. Refer to interview with the Administrator on 07/31/18 at 5:15pm.	D 451		

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D 451	Continued From page 125 Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm. Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm. 5. Review on Resident #1's current FL2 dated 03/15/18 revealed diagnoses included dementia, hypertension and cervical spine disease. Review of the Incident Repors for Resident #1 on 4/21/18 at 7:15am revealed: -Resident #1 had an unwitnessed fall in the common area where the resident was observed by the staff on her back. -911 was called and the resident was taken to the ED for assessment. -The report documented the resident would be placed on hourly checks for an indeterminate period of time. Review of the Incident Report for Resident #1 on 4/22/18 at 12:15pm revealed: -The report documented an unwitnessed fall in the common area with a quarter size skin tear (location of the skin tear was not documented) and the resident complained of pain to the neck and back. -911 was called and the resident was taken to the ED for evaluation. The report also documented the resident would have an alarm on her person and have hourly checks for an indeterminate period of time. Review of the Incident Report for Resident #1 on 06/24/18 at 6:00am revealed: -The report documented an unwitnessed fall in the resident's bedroom. -The resident was found on her right side, on the	D 451		

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D 451	Continued From page 126	D 451		

floor, parallel to the side of the bed and bleeding profusely.
-911 was called and the resident was taken to the ED for evaluation.
-The report documented the resident would have increased checks by staff, increased supervision by staff, use of a bed rail, fall mat, personal alarm and bed wedge. No time frame was listed for the implementation of these interventions.

There was no documentation in Resident#1's record the county DSS were notified of the incidents that occurred on 04/21/18, 4/24/18 or 06/24/18.

Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm.

Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm.

Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm.

Refer to interview with the Administrator on 07/31/18 at 5:15pm.

Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm.

Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm.

6. Review of Resident #12's FI2 dated 05/16/18 revealed:
-Diagnoses included unspecified dementia without behaviors, Parkinson disease, diabetes,

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D 451	Continued From page 127 hypertension and edema in the lower extremities. Review of the Incident Report for Resident #12 on 07/07/18 at 4:40pm revealed: -There was documentation Resident #12 was observed lying on his right side on the floor in his bedroom. -Resident #12 was sent to the hospital for complaints of shortness of breath. Review of the facility Progress Notes for Resident #12 revealed: -On 05/26/18 the resident was sent to the emergency department (ED) for a fall with complaints of pain in his back. No Incident report was completed. -On 06/06/18 the resident was observed on the floor in his bedroom and was sent to the ED for behaviors-unspecified. -On 07/04/18 the resident had an unwitnessed fall and was sent to the ED for evaluation. The resident was diagnosed with a right rib fracture. No Incident Report was completed. -On 07/15/18 the resident was sent to the ED due to complaints of pain and inability to move, due to an unkown cause. No Incident Report was completed. -On 07/16/18 the resident was sent to the ED due to complaints of pain and inability to move, due to an unknown cause. No Incident Report was completed. There was no documentation in Resident #11's record the county DSS were notified of the incidents that occurred between 05/26/18 and 07/16/18. Refer to the Accident and Incident Report Policy and Procedures.	D 451		

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D 451	Continued From page 128 Interview with the facility nurse for the Memory Care unit on 08/03/18 at 3:01pm revealed: -Incidents with the residents were documented on a facility form titled Occurrence Report and Investigation. -These reports were completed by medication aide (MA). -The report should be completed before the MA finished their shift. -The report includes the type of occurrence, the nature of the injury, the description of the occurrence, who was notified and interventions to be taken. -This report was to be submitted to the facility LPN and the Administrator before the end of the MA's shift. -She did not know reports were not completed for all Resident #11's incidents. -She did not know if there was an Incident Report policy for this facility. -She did know Incident Reports were to be sent to the county DSS. -She was responsible for ensuring policies and procedures were carried out by the staff. Interview with the Administrator on 08/02/18 at 10:15am revealed: -He did not know the county DSS were not notified of Resident #11's ED visits -He did not know the county DSS were not notified Resident #11 had 12 incidents between 08/31/17 and 05/15/18 that should have been reported. -He did not know only 2 incident reports were filed regarding these behaviors. -He knew Incident Reports were to be faxed to the county DSS. -This was the facility nurses' responsibility to oversee Incident Reports and ensure notifications were sent to all applicable parties.	D 451		

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D 451	Continued From page 129 Refer to interview with a representative from the local county DSS on 08/01/18 at 2:30pm. Refer to interview with Memory Care Coordinator on 08/01/18 at 4:25pm. Refer to interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm. Refer to interview with the Administrator on 07/31/18 at 5:15pm. Refer to review of the facility's in-house incident form on 08/02/18 at 3:30pm. Refer to review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm. _____ Interview with a representative from the local county DSS on 08/01/18 at 2:30pm revealed: -She had monitored the facility several times in the past few months. -She had not received any incident reports in regard to Resident #1, #5, #6, #8, #11, #12, or #13. -The Administrator was aware he was to fax the incident reports to the county DSS. Interview with Memory Care Coordinator on 08/01/18 at 4:25pm revealed: -The MA's on duty were responsible for completing the in-house incident form after an incident or accident involving a resident. -The MA placed the completed in-house incident forms in her box.	D 451		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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 451	Continued From page 130	D 451		

-She reviewed and signed the in-house incident form and then sent them to the Administrator to review and sign.
-She filed in-house incident forms in a binder after the ED signed them.
-She stated upon her hire (September 2017) she inquired about notifying the department of social services (DSS) about accidents/incidents involving residents (because this was part of her job duties in her previous facility) and was told by the Administrator to not send them to DSS.

