Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R-C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey on 07/23/19 to 07/24/19.	{D 000}		
{D 271}	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION. Based on these finding, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to respond appropriately related to care and intervention for 1 of 4 sampled residents (Resident #3) who fell and sustained a head injury. The findings are: Review of Resident #3's current FL2 dated 04/04/19 revealed: -Diagnoses included vascular dementia, mood disorder, anxiety, psychosis, and osteoporosis. -The resident was ambulatory and constantly disoriented.	{D 271}		

Reviewed and Accepted
Date: 08/27/19
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{D 271}	Continued From page 1 Observation of Resident #3 on 07/23/19 at 3:10pm revealed: -The resident was standing against the wall in the hallway. -The resident had a baseball sized bruise that started at the corner of her left eye and extended upwards towards her left eyebrow and forehead. -The skin was yellow colored with a small amount of blue and purple at the corner of the left eye. Interview with Resident #3 on 07/23/19 at 3:10pm revealed she did not know how she obtained bruising to her eye and forehead. Interview with a personal care aide (PCA) on 07/23/19 at 3:25pm revealed: -She found Resident #3 lying on the floor in the living room on 07/19/19 around 2:00pm. -She assisted Resident #3 with standing and noticed that she had a "pump knot" on her head that was not present at the beginning of her shift. -She reported to the medication aide (MA) that Resident #3 had fallen and hit her head. Review of the Incident/Accident Report dated 07/19/19 at 2:00pm for Resident #3 revealed: -Resident #3 was lying on the floor in the living room and "stated she fell". -The incident was reported to the MA. -The name of physician notified section was blank. -The name and relationship of family notified was blank. -The first aid administered section was blank. -The person involved was taken to the hospital section was blank. -The diagram showed the location of injury as an abrasion to the right eye for Resident #3.	{D 271}	(Tag D 271) First and foremost, I want to point out that the personal care aide Melinda Perez properly followed the facility medical emergency policy and procedure. The incident and accident report as well as other documentation provides the fact that the injury was unwitnessed. This incident by no way proves the resident fell down stated in the SOD report and never has the resident fallen in my care to this date. What is factual was the Med Tech on duty did not carry-out the policy and procedure. She failed to complete an accident/Incident report and contact the medical director and guardian for resident L.W. This incident was the only error in response and documentation since the last survey March 2019. All other medical emergencies were properly carried out with prompt responses and procedures. The facility will be revising the policy and procedures for medical emergency. The personal care staff will be provided additional training by August 2, 2019. The training will include policy and procedures for medical emergency as well as the hourly rounding schedule with change in staffing patterns. The RCC will be reviewing the hourly rounding schedule form on a daily basis for documentation of any accidents and/or incidents. All accident/incident reports will be reviewed by the RCC and faxed to DSS in a timely manner required by DHSR regulation. RCC will communicate with Med Tech supervisors daily. Completion Date: August 2, 2019	

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{D 271}	Continued From page 2 Telephone interview with the MA on 07/24/19 at 1:39pm revealed: -The PCA reported to her that Resident #3 had fallen on 07/18/19. -She did not notify the provider or family that Resident #3 had fallen. -The facility did provide the policies and procedures for falls during her orientation. -"I don't know how she got the knot on her head so I didn't call" the PCP or for an ambulance to send Resident #3 to the hospital for evaluation. Interview with the PCA Supervisor on 07/24/19 at 8:52am revealed: -She was not at the facility when Resident #3 had fallen. -Resident #3 falls "quite a bit or walks into stuff". -The MA should have reported the fall to her and notified the family and primary care provider (PCP) that Resident #3 had fallen. Interview with the Administrator on 07/24/19 at 10:30am revealed: -The policy and procedure of the facility regarding falls was to notify the family and the provider that the resident had fallen. A current set of vital signs would be taken and reported to the provider. The provider would recommend whether to send the resident to the hospital to be evaluated or they would follow up the next day at the facility and assess the resident that had fallen. -He had initiated an hourly rounding schedule for the facility staff that contained instructions of what to do "if a resident has fallen (found on floor)". -The medication aide on duty was responsible for contacting the physician first to determine what to do for a resident with a fall incident, and then to contact the family. - An Incident/Accident report was filled out for Resident #3 by the PCA dated 07/19/19.	{D 271}		

