STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: _____ B. WING _____	R 08/23/2018

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SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from August 14, 2018-August 17, 2018, and August 20, 2018, with an exit conference via telephone on August 23, 2018..	{D 000}		
{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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on record reviews and interviews, the facility failed to assure 1 of 8 sampled residents (#6) was tested upon admission for Tuberculosis (TB) disease with a two-step TB skin test in accordance with the control measures adopted by the Commission for Health Services. Review of Resident #6's FL-2 dated 02/12/18 revealed diagnoses included essential hypertension, secondary renal hyperparathyroidism, end stage renal disease,	{D 234}	Resident record reviews will be completed to ensure all TB screenings have been completed according to Licensure Rule 10A NCAC 13F .0703(a). TB screenings will be completed on all residents in which documentation cannot be produced as having appropriate 2-step TB screenings. Resident record reviews will be conducted by the Resident Care Coordinator and the Administrator to determine which records are currently out of compliance with Licensure Rule 10A NCAC 13F .0703(a). Residents' record reviews began immediately upon notification of non-compliance. All records missing proper TB screening documentation were identified within 72 hours. All initial screenings were completed by August 31, 2018 with the 2nd step completed within 30 days All new admits will have the 1st step TB screening completed prior to admission with the 2nd step completed within 14-21 days of admission. Residents who have experienced a positive TB screening, will receive a chest x-ray ordered by their physician for the sole purpose of screening out tuberculosis. New chest x-rays will be ordered or an addendum will be received from the physician stating the residents are free of tuberculosis disease for those residents who currently have a chest x-ray in their record, however, does not specify "free of tuberculosis disease". These ex-rays will be completed by November 17, 2018.	

POC Reviewed and accepted. Kim Olson 10/22/18

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{D 234}	Continued From page 1 anemia in chronic renal disease, mental retardation, obesity, dialysis patient noncompliant, and osteoarthritis of both knees. Review of the Resident Register revealed Resident #6's was admitted to the facility on 09/25/17. Review of Resident #6's hospital record dated 09/20/2017 revealed there was documentation of a TB skin test on 09/24/17 with a negative result. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Interview with Resident #6's guardian on 08/22/18 at 10:15 am revealed: -He did not know if the resident had ever had a TB skin test. -He did not know if the resident had ever had a positive TB skin test. Interview with the Resident Care Coordinator (RCC) on 08/22/18 at 3:35 pm revealed: -She and the Administrator were responsible for tracking the resident's need for TB skin test. -A resident was not admitted to the facility without documentation of a TB skin test or a chest x-ray if a previous positive TB skin test. -She did not know that Resident #6 did not have documentation of a second TB skin test. -They used a preadmission check list to assure that TB skin test are done prior to admission. -There was a chart audit 03/2018 and Resident #6 was an oversight. -The second 2 step TB skin test had been administered to Resident #6 and was due to be read on 08/23/2018.	{D 234}	A Pre-admission Checklist will be put in place to ensure all paperwork, including TB screenings, are completed in compliance with Licensure Rule 10A NCAC 13F. 0703(a). The Resident Care Coordinator and the Administrator will complete the checklists to ensure continued compliance with the TB screenings. A TB screening/Chest X-ray sub-folder was placed in each residents' record with a notation stating "DO NOT PURGE" on the label. All TB screenings/chest x-rays will be filed behind this sub-folder. The Resident Care Coordinator and the Administrator will ensure the sub-folders are placed in all residents' records and all TB screenings/chest x-rays are filed behind this sub-folder effective November 17, 2018. Monitoring for on-going compliance will be conducted annually.	

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(D 234)	Continued From page 2 Interview with the Administrator on 08/23/2018 at 9:05 am revealed the second 2 step TB skin test had been administered to Resident #6 and was due to be read on 08/23/2018.	(D 234)		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 8 sampled residents (#2) which resulted in an unsupervised, confused and disoriented resident leaving the facility on multiple occasions. The findings are: Review of Resident #2's current FL-2 dated 08/01/18 revealed: -Diagnoses included dementia, paranoid schizophrenia, diabetes mellitus type II, hypertension, gastro esophageal reflux disease, tardive dyskinesia, hyperlipidemia, constipation and tobacco use. -The recommended level of care for Resident #2 was documented for the need of a skilled nursing facility (SNF).	D 270	Once Administrator becomes aware that a resident tends to wander from the facility without the knowledge to sign themselves in and out appropriately or other behavioral issues, she will immediately contact the resident's physician for recommendations. Recommendations, such as placement in a locked care unit will be followed and will be implemented immediately. The RCC will contact the family regarding any recommendations the physician makes in order to maintain the safety of the individual. The necessary paperwork, such as updated FL-2s, history and physical, copy of the Medication Administration Record, etc. will be forwarded to locked care facilities as soon as possible. Follow-up TCs will be completed with these facilities until other placement arrangements can be obtained. While this process continues, the staff will be mandated to monitor the resident every hour to ensure they have not exited the facility (additional supervision, such as one-on-on supervision will be implemented, if deemed necessary). The staff will receive on-going training regarding Southern Living's Wandering and Elopement/Behavior Modification policies and will sign paperwork acknowledging the understanding of this policy. This training will be completed by all staff effective October 7, 2018 Observation, chart reviews, interviews with staff and residents will be completed daily beginning immediately by the Medication Technicians, the Administrator and RCC daily to ensure the supervision needs of the residents are met at all times.	

