

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL058008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/03/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIELDS FOUNDATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1057 LAND-FIELDS LANE</b> <b>WILLIAMSTON, NC 27892</b>
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C 000	Initial Comments  The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on May 1, 2019 through May 3, 2019.	C 000		
C 140	<p>10A NCAC 13G .0405(a)(b) Test For Tuberculosis</p> <p>10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff A) were tested for tuberculosis (TB) disease upon hire.</p> <p>The findings are:</p>	C 140		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 140	<p>Continued From page 1</p> <p>Review of Staff A's, supervisor-in-charge (SIC), personnel record revealed: -Staff A's date of hire was documented as 02/25/13. -There was documentation of a TB skin test was administered on 01/23/13 and that TB result was read as 3 millimeter (mm) on 01/25/13. -There were no other TB skin test results on record for Staff B.</p> <p>Interview with Staff A on 05/03/19 at 11:00am revealed: -He had been employed at the facility as a SIC since 2013. -He could not remember if he had a second TB skin test for this facility. -He did not remember the reading of 3mm for the TB skin test administered to him in 2013 or if he was told that he needed to follow-up with a second TB skin test. -He had other TB skin tests that were done for other employers since 2013 and they were "all negative".</p> <p>Interview with the Assistant Administrator on 05/02/19 at 12:00pm revealed: -He was responsible for making sure the TB skin tests were completed upon hire for all staff. -He did not know Staff A was missing his second step TB skin test. -He did not remember Staff A had 3mm reading from his TB skin test that was read in 2013. -He did not know if Staff A followed up regarding the 3mm TB skin result in 2013. -He had not reviewed Staff A's personnel record since he was hired.</p>	C 140		

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C 145	Continued From page 2	C 145		
C 145	<p>10A NCAC 13G .0406(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 1 of 3 sampled staff (Staff C) had no substantiated findings on their Health Care Personnel Registry (HCPR) prior to hire.</p> <p>The findings are:</p> <p>Review of Staff C's, supervisor-in-charge (SIC), personnel record revealed: -Staff C's date of hire was documented as 10/04/18. -There was no documentation in Staff C's personnel record that a HCPR check had been performed.</p> <p>Interview with Staff C on 05/02/19 at 9:55am revealed: -She had worked as a SIC at the facility since she was hired in October 2018. -She did not know if the Administrator did a HCPR check on her when she was hired.</p> <p>Interview with the Assistant Administrator on 05/02/19 at 12:00pm revealed: -He thought he had completed a HCPR check prior to hiring Staff C last fall. -He was responsible to ensure HCPR checks</p>	C 145		

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C 145	Continued From page 3  were done for all staff prior to hiring. -He forgot to make sure a HCPR check was done for Staff C. -He had not reviewed Staff C's personnel record since she was hired.  Review of a HCPR check for Staff C dated 05/02/19 revealed there were no substantiated findings listed on the HCPR.	C 145		
C 231	10A NCAC 13G .0801(b) Resident Assessment  10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.  This Rule is not met as evidenced by: Based on record reviews and interviews, the	C 231		

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C 231	<p>Continued From page 4</p> <p>facility failed to assure 1 of 3 sampled residents (#1) had a care plan that was updated annually.</p> <p>The findings are:</p> <p>Review of Resident #1's most current FL-2 dated 03/25/19 revealed diagnoses included cerebral palsy, epilepsy, dementia, hypertension, depression, anxiety, and chronic pain.</p> <p>Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/26/18.</p> <p>Review of Resident #1's most current care plan dated 03/30/18 revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of Resident #1's ambulation status.</li> <li>-He had limited strength to his upper extremities and right leg weakness.</li> <li>-He required limited assistance with dressing and eating.</li> </ul> <p>Interview with the Assistant Administrator on 05/02/19 at 12:00pm revealed:</p> <ul style="list-style-type: none"> <li>-He did not know Resident #1's care plan was outdated.</li> <li>-He thought Resident #1's care plan was up to date.</li> <li>-He was responsible for making sure the residents' care plans were updated annually.</li> </ul> <p>Attempted telephone interviews with Resident #1's physician's office on 05/01/19 at 4:31pm and 05/03/19 at 12:36pm were unsuccessful.</p>	C 231		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .0902 Health Care</p>	C 246		

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C 246	<p>Continued From page 5</p> <p>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to notify the mental health provider for 1 of 1 sampled residents (#1) who had become increasingly combative, lit a cigarette inside the facility, had suicidal ideations, and reported an intent to injure staff with a knife.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 03/25/19 revealed diagnoses included cerebral palsy, epilepsy, dementia, hypertension, depression, anxiety, and chronic pain.</p> <p>Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/26/18.</p> <p>Review of Resident #1's mental health visit summary note dated 12/14/18 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had diagnoses that included bipolar disorder, schizophrenia, and posttraumatic stress disorder.</li> <li>-Resident #1 was receiving mental health services and reported not being compliant with his medications.</li> <li>-He was alert and oriented to person, place, time, and situation.</li> <li>-Resident #1 exhibited a flat affect and had impaired intelligence.</li> <li>-Resident #1 reported depressive moods, loss of interest in usual activities, extreme fatigue,</li> </ul>	C 246		