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{D 271}	Continued From page 3 Interview with a second MA on 07/24/19 at 11:20am revealed: -The person that finds a resident that has fallen was responsible for filling out an incident report. -The policy and procedure for the facility for falls was for the PCA to report the incident to the MA. -The MA would assess the resident to determine if they needed to be sent to the hospital. -The MA would notify the physician and family. -"If they hit their head we definitely send them out" to the hospital for evaluation. Telephone interview with Resident #3's Nurse Practitioner (NP) on 07/24/19 at 1:26pm revealed: -She was on vacation at the time of the fall incident for Resident #3. -She did not know Resident #3 had fallen and sustained a head injury. -She did not know if the health care provider on call was notified of Resident #3's fall. -She was at the facility on 07/22/19 but did not see Resident #3 and was not notified by staff regarding her fall. -Resident #3 should have been sent to the hospital to be evaluated for a fall with a head injury. Interview with the Resident Care Coordinator (RCC) on 07/24/19 at 2:10pm revealed: -Resident #3 fell on 07/18/19. -Resident #3 was receiving palliative care. - The MA was to contact the PCP first regarding any incidents with residents on palliative care to see if they needed to be sent to the hospital. -She was not on duty when Resident #3 fell. -"The whole situation was not handled correctly" for Resident #3. Telephone Interview with Resident #3's family	{D 271}		

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{D 271}	Continued From page 4 member on 07/24/19 at 4:36pm revealed: -She had visited Resident #3 over the weekend and noticed the bruising to Resident #3's eye and face. -She did not know that Resident #3 had fallen on 07/18/19. -She did not know if Resident #3 had been evaluated by the PCP. -She expected the facility to call and notify the family if Resident #3 falls. _____ The failure of the facility to respond immediately to provide care and intervention according to the facility's policies and procedures in the case of an accident involving a resident who fell and sustained a head injury 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 07/24/19 for this violation.	{D 271}		
D 418	10A NCAC 13F .1103 (c) Legal IRepresentative Or Payee 10A NCAC 13F .1103 Legal Representative Or Payee (c) The administrator shall give the resident's legal representative or payee receipts for any monies received on behalf of the resident This Rule is not met as evidenced by: TYPE B VIOLATION	D 418		

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D 418	Continued From page 5 Based on interviews and record reviews, the facility failed to provide the payee a receipt for any monies received for 1 of 1 sampled resident who was his own payee (Resident #5). The findings are: Review of Resident #5's FL2 dated 03/11/19 revealed a diagnoses of vascular dementia and degenerative disease of the nervous system. Review of Resident #5's record revealed: -A document titled "Resident Financial Information" dated 03/28/18. -The resident was his own responsible party. -The monthly room and board rate was $1182.00 -A document titled "Funds Deposit Agreement" dated 03/28/18. -Resident #5 gave the facility permission to receive his Special Assistance (SA) funds, with no amount documented, toward his monthly room and board. -The Social Security box was checked with a hand-written note beside it that read "Resident would like to pay his own SS/Rent". Telephone interview with a representative from the facility's contracted pharmacy on 07/24/19 at 1:25pm revealed: -Resident #5 had an outstanding balance of $334.60. -The pharmacy had never received any payments from the facility on Resident #5's account. Interview with Resident #5 on 07/23/19 at 9:25am revealed: -He paid his own room and board in cash "to that lady in the office". -A staff member from the facility took him to the bank so he could withdraw his room and board	D 418		

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D 418	Continued From page 6 money. -The Administrator told him last week that "he owed a couple thousand dollars in past rent". -He did not understand where that bill came from because he had been paying room and board every month. -He was upset and worried because he did not have extra money and he did not know how he would ever be able to pay "that much money" back to the facility. -He did not have any receipts for his room and board payments prior to May 2019. Interview with Resident #5 on 07/23/19 at 3:45pm revealed: -Staff took him to the bank last week. -He paid his room and board in cash when he when he returned from the bank. -He gave his money to "the lady in the office". -The administrator told him to give all the money that he just withdrew as he owed back room and board money. -He did not get to keep his personal funds of $66.00 in July 2019. -The Administrator "just started giving him a receipt a few months ago". -He had 2 receipts in his possession dated May 2019 and July 2019. Review of a receipt dated 05/14/19 provided by the resident revealed the facility had received a cash payment from Resident #5 in the amount of $821.00 for his" May rent". Review of a receipt dated 07/17/19 provided by the resident revealed the facility received a cash payment from Resident #5 in the amount of $887.00 for "rent". Review of a local bank receipt dated 05/14/19	D 418	(Tag D 418) First and foremost, I would like to point out that I the Administrator identified that resident #5 was not receiving receipts for monies received on behalf of resident #5. As I became the administrator of Chunn's Cove in Late April 2019, I immediately began providing a receipt to this resident monthly complying with rule 10A NCAC 13F. 1103(c). I provided copies of the receipts to the survey team. I think that the decision to recommend a Type B penalty is unfair and erroneous as follows: • The administrator identified and corrected rule 10A NCAC 13F. 1103(c) immediately • The correction was made 3 months prior to the July survey. The facility administration will continue to provide any resident, resident's legal representative or payee receipts for any monies received on behalf of the resident. The facility administration will monitor receipt book monthly for all monies received on behalf of the resident and to ensure all receipts are provided to resident, resident's legal representative or payee. Completion Date: September 7, 2019.	