Interview with facility nurse in the Assisted Living (AL) side of the facility on 08/01/18 at 4:55pm revealed:
-The person, staff member or agency person, who found a resident who needed medical intervention or first-aid completed the incident form.
-The nurse at the facility completed an assessment of the resident to determine if the resident should be sent out to the emergency room.
-All incident forms were reviewed by her, after she reviewed them she would send them to the Administrator for review and a signature.
-After the Administrator signed the incident form it was filed away.
-She was not aware of the rule to report resident incidents/accidents to DSS until around mid-July of 2018 when the county monitors made her aware of it.
-The Administrator told her in mid-July 2018 to start faxing the incident/accident report forms to DSS when it involved the resident being sent out for medical care.

Interview with the Administrator on 07/31/18 at 5:15pm revealed:
-He was aware that DSS was not receiving the

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D 451	Continued From page 131 faxed copies of incident/accident reports due to a problem with the facility fax machine after a county monitoring visit in May 2018. -He had re-faxed some reports to DSS and received confirmations therefore he thought the issue was resolved. Review of the facility's in-house incident form on 08/02/18 at 3:30pm revealed: -The form listed the resident involved, the type of occurrence, the nature of injury, response to injury, description of occurrence, notifications, action taken by facility and if any health problems, medication or other conditions could have contributed to the incident. -The form had three signature spaces which included: "person filing report"; "executive director review" and "licensed nurse review". Review of the facility's Accident and Incident Report Policy and Procedures on 08/02/18 at 3:40pm revealed: -"It is the policy of Regency Retirement Village to ensure that all incident/accidents are reported in a timely manner in accordance with the NC state regulations. All incidents/accidents shall be documented on and investigated in a timely manner. Any resident or staff member involved shall be assessed by nursing in order to determine further treatment or follow-up." -"All incidents shall be documented on an Incident Report. Incident reports shall include (but not limited to): falls, bruises, skin tears, cuts, change in mental status or physical decline. In the event of fall involving fractures or death, the incident report must be submitted to the [local] County DHHS via fax."	D 451		

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D 468	Continued From page 132	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure staff assigned to the memory care unit had completed 6 hours of	D 468	The facility will continue to educate all new hires with reuirements of 6 and 20 hour education in regards to dementia training, facilty scheduling staffing co ordinator will perform audit of employees files to enusre all employees have had or will be given training required. Audit of employee files	

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D 468	Continued From page 133 orientation during the first week of employment and within six months of employment 20 hours of training specific to the population being served for 10 of 10 memory care unit (MCU) staff. (Staff A, B, C, D, E, F, H, J, K and L). The findings are: Review of the staff record for Staff A a contract agency personal care aide (PCA) revealed: -Staff A was hired on 04/29/18 to work in the memory care unit (MCU), as a personal care aide (PCA). -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Interview on 07/30/18 at 11:18am with Staff A (PCA) revealed: -He was contact agency staff and worked in the MCU as well as the assisted living side. -His duties were to provide personal care to the residents. -The facility had given him no MCU training prior to working on the MCU. Refer to interview with the Administrator on 08/02/18 at 4:15pm. Review of the staff record for Staff B (PCA) revealed: -Staff B was hired on 04/25/18 to work in the MCU, as a PCA. -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Refer to interview with the Administrator on	D 468	with documentation of audit to be surrendered to the adm for review. DOC 9/10/2018	

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D 468	Continued From page 134 08/02/18 at 4:15pm. Review of the staff record for Staff C (LPN) revealed: -Staff C was hired on 06/21/18 to work in the MCU, as a Licensed Practical Nurse (LPN). -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Interview on 07/30/18 at 10:58am with staff C (LPN) revealed: -She had worked as a LPN in the MCU on 07/30/18 administering medications to the residents. -She had previously worked with memory care residents. -She was not aware of any necessary special training needed when working in the MCU. -The facility did not offer any additional MCU since she had started working in the facility. Refer to interview with the Administrator on 08/02/18 at 4:15pm. Review of the staff record for Staff D (PCA) revealed: -Staff D was hired on 01/24/17 to work in the MCU, as a PCA and a Medication Aide (MA). -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Interview with Staff D (PCA) on 08/02/18 at 3:30pm revealed: -She had work in MCU as a MA and a PCA. -She had no special training only experience. -She was not aware of any necessary special	D 468		

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D 468	Continued From page 135	D 468		

training that was required for the MCU.
-When they needed her to work in MCU, she had worked evenings and weekends.

Refer to interview with the Administrator on 08/02/18 at 4:15pm.

Review of the staff record for Staff E (PCA) and a (MA) revealed:
-Staff E was hired on 08/11/17 to work in the MCU, as a PCA and a MA.
-There was no documentation of 6 hours of MCU training completion.
-There was no documentation of 20 hours of MCU training completion.

Refer to interview with the Administrator on 08/02/18 at 4:15pm.

Review of the staff record for Staff H (PCA) and a (MA) revealed:
-Staff H was hired on 11/10/17 to work in the MCU, as a PCA and a MA.
-There was no documentation of 6 hours of MCU training completion.
-There was no documentation of 20 hours of MCU training completion.

Refer to interview with the Administrator on 08/02/18 at 4:15pm.

Review of the staff record for Staff J (Administrator)revealed:
-Staff J was hired on 10/30/17 to work in the MCU as the Administrator.
-There was no documentation of 6 hours of MCU training completion.
-There was no documentation of 20 hours of MCU training completion.