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D 270	Continued From page 3 Review of Resident #2's Resident Register revealed he was admitted on 03/10/08. Review of Resident #2's Assessment and Care Plan dated 01/03/18 revealed the resident was oriented but forgetful and needed reminders. Review of Resident #2's primary care provider's (PCP's) "Physician Office Visit" note dated 11/01/17 revealed: -The reason for the visit was a follow-up for schizophrenia. -The staff reported the resident was wandering, staying out all night and disoriented. -The resident's exam was "stable", denied suicidal and hallucination ideation, denied visual and auditory hallucinations. -There was an order to call psychiatry services to report behavior since Risperdal (an antipsychotic medication used to treat schizophrenia) had been stopped. Review of Resident #2's "Nurses Notes" dated 10/05/17 revealed: -The resident walked out of the facility, down the street and did not sign out. -The resident had been "acting confused" for quite some time, "like he does not know where he is going or where his room was at times". Review of Resident #2's "Nurses Notes" dated 01/08/18 revealed: -The time documented was "11-7". -The resident was out of the facility on second shift, but was found later by a medication aide (MA) and personal care aides (PCAs) on second shift. Review of additional "Physician Office Visits" from	D 270		

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D 270	Continued From page 4 the PCP for Resident #2 revealed: -On 02/07/18, the reason for the visit included schizophrenia. There was an order the resident may not leave the facility without a guardian. -On 02/21/18, the reason for the visit included schizophrenia. There was an order the resident may not leave the facility without a guardian. -On 05/15/18, the reason for the visit included schizophrenia, "states hallucinations better". -On 07/25/18, the reason for the visit included schizophrenia/dementia- continued wandering, facility requesting increased level of care". There was an order the resident needed a locked memory care unit. Review of Resident #2's "Nurses Notes" dated 07/19/18 revealed: -The documentation time was during the 3-11 shift. -The "residents status" of leaving the facility during the day, but mostly at night during the time staff were giving bathes or getting the "round done". -The resident was able to be found during the day or night and brought back to the facility. -The resident could not comprehend what you were saying to him, "some things he knows, and some things he don't". -There was a second entry on 07/19/18, signed by the Administrator that included upon knowledge of the above (referencing the documentation dated 07/19/18 during the 3-11 shift) the Administrator had the MA to call the PCP with this information. It may be necessary at this point to have the resident placed in a locked facility for his safety, will wait to hear from the PCP before proceeding. Review of Resident #2's "Nurses Notes" dated 07/27/18 revealed:	D 270		

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D 270	Continued From page 5 -The documentation time was during the 3-11 shift. -At 2:50 p.m., the resident went out the front door and was walking toward the street. -The personal care aide (PCA) along with and another PCA coming to work got the resident and brought him back into the facility, and "sat" him in the library room. -We (staff) thought he was still sitting in the library. -During the 5:00 p.m. feeding (first seating for the residents' dinner meal), the PCA picked up a resident from a doctor's office and as the PCA was coming back toward the facility, the PCA noticed Resident #2 coming between "the motel". -The PCA stopped and put Resident #2 in the van, brought him back to the facility "and put him back down" in the library room. -During the second feeding (2nd seating for the residents' dinner meal), the MA was looking for Resident #2 to give him his medication but the resident was not in the building again. -The MA and the PCA got into the van to go get Resident #2. -Resident #2 was going down the street turning right by a nursing home (named) and a dialysis center. -They (the MA and PCA) stopped and put Resident #2 in the van and brought him back to the facility. -All three times the resident left, he was able to be found. "We" kept the resident down the men's hall the rest of the night. Observation of the nursing home and dialysis center where Resident #2 was found on 07/27/18 revealed both establishments were approximately 1.1 miles from the facility along a four-lane highway.	D 270		

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D 270	Continued From page 6 Review of Resident #2's "Resident In House Verification Forms" revealed: -There was scheduled hourly interval checks labeled for 1st, 2nd and 3rd shifts that started at 7:30 a.m. on 1st shift through 6:30 a.m. on 3rd shift. -In June 2018 from 06/01/18 - 06/3018, hourly interval checks had been documented by staff for Resident #2 excluding 06/05/18 - 06/07/18 due to the resident being hospitalized during that time. -In July 2018 from 07/01/18 - 07/31/18, hourly interval checks had been documented by staff. Interview with the Resident Care Coordinator (RCC) on 08/14/18 at 11:00am revealed: -Resident #2 was confused. -Resident #2 often left the facility. -When Resident #2 was out of the facility they knew "right where he was". -They were in the process of getting Resident #2 transferred to a locked down facility. Interview with a personal care aide (PCA) on 08/15/18 at 4:40 p.m. revealed: -Resident #2 would walk off from the facility and would be seen walking down the road. -When the resident was seen walking down the road the staff would pick the resident up on the facility van and bring him back. -It had been "awhile" since Resident #2 had walked off (she could not give and estimation of a time frame the last time this occurred). -The PCAs used a "check off sheet" to check on all resident's hourly to make sure they were in the building. Interview with a second PCA on 08/15/18 at 5:30pm revealed: -"That man" (Resident #2), one minute he could be seen walking down the hall and then he would	D 270		