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D 418	Continued From page 7 provided by the resident revealed a cash withdrawal of $887.00 and a remaining balance of $193.90. Interview with Resident #5 on 07/24/19 at 10:07am revealed: -He only had one bank account. -He had never received a receipt until the Administrator began giving him one a "few months ago". -The previous Administrator "always" told him the "computer was down" and could never give him a receipt. -The facility stopped giving him his $66.00 since the current Administrator told him last week that he "owed rent". Interview with a Personal Care Aide Supervisor on 07/24/19 at 8:50am revealed: -She took Resident #5 to the bank monthly. -Resident #5 would "usually" withdrawal his whole check. -Resident #5 would pay his "rent" in cash to the previous Administrator. -Resident #5 would give all the money he received from cashing his check, except for the $66.00. -She did not know anything about an outstanding room and board balance. -She had never been involved with the financial aspect of the residents' monies. -She did not know how much money he had in the bank. Interview with the Administrator on 07/23/19 at 3:05pm revealed: -He took over as Administrator at the end of April 2019 or the first part of May 2019. -The facility had recently become Resident #5's payee but had yet to receive any payments.	D 418		

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D 418	Continued From page 8 -He gave receipts to the residents for any payments they made, including Resident #5. -He did not have any receipt books prior to May 2019. -He had copies of 'Resident Trust Ledger' Sheets. -He had two different ledger sheets for Resident #5. -He did not have any financial records for Resident #5 prior to February 2019. -He had a copy of the July 2019 'Population Financial' Report. Review of the July 2019 Population Financial report shows a beginning balance due of $1891.52 and two payments towards his account in the amounts of $291.00 and $891.00 Interview with the Administrator on 07/24/19 at 11:26am revealed: -The corporate office looked at the resident balances monthly. -The books were audited approximately every six months. Review of the facility's receipt book revealed: -The receipt book started in May 2019. -There were four rent receipts written out for Resident #5 ranging in date from 05/14/19 through 07/17/19. -There were two receipts written on 07/17/19; Receipt #853417 written for $891.00 and Receipt #853418 written for $887.00. -Receipt #853418 for $887.00 had "error" written on it. -The original copy of receipt #853417 for $891.00 was still with the receipt book. Review of Resident #5's Resident Trust Ledger Sheets revealed: -There were two different ledger sheets.	D 418		

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D 418	Continued From page 9 -The first ledger sheet had entries from 02/10/19 through 05/19. -The second ledger sheet started with an entry dated 6/19 and ended with an entry dated 5/19. Review of Resident #5's February 2019 through May 2019 Resident Trust Ledger Sheet revealed: -This first ledger sheet was dated 02/10/19. -There was a $1678.32 negative beginning balance. -The ledger did not show where the beginning negative balance came from. -There were nine entries on this ledger sheet. -Entry #5 in April 2019 showed a math error which increased Resident #5's debt by $700.00. -There was no documentation that the math error had ever been corrected. -There was a May 2019 payment entry, but it did not show the amount. Review of Resident #5's June 2019 through May 2019 Resident Trust Ledger Sheet revealed: -The ledger had four entries with a June 2019 date, one entry with a July 2019 date and one entry with a May 2019 date. -This ledger sheet started 6/2019 and showed a $1821.52 negative beginning balance. -The negative beginning balance did not match the ending balance of the previous ledger sheet. -There was still no documentation that the math error had ever been corrected. -Entries for May 2019 and June 2019 indicated charges for cigarettes in the amounts of 18.01 and 14.98 respective to the previous dates. -After the July 2019 entry for room and board, the negative balance was $3088.50. -The $891.00 payment Resident #5 had made in July 2019 had not been credited to his account. ---	D 418		