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D 468	Continued From page 136 Interview with the Administrator on 08/02/18 at 4:15pm revealed: -He was aware of the MCU staff requirement for completion MCU training. -"I guess the training just got over-looked." Refer to interview with the Administrator on 08/02/18 at 4:15pm. Review of the staff record for Staff K (LPN) revealed: -Staff K was hired on 05/01/18 work in the MCU, as an LPN. -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Refer to interview with the Administrator on 08/02/18 at 4:15pm. Review of the staff record for Staff L (LPN) revealed: -Staff L was hired on 05/12/18 to work in the MCU, as an LPN. -There was no documentation of 6 hours of MCU training completion. -There was no documentation of 20 hours of MCU training completion. Refer to interview with the Administrator on 08/02/18 at 4:15pm. Interview with the Administrator on 08/02/18 at 4:15pm revealed: -He was aware of the requirement for completion of 6 hours of MCU training during the first week of employment for any memory care unit employee. -He was also aware of the requirement for an additional 20 hours of MCU training to be	D 468		

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D 468	Continued From page 137 completed within 6 months of hire for any memory care unit employee. -He was responsible for completing training for the staff because he was a Registered Nurse. -Mostly contract agency staff worked in the MCU. -None of the agency staff had completed the MCU 6 hour training prior to working in the MCU or completed the 20 additional SCU training hours in 6 months of hire. -"I guess the training just got over-looked."	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to 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 supervision, referral and follow-up, implementation, written policy and procedures, and ACH infection prevention requirements. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 4 of 8 sampled residents (#13, #1, #11, and #12) related to elopement Resident #13,	D912		

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D912	Continued From page 138 a fall with inury and multiple falls (Resident #1 and #12) and agreesive behaviors (Resident #11). Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 2. Based on observations, interviews, and record reviews the facility failed to assure physician contact for 5 of 5 sampled residents; Resident #5 sustained rib fractures, (Resident #8) an infectious leg wound, (Resident #13) elopement from the facility, (Resident #11) aggressive behavior and (Resident #12) for multiple falls over a 3 month period.[Refer to Tag 273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the Administrator 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 physical environment, multiple housekeeping tags, supervision, referral and follow, infection prevention requirements, reporting of accidents and incidents, self-administration of medications, resident TB, therapeutic diets, building and fire safety, food service orientation ,written policy and procedures, medication administration, sanitation grade less than 85, staff qualifications, and special care unit training, all of which are the responsibility of the Administrator. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A2 Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention	D912	Facility will adhere to all resident rights, with respect to dignity, personal care and supervison. Facility will continue to monitor rule areas that would affect resident rights, ex: elopment, falls, physcian referral and followup. Facility will monitor through auidts from related rule areas, with adm and or designee. This will be and ongoing process. DOC-9/17/18	

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D912	Continued From page 139 guidelines to assure proper infection control procedures for the use of glucometers for 6 of 7 diabetic residents sampled (Residents #6, #14, #15, #16, #17 and #18) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation).] 5. Based on interviews and record reviews, the facility failed to develop and implement a written policy and procedure for the management of physical aggression or assault by a resident, and the facility did not have a policy for contact isolation in regard to the scabies infection control. [Refer to Tag 448, 10A NCAC 13F .1211Written Policies And Procedures (Type B Violation).]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.	D932	Facility will review and update as necessary infection control guidelines, consistent with CDC guidelines on infection control, facility replaced all glucometers, all were labled patient specific, RCC will review glucometers weekly and clean per guidelines audit to be performed weekly x 4wks DOC 9/11/18	

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D932	Continued From page 140 c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention	D932		

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D932	Continued From page 141 guidelines to assure proper infection control procedures for the use of glucometers for 6 of 7 diabetic residents sampled (Residents #6, #14, #15, #16, #17 and #18) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. The findings are: Observation on 07/31/18 at 10:20 am revealed: -The facility had 2 medication carts on the assisted living side and 1 on the memory care unit containing residents' glucometers. -The medication carts had glucometer pouches labeled with resident's name. -The glucometer pouches contained glucometers (Brand A) labeled with a corresponding resident's name and some of which were not labeled with a resident's name. Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed the CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list disinfection information, the glucometer should not be shared between residents. Review of the manufacturer instructions for the Brand A glucometer revealed the glucometers were not recommended for use by more than one person, and should not be shared. No disinfection procedures were recommended. Interview with the Administrator on 07/31/18 at 12:50pm revealed: -The facility had 16 residents receiving finger	D932		

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D932	Continued From page 142	D932		

stick blood sugar (FSBS) checks.
-All the residents had the same type A glucometers.
-There were no residents that had a diagnosis of a blood borne pathogen disease.

1. Review of Resident #14's current FL2 dated 06/08/17 revealed diagnoses included type 2 diabetes mellitus.

Review of Resident #14's physician orders revealed an order dated 07/24/18 to obtain fingerstick blood sugar (FSBS) twice daily at breakfast and dinner notify physician if blood sugar is less than 50 or higher than 300.

Observation on 07/31/18 at 5:08pm of Resident #14's black glucometer pouch revealed:
-The pouch was labeled with Resident #14's name.
-The Brand A glucometer located in the pouch was labeled with the resident's name.
-The date was not set to current date, time, or year,
-The date was set as 05/03 and the time was set to 5:54am.

Review of Resident #14's July 2018 electronic Medication Administration Record (eMAR) revealed:
-There was an entry to check FSBS twice daily at daily 9:00 am and at 5:00pm.
-FSBS values were documented at 9:00 am and at 5:00pm with a FSBS range from 513-175.