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D 270	Continued From page 7	D 270		

be out the door.
-Resident #2 was a wanderer and went out of the facility for an entire night a few months ago.
-That night they had seen him at 8:00pm during snack time but he was missing at 9:30pm.
-They had checked the perimeter of the building and then took the facility van out to look for him.
-They called the RCC to report him missing at 10:30pm.
-They left their 3-11 shift and told the 11-7 shift to "keep an eye out for him".
-She was told they found him early that next morning.
-Since that night, they've had to go get him outside and could catch him on foot.
-They had to go get him a few days ago when he left and had to redirect him to walk back.
-When Resident #2 left the facility he would usually go out through the front door of the facility.
-Resident #2 had health issues and shortness of breath which was concerning when he left the facility because he did get confused.

Interview with the Administrator on 08/15/18 at 6:00pm revealed:
-She was not aware that Resident #2 had ever been missing for overnight.
-They were waiting on approval to get Resident #2 transferred to a locked unit.

Interview with two PCAs on 8/16/18 at 4:30pm revealed:
-The PCAs had a verification book that they were to sign off on every hour for each resident when they check on them.
-The staff did not do any additional monitoring of Resident #2.
-The staff were not told to do anything else for Resident #2 different than what they did for other

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D 270	Continued From page 8 residents. -When Resident #2 went out of the building they had to redirect him back in. Interview with the Transporter/PCA on 08/16/18 at 4:55pm and at 5:30 p.m.revealed: -Resident #2 wandered out of the facility. -They monitored Resident #2 the same as they did other residents. -The staff were not instructed to do anything different for Resident #2. Interview with a Medication Aide (MA) on 08/16/18 at 5:10pm revealed: -She was not aware that Resident #2 had orders back in February to not the leave facility without someone accompanying him. -The facility policy was to monitor all residents every one hour. -They were not told to do any additional monitoring or anything different for Resident #2. -No staff member had been assigned to Resident #2 specifically; everyone just "kind of watched him". Interview with a female resident on 08/17/18 at 1:20 p.m. revealed: -The resident had lived at the facility for 4 1/2 years. -Resident #2 was not in "his right mind". -The resident was aware of recent incidences when Resident #2 was missing because he had left the facility and staff had to go search for him. -She knew that the resident would walk off from the facility "right by himself". -She thought that it was difficult for the staff to watch Resident #2 as much as needed, "they can't watch him all the time". Confidential interview with a staff revealed:	D 270		

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D 270	Continued From page 9 -"It was impossible" to monitor Resident #2 so he would not leave the facility. -The resident had been picked up in the community recently and could tell the resident was "lost and scared" (date, time and location not included due to confidential interview). -The staff was always fearful Resident #2 would get hit by a car when he left the facility because he would sometime cross busy streets which was concerning to the staff due to the severity of the residents decreased mental state and awareness of his surroundings. Telephone interview with Resident #2's family member on 08/17/18 at 10:00 a.m. revealed: -The family member understood that Resident #2 was having difficulty of not being clear on what he was doing, who he was with, or where he was going. -The facility kept the family member informed of the resident's "habits" and "traits". -The resident had walked away from the building at night but the family member was not sure when this was but it was "definitively" within the last month. -The facility was one of those facility's that had "door buzzers" and had residents walking in and out going out to smoke and they (staff) may not be paying attention to alarms because so many residents were in and out of the doors. Interview with the RCC on 8/20/18 at 11:15am revealed: -She was not aware that the PCP had ordered on 02/07/18 and 02/21/18 that Resident #2 be supervised if he left the facility. -Resident #2 started getting confused in May 2018 and this had continued to present. -There was a time when the staff performed hourly checks on all residents but they stopped	D 270		

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D 270	Continued From page 10 that the beginning of 2018 and only perform hourly checks on residents with a diagnosis of dementia. -In June of 2018 they began hourly checks on Resident #2 because they were concerned about him leaving. -In early July of 2018 she received a call that Resident #2 was not in the building to take his medications around 8:30pm or 9:00pm, so she came to the facility and then went out in her personal vehicle to look for Resident #2. -That's when the staff had to start telling Resident #2 to not leave the facility, about four weeks ago. -The staff did not do one-on-one supervision for him in the past, but the PCAs had assigned hall duty each shift to monitor residents and that helped some to keep him inside -For the last four weeks Resident #2 had tried to get away from the facility and the staff would find him next door at the hotel or the restaurant, even when he was told not to leave the facility. -Resident #2's Primary Care Provider (PCP) was made aware of Resident #2's wandering behaviors a month ago. -On 08/01/18 Resident #2 was diagnosed with dementia and the staff was then required to monitor him every hour. Observation of the local store that sold cigarettes and wine on 07/20/18 revealed the store was located approximately 1.6 miles from the facility, located at traffic intersection with at least 8 lanes of heavy traffic to cross. Interview with Resident #2's PCP on 08/20/18 at 1:00pm revealed: -She had been taking care of Resident #2 for three and a half years. -Resident #2's dementia had gotten worse.	D 270		