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D 418	Continued From page 10 The facility failed to provide Resident #5 a receipt for monies received for payment of room and board resulting in a past due room and board balance of $3088.50. The facility's failure to provide the resident with an accurate accounting of his payments resulted in the misappropriation of resident monies and caused the resident to be upset and worried over how to pay his room and board debt which was detrimental to the health 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 07/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2019.	D 418		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: TYPE B VIOLATION	D 421		

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D 421	Continued From page 11 Based on observations, interviews, and record reviews, the facility failed to ensure a record of each transaction involving the use of the resident's personal funds was maintained and signed by the resident or legal representative at least monthly verifying the accuracy of the disbursement of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6). The findings are: 1. Review of Resident #6's current FL2 dated 05/25/19 revealed diagnoses included dementia, diabetes mellitus type II, hypertension, and neuropathy. Interview with Resident #6 on 07/23/19 at 9:30am revealed: -He had lived at the facility for one year. -He had stopped getting his personal funds money. -He used to get $40 and the remaining amount went to pay his pharmacy co-pays. Interview with Resident #6 on 07/23/19 at 3:25pm revealed: - "I was getting my money at the last facility I lived." - "I talked to the last Administrator and she said I owed $5400.00 here." - "Sometimes I get my personal money." - "I got upset and asked them where my money was going." - "I was given $40.00 last month in June." - "I wasn't given any money this month in July." - "They told me they were taking my money for room, board and prescriptions." - "They showed me a prescription bill for $14.00 and that was the last time I saw bills."	D 421	(Tag D 421) The facility will be revising the resident trust account sheets and getting resident signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record will be maintained in the facility. The administration will monitor the resident trust account book monthly for accurate and proper transactions with resident signatures verifying the disbursement of personal funds. The record will be maintained in the facility. Completion Date: September 7, 2019	

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D 421	Continued From page 12 - "I sign my name when they give me money." - "I asked about this month of July's money and was told that I got it." - "They told me, "your paper has been signed" and I said "no I didn't sign it." - "I never get $66.00." - "They take care of my money." - "I don't know where my money is going." Review of Resident #6's Home Contract on 07/24/19 revealed: - Resident #6 had checked the 4th block under Resident's Personal Funds Agreement showing, "I authorize the management of (the facility) to manage my entire personal spending funds account following procedures outlined in accordance with licensing rules." - Resident #6 had signed and dated the facility's Home Contract on 04/17/19. -The former Administrator had signed and dated the Home Contract on 04/17/19. Review of Resident #6's Trust Ledger Sheet revealed: -There was a hand written entry dated 12/10/18 for $40.00 cash paid out, leaving a balance owed of $5340.75 and signed only by Resident #6. -There was a hand written entry dated 01/10/19 for $40.00 cash paid out, leaving a balance owed of $4141.75 and signed only by Resident #6. -There was a hand written entry dated 02/10/19 for $40.00 to the pharmacy, leaving a balance owed of $4080.75 and signed only by Resident #6. -There was a hand written entry dated 02/14/19 for $40.00 cash paid out, leaving a balance owed of $5302.75 and signed by Resident #6 and a prior staff member. -There was a hand written entry dated 03/11/19 for $40.00 cash paid out, leaving a balance owed	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011262	A. BUILDING: _____ B. WING _____	R-C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHUNN'S COVE ASSISTED LIVING	67 MOUNTAIN BROOK ROAD ASHEVILLE, NC 28805

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D 421	Continued From page 13 of $5241.75 and signed only by Resident #6. -There was a hand written entry dated 05/14/19 for $40.00 cash paid out, leaving the balance owed blank and signed only by Resident #6. -There were no entries for cash paid out in the months of February 2019, April 2019 or July 2019 to Resident #6. -None of the payments made to the pharmacy in 2019 for Resident #5 had been deducted from the balance owed to the facility. Telephone interview with a representative at the contracted facility pharmacy on 07/24/19 at 1:25pm revealed: -The pharmacy began service for Resident #6 on 04/17/18. -There had been no facility payments to the pharmacy for Resident #6 in 2018. -On 01/11/19, the facility made a $5.00 payment to the pharmacy for Resident #6. -On 03/08/19, the facility made a $40.00 payment to the pharmacy for Resident #6. -On 03/28/19, the facility made a $61.00 payment to the pharmacy for Resident #6. -On 05/30/19, the facility made a $5.00 payment to the pharmacy for Resident #6. -The current balance owed on Resident #6's account was $3,403.57. Interview with the Administrator on 07/23/19 at 3:00pm revealed: -Resident #6's admission date was 04/17/18. -A family member had been "doing the books for the last three months." -The family member had signed the Resident Trust Ledger Sheet for June and July 2019. -Resident #6's funds had gone directly to him until "I'm not sure of date." -Resident #6 had lived at another facility and "it took us three months to figure out the	D 421		

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D 421	Continued From page 14	D 421		

accounting."
-"I don't know what was happening with the last Administrator."