Review of Resident #14's Brand A glucometer's history revealed:
-FSBS values recorded in the glucometer's history compared to values documented on Resident #14's July 2018 eMAR were

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY AT PINEVILLE	9120 WILLOW RIDGE DRIVE CHARLOTTE, NC 28210

(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
D932	Continued From page 143 inconsistent. -FSBS values documented on Resident #14's July eMAR were not recorded in Resident #14's glucometer's history. -Resident #14's glucometer's history had days when multiple FSBS values were recorded in a short period of time. Examples of multiple FSBS values recorded in the glucometer labeled with Resident #14's name within a short period of time were as follows: -On 04/28 FSBS reading 124 at 6:00am and 267 at 6:11am -The FSBS reading 267 matched the corresponding FSBS value documented on Resident #14's eMAR on 07/26/18. -The FSBS reading 124 did not match FSBS documented on Resident #14's eMAR. Examples of FSBS values recorded in Resident #14's glucometer history that did not correspond with Resident #14's documented FSBS entry on the eMAR are as follows: -On 05/02 at 6:59am FSBS 384 -On 04/29 at 9:48pm FSBS 199 -On 04/26 at 6:52am FSBS 269 and at 9:25pm FSBS 189 -On 04/24 at 10:13pm FSBS 368 -On 04/22 at 5:40am FSBS 186 -On 04/21 at 9:32pm FSBS 211 Based on review of Resident #14's Brand A glucometer's history compared to the eMAR for July 2018, Resident #14 had 18 FSBS values documented on the eMAR and recorded in the glucometer's history from 07/18/18 to 07/31/18. There were 10 additional FSBS values recorded in Resident #14's glucometer's history that were not documented on the resident's eMAR.	D932		

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D932	Continued From page 144 Refer to interview with a medication aide (MA) on 08/01/18 at 5:05pm. Refer to interview with a second MA on 08/01/18 at 4:45pm. Refer to interview with the Administrator on 08/01/18 at 5:45pm. 2. Review of Resident #15's current FL2 dated 01/16/18 revealed diagnoses included diabetes mellitus. Review of Resident #15's physician orders revealed an order dated 07/24/18 to obtain FSBS four times daily at breakfast, lunch, dinner and nightly notify physician if blood sugar is less than 50 or higher than 300. Observation on 07/31/18 at 5:10pm of Resident #15's glucometer pouch revealed: -The pouch was labeled with Resident #15's name. -The Brand A glucometer was labeled with the resident's name. -The date was not set to current date, time, or year. -The date was set as 05/14 and the time was set to 5:05am. Review of Resident #15's July 2018 eMAR revealed: -There was an entry to check FSBS four times daily at 7:30am, 11:30am, 4:30pm, and at 9:00pm. -FSBS values were documented at 7:30am,11:30am, 4:30pm and at 9:00pm with a FSBS range from 563-81. Review of Resident #15's Brand A glucometer's	D932		

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D932	Continued From page 145	D932		

history revealed:
-FSBS values recorded in the glucometer's history compared to values documented on Resident #15's July 2018 eMAR were inconsistent for values documented on the eMAR.
-FSBS values documented on Resident #15's July eMAR were not recorded in Resident #15's glucometer's history.

Examples of FSBS values recorded in Resident #15's glucometer history that did not correspond with Resident #15's documented FSBS entry on the eMAR are as follows:
-On 05/13 at 5:07am FSBS 374
-On 05/12 at 5:13pm FSBS 199
-On 05/11 at 5:40am FSBS 174 and at 12:18pm FSBS 238
-On 05/10 at 5:48am FSBS 332
-On 05/08 at 5:08am FSBS 121

Based on review of Resident #15's Brand A glucometer's history compared to the eMAR for July 2018, Resident #15 had 12 FSBS values documented on the eMAR and recorded in the glucometer's history from 07/25/18 to 07/31/18. There were 6 additional FSBS values recorded in Resident #15's glucometer's history that were not documented on the resident's eMAR.

Interview with Resident #15 on 08/01/18 at 1:45pm revealed he did not know what brand of glucometer was used to check his FSBS.

Refer to interview with a medication aide (MA) on 08/01/18 at 5:05pm.

Refer to interview with a second MA on 08/01/18 at 4:45pm.

Refer to interview with the Administrator on

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D932	Continued From page 146 08/01/18 at 5:45pm. 3. Review of Resident #16's current FL2 dated 05/21/18 revealed diagnoses included diabetes mellitus. Review of Resident #16's physician orders revealed an order dated 07/24/18 to measure FSBS twice daily at breakfast and dinner, notify physician if blood sugar is less than 50 or higher than 300. Observation on 07/31/18 at 5:28pm of Resident #16's glucometer pouch revealed: -The pouch was labeled with Resident #16's name. -The Brand A glucometer located in the pouch was labeled with the resident's name. -The date was not set to current date, time or year. -The date was set as 06/15 and the time was set to 8:20am. Review of Resident #16's July 2018 eMAR revealed: -There was an entry to check FSBS twice daily at 6:30am and 4:30pm. -FSBS values were documented at 6:30am and at 4:30pm with a FSBS range from 144-92. Review of Resident #16's Brand A glucometer's history revealed: -FSBS values recorded in the glucometer's history compared to values documented on Resident #16's July 2018 eMAR were inconsistent for values documented on the eMAR. -FSBS values documented on Resident #16's July eMAR were not recorded in Resident #16's glucometer's history.	D932		

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D932	Continued From page 147 Examples of FSBS values recorded in Resident #16's glucometer history that did not correspond with Resident #16's documented FSBS entry on the eMAR are as follows: -On 06/13 at 10:53am FSBS 101 -On 06/08 at 8:04am FSBS 120 -On 06/05 at 7:41am FSBS 103 -On 06/02 at 8:15am FSBS 107 -On 05/31 at 8:13am FSBS 103 -On 05/30 at 9:28pm FSBS 106 -On 05/29 at 7:30am FSBS 128 and at 9:31pm FSBS 103 -On 05/28 at 7:33am FSBS 112 -On 05/27 at 8:12am FSBS 109 Based on review of Resident #16's Brand A glucometer's history compared to the eMAR for July 2018, Resident #16 had 5 FSBS values documented on the eMAR and recorded in the glucometer's history from 07/21/18 to 07/31/18. There were 9 additional FSBS values recorded in Resident #14's glucometer's history that were not documented on the resident's eMAR. Refer to interview with a medication aide (MA) on 08/01/18 at 5:05pm. Refer to interview with a second MA on 08/01/18 at 4:45pm. Refer to interview with the Administrator on 08/01/18 at 5:45pm. 4. Review of Resident #17's current FL2 dated 07/03/18 revealed diagnoses included type 2 diabetes mellitus. Review of Resident #17's physician orders revealed an order dated 07/03/18 to measure FSBS twice daily at breakfast and dinner, notify	D932		