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C 246	<p>Continued From page 6</p> <p>problems with concentration, agitation, easily distracted, and racing thoughts evidenced by excessing talking and elevated mood swings.</p> <p>Interview with Resident #1 on 05/01/19 at 11:40am and 12:00pm revealed: -Resident #1 declined to speak to with the survey staff. -He would only speak with the ombudsman. -"I don't want you looking at any of my incident reports if you do I will call the police." -He threatened to call the police if the survey staff attempted to look any of his incident reports or attempted to review his record.</p> <p>Observation of Resident #1 on 05/01/19 at 11:55am revealed: -Resident #1 came and sat down on the sofa in the living room adjacent to the dining room. -Resident #1 spoke with the supervisor-in-charge/medication aide (SIC/MA) and survey staff.</p> <p>Observation of Resident #1 on 05/01/19 at 12:15pm revealed: -Resident #1 ambulated from the living room to the activity room where the survey staff was. -He sat in a chair adjacent to the room exit and yelled at the survey staff. -"You better not try to look at my record; I came back here to make sure you don't." -"I better not find out you looked at my records or my incident reports." -The SIC/MA came to the activity room and asked Resident #1 to leave the activity room and he refused. -He said, "I am not going until she (survey team) is gone. I got to watch her because if she looks at my records then I am calling the police". -Resident #1 stood up and was pointing his finger</p>	C 246		

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C 246	<p>Continued From page 7</p> <p>aggressively at the survey staff and was partially blocking the exit of the activity room when the survey staff attempted to leave the room and the survey staff stepped back away from the entrance.</p> <p>-He yelled, "You are going out first because I have to watch you".</p> <p>-The SIC/MA told Resident #1 that he would need to leave the room first and the survey staff and she would follow him.</p> <p>-Resident #1 argued with the SIC/MA for at least five minutes and the SIC/MA told Resident #1 that she would call the Assistant Administrator if he did not leave the activity room.</p> <p>-Resident #1 then exited the activity room ahead of the SIC/MA and the survey staff.</p> <p>Interview with the SIC/MA on 05/01/19 at 12:22pm revealed:</p> <p>-Resident #1 was "controlling" and she had problems with Resident #1 blocking the office door when she had to fax accident/incident reports.</p> <p>-Resident #1 "refused to follow instructions when staff asked him to do things and house rules, and became angry" when staff had to send in reports to the Assistant Administrator.</p> <p>-Resident #1 had been refusing to listen to staff instructions since he had been admitted to the facility.</p> <p>-She had to call the Assistant Administrator several times when Resident #1 became aggressive and was yelling and ripping up her reports.</p> <p>-The Assistant Administrator had spoken with Resident #1 several times about his behaviors, but "it didn't do any good".</p> <p>Review of a facility accident/incident report dated 12/18/18 at 1:00pm revealed Resident #1 refused</p>	C 246		

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C 246	<p>Continued From page 8</p> <p>to follow instruction by staff and threatened to stop staff if they wrote the accident/incident report.</p> <p>Interview with a second SIC/MA on 05/02/19 at 9:55am revealed:</p> <ul style="list-style-type: none"> <li>-She could not remember exactly what she had asked Resident #1 to do but Resident #1 refused to follow her instructions.</li> <li>-She wrote the accident/incident report dated 12/18/18 after Resident #1 threatened to try to take the report and Resident #1 blocked the entrance to the office where the fax machine was.</li> <li>-She did not try to force her way past Resident #1 when he blocked the door.</li> <li>-She waited until Resident #1 was distracted and faxed the accident/incident report to the Assistant Administrator.</li> <li>-Staff usually faxed accident/incident reports to the Assistant Administrator and let the Assistant Administrator then deal with any situations regarding Resident #1.</li> </ul> <p>Review a second facility accident/incident report dated 01/05/19 at 1:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff gave Resident #1 "all of his available pain medication for unexplained chest pain".</li> <li>-Resident #1 complained the pain medication was not enough and wanted more pain medication.</li> <li>-Resident #1 then called 911 without staff's knowledge to be transported to the hospital.</li> <li>-Resident #1 was told by emergency medical technicians (EMTs) that if nothing was found to be wrong with him when he got to the hospital; the EMTs would have Resident #1 arrested or committed because of his excessive use of 911.</li> </ul> <p>Interview with the second SIC/MA on 05/02/19 at 9:55am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 constantly called 911.</li> </ul>	C 246		

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C 246	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>-The staff had given Resident #1 pain medication but Resident #1 had not given the pain medication time to work.</li> <li>-She did not know Resident #1 had called 911 until the EMTs knocked on the door and Resident #1 walked out.</li> <li>-He "had a habit of calling 911 unnecessarily and that was why the EMTs threatened to have him prosecuted" on 01/05/19.</li> <li>-Resident #1 did come back from the emergency room with a muscle relaxer for muscle strain.</li> </ul> <p>Review a third facility accident/incident report dated 01/10/19 at 8:15am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 refused to allow staff to write in the facility's activity log.</li> <li>-Resident #1 tried to take the activity log away from the staff.</li> <li>-Staff called the Assistant Administrator to come to the facility.</li> </ul> <p>Interview with a second SIC/MA on 05/03/19 at 3:15pm revealed:</p> <ul style="list-style-type: none"> <li>-It was difficult for staff to deal with Resident #1's behaviors and get Resident #1 to follow staff's instruction.</li> <li>-She wrote the accident/incident report dated 01/10/19 because Resident #1 got angry when he saw staff writing his name in the activity log and ripped out a page of the activity log.</li> <li>-She could not get Resident #1 to calm down and let staff finish documentation.</li> <li>-She had to call the Assistant Administrator to come the facility and try to calm Resident #1 down.</li> <li>-If staff could not handle Resident #1, they wrote an accident/incident report most of the time and called the Assistant Administrator to help them.</li> <li>-She did not know if the Assistant Administrator contacted Resident #1's mental health provider</li> </ul>	C 246		

