

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 000	Initial Comments The Adult Care Licensure Section and the Franklin County Department of Social Services conducted a complaint investigation on 2/3/15, 2/4/15, 2/5/15, 2/6/15 and 2/10/15.	D 000		
D 076	<p>10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews the facility failed to have furniture in good repair, including chairs in the front day room, chairs in the kitchen, back day room, and a chair in resident bedroom 102.</p> <p>The findings are:</p> <p>Observation in the front day room on 2/4/15 at 11:45 a.m. revealed:</p> <ul style="list-style-type: none"> -A blue chair with the support springs in the seat sagging approximately 6 inches down and underneath the chair seat the same seat springs were approximately 2 inches off the floor. -Another blue chair had several rips in the seat cushion. -The face of both arms of the brown/beige cloth covered recliner were heavily worn with the foam rubber padding exposed. -Residents were observed sitting in these chairs. <p>Observation of the dining room on 2/5/15 at 10:00 a.m. revealed:</p>	D 076		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 076	<p>Continued From page 1</p> <p>-1 black vinyl covered chair with multiple rips across the seat of the chair.</p> <p>-1 black vinyl covered chair had torn vinyl across the back of the chair.</p> <p>Observation of Room 102, a resident' s bedroom, on 2/5/15 at 10:05 a.m. revealed:</p> <p>-A fabric covered chair with a high back. The fabric was torn away from the right upper corner half way down the back and all the way across the top. The fabric was hanging in down in a triangle shape.</p> <p>Observation of the back day room on 2/5/15 at 10:20 a.m. revealed:</p> <p>-2 large chairs with rips across the cushions.</p> <p>Interview with a resident sitting in the back day room on 2/5/15 at 10:20 a.m. revealed both of the chairs had been that way for months.</p> <p>Interview with a housekeeper on 2/5/15 at 10:30 a.m. revealed:</p> <p>-The2 blue chairs in the front day room had been in there for a long time.</p> <p>-The residents had not complained about the chairs.</p> <p>Interview with the Manager on 2/5/15 at 11:50 a.m. revealed:</p> <p>-He would have the chairs removed from the facility at once and put in chairs for residents to sit on that were in good repair.</p> <p>Follow up observation on 2/5/15 at 1:30 p.m. revealed:</p> <p>-The 2 blue chairs with damage had been replaced.</p> <p>-The recliner was still in the front day room with a resident sitting on it.</p>	D 076		

Division of Health Service Regulation

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D 083	<p>10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure privacy curtains, drapes or window coverings were in 1 of 4 common bathrooms used by residents.</p> <p>The findings are:</p> <p>Observations of a common bathroom on 2/3/15 at 10:30 a.m. revealed: -A window facing the highway, parking area and area residents stand to socialize had no privacy covering. -The window was above the bathtub and straight across from the shower area. -The window was a clear one pane over one pane. -The window seal was 27 inches from the floor and measured approximately 2 1/2 feet wide and 4 feet high.</p> <p>Confidential interviews with 6 residents on 2/3/15 revealed there had not been a curtain up to that bathroom window for a long time, maybe a month or more.</p> <p>Interview with a housekeeper on 2/3/15 at 10:30 a.m. revealed:</p>	D 083		

Division of Health Service Regulation

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D 083	Continued From page 3 -He did not know there was no curtain in the bathroom window. Observations of the bathroom on 2/5/15, 2/6/15 and 2/10/15 revealed there was no privacy curtain, drapes or blinds at the window. Interview with the Administrator on 2/10/15 at 2:30 p.m. revealed he was unaware there was not a privacy curtain in the men's bathroom (bathroom #2) north men's hall.	D 083		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 3 of 5 sampled staff (Staff C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff C's personnel file revealed: - Staff C's hire date of was 1/8/15 as a personal care aide. - No documentation of a HCPR check	D 137		