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D932	Continued From page 148 physician if blood sugar is less than 50 or higher than 300. Observation on 07/31/18 at 5:15pm of Resident #17's glucometer pouch revealed: -The pouch was labeled with Resident #17's name. -The Brand A glucometer located in the pouch was labeled with the resident's name. -The date was not set to current date, time, or year. -The date was set as 05/05 and the time was set to 6:53am. Review of Resident #17's July 2018 eMAR revealed: -There was an entry to check FSBS twice daily at 7:30am and 4:30pm. -FSBS values were documented at 7:30am and at 4:30pm with a FSBS range from 212-112. Review of Resident #17's Brand A glucometer's history revealed: -FSBS values recorded in the glucometer's history compared to values documented on Resident #17's July 2018 eMAR were inconsistent for values documented on the eMAR. -FSBS values documented on Resident #17's July eMAR were not recorded in Resident #17's glucometer's history. Examples of FSBS values recorded in Resident #17's glucometer history that did not correspond with Resident #17's documented FSBS entry on the eMAR are as follows: -On 05/05 at 6:53am FSBS 126 -On 05/03 at 9:56pm FSBS 146 -On 05/02 at 9:49am FSBS 126 -On 04/29 at 9:28pm FSBS 102 -On 04/25 at 10:14pm FSBS 102	D932		

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D932	Continued From page 149 -On 04/20 at 8:23pm FSBS 108 -On 04/19 at 9:44am FSBS 97 -On 0418 at 9:09am FSBS 91 -On 04/16 at 9:45am FSBS 111 Based on review of Resident #17's Brand A glucometer's history compared to the eMAR for July 2018, Resident #17 had 5 FSBS values documented on the eMAR and recorded in the glucometer's history from 07/21/18 to 07/31/18. There were 10 additional FSBS values recorded in Resident #14's glucometer's history that were not documented on the resident's eMAR. Refer to interview with a medication aide (MA) on 08/01/18 at 5:05pm. Refer to interview with a second MA on 08/01/18 at 4:45pm. Refer to interview with the Administrator on 08/01/18 at 5:45pm. 5. Observation on 07/31/18 of the Memory Care medication cart at 3:30pm revealed: -The memory care unit had 1 medication cart and contained 3 resident's glucometers. -The glucometer pouches contained test strips which were not labeled with the resident names. -The 3 glucometers were dirty with brown smudges on the face of the devices. Review of Resident #6's current FL2 dated 07/24/18 revealed: -The diagnoses included type 2 diabetes mellitus. -There was an order for Lantus 100u/ml, inject 10 units every night at bedtime -There was an order to check fingerstick blood sugar (FSBS) daily. -There was an order to check FSBS as needed	D932		

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(prn) if there were symptoms of hypoglycemia or hyperglycemia. If the FSBS is less than 60mg/dl give (the resident) 1 cup of orange juice, 1 sugar packet and re-check the FSBS in 15 minutes.
-The physician was to be contacted if FSBS continued to be less than 60mg/dl or greater than 300mg/dl.

Observation on 07/31/18 at 3:45pm revealed:
-There was a black glucometer pouch labeled with Resident #6's name.
-The Brand A glucometer was not labeled with the resident's name.
-The glucometer was not set to the correct year or time.
-The date was set to 07/30 and the time was set to 5:00pm.

Review of Resident #6's July 2018 electronic medication administration record (eMAR) revealed:
-There was an entry on 07/11/18 to check the FSBS daily at 7:00am.
-The FSBS values were documented once a day.
-There was no entry for FSBS to be documented prior to 07/11/18.

Review of Resident #6's Brand A glucometer's history revealed:
-There were 26 entries recorded on the Brand A glucometer from 07/05/18-07/31/18.
-The readings from 07/05/18-07/10/18 were recorded before the physician's order dated 07/11/18.
-The FSBS values recorded in the glucometer's history were inconsistent for values documented on the eMAR from 07/11/18-7/31/18.
-The were FSBS values documented on Resident #6's July 2018 eMAR that were not recorded in Resident #6's glucometer.

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D932	Continued From page 151 Review of Resident #6's July 2018 eMAR revealed: -There were 20 entries documented for FSBS from 07/11/18-07/31/18. -Documentation of the FSBS from 07/11-07/31 were not consistent with the values recorded in Resident #6's glucometer history. Examples of the FSBS values recorded in Resident #6's glucometer history not corresponding with Resident #6's documented FSBS entries on the eMAR were as follows: -On 07/12/18 at 7:00am the FSBS was 255. -On 07/13/18 at 7:00am the FSBS was 159. -On 07/14/18 at 7:00am the FSBS was 133. -On 07/15/18 at 7:00am the FSBS was 239. -On 07/16/18 at 7:00am the FSBS was 135. -On 07/17/18 at 7:00am the FSBS was 104. -On 07/18/18 at 7:00am the FSBS was 182. -On 07/19/18 at 7:00am the FSBS was 163. -On 07/20/18 at 7:00am the FSBS was 104. -On 07/21/18 at 7:00am the FSBS was 159. -On 07/22/18 at 7:00am the FSBS was 129. -On 07/23/18 at 7:00am the FSBS was 126. -On 07/24/18 at 7:00am the FSBS was 103. -On 07/25/18 at 7:00am the FSBS was 110. -On 07/26/18 at 7:00am the FSBS was 164. -On 07/27/18 there was no documentation of an FSBS value on the eMAR. -On 07/28/18 there was no documentation of an FSBS value on the eMAR. -On 07/29/18 at 7:00am the FSBS was 132. -On 07/30/18 there was no documentation of an FSBS value on the eMAR. -On 07/31/18 There was no documentation of an FSBS value on the eMAR. Based on a review of Resident #6's Brand A glucometer history, compared to the eMAR for	D932		