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C 246	<p>Continued From page 10</p> <p>regarding his behaviors.</p> <ul style="list-style-type: none"> <li>-The accident/reports were written so the staff could make the Assistant Administrator informed of Resident #1's behaviors.</li> <li>-Notifications to the mental health providers was the Assistant Administrator's responsibility.</li> </ul> <p>Review a fourth facility accident/incident report dated 01/12/19 at 8:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 refused to take 8:00pm medications and would not allow staff to document his medication refusal.</li> <li>-Resident #1 blocked staff's access to the facility office to fax the accident/incident report completed by staff.</li> <li>-Resident #1 ripped the paper from the staff's notebook and threw it on the floor and attempted to burn the accident/incident with his lighter.</li> <li>-Staff called the police to help with Resident #1's behaviors.</li> <li>-Resident #1 still refused to take his nighttime medications while the sheriff's deputy was present.</li> <li>-Resident #1 did take his nighttime medications at 8:45pm.</li> </ul> <p>Review of a sheriff's office operations report dated 01/12/19 at 8:26pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 refused to take his medication and became irate with staff.</li> <li>-Resident #1 became irate with staff when staff attempted to complete documentation to fax to the Assistant Administrator regarding his medication refusal.</li> <li>-The sheriff's deputy tried to get Resident #1 to take his medication but he continued to refuse take his medications.</li> </ul> <p>Interview with the SIC/MA on 05/03/19 at 3:15pm revealed:</p>	C 246		

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C 246	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-Resident #1 had a habit of refusing his 8:00pm psychiatric medication because the medications made him sleepy.</li> <li>-Resident #1 wanted to be able to wake up so he could get up at 1:00am and smoke a cigarette.</li> <li>-If he took the 8:00pm psychiatric medications then he would not be able to wake up and smoke.</li> <li>-She called 911 because she could not get in contact with the Assistant Administrator and she did not know what else to do since Resident #1 was loud and threatened to hit her if she tried to get inside the office.</li> <li>-Resident #1 snatched a clipboard out of her hands, broke it and then threw it on the floor.</li> <li>-She later faxed an accident/incident report to the Assistant Administrator.</li> <li>-She did not know if the Assistant Administrator had contacted the Resident #1's mental health provider about his behaviors.</li> </ul> <p>Review a fifth facility accident/incident report dated 01/17/19 revealed:</p> <ul style="list-style-type: none"> <li>-There was no time documented for this entry.</li> <li>-Resident #1 became upset and refused to participate in a planned social outing.</li> <li>-He repeatedly used racial slurs regarding the outing.</li> <li>-Resident #1 "claimed to be a member of a white supremacist hate group and refused to participate in an activity that celebrated another ethnicity".</li> <li>-"None of the residents or staff had provoked his behavior".</li> </ul> <p>Interview with the second SIC/MA on 05/02/19 at 9:55am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 used racial slurs mostly towards the staff and occasionally with the residents.</li> <li>-He refused to participate in the outing on 01/17/19 because it celebrated another ethnicity and began yelling and using racial slurs in front of</li> </ul>	C 246		

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C 246	<p>Continued From page 12</p> <p>the other residents of the same ethnicity. -The staff tried to calm Resident #1 down but he became "very angry". -Staff separated Resident #1 from the rest of the residents when he started using racial slurs. -A staff member stayed with Resident #1 at the facility while the rest of the residents went on the outing. -The Assistant Administrator was present when Resident #1 was using the racial slurs and yelling.</p> <p>Interview with a resident on 05/02/19 at 11:28am revealed: -The resident witnessed Resident #1 using the racial slurs before the other residents went on their outing on 01/17/19. -Resident #1 was yelling at the residents and said that he "was trained from a boy to kill" people of other ethnicities and he "should not have to go to any celebration" about people of other ethnicities. -The resident ignored Resident #1 but it did make the resident feel uncomfortable being around Resident #1 then.</p> <p>Review a sixth facility accident/incident report dated 01/26/19 at 12:30pm revealed: -Resident #1 was on an outing in a nearby town. -Resident #1 refused to return to the facility van when it was time to return to the facility. -Resident #1 told the Assistant Administrator that he "was going to see his boss". -The Assistant Administrator called 911 for assistance to get Resident #1 to return to the facility.</p> <p>Interview with the Assistant Administrator on 05/02/19 at 11:35am revealed: -He had taken Resident #1 and the other residents on an outing to the store. -Resident #1 refused to come back to the van</p>	C 246		

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C 246	<p>Continued From page 13</p> <p>when it was time to return the facility.</p> <p>-Resident #1 told the Assistant Administrator that the resident wanted to go and see his previous employer and walked away from the Assistant Administrator.</p> <p>-The Assistant Administrator repeatedly called out for Resident #1 to return with him to the facility but Resident #1 kept walking away from him.</p> <p>-He called the police when he refused to come back to the facility.</p> <p>-The police later found Resident #1 and brought him back to the facility from a local car wash.</p> <p>Review a seventh facility accident/incident report dated 01/29/19 at 8:59am revealed:</p> <p>-Resident #1 lit a cigarette inside of the facility.</p> <p>-Staff repeatedly had to ask Resident #1 to go outside with the lit cigarette before he went out on the front porch to smoke.</p> <p>Interview with the second SIC/MA on 05/02/19 at 9:55am revealed:</p> <p>-She saw Resident #1 when he lit the cigarette in the living room on 01/29/19.</p> <p>-She asked him repeatedly not to light the cigarette but Resident #1 did it anyway.</p> <p>-Resident #1 then started smoking the cigarette while he was sitting on the sofa in the living room.</p> <p>-She finally told Resident #1 that she was going to call 911 and the Assistant Administrator.</p> <p>-Resident #1 did finally go outside on the front porch and finished smoking his cigarette once she told him this.</p> <p>-She reported this to the Assistant Administrator and the Assistant Administrator came over and spoke with Resident #1.</p> <p>-This was the first time Resident #1 had lit a cigarette in the facility that she was aware of.</p> <p>-Resident #1 was allowed to keep his lighter and his cigarettes.</p>	C 246		