Division of Health Service Regulation

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D 137	<p>Continued From page 4 completed.</p> <p>Refer to the interview with the Administrator on 2/6/15 at 3:30 p.m.</p> <p>Refer to the interview with the Manager on 2/10/15 at 12:15pm</p> <p>2. Review of Staff D's personnel file revealed:</p> <ul style="list-style-type: none"> - Staff D' s date of hire was 12/24/14 as a medication aide. - No documentation of a HCPR check completed. <p>Refer to the interview with the Administrator on 2/6/15 at 3:30 p.m.</p> <p>Refer to the Refer to the interview with the Manager on 2/10/15 at 12:15pm</p> <p>3. There was no personnel file for Staff E (Manager):</p> <ul style="list-style-type: none"> - No documentation of a HCPR check completed. <p>Interview with Staff E (Manager) on 2/6/15 at 2:20 p.m. revealed:</p> <ul style="list-style-type: none"> -He was the Manager of the facility. -He began working at the facility as the Manager approximately one year ago when there was a change in ownership of the facility. -He has a 1% ownership in the facility under his wife' s ownership who owns 51% of the facility. -He works with the residents on a frequent basis through therapeutic conversations, ensuing their needs were met. <p>Interview with the Business Office Manager on 2/10/15 at 2:00 p.m. revealed:</p> <ul style="list-style-type: none"> -There was not a personnel file for Staff E 	D 137		

Division of Health Service Regulation

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D 137	Continued From page 5 (Manager). Interview with the Administrator on 2/6/15 at 3:30 p.m. revealed: -If the information was not in the file then it probably was not completed but he can easily pull up the registry and complete the checks now. Interview with the Manager on 2/10/15 at 12:15 p.m. revealed: - "We" [the facility] did not know we had to print out the Health Care Personnel Registry (HCPR) check verification form. -We just checked the HCPR and did not write down the dates and verification numbers when we checked them. -We were told by the previous Administrator, a private consultant [name], and another person that they [the facility] did not have to print or document the information from the HCPR check on each staff. -There was miscommunication about the HCPR checks regarding the information being on file. The facility provided a Plan of Protection: -The Administrator or designated staff would go through each employees personnel file to assure a HCPR check was on file. -The Administrator or designated staff would assure any employees who did not have a HCPR check in their personnel file will be checked by the close of business day today. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2015.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications	D 139		

Division of Health Service Regulation

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D 139	<p>Continued From page 6</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40;</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and review of personnel files, the facility failed to assure 5 of 5 sampled staff (Staff's A, B, C, D, and E), had a criminal background check prior to each staff 's working start date.</p> <p>The finding are:</p> <p>1. Review of Staff A' s personnel file on 2/6/15 revealed the following: -Staff A was hired as a Personnel Care Assistant. -Hire date was 11/13/14. -No documentation of the criminal background check being done.</p> <p>Refer to the interview with the Administrator and Manager on 2/6/15 at 3:30 p.m.</p> <p>2. Review of Staff B' s personnel file on 2/6/15 revealed the following: -Staff B was hired as a Nursing Assistant I. -No hire date was available. -No documentation of a criminal background check being done.</p> <p>Refer to the interview with the Administrator and Manager on 2/6/15 at 3:30 p.m.</p> <p>3. Review of Staff C' s personnel file on 2/6/15 revealed the following: -Staff C was hired as a Personal Care Aide. -Hire date was 1/8/15.</p>	D 139		