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D932	Continued From page 152 July 2018, revealed: -Resident #6 had 20 FSBS values documented on the eMAR and 26 values recorded in the glucometer's history from 07/05/18 to 07/31/18. -There were 6 additional FSBS values recorded in Resident #6's glucometer history from 07/5/18-07/11/18 not documented on the resident's eMAR. Interview with the medication aide (MA) on 8/01/18 at 11:50am revealed: -She worked first shift fulltime on the Memory Care unit. -The diabetic residents with FSBS orders had their own glucometers. -Each glucometer pouch was labeled. -She did not share glucometers and did not see anyone else share glucometers. -The facility policy stated the glucometers were for single use only. Interview with the second shift MA on 07/31/18 at 3:35pm revealed: -She cleaned the glucometers at the end of her shift. -She did not have any Sani-wipes on her cart, which she would generally use. -She cleaned the glucometers with alcohol wipes. -She did not know the resident's glucometers were dirty. Review of the manufacturer's guide for Brand A glucometers revealed: -The meter should be cleaned whenever visibly dirty by wiping the outside of the meter with a cloth, either dampened by mild detergent mixed with water or 70% rubbing alcohol. -Do not use bleach or harsh abrasives. -There were no instructions for disinfecting the gluocometers.	D932		

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D932	Continued From page 153 Refer to interview with a MA on 08/01/18 at 5:05pm. Refer to interview with a second MA on 08/01/18 at 4:45pm. Refer to interview with the Administrator on 08/01/18 at 5:45pm. Refer to observation of the Administrator reviewing the resident's glucometers in his office on 08/01/18 at 3:45pm. 6. Review of Resident #18's current FL2 dated 06/12/18 revealed: -The diagnoses included type 2 diabetes mellitus. -There was an order for Humalog solution 100u/ml insulin (lispro) per sliding scale: 0-200 = 0 units; 201-250 = 2 units; 251-300 = 4 units; 301-350= 6 units; 351-400 = 8 units; 401-1000 = 10 units, and call the physician for further instructions. -There was an order for fingerstick blood sugar (FSBS) three times a day before meals. Observation on 07/31/18 at 4:45pm of Resident #18's glucometer and black pouch revealed: -The glucometer pouch was labeled with Resident #18's name. -The Brand A glucometer located in the pouch was not labeled with the resident's name. -The glucometer was not set to the current date or time. -The date was set as 05/06 and the time was set to 2:00am. Review of Resident #18's July 2018 eMAR revealed:	D932		

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D932	Continued From page 154 -There was an entry to check FSBS three times daily at 7:00am, 11:30am and 4:30pm. -The FSBS values were documented three times daily. Review of Resident #18's Brand A glucometer history revealed: -There were 30 entries for FSBS recorded on Brand A glucometer from 07/22/18-07/31/18. -The FSBS values recorded in the glucometer's history were inconsistent with the values documented on the July 2018 eMAR from 07/22/18-07/31/18. -The FSBS values documented on Resident #18's July 2018 eMAR were not recorded in Resident #18's glucometer history. Review of Resident #18's July 2018 eMAR revealed: -There were 30 entries documented for FSBS from 07/22/18-07/31/18. -There were 7 entries for FSBS, three times daily, documented from 07/22/18-07/24/18 consistent with Brand A's glucometer history of the same time period. -The entries for FSBS three times daily documented from 07/24/18-07/31/18 were not consistent with Brand A's glucometer history of the same time period. -There were 23 entries for FSBS documented on the July 2018 eMAR were not consistent with the values recorded in Resident #18's Brand A glucometer history. Examples of the FSBS values recorded in Resident #18's glucometer history that did not correspond with Resident #18's documented FSBS entry on the eMAR were as follows: -On 07/24/18 at 7:00am FSBS was 60, at 11:30am FSBS was 237 and at 4:30pm FSBS	D932		

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D932	Continued From page 155 was 163. -On 07/25/18 at 7:00am FSBS was 297, at 11:30am FSBS was 326 and at 4:30pm FSBS was 274. -On 07/26/18 at 7:00am FSBS was 171, at 11:30am FSBS was 245 and at 4:30pm FSBS was 261. -On 07/27/18 at 7:00am FSBS was 150, at 11:30am FSBS was 198 and at 4:30pm FSBS was 273. -On 07/28/18 at 7:00am FSBS was 149, at 11:30am FSBS was 308 and at 4:30pm FSBS was 233. -On 07/29/18 at 7:00am FSBS was 155, at 11:30am FSBS was 241 and at 4:30pm FSBS was 133. -On 07/30/18 at 7:00am FSBS was 255, at 11:30am FSBS was 207 and at 4:30pm FSBS was 144. -On 07/31/18 at 7:00am FSBS was 204, at 11:30am FSBS was 245 and at 4:30pm FSBS was 237. Refer to interview with a medication aide (MA) on 08/01/18 at 5:05pm. Refer to interview with a second MA on 08/01/18 at 4:45pm. Refer to interview with the Administrator on 08/01/18 at 5:45pm. _____ Interview with a medication aide (MA) on 08/01/18 at 5:05pm revealed: -She routinely worked the day shift. -She obtained FSBS checks for residents. -The facility policy was for each resident to have an assigned glucometer.	D932		

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	HAL060139	A. BUILDING: _____ B. WING _____	R 08/02/2018