Interview with Administrator on 07/24/19 at 11:25am revealed:
-"Unfortunately, we own several buildings and I trust each facility to manage their own records."
-The past Administrator didn't communicate these issues to him.
-He wouldn't let residents go three or four months without paying.
-He audited the records every six months.
-"I can't say that impropriety did or didn't happen."
-His expectation was for the Administrator to call Social Security to switch over the payee within five to ten days of admission of new residents.
-"We do have to document on the financial reports at the corporate office."
-A financial report was sent from the corporate office to the local office with the highlighted areas of residents having unpaid balances.
-The local facilities were responsible for follow up with the residents of the highlighted areas on the financial reports.
-The facility had a deposit cover sheet every Friday that has itemized resident funds and which payor source the funds come from.
2. Review of Resident #1's current FL2 dated 07/04/19 revealed:
-Diagnoses included vascular dementia, depression, congestive heart failure, and atrial fibrillation.
-The resident was intermittently disoriented.

Review of Resident #1's Resident Register signed 02/22/12 revealed:
-The resident was admitted 02/22/12.
-The responsible person section of the form was blank.

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D 421	Continued From page 15 Attempted interview with Resident #1 on 07/24/19 was unsuccessful due to the resident being out of the facility. Review of Resident #1's Home Contract signed 02/22/12 revealed: -Personal funds may be managed by the home, resident, family, or responsible party. -Personal funds given to the resident after payment of cost of care will be dated and signed by the resident. -Personal funds will be managed by the administrator/SIC (by the following procedure) if no other means are provided: a. Written authorization of resident or responsible party. b. At least monthly every transaction (receipts or disbursements), records will be signed by resident. c. All or any portion of funds will be available to resident, legal guardian or his/her payee anytime during business hours as long as the currently residing in the home. Review of a Resident Trust Ledger Sheet for Resident #1 revealed: -There was a beginning balance of $248.64 starting on 01/10/19. -Resident #1 was charged for room and board each month from January 2019-May 2019 in the amount of $1182 for each transaction. -The facility received funds in the amount of $1203.60 each month from January 2019-May 2019 for Resident #1. -The ending balance on 05/19/19 was $355.44. -The last entry on the ledger was dated 04/19/19 and charged Resident #1 $355.44 with the description of "Rx" and an ending balance of $0. -The entries on the ledger dated "5/19, and 4/19" were not signed. -Resident #1 had not signed the Resident Trust	D 421		

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D 421	Continued From page 16 Ledger Sheet. Review of a second Resident Trust Ledger Sheet with a starting date of 06/20/19 for Resident #1 revealed: -There was a negative beginning balance of $27.93. -Resident #1 was charged for room and board for June 2019 and July 2019. -The facility received funds in the amount of $1203.60 in June 2019 for Resident #1. -There was an entry dated 04/19/19 for "Rx" in the amount of $21.60 for Resident #1. -The last entry had no date, description of transaction was documented as "credit wrong Rx amt" and $355.44 was documented in the deposit section of the ledger for Resident #1 with no ending balance. -The entries on the ledger dated "6/2019, 4/19" and another entry not dated were not signed. -Resident #1 had not signed the Resident Trust Ledger Sheet. Review of the facility's contracted pharmacy account record for Resident #1 revealed: -The previous balance was documented as $797.02 for April 2019. -Charges for medications in April 2019 were documented as $37.09. -Charges for medications in May 2019 were documented as $73.46. -Charges for medications in June 2019 were documented as $41.48 with a payment of $21.60. -The ending balance due in June 2019 was documented as $927.45. Interview with Administrator on 07/24/19 at 11:25am revealed: -"Unfortunately, we own several buildings and I trust each facility to manage their own records."	D 421		