Division of Health Service Regulation

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D 139	<p>Continued From page 7</p> <p>- No documentation of a criminal background check being done.</p> <p>Refer to the interview with the Administrator and Manager on 2/6/15 at 3:30 p.m.</p> <p>4. Review of Staff D' s personnel file on 2/6/15 revealed the following: -Staff D was hired as a Medication Aide. -Hire date was 12/24/14. -No documentation of a criminal background check being done.</p> <p>Refer to the interview with the Administrator on 2/6/15 at 3:30 p.m.</p> <p>5. There was not a personnel file for Staff E.</p> <p>Interview with the Business Office Manager on 2/6/15 at 3:00 p.m. revealed: -Staff E (Manager) did not have a personnel file.</p> <p>Refer to the interview with the Administrator and Manager on 2/6/15 at 3:30 p.m.</p> <p>Follow up review of Staffs A, B, C, and D' s personnel records on 2/10/15 revealed: -Staffs (A, B, and D) had criminal background checks requested on 2/8/15. -Staff C had a criminal background check requested on 1/20/15. -Staff E did not have a personnel file.</p> <p>Interview with the Administrator and Manager on 2/6/15 at 3:30pm revealed: -The Licensee would have those criminal background checks and they would have to get them from her.</p>	D 139		

Division of Health Service Regulation

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D 139	Continued From page 8 The facility provided a Plan of Protection: -The Administrator or designated staff would go through each employees' personnel file to assure a criminal background check was on file for each staff. -The Administrator or designated staff would assure any employees who did not have a criminal background check in their personnel file will be checked by the close of business day today. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2015.	D 139		
D 176	10A NCAC 13F .0601 Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Facility Services and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation and interview, the facility failed to assure an administrator or administrator	D 176		

Division of Health Service Regulation

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D 176	<p>Continued From page 9</p> <p>in charge was responsible for the total operation of the home, to meet and maintain the rules in rule areas of Personal Care and Supervision, Other Staff Qualifications, Health Care, and Health Care Personnel Registry.</p> <p>The findings are :</p> <ol style="list-style-type: none"> 1. Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 1 sampled resident (Resident #8) with a documented history of combative behavior who assaulted staff, attempted to assault a resident and physically assaulted another resident. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews and record review, the facility failed to provide personal care and grooming (finger nails and toenails were clean and cut and feet were washed) for 2 of 2 sampled residents who had been assessed as being totally dependent on staff for grooming, hygiene and bathing (Resident #1, #2). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations and interview, the facility failed to assure residents were treated with dignity and basic rights in having toilet paper and paper towels in 4 of 4 residents' common bathrooms at all times for residents use. [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 5 sampled staff (Staff C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon 	D 176		

Division of Health Service Regulation

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D 176	<p>Continued From page 10</p> <p>hire. [Refer to Tag 0137 10A NCAC 13F .0407 (a) (5) Other Staff Qualifications (Type B Violation)].</p> <p>5. Based on interviews and review of personnel files, the facility failed to assure 5 of 5 sampled staff (Staff's A, B, C, D, and E), had a criminal background check prior to each staff ' s working start date. [Refer to Tag 0139 10A NCAC 13F .0407 (a) (7) Other Staff Qualifications (Type B Violation)].</p> <p>6. Based on interviews and record review, the facility failed to report to the North Carolina Health Care Personnel Registry and investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #3). [Refer to Tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].</p> <p>7. Based on interviews and record review, the facility failed to assure referral and follow up to meet the acute mental health care needs and chronic medical health care needs of 1 of 1 sampled resident (Resident #8) by not notifying the mental health provider or the resident' s primary physician the resident ' s combative and aggressive behaviors; by not following up on a panic lab value; and by not assuring resident continued to receive a renal medication when discharged from the hospital. [Refer to Tag 0273 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].</p> <p>DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 11, 2015.</p>	D 176		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

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D 269	<p>Continued From page 11</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record review, the facility failed to provide personal care and grooming (finger nails and toenails were clean and cut and feet were washed) for 2 of 2 sampled residents who had been assessed as being totally dependent on staff for grooming, hygiene and bathing (Resident #1, #2). The findings are:</p> <p>1. Observations of Resident #1 on 2/3/15 at 10:12am revealed: Resident #1 was lying on his back in bed with the covers pulled up and a baseball cap on his head. The length of Resident #1' s fingernails on both hands ranged from 1/4th to 3/4th inches long and had a black substance underneath.</p> <p>Interview with the resident during the above observation revealed he could not cut his nails and he had no clippers to cut them. The resident then asked, "Can you cut them?"</p> <p>Review of the resident's current FL2 dated 5/13/14 revealed: · Diagnoses included Dementia, Depression, Hypertension, Gout, Mild Ileus, Stroke and Alcohol Abuse.</p>	D 269		