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D 270	Continued From page 11 -Resident #2's schizophrenia at baseline involves hallucinations. -She had recently changed Resident's FL2 level of care to a skilled nursing facility (SNF). -She had written an order for Resident #2 to not leave the facility without a guardian back in February 2018. -She defined "guardian" as family or staff. -She was not aware that the staff had not implemented the two orders for Resident #2 to not leave without a guardian beginning February 2018. -She was concerned if Resident #2 got out of the facility alone he could not find his way back. -The facility did not have the staff to take care of Resident #2. Interview with the Administrator on 08/20/18 at 5:40pm revealed: -She had received an order from the PCP on 07/25/18 to get Resident #2 transferred to a locked unit. -The RCC was responsible for health care, personal care an supervision of the residents. -The RCC communicated with Resident #2's PCP and should have reported any issues involving Resident #2. -She was not aware of the two orders from the PCP in February 2018 to not allow Resident #2 to leave the facility without a guardian. -She was told by the RCC today about the guardian orders. -The RCC and staff should have worked together to put a plan in place for Resident #2 to not leave the facility without a guardian back in February 2018 when the PCP wrote the order. Based on record reviews, observations, attempted interviews, the resident was not interviewable.	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING ASSISTED CARE	2060 WEST FIFTH STREET GREENVILLE, NC 27835

(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 270	Continued From page 12 The facility failed to provide supervision for Resident #2 who had a diagnosis of paranoid schizophrenia and was disoriented. The failure to implement two written orders by the primary care provider that Resident #2 should be accompanied by a Guardian or staff when leaving the facility, resulted in the resident leaving the facility multiple times, including during the night without staff knowledge, requiring the staff to go out in the community to look for the resident. This noncompliance was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 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: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B	{D 273}		

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{D 273}	Continued From page 13 Violation was not abated. Based on interviews and record reviews, the facility failed to notify the medical provider who ordered parameters for daily weights for 1 of 8 sampled residents (#5) who had diabetes, acute kidney failure and hypertension with daily weight fluctuations. The findings are: 1. Review of Resident #5's current FL-2 dated 05/22/18 revealed diagnoses included type II diabetes, chronic pain syndrome, acute kidney failure, hypertension, muscle weakness and major depressive disorder. Review of Resident #5's Resident Register revealed an admission date of 03/27/17. Review of Resident #5's cardiology provider visits notes dated 07/09/18 revealed: -There was documentation the resident walked into the clinic today, (07/09/18) using a rollator feeling tired and short of breath with minimal walking. -The resident had gained weight and had leg and arm swelling. -The resident's cardiovascular assessment findings included "+3-4 BLE" (bilateral lower extremities with pitting fluid/edema that has accumulated in the tissues and is graded on a scale of one to four); and "BUE" (Bilateral upper extremities with +1 pitting edema (2mm or less, slight pitting, no visible distortion, disappears rapidly). -The resident's pulmonary/chest findings included a crackling noise heard at the right base area of the lungs that could be caused by fluid or lack of air movement and there was no wheezing.	{D 273}	Care will be provided to the residents, as ordered by their physicians. Medications staff were re-educated on expectations for handling physician's orders during a in-service on 08/24/2018 conducted by [redacted], Resident Care Coordinators. Orders for labs, weights, etc. will be placed in residents' records, as well as, a communication book as an additional reminder for the medication staff. This communication book will be maintained in the nurse's station. Calls will be made by medication technicians to physicians to give/obtain information on labs, fluctuations in weights, vitals, change in mental status etc,. as directed. Recommendations by physicians will be followed. Documentation of these calls to give/obtain orders, labs, etc. from physicians will be obtained in resident's records. Lab results will be filed in the resident's records. Residents will be transported to their appointments by [redacted] Medical Transporter or her substitute. Refusals by residents to attend these appointments will be documented in the resident's records. The residents' physicians will also be notified of their refusals to attend appointments. Documentation of the notification to physicians will be completed by the medication technicians and will be maintained in the resident's record. Chart audits will be conducted weekly by the Resident Care Coordinator or designee to ensure compliance with physician's orders, as well as, proper documentation of care provided. Immediately; Weekly chart audits; In-service 8/24/2018	

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{D 273}	Continued From page 14 -In the plan and assessment section of the note chronic systolic and diastolic heart failure with detailed education given on sodium and fluid restrictions, medication adherence, daily weight and signs and symptoms of worsening heart failure (Chronic diastolic heart failure includes stiffness of the left ventricle, causing the heart not to relax and fill with blood normally and systolic heart failure occurs due to a weakened pump function of the heart). Review of orders from Resident #5's cardiology provider's clinic dated 07/09/18 revealed: -There was an order to increase Bumex (a medication used to reduce extra fluid in the body caused by conditions such as heart failure), from 2 mg daily to 2 mg twice daily. -There was an order for a high protein diet. -There was an order for a two liter fluid restriction. -There was an order for a low sodium diet. -There was an order for daily weights with parameters to call with a weight gain of greater than 3 lbs. in one day or greater than 5 lbs. in 5 to 7 days. Review of Resident #5's July 2018 medication administration record (MAR) revealed: -There was a handwritten entry to weigh daily, call "MD" if gain greater than 3 lbs. in one day or greater than 5 lbs. in 5-7 days. -Daily weights were documented from 07/10/18 - 07/31/18 with the exception on 07/11/18, there was no weight documented. -On 07/13/18, there was a documented weight of 359.0 lbs. and 363.2 lbs. on 07/14/18 that equaled a of 4.2 lb. weight gain in one day. -On 07/15/18, there was a documented weight of 366.4 lbs. that equaled a 3.2 lb. weight gain in one day. -On 07/23/18, there was a documented weight of	{D 273}		