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D 421	Continued From page 17 -The past Administrator didn't communicate these issues to him. -He wouldn't let residents go three or four months without paying. -He audited the records every six months. -"I can't say that impropriety did or didn't happen." -His expectation was for the Administrator to call Social Security to switch over the payee within five to ten days of admission of new residents. -"We do have to document on the financial reports at the corporate office." -A financial report was sent from the corporate office to the local office with the highlighted areas of residents having unpaid balances. -The local facilities were responsible for follow up with the residents of the highlighted areas on the financial reports. -The facility had a deposit cover sheet every Friday that has itemized resident funds and which payor source the funds come from. 3. Review of Resident #2's current FL2 dated 06/20/19 revealed diagnoses included chronic obstructive pulmonary disease, degenerative joint disease, and schizophrenia. Review of Resident #2's Resident Register revealed an admission date of 09/03/04. Review of Resident #2's Home Contract dated 04/08/19 revealed the facility had been authorized to manage the resident's personal funds. Review of Resident #2's Trust Ledger Sheet from 01/10/19 to 05/2019 revealed: -There was an entry for a pharmacy payment on 01/10/19 for $20.00 and the entry was signed by Resident #2. -There was an entry for a pharmacy payment on 02/10/19 for $20.00 and the entry was signed by	D 421		

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D 421	Continued From page 18 Resident #2. -There was an entry for a pharmacy payment on 03/06/19 for $20.00 and the entry was signed by Resident #2. -There was an entry for a pharmacy payment on 04/12/19 for $10.00 and the entry was signed by Resident #2. -There was an entry for a pharmacy payment on 04/2019 for $81.00 which was not signed by the resident. -There was an entry for a pharmacy payment on 05/2019 for $24.31 which was not signed by the resident. -The transactions from 01/10/19 to 05/2019 totaled $175.31. Telephone interview with a representative at the facility's contracted pharmacy on 07/24/19 at 1:25pm revealed: -A payment of $10.00 had been received for Resident #2 on 01/11/19. -A payment of $20.00 had been received for Resident #2 on 03/08/19. -A payment of $20.00 had been received for Resident #2 on 03/28/19. -A payment of $20.00 had been received for Resident #2 on 04/29/19. -A payment of $10.00 had been received for Resident #2 on 05/30/19. -A payment of $182.00 had been received for Resident #2 on 06/21/19. -The current balance owed on Resident #2's account was $185.53. -The pharmacy did not "cut anybody off" with their medication supply as long as there was an insurance source paying on the medications. Interview with the Administrator on 07/24/19 at 10:05am revealed: -Prior to May 2019, the previous Administrator	D 421		

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D 421	Continued From page 19 and Business Office Manager had been responsible for managing residents personal funds. -Prior to May 2019, he would audit the residents financial records "about every six months." -In May 2019, he and a family member began looking over the residents' Trust Ledger Sheets. -Discrepancies had been discovered in some of the Trust Ledger Sheets. -They had not yet been able to get through all of the Trust Ledger Sheets to make all of the corrections. Based on interviews and record reviews, it was determined Resident #2 was not interviewable. 4. Review of Resident #5's FL2 dated 03/11/19 revealed a diagnoses of vascular dementia and degenerative disease of the nervous system. Interview with Resident #5 on 07/23/19 at 9:25am revealed: -A staff member from the facility took him to the bank so he could withdraw his room and board money. -The Administrator told him last week that "he owed a couple thousand dollars in past rent". -He did not understand how that was possible because he had been paying room and board every month. -He was upset because he did not have extra money and did not know how he would ever be able to pay "that much money" back to the facility. -He did not have any receipts for his room and board payments prior to May 2019. Interview with Resident #5 on 07/23/19 at 3:45pm revealed: -Staff took him to the bank last week. -He paid his room and board in cash when he	D 421		

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D 421	Continued From page 20 when he returned from the bank. -He gave his money to "the lady in the office". -The administrator told him to give all the money that he just withdrew as he owed back room and board money. -He did not get to keep his personal funds of $66.00 in July 2019. -The Administrator "just started giving him a receipt a few months ago". -He had 2 receipts in his possession dated May 2019 and July 2019. Interview with Resident #5 on 07/24/19 at 10:07am revealed: -He had never received a receipt until the Administrator began giving him one a "few months ago". -The previous Administrator "always" told him the "computer was down" and could never gave him a receipt. -The facility stopped giving him his $66.00 since the current Administrator told him last week that he "owed rent". Interview with the Personal Care Aide Supervisor on 07/24/19 at 8:50am revealed: -She took Resident #5 to the bank monthly. -Resident #5 would "usually" withdrawal his whole check. -Resident #5 would pay his "rent" in cash to the previous Administrator. -Resident #5 would give all the money he received from cashing his check, except for the $66.00. -She did not know anything about an outstanding room and board balance. -She had never been involved with the financial aspect of the residents' monies. Interview with the Administrator on 07/23/19 at	D 421		