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D 269	<p>Continued From page 12</p> <ul style="list-style-type: none"> · Resident #1 was admitted to the facility on 10/04/10. · The resident was non-ambulatory. <p>Review of Resident #1's current care plan dated 4/22/14, with a physician's signature dated 5/12/14 revealed the resident was totally dependent on facility staff for all activities of daily living except eating, for which he required extensive assistance.</p> <p>Interview on 2/3/15 at 2:10pm with the restorative aide revealed personal hygiene should be done every day.</p> <p>Interview with the restorative aide on 2/3/15 at 9:35am revealed Resident #1 had already had his bath and his aid was getting him up today.</p> <p>Observations on 2/5/15 at 9:50am with the restorative aide revealed:</p> <ul style="list-style-type: none"> · Resident #1 was lying in bed on his back with a baseball cap on his head. · Resident #1's nails were the same length as they were on the observation on 2/3/15 at 10:12am and a black substance remained under his nails. · The resident's feet emitted a foul odor and flakes of dry skin fell from his socks when they were removed. · The resident's feet were very dry and skin appeared scaly. · The resident's toenails on both feet were extremely long and had begun to curl over toes. <p>During the observation, one of the three aides in the room commented, "They don't look like they have been washed in a long time." The other aide stated she had not bathed Resident #1 yet.</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 269	<p>Continued From page 13</p> <p>Interview with the restorative aide on 2/5/15 at 10:10am revealed:</p> <ul style="list-style-type: none"> · When residents get their bath, staff are supposed to wash the resident's feet and check their toenails. · Resident #1 gets a bath three times a week. <p>Review of the "Residents Showers/Bath Days" form revealed Resident #1 is scheduled for bath every Monday, Wednesday and Friday on 7A shift.</p> <p>On 2/5/15, review of the the form used by aides to document completion of baths and linen changes revealed a personal care aide had signed that Resident #1 had received a bath and linens had been changed on Monday, 2/2/15.</p> <p>2. Review of Resident #2' s current FL-2 dated 9/18/14 revealed an admission date of 09/18/14.</p> <p>Review of Resident #2' s Care Plan dated 9/18/14 revealed:</p> <ul style="list-style-type: none"> -A 4 was entered into the box for Activities of Daily Living (ADL) for grooming/personal hygiene. -A 4 was entered into the box for ADLs for bathing. -Review of the Care Plan codes revealed a 4 was the resident was totally dependent on staff for providing care. <p>Observation of Resident #2 on 2/3/15 at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident was sitting in a wheelchair in his bedroom. -Resident' s right hand was contracted with fingers rolled over into the palm of his hand. -Resident' s right hand thumb nail was approximately ¼ inch long and curved over the 	D 269		