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{D 273}	Continued From page 15 360.5 lbs. and 364.2 lbs. on 07/24/18 that equaled a 3.7 lb. weight gain in one day. -On 07/26/18, there was a documented weight of 352.9 lbs. and 357.2 lbs. on 07/27/18 that equaled a 4.3 lb. weight gain in one day. Review of Resident #5's July 2018 "Nurses Notes" revealed: -There was a handwritten entry to weigh daily. -There was a second handwritten call "MD" if gain greater than 3 lbs. in one day or greater than 5 lbs. in 5-7 days. -On 07/09/18. There was documentation signed by a medication aide (MA) the resident went to the cardiologist institute today. Bumex was changed to twice daily, weigh daily, two-liter fluid restriction and a low sodium diet ordered. -On 07/27/18, there was documentation signed by a MA, the resident's weight was 357.2 lbs., a call was placed to the primary care provider's (PCP), (not the cardiology provider) office and spoke with a named person who would let the PCP know. -There was no documentation the resident's cardiology provider had been contacted on 07/14/18, 07/15/18 and 07/23/18. Review of Resident #5's August 2018 MAR daily weights revealed: -Daily weights were documented from 08/01/18 - 08/21/18. -On 08/07/18, there was a documented weight of 352.1 lbs. and 357.3 lbs. on 08/08/18 that equaled a of 5.2 lb. weight gain in one day. -On 08/09/18, there was a documented weight of 359.5 lbs. and 364.2 lbs. on 08/10/18 that equaled a of 4.7 lb. weight gain in one day. -On 08/14/18, there was a documented weight of 355.1 lbs. and 358.6 lbs. on 08/15/18 that equaled a of 3.5 lb. weight gain in one day.	{D 273}		

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{D 273}	Continued From page 16 -On 08/18/18, there was a documented weight of 354.7 lbs. and 359.3 lbs. on 08/19/18 that equaled a of 4.6 lb. weight gain in one day. Review of Resident #5's "Nurses Notes" revealed: -On 08/08/18, there was documentation signed by a MA the resident's weight this morning was 357.3 lbs., yesterday morning the weight was 352.1 lbs. The "doctor" was called and awaiting a call back. -On 08/19/18, there was documentation the resident had a weight gain of 5 lbs. overnight. The cardiologist clinic was called and was awaiting a call back. The resident was not having any chest pain, shortness of breath or any other pain. -There was no documentation the resident's cardiology provider was contacted on 08/10/18 and 08/15/18. Review of a telephone order for Resident #5 on 08/09/18 revealed: -There was an order for Bumex 1 mg, take 3 tablets to equal 3 mg twice daily for two days and stop on 08/11/18. -The order was given by the cardiology provider. -The order was signed by a cardiology provider on 08/09/18. Review of an office visit noted from Resident #5's cardiology provider dated 08/10/18 revealed: -The reason for the visit was heart failure and weight gain. -There was documentation in the physician comments section, "stable with volume". -There was an order to take two more doses of Bumex 3mg twice daily, then decrease to 3 mg in the morning and 2mg in the evening -There was an order to take one dose of 2.5 mg	{D 273}		

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{D 273}	Continued From page 17 of Metolazone (a medication used to remove fluid) with dose of Bumex. -There was an order to increase Magnesium Oxide (a mineral supplement important for the normal functioning of the heart) from 400mg three times daily to 8 mg twice daily. -There was an order to return to the clinic in two weeks. Telephone interview with the resident care coordinator (RCC) on 08/22/18 at 11:20 a.m. revealed: -The medication aides (MAs) were responsible for weighing Resident #5 daily. -The RCC was aware of the July 2018 daily weight order and parameters for Resident #5's ordered by the cardiology provider. -MAs were responsible to contact the cardiology provider if resident #5 had gained greater than 3 lbs. in one day or greater than 5 lbs. in one week and if contact was made with a message left with the provider and there was no return, then the MAs were responsible to place a call back. -She was aware that Resident #5's weights jumped back and forth, he was noncompliant with his diet and fluid restrictions. -She had "worked with staff" and they should all know when to contact Resident #5's cardiology provider. -She would review Resident #5's recorded weights and documentation to see if there was any additional information regarding contacts with the cardiologist provider when the resident's weights were out of the ordered parameters. -The MAs should contact Resident #5's cardiology provider as ordered but the PCP should know for general information only. -She was not aware of any complaints Resident #5 had regarding increased shortness of breath.	{D 273}		