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C 246	<p>Continued From page 14</p> <p>Review of an eighth facility accident/incident report dated 01/30/19 at 3:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a verbal altercation with another resident.</li> <li>-Resident #1 verbally threatened the other resident that he would "go in his room and beat the (expletive) out" of the other.</li> <li>-The other resident told the staff that he was afraid of Resident #1 after the other resident was verbally threatened by Resident #1.</li> </ul> <p>Interview with the first SIC/MA on 05/03/19 at 3:15pm revealed:</p> <ul style="list-style-type: none"> <li>-She wrote the accident/incident report dated 01/30/19.</li> <li>-She did not remember why the other resident and Resident #1 ended up fussing.</li> <li>-Resident #1 did threatened to "beat up" the other resident.</li> <li>-She made sure Resident #1 and the other resident were kept apart.</li> <li>-Resident #1 did have habit of bothering the other resident repeatedly by knock and banging on the other resident's bedroom door.</li> <li>-Resident #1 wanted the other resident to carry his shopping bags and when the other resident refused; Resident #1's banging on other resident's bedroom door intensified.</li> <li>-Resident #1 would then start calling the other resident "a slave" and cursing at the other resident.</li> <li>-Resident #1 had "threatened to beat up" and to go inside the other resident's bedroom so he could "burn him (the other resident)" for refusing to carry his shopping bags.</li> <li>-Resident #1 had been doing to the other resident for the least 5 or 6 months.</li> <li>-She always told the Assistant Administrator about Resident #1 threats and behaviors against</li> </ul>	C 246		

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C 246	<p>Continued From page 15</p> <p>the other resident each time it happened.</p> <p>-She had not notified Resident #1's mental health provider about his behaviors and did not know if the Assistant Administrator had contacted Resident #1's mental health provider either.</p> <p>-The Assistant Administrator was in charge of contacting mental health provider for the residents.</p> <p>Interview with a resident on 05/01/19 at 3:00pm revealed:</p> <p>-He could not remember the exact events documented on the accident/incident report dated 01/30/19.</p> <p>-He got along with all of the residents except Resident #1.</p> <p>-Sometimes Resident #1 "picked on" him and called him names like "stupid and dumb".</p> <p>-He could not specify how often Resident #1 intimidated him or the last time Resident #1 had bothered him.</p> <p>Review of a ninth facility accident/incident report dated 03/10/19 at 5:00pm revealed:</p> <p>-Resident #1 became upset with his significant other after they refused to visit him at the facility.</p> <p>-He threatened to kill himself with an electrical cord in his room.</p> <p>-A crisis intervention team advised staff to remove any cords from Resident #1's bedroom and the police were contacted.</p> <p>-The Assistant Administrator did come to the facility and spoke with Resident #1.</p> <p>-There was no documentation that Resident #1's mental health provider was contacted by the facility regarding his suicidal ideations.</p> <p>Review of a sheriff's office operations report dated 03/10/19 at 6:15pm revealed:</p> <p>-Resident #1 reported that his significant other</p>	C 246		

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C 246	<p>Continued From page 16</p> <p>told him to never call again.</p> <p>-Resident #1's significant other told him to kill himself.</p> <p>-Resident #1 got upset and called the crisis intervention team and told the team that he wanted to kill himself by choking himself with an extension cord.</p> <p>-Resident #1 told the sheriff's deputy that he did not want to hurt himself and he was just upset.</p> <p>Interview with the first SIC/MA on 05/03/19 at 3:15pm revealed:</p> <p>-She wrote the accident/incident report dated for 03/10/19.</p> <p>-Resident #1 called the crisis intervention team and 911 himself on 03/10/19.</p> <p>-He had not told staff that he wanted to kill himself before he called for help.</p> <p>-It was not the first time Resident #1 had called crisis intervention with suicidal ideations.</p> <p>-Resident #1 had called crisis intervention at least five times since January 2019.</p> <p>-The Assistant Administrator was notified but she was not sure of the specific dates that Resident #1 had made the calls.</p> <p>-She did not know if Resident #1's mental health provider had been contacted by the Assistant Administrator regarding his suicidal ideations.</p> <p>Interview with the Assistant Administrator on 05/02/19 at 11:35am revealed:</p> <p>-"There was always something going on with" Resident #1.</p> <p>-Staff told the Assistant Administrator that Resident #1 used his own cellphone to call the crisis intervention.</p> <p>-He did not talk with the crisis intervention team.</p> <p>-He thought when Resident #1 called the crisis intervention team on 03/10/19 that it was the same as Resident #1's mental health provider.</p>	C 246		

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C 246	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-Resident #1 had called crisis intervention several times this year, but he was not sure how many times Resident #1 had called.</li> <li>-He never notified Resident #1 mental health provider directly about Resident #1's thoughts of committing suicide.</li> <li>-He believed Resident #1 "was just trying to get his way" with his significant other when he called crisis intervention on 03/10/19.</li> </ul> <p>Review of a tenth facility accident/incident report dated 04/02/19 at 7:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 became upset with staff and refused his night time medications.</li> <li>-When staff tried to fax the accident/incident report to the Assistant Administrator, Resident #1 threatened to pull the phone out of the wall so the report could not be sent.</li> </ul> <p>Interview with a third SIC/MA on 05/03/19 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-Staff are supposed to send an accident/incident report to the Assistant Administrator whenever a resident refused medications.</li> <li>-Staff called the Assistant Administrator about Resident #1's behaviors if it was not too late in the evening or if there was an emergency.</li> <li>-He wrote the accident/incident report dated 04/02/19 because Resident #1 refused his evening medications.</li> <li>-Resident #1 became upset and physically aggressive when he saw staff start to write the report.</li> <li>-Resident #1 blocked the office door and threatened to pull the phone out of the wall to prevent staff from faxing the report.</li> <li>-He had to wait until Resident #1 went to bed before he could fax the report to the Assistant Administrator.</li> <li>-He told the Assistant Administrator the next day</li> </ul>	C 246		