Division of Health Service Regulation

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D 269	<p>Continued From page 14</p> <p>end of the thumb.</p> <ul style="list-style-type: none"> -Resident' s fingernails were approximately ¼ inch long and jagged on both hands. -All of the resident' s fingernails and both thumbnails had a dark brown embedded substance underneath the nails. -His right palm had slight indentions from his fingernails. -Resident did not have use of his right hand. He kept his right arm bent at the elbow with his right hand contracted in his lap. -He propelled the wheelchair using his left arm and hand. <p>Interview with the Restorative Aide on 2/3/15 at 2:20 p.m. revealed:</p> <ul style="list-style-type: none"> -She assisted with personal care daily. -Resident #2 gets a bath in the mornings 3 times a week. -She assigned personal care aides each day for residents' baths. -She did not know the last time Resident #2' s nails were trimmed. -She assumed the personal care aides would assure Resident #2' s nails were cut and clean. <p>Interview with Resident #2 and observation on 2/3/15 at 3:00 p.m. revealed:</p> <ul style="list-style-type: none"> -A staff [name] cut his fingernails a month ago. - "My toenails are ok." -No one ask about his fingernails. -He relies on staff to cut his nails. -Staff have to help him bathe and keep his fingernails clean. -The facility used to have a service that come out once a month to cut our nails but that had not happened in months. -Resident #2' s fingernails continued to have the embedded substance underneath his nails and his fingernails on his right hand had not been 	D 269		