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{D 273}	Continued From page 18 Telephone interview with a MA on 08/22/18 at 11:51 a.m. revealed: -She was the MA who documented Resident #5's Nurse's Note on 08/19/18 regarding a weight gain of "5 Lbs." -She was aware this was on a Sunday (08/19/18). -She remembered she initially called the PCP on 08/19/18 because of Resident #5's blood sugar levels were high and though she was not supposed to call the PCP concerning Resident #5's weights, she did explain that he had a weight gain of 5 lbs. overnight. -She notified Resident #5's cardiology provider and spoke with a female but, could not remember the "ladies" name. -She received a call back from the on-call physician and received a telephone order to give an extra dose of Bumex 3 mg but could not remember the physician's exact name. -She estimated the time she administered the extra dose of Bumex 3 mg to Resident #5 was around 11:00 a.m. on 08/19/18. -She did not write an order for the extra dose of Bumex 3mg or that the medication was administered to Resident #5 because she had a lot going on that day. -Resident #5 was weighed on the same digital scales every day, weighed around the same time each day and with approximately the same amount of clothes on each day. -The MAs were responsible to make sure the digital scales were on "0" prior to the resident standing on the scale and the resident's hands were by his side when the weight was recorded. -Resident #5 was always weighed in the morning prior to eating or taking any of his medicines. -Resident #5 was very noncompliant with diet and some of medical appointments. -She was aware the cardiologist clinic should be notified each time Resident #5's weights were out	{D 273}		

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{D 273}	Continued From page 19 of the ordered parameters. - All MAs should have been aware to call each time Resident #5's weight was out of the ordered parameters to the cardiology provider not the PCP. Telephone interview with a second MA on 08/22/18 at 12:05 p.m. revealed: -She was the MA who documented Resident #5's Nurse's Note on 08/08/18 regarding a weight of 357.3 lbs. and the prior day of 352.1 lbs. The "doctor" was called and awaiting a call back. -The MAs weighed Resident #5 every morning prior to breakfast and made sure the scale was on "0" before asking the resident weighing with his shoes on. -She was aware that Resident #5 had parameters for his weights and if the weight exceeded a certain amount to contact the cardiology provider. -Resident #5's weights were not supposed to be called into his PCP but to the cardiology provider. -She was not sure why there was documentation in Resident #5's record that the PCP was contacted for weight gains at times. -She added (handwritten entry) the daily weight order for Resident #5 to his July 2018 MAR and to call to the cardiology provider when his weights exceeded the parameters. -MAs usually transcribed new orders on the MAR by handwriting the order in. The MAs then sent the order to the contracted pharmacy provider and the following month the order would be entered in by the pharmacy provider as a computer printed entry if the order was sent to pharmacy prior to the printing of the next month's MAR. -She remembered when she contacted Resident #5's cardiology provider on 08/08/18 she was told that the provider was not there and to send the resident to the emergency room, but the resident	{D 273}		

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{D 273}	Continued From page 20 refused to go. The cardiology provider did call back the next day (08/09/18) and gave a telephone order for the resident's weight increase. -She did not document the return call information in her note on 08/08/18 and did not write a note on 08/09/18. -If Resident #5 had a weight gain of greater than 3 lbs. in one day or greater than 5 lbs. in one week, MAs were responsible to contact the cardiology provider each time and document it. A telephone interview with a third MA on 08/22/18 at 12:15 p.m. revealed: -She was the MA who documented Resident #5's Nurse's Note on 07/27/18 regarding the resident's weight was 357.2 lbs., with a call placed to the PCP's office and spoke with a named person who would let the PCP know. -She remembered when she thought she was supposed to contact the PCP for Resident #5's weight gain. -The PCP called back a day or so later told her she needed to call the cardiologist for weight gain, "I called the wrong place" -She never called Resident #5's cardiology provider for the weight gain on 07/27/18 but would do so in the future. Telephone interview with Resident #5 on 08/22/18 at 12:26 p.m. revealed: -The resident was weighed by staff every morning before breakfast and before he took any morning medications. -The staff told him when he gained weight. -When he gained weight sometimes he was shorter of breath than his normal baseline. -He was not sure if his cardiologist was called when he had a weight gain or not.	{D 273}		

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{D 273}	Continued From page 21 A second telephone interview with the RCC on 08/22/18 at 1:25 p.m. revealed she had not found out any additional information regarding contacts with Resident #5's cardiologist when his weights exceeded the ordered parameters. A telephone interview with the PCP on 08/22/18 at 3:15 p.m. revealed: -In the past she had been contacted by staff regarding Resident #5's weight increase, however, just like a psychiatry medication she was not comfortable adjusting his diuretics for the treatment of his heart failure and had instructed them to contact the cardiology provider for weight gains. A telephone interview with the Administrator on 08/23/18 at 9:05 a.m. -She expected for staff to follow all orders as written by the ordering provider. -When contact was made with providers staff were to document the contact in the resident's record. Telephone interview with a nurse for Resident #5's cardiologist provider on 08/22/18 at 9:30 a.m. revealed: -The only call documented as received in the resident's record from the facility regarding weight gain was on 08/09/18, with an appointment and lab work ordered. -There was no documentation in the chart involving contact with the on-call provider on 08/19/18 and contact should be made with the facility to follow-up which on-call provider was contacted on 08/19/18. -Typically, contacts made after hours through on call services were forwarded to the cardiology office however she did not see any documentation.	{D 273}		