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C 246	<p>Continued From page 18</p> <p>how Resident #1 blocked the office door, but nothing was done about it.</p> <p>Review of a sheriff's office operations report dated 04/15/19 at 9:30pm revealed: -Resident #1 called 911 and requested to speak with a deputy. -Resident #1 complained that someone refused to bring a bed that he reported belonged to him. -The deputy informed Resident #1 that the deputy could not make anyone bring him the bed. -The deputy advised Resident #1 to ask the person to bring the bed to him.</p> <p>Review of a sheriff's office operations report dated 04/16/19 at 5:10pm revealed: -Resident #1 called 911 and complained someone had turned off his television in his room while he was gone. -The deputy explained to Resident #1 that it was not a crime for the staff to turn off his television if he was not at the facility. -Resident #1 told the deputy that he would press charges if it happened again.</p> <p>Review of an eleventh facility accident/incident report dated 04/20/19 revealed: -There was no time documented except for a check mark by 'PM'. -Resident #1 told staff that he had an argument with another staff member a few nights before (date was not specified). -Resident #1 told staff that he "was going to buy a knife online and hurt staff if the staff member bothered him again". -There was no documentation that Resident #1's mental health provider was notified of Resident #1's plans to purchase a knife to hurt staff.</p> <p>Interview with the second SIC/MA on 05/02/19 at</p>	C 246		

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C 246	<p>Continued From page 19</p> <p>9:55am revealed:</p> <ul style="list-style-type: none"> <li>-She wrote the accident/incident report dated 04/20/19 because she was concerned that Resident #1 was communicating threats about another staff.</li> <li>-She wanted to make sure the Assistant Administrator was aware of Resident #1's threat to buy a knife off the internet.</li> <li>-She was afraid that since Resident #1 called 911 frequently without staff knowledge from his cellphone that he may use his cellphone to order the knife and hurt staff or other residents.</li> <li>-She was not sure if the Assistant Administrator spoke with Resident #1 about the threats but she faxed the accident/incident report.</li> <li>-She did not contact Resident #1's mental health provider because the Assistant Administrator was responsible to make that contact.</li> </ul> <p>Interview with the Assistant Administrator on 05/03/19 at 12:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had asked if he could purchase a knife a couple of weeks ago but the Assistant Administrator did not know that Resident #1 had threatened to hurt staff with the knife.</li> <li>-The Assistant Administrator did not know about the facility accident/incident report dated 04/20/19.</li> <li>-He had not contacted Resident #1's mental health provider.</li> </ul> <p>Telephone interview with a fourth SIC/MA on 05/03/19 at 4:09pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 "always did the opposite of what staff asked him to do" and had cursed at staff and residents several times.</li> <li>-The Assistant Administrator was in charge of the facility and the staff contacted him for any issues and not the Administrator.</li> <li>-Resident #1 lied to the Assistant Administrator</li> </ul>	C 246		

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C 246	<p>Continued From page 20</p> <p>about not following instructions and that he cursed at the residents and staff.</p> <ul style="list-style-type: none"> <li>-The Assistant Administrator "did not do anything when staff complained" about Resident #1's behaviors and the Assistant Administrator ignored staff's complaints about Resident #1's behaviors.</li> <li>-Resident #1 would call 911 from his personal phone when Resident #1 became angry with staff and wanted a way out of the facility.</li> <li>-She did not believe that staff was able to cope with Resident #1's behaviors and the staff complained to the Assistant Administrator about this last month during a staff meeting.</li> <li>-She did get into an argument with Resident #1 a couple of days ago.</li> <li>-Resident #1 threatened to slash her car tires and scratch the paint on her car about a month ago.</li> <li>-She and Resident #1 had an argument about a week and a half ago about religion because he was complaining about the religious group Resident #1 had invited to study to with him.</li> <li>-Resident #1 did not threaten her at that time.</li> <li>-However, another staff warned her to be on alert for Resident #1 because he had threaten to buy a knife.</li> <li>-The incident had been reported to Assistant Administrator but nothing was done.</li> <li>-The Assistant Administrator did not take Resident #1's threats seriously but she did.</li> <li>-"You never knew what he (Resident #1) was going to do because he did not think rationally."</li> <li>-The other residents in the facility tried to avoid Resident #1 because of his irrational behavior and because Resident #1 was not easy to get along with.</li> </ul> <p>Review of a twelfth facility accident/incident report dated 04/25/19 at 3:00pm revealed Resident #1 was making harassing phone calls to another assisted living facility and the other facility called</p>	C 246		

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C 246	<p>Continued From page 21</p> <p>the police to report Resident #1.</p> <p>Interview with the second SIC/MA on 05/02/19 at 9:55am revealed:</p> <ul style="list-style-type: none"> <li>-She did not know what had happened with the event on 04/25/19 until the she saw the sheriff's deputy knocking at the front door of the facility.</li> <li>-She was shocked when she found out that Resident #1 was making harassing phone calls to another facility.</li> <li>-The sheriff's deputy spoke with Resident #1 and told him not to call the other facility anymore or charges would be pressed against him.</li> <li>-Resident #1 denied making any harassing phone calls and said he was only trying to contact his significant other at the facility.</li> <li>-She called the Assistant Administrator when this happened on 04/25/19 and she sent the accident/incident report to the Assistant Administrator.</li> <li>-The Assistant Administrator did not give staff any instructions on dealing with Resident #1 and the harassing phone calls.</li> <li>-The Assistant Administrator spoke with Resident #1 on the following day.</li> </ul> <p>Interview with Resident #1 on 05/02/19 at 9:20am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 reported he "got along with everybody at the facility" and he "did not bother any of other residents at the facility".</li> <li>-He was upset 05/01/19 because the SIC/MA had written an accident/incident report regarding his actions on 05/01/19 and he did not believe he had done anything wrong.</li> <li>-It made him upset when staff wrote accident/incident reports about his behaviors.</li> <li>-He did sometimes block the entrance to the facility's office and refused to move so staff could not fax the reports to the Assistant Administrator.</li> </ul>	C 246		