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D 421	Continued From page 21 3:05pm revealed: -He took over as Administrator at the end of April 2019 or the first part of May 2019. -The facility had recently become Resident #5's payee but had yet to receive any payments. -He gave receipts to the residents for any payments they made, including Resident #5. -He did not have any receipt books prior to May 2019. -He did not have any financial records for Resident #5 prior to February 2019. Review of Resident #5's February 2019 through May 2019 Resident Trust Ledger Sheet revealed: -This first ledger sheet was dated 02/10/19. -There was a $1678.32 negative beginning balance. -The ledger did not show where the beginning negative balance came from. -There were nine entries on this ledger sheet. -Entry #5 in April 2019 showed a math error which increased Resident #5's debt by $700.00. -There was no documentation that the math error had ever been corrected. -There was a May 2019 payment entry, but it did not show the amount. Review of Resident #5's May 2019 through July 2019 Resident Trust Ledger Sheet revealed: -The ledger had four entries with a June 2019 date, one entry with a July 2019 date and one entry with a May 2019 date. -This ledger sheet started 6/2019 and showed a $1821.52 negative beginning balance. -The negative beginning balance did not match the ending balance of the previous ledger sheet. - There was no documentation that the math error had ever been corrected. -After the July 2019 entry for room and board, the negative balance was $3088.50.	D 421		

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D 421	Continued From page 22 -The $891.00 payment Resident #5 had made in July 2019 had not been credited to his account. --- The facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and verification of the accuracy of disbursements of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6) which resulted in the facility using residents' personal funds allowance to pay room and board debt and pay pharmacy bills without their consent and residents feeling upset because of their inability to decide how their personal funds were spent. This failure of the facility to provide residents access to their personal funds resulted in misappropriation of residents funds which was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2019.	D 421		
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.	D914		

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D914	Continued From page 23 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and exploitation in compliance with federal and state laws and rules and regulations related to Personal Care and Supervision, Legal Payee, and Accounting for Residents' Personal Funds. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to respond appropriately related to care and intervention for 1 of 4 sampled residents (Resident #3) who fell and sustained a head injury.[Refer to Tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Unabated Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to provide the payee a receipt for any monies received for 1 of 1 sampled resident who was his own payee (Resident #5). [Refer to Tag 418, 10A NCAC 13F .1103(c) Legal Representative or Payee (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure each transaction involving the use of personal funds was maintained in the facility and verification of the accuracy of disbursements of personal funds for 4 of 4 sampled residents (Resident #1, #2, #5, and #6). {Refer to Tag 421, 10A NCAC 13F .1104(c) Accounting for Residents' Personal Funds (Type B Violation)].	D914	See Attached	

(Tag D 914)

The facility will provide training of THE FOLLOWING RIGHTS: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. (2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations. (3) To receive upon admission and during his or her stay a written statement of the services provided by the facility and the charges for these services. (4) To be free of mental and physical abuse, neglect, and exploitation. (5) Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need. (6) To have his/her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom disclosure may be made, except as required by applicable state or federal statue, regulations, or third party contracts. In the case of an emergency, disclosure can be made to agencies, institutions or individuals who are providing the emergency medical services. (7) To receive a reasonable response to his or her requests from the facility administrator and staff. (8) To associate and communicate privately and without restriction with people and groups of his or her own choice on his or her own or their initiative at any reasonable hour. (9) To have access at any reasonable hour to a telephone where he or she may speak privately. (10) To send and receive mail promptly and unopened, unless the resident requests that someone open and read mail, and to have access at his or her expense to writing instruments, stationary, and postage. (11) To be encouraged to exercise his or her rights as a resident and citizen, and to be permitted to make complaints and suggestions without fear of coercion or retaliation. (12) To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the residents, administrator and supervisor-in-charge. (13) To manage his or her personal needs funds unless such authority has been delegated to another. If authority to manage personal needs funds has been delegated to the facility, the resident has the right to examine the account at any time. (14) To be notified when the facility is issued a provisional license or notice of revocation of license by the Carolina Department of Human Resources and the basis on which the provisional license or notice of revocation of license was issued. The resident's responsible family member or guardian

shall also be notified. (15) To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation. (16) To receive upon admission to the facility a copy of this section. (17) To not be transferred or discharged from a facility except for medical reasons, the resident's own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident. The resident shall be allowed to remain in the facility until resolution of the appeal.