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{D 273}	Continued From page 22 -It was important to follow the resident's ordered parameters regarding weight gain due to his diagnoses of heart failure. -Weight parameters were placed for the resident because an increase in weight was a sign of holding on to fluids and knowing the weight gain sooner allowed the cardiology provider to institute treatment better which could allow a better response that could be expected from the resident. -The resident's weight gain could lead to increased shortness of breath, increased swelling and cause decompensation with the resident's heart failure. _____ The facility's failure to contact Resident #5's cardiology provider as ordered for six of eight times when the resident's weight increased by three or more pounds in twenty four hours. The non-compliance placed the resident at risk for further heart failure and was detrimental to the health of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/18 for this violation.	{D 273}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338	A mandatory resident's rights in-service for all staff was held on August 24, 2018 at 1:00 p.m. by [redacted] Regional Ombudsman. A roster of all staff who attended was obtained and each staff member obtained a Certificate of Achievement signed and dated by [redacted] Management will interview residents at least monthly to ensure each resident is treated with respect and dignity. Any concerns noted will be thoroughly investigated by the Administrator. An Initial Report of the allegations will be completed and forwarded to the Health Care Personnel Registry within 24 hours of the Administrator being made aware of the allegations. Alleged perpetrators will be pulled off the schedule pending investigation, as deemed necessary by the Administrator. The 5 Day Investigative Report will be completed within 5 working days and will be forwarded to the Health Care Personnel Registry for their review. Corrective action will be taken regarding staff, as needed, per facility policy, as deemed necessary.	

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D 338	Continued From page 23 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 1 of 8 residents sampled (#8) was treated with dignity and respect by three staff members (Staff A, Staff B and Staff C). The findings are: Review of Resident #8's current FL-2 dated 01/30/18 revealed: -Diagnoses included schizoaffective disorder-depressive type, tardive dyskinesia, hypertensive disorder, unspecified anxiety bipolar disorder, asthma, arthritis, gastro esophageal reflux disease and neuropathy, mental retardation, diabetes, sleep apnea, and obesity. -The orientation section was blank. -The resident had verbally abusive inappropriate behavior. Review of Resident #8's Resident Register revealed an admission date on 02/08/18. Review of Resident #8's assessment and care plan dated 02/21/18 revealed: -The resident's social/mental health history and orientation was blank. -The resident required limited assistance from staff with bathing, dressing, grooming, and toileting. Interview with Resident #8 on 08/15/18 at 11:35 a.m. revealed: -Some of the staff that worked at the facility did a	D 338	Interviews with residents will begin monthly starting in August. A thorough investigation of a potential violation of resident's rights will begin immediately following the notification to the Administrator.	

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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 338	Continued From page 24 really good job, were very pleasant and helpful, however, at times some would "lose their temper". -Approximately 2 months ago, the resident was unable to do some of the things she usually did for herself because of decreased ambulation and bouts of diarrhea. -Resident #8 reported during that time (approximately 2 months ago), Staff A came into her room and saw a clothes hanger on the floor in the resident's room. Staff A asked the resident was she too lazy to pick up the hanger. -A second incident occurred around the same time (approximately 2 months ago) Staff B and Staff C took pictures of items she had dropped and could not pick up that were lying on the floor of the resident's room. The resident also recalled on this day that she had a bout of diarrhea and had also "messed up the bed". The resident reported that she was called lazy and nasty by Staff B or Staff C but unsure exactly which one said it. -She was "written-up" and had to go talk with the Administrator about the condition of her room. -Resident #8 did not know why, but when she spoke with the Administrator, she did not report being called lazy and nasty by the named staff members. Interview with the Administrator on 08/15/18 at 2:50 p.m. revealed: -She remembered a month or so ago, Resident #8 was lying around a lot and she felt concerned about her. -She recalled instructing Staff B to assist Resident #8 to clean out her closet around that time. -She was not sure what Resident #8 was referring to as far as being "written up" and was not aware any staff inappropriately speaking to	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL074038	A. BUILDING: _____ B. WING _____	R 08/23/2018

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D 338	Continued From page 25 Resident #8 by calling her lazy or nasty. A second interview with Resident #8 on 08/15/18 at 3:05 p.m. revealed: -She had already spoken with the Administrator today (08/15/18) about the way the named staff had spoken to her. -The comments the staff had made about her "really hurt", I already have depression and that didn't help me in anyway". A second interview with the Administrator on 08/15/18 at 5:57 p.m. revealed: -She had started her internal investigation and had completed the initial report to HCPR. -Staff C admitted she told Staff B that Resident #8 was lazy, however, Staff C did not intend for Resident #8 to hear her comment. -After Staff C was interviewed today (08/15/18), she was suspended for at least two days and further action was possible pending her internal investigation. Attempted telephone interview with Staff C on 08/22/18 at 1:09 p.m. and 1:49 p.m. were unsuccessful. Interview with Staff B on 08/15/18 at 4:40 p.m. revealed: -She had worked as a personal care aide (PCA) for 12 years. -She had received resident right training by the facility over the years since she had been employed and had a mandatory upcoming resident right training on 08/25/18. -She could not recall any specific incidences with Resident #8 and had never referred to any resident in a negative way or ever called a resident a name or labeled them. -Before she spoke harshly or inappropriately to	D 338		