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D932	Continued From page 156 -The facility policy was never to share a glucometer between residents. -She had diabetic training by the contracted pharmacy representative, but could not recall when. -She had received the mandatory State training on infection control within the last year. -She wiped residents' glucometers with alcohol wipes when the glucometer was visibly soiled. Interview with a second MA on 08/01/18 at 4:45pm revealed: -She used to work the evening shift from 7:00 pm to 7:00 am. -During that shift, she routinely checked FSBS for residents. -The facility policy was for each resident to have an assigned glucometer and to use only the assigned resident's glucometer for FSBS. -The facility policy was never to share a glucometer between residents. -She did not know of any staff member sharing glucometers between residents. Interview with the Administrator on 08/01/18 at 5:45pm revealed: -The facility policy was one glucometer was assigned to each resident and there was no sharing of glucometers between residents. -The MAs on duty were responsible to assure each resident had an assigned glucometer and the glucometer was in working order. -He did not know staff were sharing glucometers between residents. -He would immediately purchase new glucometers for each diabetic resident. -He would immediately conduct diabetic training and infection requirements with all clinical staff. -There was no written facility policy on glucometers available for review.	D932		

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D932	Continued From page 157 -The only policy was the glucometers were not to be shared with other residents. The facility's failure to implement infection control procedures consistent with the federal Center for Disease Control (CDC) guidelines placed residents receiving finger stick blood sugar checks with glucometers shared between residents at risk due to possible exposure of blood borne pathogens diseases for Residents #14, #15, #16, and #17. This failure was detrimental to the health, 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 for this violation.	D932		
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 Administrator 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	D980	Facility administrator has developed policies for facility in relation to rule area requirements to protect residents and staff. Education provided to staff regarding reporting accidents and injury to DSS. Administrator met with in house maintence to immediately begin work on issues in order to be able to call for re-inspection, re-inspection has occurred and score raised to 87, facility will continue to do repairs to our ability, major repairs have been sent to corp office for authorization doc 9-1-18	

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D980	Continued From page 158 homes as related to physical environment, multiple housekeeping tags, supervision, referral and follow, infection prevention requirements, reporting of accidents and incidents, self-administration of medications, resident TB, therapeutic diets, building and fire safety, food service orientation ,written policy and procedures, medication administration, sanitation grade less than 85, staff qualifications, and special care unit training, all of which are the responsibility of the Administrator. The findings are: Interview with a resident guardian on 08/01/18 at 3:30pm revealed the guardian did not like going to the Administrator with any problems because the Administrator would not communicate with her. Interview with a resident on 08/01/18 at 9:52am revealed that it "does no good to talk to the Administrator about any problems because he brushes you off, "like I am crazy or something." Confidential staff interview revealed: -The Administrator worked Monday through Friday. -"Staff did not know their role, there is no communication among the staff and the Administrator. -"There is so much agency working in the facility, "he can't keep staff." Attempted telephone interviews with the owner/licensee on 07/31/18 at 4:30pm and at 4:45pm was unsuccessful. Interview with the Administrator on 08/01//18 at 3:30pm revealed:	D980		

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D980	Continued From page 159 -He started as Administrator in October 2017. -He had never seen so many "issues" in one building. -He used contracted agency staff throughout the facility for staffing needs. -He had trouble locating the information that was needed for the survey. -He had a few residents who complained to him daily about everything. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations and interviews, the facility failed to assure a housekeeping (HK) room, containing hazardous materials, was locked and not accessible to residents.[Refer to Tag 056, 10A NCAC 13F .0305(f) (4) (B) Physical Environment.] 2. Based on observations, and interviews the facility failed to maintain the walls, ceilings, and floor coverings clean and good repair in the hallways on 2nd and 3rd floor, carpeting in multi-media room, cracks in main dining room floor, and bathroom floors in the hallway of the 3rd floor.[Refer to tag 074 10A NCAC 13F .0306 (a)(1) Housekeeping And Furnishings]. 3. Based on observations and interviews, the facility failed to assure the chairs in hallways on the 2nd and 3rd floors, table and chairs in the multimedia room on the 3rd floor, shower chairs, benches and chairs on the patio of the memory care unit (MCU), were kept clean and in good repair.[Refer to Tag 076, 10A NCAC 13F .0306(a) (3)Housekeeping And Furnishings]. 4. Based on observations, record reviews and interviews, the facility failed to assure the North	D980		

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D980	Continued From page 160 Carolina Division of Environmental Health sanitation scores remained 85 or above at all times. [Refer to Tag 077, 10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings.] 5. Based on observations, interviews, and record review the facility failed to maintain the facility in a clean and orderly manner, free of all obstructions and hazards due to unsanitary pet conditions for 2 of 2 residents (Resident #10 and #14) with pet cats.[Refer to Tag 079, 10A NCAC 13F .0306(a)(5)Housekeeping and Furnishings.] 6. Based on observations, record reviews, and interviews, the facility failed to assure all residents had a readily accessible supply of pillow cases, and bed sheets for use at all times. [Refer to Tag 080,10A NCAC 13F .0306(a)(6)Housekeeping And Furnishings]. 7. Based on record reviews, observations, and interviews the facility failed to assure the fire alarm switch and electrical equipment (room 124) were maintained in safe and operating condition in the memory care unit where twenty residents who were intermittently or constantly disoriented resided, and a wall unit airconditioner's front cover was off exposing wiring in room 303, and insufficient lighting and a flickering hallway light at the entrance to the elevator on the third floor on the assisted living unit.Refer to Tag 105, 10A NCAC 13F .0311(a) Other Requirements]. 8. Based on observations, and interviews the facility failed to assure the staff person in charge of the preparation and serving of food (the Assistant Administrator) had completed a food service orientation program established by the Department or an equivalent with 30 days of hire for those staff hired on or after July 2, 2004.[Refer	D980		