The facility will be revising the policy and procedures for medical emergency. The personal care staff will be provided additional training by August 2, 2019. The training will include policy and procedures for medical emergency as well as the hourly rounding schedule with change in staffing patterns.

The RCC will be reviewing the hourly rounding schedule form on a daily basis for documentation of any accidents and/or incidents. All accident/incident reports will be reviewed by the RCC and faxed to DSS in a timely manner required by DHSR regulation. RCC will communicate with Med Tech supervisors daily.

Completion Date: August 2, 2019

MEDICAL EMERGENCY

POLICY: The Assisted Living Facility makes a conscious effort to provide for the care of residents on a daily basis and obtain the most appropriate care in the event of an accident or sudden illness. The following guidelines will be used when a resident experiences an accident or sudden illness.

PROCEDURE:

Sudden Illness

1. Chest Pain – Call 911, assign one staff person to remain with and reassure the resident until paramedics arrive. Notify the physician and the family if the resident is transported to the hospital.

2. Unresponsiveness – Check for a pulse and respirations. If the resident is not breathing start mouth-to-mouth resuscitation. If they do not have a pulse begin **CPR** and call 911. Once started you must continue CPR until help arrives to relieve you.

   a. If unresponsive but respirations and pulse are present and the resident is diabetic, perform a blood sugar check. If the blood sugar is less than 60 call 911 and follow any physician orders you may have for low blood sugar. If the blood sugar is greater than 300 notify the physician and follow their instructions.

3. For any other sudden change of condition of a resident notify the attending physician and follow their instruction.

Accident or Illness

1. Resident found lying on the floor- Perform a fall assessment. If the resident complains of pain do not move them. Call 911. Keep resident comfortable and let EMS evaluate the resident further.

2. Heavy bleeding – Use universal precautions, hold firm pressure against the bleeding area with a towel and call 911.

3. When a resident is a threat to themselves or others –call 911 **immediately**.

4. Head Injury (witnessed) –If the resident hits their head in a fall and suffers any loss of consciousness or has any jerking motions that resemble a seizure, or if the resident begins to vomit, call 911.

5. Possible head injury (unwitnessed) – If you are unsure whether or not the resident has hit their head in a fall, call the resident's physician for directions in care. If the physician is unavailable call EMS to evaluate the resident for a head injury.

ROUNDING CRITERIA

1. Please knock before entering a resident's room.
2. If a resident is in pain, contact supervisor immediately
3. Offer toileting assistance
4. Bed is in safe position. (check rails for safety)
5. Appropriate/sanitized urinal/bedside commode within reach of resident
6. Room is clean and clutter free
7. Check room floors for spills & hazards
8. Encourage resident to call for help whenever help is needed in getting in and out of bed
9. If resident is awake, before leaving room ask "Is there anything I can do before I leave?
10. If a resident has **falling** (found on the floor), contact supervisor immediate (identify as risk for falls/Assessment)
11. If a resident is **wandering**, contact supervisor immediately (identify as high risk/Assessment)
12. If a resident is displaying **aggressive or inappropriate behavior**, contact supervisor immediately
    a. Speak calmly to resident
    b. Do not point finger, touch or get in a defensive stance
    c. Do not step to close/confront the resident
    d. Any physical altercation must be reported on Incident Report Form
    e. Call 911 for medical emergency
    f. Notify family & Physician
13. **Chest Pain** – Call 911, assign staff person to remain with resident until EMS arrive. Notify family & Physician
14. **Unresposiveness** – Check for pulse & respirations. If resident is not breathing start mouth-to-mouth resuscitation. If they do not have a pulse begin CPR and call 911. You must continue CPR until EMS arrive.
    a. If unresponsive and repirations and pulse are present and the resident is diabetic, perform a blood sugar check. If the blood sugar is less than 60 call 911 and follow any physician orders you may have for low blood sugar. If the blood sugar is greater than 300 notify the physician and follow their instructions.
15. **When a resident is a threat to self or others – call 911**
16. **Missing Resident** - contact supervisor immediately
    a. Check all rooms, closets, under beds & storage areas
    b. If the resident is not found after checking these areas, call 911
    c. Carry-out the missing resident policy & procedure