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D 338	Continued From page 26 any resident she would simply just walk away without saying anything. -She did not recall an incident of hearing any other staff calling Resident #8, or any other resident a name. -If she ever heard of a resident being spoken to inappropriately by staff she would immediately report it to the Administrator. -She thought the facility had a resident right policy. Attempted telephone interview with Staff A on 08/22/18 at 1:12 p.m. and 5:25 p.m. were unsuccessful. _____ The facility failed to assure Resident #8, who had diagnoses including mental retardation, was treated with dignity and respect by staff members (Staff A, Staff B, Staff C who were named by the resident) called the resident lazy and nasty. This non-compliance was detrimental to the residents' welfare which constitutes a TYPE B VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/2018 with an addendum per a telephone conversation on 05/31/2018 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 2018.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration,	D911		

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D911	Continued From page 27 dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 8 residents (#8) was treated with dignity and respect. The findings are: Based on record reviews and interviews, the facility failed to assure 1 of 8 residents sampled (#8) was treated with dignity and respect by three staff members (Staff A, Staff B and Staff C). [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911	A mandatory resident's rights in-service for all staff was held on August 24, 2018 at 1:00 p.m. by [redacted] Regional Ombudsman. A roster of all staff who attended was obtained and each staff member obtained a Certificate of Achievement signed and dated by [redacted] Management will interview residents at least monthly to ensure each resident is treated with respect and dignity. Any concerns noted will be thoroughly investigated by the Administrator. An Initial Report of the allegations will be completed and forwarded to the Health Care Personnel Registry within 24 hours of the Administrator being made aware of the allegations. Alleged perpetrators will be pulled off the schedule pending investigation, as deemed necessary by the Administrator. The 5 Day Investigative Report will be completed within 5 working days and will be forwarded to the Health Care Personnel Registry for their review. Corrective action will be taken regarding staff, as needed, per facility policy, as deemed necessary. Interviews with residents will begin monthly starting in August. A thorough investigation of a potential violation of resident's rights will begin immediately following the notification to the Administrator.	
{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 care and services related to health care referral and follow-up needs. The findings are:	{D912}		

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{D912}	Continued From page 28 Based on interviews and record reviews, the facility failed to notify the medical provider who ordered parameters for daily weights for 1 of 8 sampled residents (#5) who had diabetes, acute kidney failure and hypertension with daily weight fluctuations. [Refer to Tag 0273 10A NCAC .0902(b) Health Care Unabated Type B Violation).]	{D912}	Care will be provided to the residents, as ordered by their physicians. Medications staff were re-educated on expectations for handling physician's orders during a in-service on 08/24/2018 conducted by [redacted], Resident Care Coordinators. Orders for labs, weights, etc. will be placed in residents' records, as well as, a communication book as an additional reminder for the medication staff. This communication book will be maintained in the nurse's station.	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 8 sampled residents (#2) which resulted in an unsupervised, confused and disoriented resident leaving the facility on multiple occasions. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).]	D914	Calls will be made by medication technicians to physicians to give/obtain information on labs, fluctuations in weights, vitals, change in mental status etc,. as directed. Recommendations by physicians will be followed. Documentation of these calls to give/obtain orders, labs, etc. from physicians will be obtained in resident's records. Lab results will be filed in the resident's records. Residents will be transported to their appointments by [redacted] Medical Transporter or her substitute. Refusals by residents to attend these appointments will be documented in the resident's records. The residents' physicians will also be notified of their refusals to attend appointments. Documentation of the notification to physicians will be completed by the medication technicians and will be maintained in the resident's record. Once Administrator becomes aware that a resident tends to wander from the facility without the knowledge to sign themselves in and out appropriately or other behavioral issues, she will immediately contact the resident's physician for recommendations. Recommendations, such as placement in a locked care unit will be followed and will be implemented immediately. The RCC will contact the family regarding any recommendations the physician makes in order to maintain the safety of the individual. The necessary paperwork, such as updated FL-2s, history and physical, copy of the Medication Administration Record, etc. will be forwarded to locked	

care facilities as soon as possible. Follow-up TCs will be completed with these facilities until other placement arrangements can be obtained. While this process continues, the staff will be mandated to monitor the resident every hour to ensure they have not exited the facility (additional supervision, such as one-on-on supervision will be implemented, if deemed necessary). The staff will receive on-going training regarding Southern Living's Wandering and Elopement/Behavior Modification policies and will sign paperwork acknowledging the understanding of this policy. This training/paperwork will be completed by all staff effective October 7, 2018
Observation, chart reviews, interviews with staff and residents will be completed daily beginning immediately by the Medication Technicians, the Administrator and RCC daily to ensure the supervision needs of the residents are met at all times.