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D980	Continued From page 161 to Tag 169,10A NCAC 13F .0509(e)(4) Food Service Orientation]. 9. Based on interviews and record reviews the facility failed to tested for tuberculosis (TB) disease for 1 of 7 residents (Resident #3) in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205.[Refer to Tag 234,10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examination & Immunizations.] 10. Based on observations, interviews and record reviews, the facility failed to provide adequate supervision for 4 of 8 sampled residents (#13, #1, #11, and #12) related to elopement Resident #13, a fall with inury and multiple falls (Resident #1 and #12) and agreesive behaviors (Resident #11). [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 11. Based on observations, interviews, and record reviews the facility failed to assure physician contact for 5 of 5 sampled residents; Resident #5 sustained rib fractures, (Resident #8) an infectious leg wound, (Resident #13) elopement from the facility, (Resident #11) aggressive behavior and (Resident #12) for multiple falls over a 3 month period. [Refer to Tag 273, 10A NCAC 13F .0902 Health Care (b) (Type A2 Violation).] 12. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets (Cardiac, and Mechanical Altered) were served as ordered for 2 of 10 residents. (Resident #4, #8).[Refer to Tag 310, 10A NCAC 13F .0904(e)(5) Nutrition and Food Service.]	D980		

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D980	Continued From page 162 13. Based on observations, interviews and record reviews, the facility failed to ensure medications were available and administered as ordered by physician for 2 of 6 residents (Residents #4) with orders for Finasteride 5mg, Atorvastatin Calcium 80mg, Melatonin 5mg, and Tramadol 50mg, and (Resident #1) orders for Clobetasol 0.05% cream and Tramadol 50mg. (Residents #4 and #1). [Refer to Tag 358,10A NCAC 13F .1004(a) (1) Medication Administration]. 14. Based on observation, interviews, and record reviews the facility failed to assure 1 of 5 sampled residents (Resident #3) had medications properly labeled in her room and 1 of 3 sampled residents had orders to self-administer medications (Resident #7).[Refer to Tag 375, 10A NCAC 13F .1005(a)(2) Self -Administration Of Medications.] 15. Based on interviews and record reviews, the facility failed to develop and implement a written policy and procedure for the management of physical aggression or assault by a resident, and the facility did not have a policy for contact isolation in regard to the scabies infection control. [Refer to Tag 448,10A NCAC 13F .1211Written Policies And Procedures (a)(8) (Type B Violation]. 16. Based on observation, facility policy/documentation and interviews, the facility failed to report accidents/incidents to the county department of social services for 7 out of 12 (Resident #1, #5, #6, #8, #11, #12, #13). [Refer to Tag 451, 10A NCAC 13F .1212 (a)Reporting of Accidents and Incidents.] 17. Based on interviews and record reviews, the facility failed to assure staff assigned to the memory care unit had completed 6 hours of orientation during the first week of employment	D980		

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D980	Continued From page 163 and within six months of employment 20 hours of training specific to the population being served for 10 of 10 memory care unit (MCU) staff. (Staff A, B, C, D, E, F, H, J, K and L). Refer to Tag 468,10A NCAC 13F .1309(3) Special Care Unit Staff Orientation And Training]. 18. Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines to assure proper infection control procedures for the use of glucometers for 6 of 7 diabetic residents sampled (Residents #6, #14, #15, #16, #17 and #18) with orders for blood sugar monitoring resulting in sharing of glucometers between residents. [Refer to Tag 932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation).] 19. Based on observations, interviews, and record reviews, the Administrator 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 multiple Housekeeping tags, supervision, referral and follow, infection prevention requirements, physical environment, reporting of accidents and incidents, self-administration of medications, resident TB, therapeutic diets, building and fire safety, food service orientation ,written policy and procedures, medication administration, sanitation grade less than 85, staff qualifications, and special care unit training, all of which are the responsibility of the Administrator. [Refer to Tag 980, G.S. 131D-25 Implementation(Type A2 Violation)].	D980		

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D980	Continued From page 164 The Administrator, who was responsible for the overall operations of the facility, failed to assure the management, day to day operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced of a non-secured housekkeping storage room on the third floor of the facility with containers of hazardous chemicals, walls, ceilings, and floors or floor coverings kept clean and in good repair, furniture clean and in good repair, supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for residents at all times, unsanitary living conditions in resident's rooms with cat feces, odor, and clutter, supervision of multiple residents with abusive behaviors, multiple residents falls leading to injury of rib fractures and lacerations, elopement of residents from the facility, resident aggressive behavior, physician, family not made aware of resident behaviors or elopement, medication refusal, falls resulting in ER evaluation for injury, sharing of glucometers among the diabetic residents, not reporting of accidents and incidents to DSS when injury or elopement occurred, not following policy for for self-administration of medications, resident's tuberculosis not obtained upon admission, no therapeutic diets for the kitchen staff to follow as ordered by the physician, building and fire safety related to electrical outlet cover was broken with jagged rough edges and exposed the electric box wiring in MCU, uncovered and unsafe fire switch un-operative in the MCU, no kitchen training on food service orientation, no written policy and procedures related to resident behaviors or scabies infection policy, medication not administered as ordered by the physician, a facility sanitation grade of 84.5, no MCU 6 hours training prior to working in MCU or 20 hours in six months for staff working in the	D980		

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D980	Continued From page 165 memory care unit, all of which are the responsibility of the Administrator. The Administrator's failure resulted in substantial risk that serious harm, abuse, and neglect will occur which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLTAION SHALL NOT EXCEED SEPTEMBER 1, 2018.	D980	Community administrator has provided plans of protection immediately regarding all rule areas cited. Administrator will monitor designees for quality and accuracy of audits in all rule areas. Community administrator and or designee will randomly audit all rule areas for continous accuracy and safety of residents. Administrator has reached out to corporate officials for staffing of key management staff, and physcial and plant enviroments regarding necessary repairs as cited orginally in 2017 survey. doc9-1-18	