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NAME OF PROVIDER OR SUPPLIER  <b>FIELDS FOUNDATION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1057 LAND-FIELDS LANE</b> <b>WILLIAMSTON, NC 27892</b>
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C 246	<p>Continued From page 22</p> <p>-"They (facility staff) do not have a right to tell what I do to anybody else."</p> <p>-The staff wanted to control him but he "was the boss here".</p> <p>-He had called 911 several times and he did not tell the staff at the facility because that was his business and he would call 911 whenever he wanted to.</p> <p>Review of health services reports dated from 12/14/18 through 04/16/18 revealed there was no documentation that Resident #1's mental health provider was notified of his behaviors including communicating threats of physical harm, suicidal thoughts, harassing behaviors, or harassing phone calls.</p> <p>Interview with the Assistant Administrator on 05/03/19 at 12:30pm revealed:</p> <p>-Resident #1 had been "a problem" with since he was admitted at the facility.</p> <p>-He had noticed that Resident #1 had been acting out a lot more.</p> <p>-He had talked with Resident #1 when he lit the cigarette in the facility and that had not happened again.</p> <p>-Resident #1 had gotten in several verbal altercations with other residents at the facility, but he did not know of anything that he considered "serious".</p> <p>-He did not remember staff reporting any of the other residents being afraid or uncomfortable being around Resident #1.</p> <p>-When Resident #1 had outbursts at the facility, he (the Assistant Administrator) talked with Resident #1 and the situations were resolved.</p> <p>-He last spoke with Resident #1's mental health provider sometime around October 2018 about Resident #1's behaviors but he was unable to specify dates and his attempt was not</p>	C 246		

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C 246	<p>Continued From page 23</p> <p>documented in Resident #1's record.</p> <ul style="list-style-type: none"> <li>-He was not allowed to be with Resident #1 when he went to his mental health appointments.</li> <li>-He did not think his facility was able to accommodate Resident #1's behaviors and he did not know what else to do.</li> <li>-No other facility was willing to take Resident #1 as an admission.</li> <li>-He would try to contact Resident #1's mental health provider to inform of Resident #1's behaviors.</li> </ul> <p>Attempted telephone interviews with Resident #1's mental health provider on 05/01/19 at 4:11pm, 05/02/19 at 10:45am, and 05/03/19 at 12:14pm were unsuccessful.</p> <p>_____</p> <p>The facility failed to notify the mental health provider of Resident #1's increasingly hostile behaviors as evidenced by smoking inside the facility, suicidal ideations, verbal altercations, calls to 911, and intent to hurt staff with a knife. The facility's failure to report Resident #1's behaviors resulted in serious neglect which constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/19 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2019.</p>	C 246		
C 311	<p>10A NCAC 13G .0909 Residents' Rights</p> <p>10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,</p>	C 311		

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C 311	<p>Continued From page 24</p> <p>Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled resident (Resident #2) was protected from verbal abuse and intimidation by another resident.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 06/06/18 revealed: -Diagnoses included mental retardation, seizure disorder, obesity, and schizophrenia. -Resident #2 was ambulatory and had functional limitations with his sight and speech. -There was no information regarding Resident #2's mental status. -Resident #2 was incontinent of bowel and bladder.</p> <p>Review of Resident #2's current care plan dated 08/30/18 revealed Resident #2 required limited assistance with eating and toileting and extensive assistance with bathing, dressing, and grooming.</p> <p>Review of an accident/incident report dated 01/30/19 at 3:30pm revealed: -Resident #2 and another resident had a verbal altercation. -Resident #2 was afraid of the other resident after other resident verbally threatened Resident #2. -The other resident told Resident #2 that he would "go in his room and beat the (expletive) out of him".</p>	C 311		

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C 311	<p>Continued From page 25</p> <p>-Resident #2 told staff that he was afraid of other resident after he was verbally threatened by other resident.</p> <p>Interview with Resident #2 on 05/01/19 at 3:00pm revealed:</p> <p>-He could not remember the exact events documented on the accident/incident report dated 01/30/19.</p> <p>-He got along with all of the residents except the other resident.</p> <p>-Sometimes the other resident "picked on" him and called him names like "stupid and dumb".</p> <p>-The other resident had used racial slurs too when he "picked on" him.</p> <p>-He could not specify how often the other resident intimidated him or the last time the other resident had bothered him.</p> <p>-He did not like it when the other resident called him names because it made him feel bad.</p> <p>-He did not bother the other resident and he did not understand why the other resident liked to bother him.</p> <p>-He went to his room sometimes to get away from the other resident when the other resident would not stop calling him names.</p> <p>-He read in his room to take his mind off the other resident calling him names and racial slurs.</p> <p>Interview with a supervisor-in-charge/medication aide (SIC/MA) on 05/03/19 at 3:15pm revealed:</p> <p>-She wrote the accident/incident report dated 01/30/19.</p> <p>-She did not remember why Resident #2 and the other resident "ended up fussing".</p> <p>-The other resident did threatened to "beat up" Resident #2 and Resident #2 told her that he was afraid of the other resident after he was threatened.</p> <p>-She made sure Resident #2 and the other</p>	C 311		

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C 311	<p>Continued From page 26</p> <p>resident were kept apart.</p> <ul style="list-style-type: none"> <li>-Resident #2 went inside his room and the other resident went out on the porch to smoke.</li> <li>-The other resident did have habit of bothering Resident #2.</li> <li>-The other resident would knock on Resident #2's bedroom door several times throughout the month and ask Resident #2 to carry his shopping bags when they went to the store.</li> <li>-Resident #2 would not open his bedroom door and refused the other resident's request and asked the other resident to leave him alone.</li> <li>-The other resident would continue to bang on Resident #2's bedroom door and nag Resident #2 continuously to carry his bags.</li> <li>-When Resident #2 continued to refuse to comply with the other resident's requests and then the other resident would start calling Resident #2 "a slave" and cursing at Resident #2.</li> <li>-The other resident would continue banging on Resident #2's bedroom door and the name calling and cursing.</li> <li>-The other resident would also "threaten to beat up" and threatened to come into Resident #2's bedroom so he could "burn him (Resident #2)" when Resident #2 refused to carry his shopping bags.</li> <li>-The other resident's behavior made Resident #2 upset and fearful because Resident #2 believed the other resident was going to come into Resident #2's room to harm him.</li> <li>-Staff tried to keep the other resident from aggravating Resident #2 but "it seemed like the other resident liked to bother" Resident #2 because he knew Resident #2 would not fight back and Resident #2 would go in his bedroom to avoid the other resident.</li> <li>-She tried to keep the other resident away from Resident #2's door when he started threatening Resident #2.</li> </ul>	C 311		

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C 311	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>-She did not like the way the other resident treated Resident #2 because "it seemed like the other resident targeted" Resident #2 because of Resident #2's mental status.</li> <li>-She tried to keep the other resident away from Resident #2 when she saw the other resident was in "one of his nagging moods".</li> <li>-She told the Assistant Administrator about the other resident threats and behaviors against Resident #2 each time it happened.</li> <li>-The last time the other resident had threatened or attempted to aggravate Resident #2 was about a week ago.</li> </ul> <p>Interview with a second SIC/MA on 05/3/19 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-The other resident was "very verbally abusive" toward Resident #2.</li> <li>-The other resident told Resident #2 that "he was stupid and dumb" and used racial slurs toward Resident #2.</li> <li>-Resident #2 did not bother the other resident but the other resident seemed to like "to annoy" Resident #2 especially when the other resident liked to bang on Resident #2's bedroom because the other resident knew it was upsetting to Resident #2.</li> <li>-The other resident just wanted to have his way and when Resident #2 refused to carry shopping bags for the other resident, it made the other resident more intent to make Resident #2 agree to carry his shopping bags.</li> <li>-Resident #2 tried to ignore the other resident but it was hard when the other resident wouldn't stop banging on Resident #2's bedroom door.</li> <li>-He had reported the other resident's behavior toward Resident #2 several times to the Assistant Administrator but nothing was ever done.</li> </ul> <p>Interview with a resident on 05/02/19 at 11:28am</p>	C 311		

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C 311	<p>Continued From page 28</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-The other resident "liked to pick on" Resident #2 by calling him "stupid".</li> <li>-If Resident #2 was trying to complete a tasks, the other resident would stand over him and criticize him.</li> <li>-The other resident had threatened to beat up Resident #2 several times and the resident last heard the other resident threaten Resident #2 about a week ago.</li> <li>-Resident #2 cried sometimes when the other resident annoyed him and Resident #2 would go to his room.</li> <li>-The resident had complained to the Assistant Administrator and other staff several times about how the other resident liked to upset Resident #2.</li> <li>-The staff did try to keep Resident #2 and the other resident separated when the other resident was annoying Resident #2.</li> <li>-The resident last complained about a week ago to the Assistant Administrator.</li> </ul> <p>Second interview with Resident #2 on 05/02/19 at 11:48am revealed:</p> <ul style="list-style-type: none"> <li>-The other resident "liked being mean" to him and did not understand why.</li> <li>-He admitted that the other resident's behaviors had made him cry and he was sometimes afraid that the other resident was coming inside his room "to burn him up".</li> <li>-The other resident needed to stay away from his bedroom door knocking.</li> <li>-"I don't bother him (the other resident) but he likes to bother me".</li> <li>-Staff tried to keep the other resident away from him but the other resident would not stop bothering him.</li> </ul> <p>Attempted telephone interviews with two family members of Resident #2 were unsuccessful on</p>	C 311		

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C 311	<p>Continued From page 29</p> <p>05/03/19 at 12:59pm and 1:01pm.</p> <p>Interview with the Assistant Administrator on 02/07/19 at 3:45pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff had told him about how the other resident had previously made threats and called Resident #2 names using profanity.</li> <li>-He was not aware that the other resident had used any racial slurs toward Resident #2.</li> <li>-He understood why the other resident seemed intimidating to Resident #2.</li> <li>-the other resident had never hurt Resident #2 or any other residents.</li> <li>-Staff had complained to him several times about the other resident's behaviors towards Resident #2.</li> <li>-He did not think the other resident was a danger to Resident #2 and Resident #2 had not complained to him about the other resident.</li> </ul> <p>_____</p> <p>The facility's failure to protect Resident #2 from verbal abuse and intimidation by another resident resulted in Resident #2 suffering emotional distress and fear of physical harm. The facility's failure to protect Resident #2 from repeated verbal threats, racial slurs, and threats of physical harm resulted in serious abuse and neglect which constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/19 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2019.</p>	C 311		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry	C 428		

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C 428	<p>Continued From page 30</p> <p>10A NCAC 13G .1206 Health Care Personnel Registry</p> <p>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to report an allegation of verbal and mental abuse toward a resident by one staff (Staff A) to the Health Care Personnel Registry (HCPR) within 24 hours.</p> <p>The findings are:</p> <p>Review of Staff A's, supervisor-in-charge/medication aide (SIC/MA), personnel record revealed: -Staff A was hired on 02/25/13. -There was documentation of a HCPR check for Staff A dated 04/23/15 with no substantiated findings.</p> <p>Review of a sheriff's office operation report dated 03/16/19 at 3:33pm revealed: -A sheriff deputy was dispatched to the facility for a complaint of the communication of threats. -The resident told the deputy that Staff A had threatened to hit the resident earlier on the morning of 03/16/19.</p> <p>Review of a facility accident/incident report dated 03/16/19 at 3:30pm revealed:</p>	C 428		

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C 428	<p>Continued From page 31</p> <ul style="list-style-type: none"> <li>-The resident called 911 and reported Staff A had communicated threats to the resident on the morning of 03/16/19.</li> <li>-A sheriff deputy came to the facility and advised the resident that he would have to go to the magistrate in order to press charges.</li> </ul> <p>Interview with the resident on 05/01/19 at 1:30pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff A "wanted to fight" him "in March" after he and Staff A got into an argument about Staff A playing the radio in the kitchen and the resident had tapped Staff A on the shoulder.</li> <li>-Staff A told him "to go outside" and the resident went outside to smoke a cigarette.</li> <li>-Then Staff A came outside on the front porch and down the steps in to the front yard.</li> <li>-Staff A told him to come down off the front porch and into the front yard.</li> <li>-The resident followed Staff A into the front yard and Staff A told the resident "now swing".</li> <li>-He did not swing at Staff A.</li> <li>-Staff A told the resident that the next time he put his hands on Staff A that Staff A would beat him up.</li> <li>-He could not remember if any other residents witnessed what occurred between him and Staff A.</li> <li>-He did not tell the Assistant Administrator or any other staff at the facility after this happened.</li> <li>-He did not want to get Staff A in trouble, but he was worried that Staff A may threatened him again in the future.</li> <li>-He called 911 later around 3:30pm to report that Staff A had threatened him.</li> <li>-The Assistant Administrator knew about the incident because the police were called to the facility.</li> </ul> <p>Interview with Staff A on 05/03/19 at 11:00am</p>	C 428		

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C 428	<p>Continued From page 32</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-He and the resident did get into an argument on 03/16/19 around 7:30am about Staff A playing the radio in the kitchen after breakfast.</li> <li>-The resident was very upset and tapped him on the back of his left shoulder.</li> <li>-He asked the resident to go outside on the porch because the resident was loud and he wanted to give the resident a chance to calm down.</li> <li>-The resident ended up standing in the front yard and the staff went out on the front porch to check on the resident.</li> <li>-He did not go in the front yard with the resident and he did not threaten the resident.</li> <li>-There were no other residents present in the kitchen or on the front porch when he and the resident were arguing.</li> <li>-All of the other residents were in their bedrooms.</li> <li>-He left the facility when his shift was over at 8:00am on 03/16/19 and the resident was less agitated.</li> <li>-He did not know the resident had accused him of communicating threats until the police came to his house to question him later on 03/16/19 sometime after 3:30pm.</li> <li>-He had spoken with the Assistant Administrator after the police left his home regarding the incident on 03/16/19.</li> <li>-The Assistant Administrator told him not to worry about the incident because "nobody believed" the resident's allegations.</li> <li>-He had continued to work at the facility after the incident</li> </ul> <p>Review of a HCPR initial allegation report and a HCPR 5-day investigation report revealed both reports were completed on 04/16/19 but there was no fax confirmation the reports had been sent to the HCPR.</p>	C 428		

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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
C 428	<p>Continued From page 33</p> <p>Telephone interview with an investigator at HCPR on 05/02/19 at 9:29am revealed: -The initial allegation and 5-day investigation reports were both received by fax at the HCPR on 05/01/19 regarding the alleged incident on 03/16/19. -No previous reports had been received prior to 05/01/19.</p> <p>Interview with the Assistant Administrator on 05/02/19 at 11:35am revealed: -He knew about the incident when it occurred 03/16/19 and when the police were called by the resident. -He did not know initially he needed to complete a report or an investigation for the HCPR. -The ombudsmen told the Assistant Administrator to make the reports to the HCPR regarding the alleged incident that occurred on 03/16/19 in April 2019. -He completed the reports on 04/16/19, but the reports were not faxed to the HCPR until 04/30/19. -He "did not see the need to send the reports to the HCPR" because from what he was told about the incident on 03/16/19 "nothing really happened".</p> <p>_____</p> <p>The facility failed to report allegations to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations Staff A had communicated threats of physical harm to a resident, which resulted in Staff A continuing to work at the facility, exposing residents to possible subsequent abuse. This failure resulted in substantial risk of serious physical harm and serious neglect to the residents and constitute a Type A2 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in</p>	C 428		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL058008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/03/2019</b>
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C 428	Continued From page 34  accordance with G.S. 131D-34 on 05/02/19 with this violation.  CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2019.	C 428		
C 914	G.S 131D-21(4) Declaration Of Resident's 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 assure residents were free of mental and physical abuse, and neglect as related to residents' rights, health care, and Health Care Personnel Registry.  The findings are:  1. Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled resident (Resident #2) was protected from verbal abuse and intimidation by another resident [Refer to Tag D0311 10A NCAC 13G .0909 Residents' Rights (Type A1 Violation)].  2. Based on observations, record reviews, and interviews, the facility failed to notify the mental health provider for 1 of 1 sampled residents (#1) who had become increasingly combative, lit a cigarette inside the facility, had suicidal ideations, and reported an intent to injure staff with a knife [Refer to Tag D0246 10A NCAC 13G .0902(b) Health Care (Type A1 Violation)].	C 914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL058008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/03/2019</b>
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C 914	Continued From page 35  3. Based on interviews and record reviews, the facility failed to report an allegation of verbal and mental abuse toward a resident by one staff (Staff A) to the Health Care Personnel Registry (HCPR) within 24 hours [Refer to Tag C428 10A NCAC 13G.1206 Health Care Personnel Registry (Type A2 Violation)].	C 914		