Division of Health Service Regulation

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D 269	<p>Continued From page 15</p> <p>trimmed.</p> <p>Interview with the Administrator on 2/3/15 at 3:40 p.m. revealed: -The Personal Care Aides were responsible for the bathing and grooming of Resident #2. -He was "shocked" Resident #2 let the surveyor look at his right hand and his fingernails. -Resident #2 was resistive to others looking at his right hand fingers. -He had only started working at the facility on 12/8/14 and was trying to get things in shape. -He would look into why Resident #2' s fingernails had not been trimmed and clean.</p> <p>Observation of Resident #2 on 2/5/15 at 8:55 a.m. revealed: -His nails had not been trimmed or cleaned.</p> <p>The facility provided a Plan of Protection: -Residents who had been assessed as being totally dependent on staff for grooming, hygiene and bathing would be checked immediately and provided care as needed.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2015.</p>	D 269		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p>	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 16</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 1 sampled resident (Resident #8) with a documented history of combative behavior who assaulted staff, attempted to assault a resident and physically assaulted another resident.</p> <p>The findings are:</p> <p>On 2/5/15 at 11:35am, a resident approached the surveyor and stated, "Look where that man [Resident #8] hit me with his cane" .</p> <p>Observations of the left side of Resident #7's face revealed a row of sutures approximately 2-3cm long running perpendicular to the resident's left ear.</p> <p>Subsequent interview on 2/5/15 at 1:10pm with Resident #7 revealed:</p> <ul style="list-style-type: none"> · Resident #7 walked by Resident #8's room. · Resident #8 was standing in his doorway with his cane. · Resident #7 said good morning to Resident #8 and, "He just hit me". <p>Review of Resident #7's assessment and care plan (DMA 3050R) dated 1/18/15 revealed the resident was oriented and memory was adequate.</p> <p>Review of documentation from the local hospital's emergency room dated 1/30/15 for Resident #7 revealed:</p> <ul style="list-style-type: none"> · Patient is alert and oriented x 3. Respirations are unlabored. Skin is warm and dry, vascular 	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 17</p> <p>status intact.</p> <ul style="list-style-type: none"> · Laceration that is jagged and deep to the left ear. · Patient agreed to have laceration repaired. <p>Review of the Resident Log for Resident #7 revealed:</p> <ul style="list-style-type: none"> · An incomplete note dated 1/30/15 and timed 7A was documented. · The note in its entirety read, "Resident was hit with cane by another resident this morning, EMS (Emergency Management Service) responded on scene; area" · The note was not completed or signed by staff. <p>Interview with the nurse at Resident #7's physician office on 2/6/15 at 11:40am revealed there was no documentation the facility had contacted the physician regarding Resident #7's injury.</p> <p>Review of Resident #8's current FL2 signed by the physician and dated 11/14/14 revealed:</p> <ul style="list-style-type: none"> · Resident #8 was returned to the facility on 12/8/14 from an extended hospital stay from 11/8/14 to 12/8/14 <p>The resident's diagnoses included acute Metabolic Encephalopathy, Dementia, Diabetes Mellitus and End Stage Renal Disease.</p> <ul style="list-style-type: none"> · Inappropriate behavior was documented as history of combative behavior. · Hemodialysis was documented on the FL2 with no frequency included. · The requested level of care was Nursing Facility and the discharge plan was Skilled Nursing Facility. <p>Review of Resident #8's Resident log revealed no documentation of the incident on 1/30/15 when</p>	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 18</p> <p>he hit another resident with his cane.</p> <p>Interview with the facility's Administrator on 2/6/15 at 10:00am revealed there was no documented report of the incident which occurred on 1/30/15 when Resident #8 hit Resident #7 with his cane.</p> <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> · Resident #8 raised his cane to hit this staff member but the staff member quickly got out of the way. · The resident asked for toilet tissue and the staff did not have any. · The staff told the resident she would bring him some tissue when she came back up the hall. · The resident started yelling cussing and that he wanted it now and raised his cane to hit staff. <p>Another confidential staff interview revealed Resident #8 had never hit or attempted to hit this staff member.</p> <p>A third confidential staff interview revealed the resident had never hit this staff member but had hit other staff.</p> <p>Review of the Resident #8's Resident Log (confirmed by a fourth confidential staff interview) revealed the following documentation:</p> <ul style="list-style-type: none"> · On 9/8/14, the resident became aggressive and combative when the Medication Aide (MA) went to give him his bedtime meds. · Resident proceeded to fuss and kick at the MA who quickly moved to the side and the MA landed in the closet. · The resident then shut and locked the door and stood between MA and the locked exit door. <p>Review of the Resident #8' s Resident Log</p>	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 19</p> <p>(confirmed by the fourth confidential staff interview) revealed the following documentation:</p> <ul style="list-style-type: none"> · On 9/28/14, when MA went to give the resident his medications, the resident began to yell, jumped up out of his chair and as the MA was leaving the room, Resident #8 hit the MA in the back with his fist. · The resident then came into the hallway with his cane and attempted to hit the MA with his cane. · The MA ran down the hall into a bathroom and shut the door. <p>Interview with the Administrator on 2/6/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> · The Administrator was aware of only 2 incidents involving Resident #8. · One with Resident #7 and one with Resident #5. · The incident involving Resident #7 had not been reported to the resident's family or the County Department of Social Services. <p>Review of a progress note dated 12/19/14 documented by the therapist from Resident #8's mental health provider revealed, "Pt. [patient] was very agitated today, has hit some of his peers includes some staff members. Pt finally calm down after several intervention and promise not [to] hit his peers".</p> <p>A subsequent note documented by the same therapist on 12/23/14 revealed, "F/U [follow up] from last week pt. [patient] is doing well, however still has some agitation but doing well".</p> <p>Interview on 2/6/15 at 12:15pm with the therapist revealed:</p> <ul style="list-style-type: none"> · The therapist meant to write "trying" to hit, instead of "has hit" in the note dated 12/19/14. 	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 20</p> <ul style="list-style-type: none"> · He did not hit anybody. · The incident occurred in the dining room. · The resident was standing in a boxing stance (as demonstrated by the provider) in front of another resident and trying to hit the other resident. · Resident #8 then went towards a medication aide. · When the resident saw the therapist, he stopped, because he likes the therapist. · Interventions included sitting the resident down; telling him to take deep breaths; and walking him down the hall and back to his room. · Before the resident was discharged to the hospital [in November 2014], the therapist had never seen combative behaviors in the resident. But when he came back [from the hospital 12/8/14], he had this [combative] behavior. · The therapist had never been contacted for behaviors of Resident #8 trying to fight or hit other residents. <p>Interview with the nurse at Resident #8's physician office on 2/6/15 at 11:40am revealed there was no documentation the facility had contacted the physician regarding Resident #8's combative behavior.</p> <p>Observations of Resident #8 throughout the survey on February 3-6, 10, 2015 revealed the resident sat in the living room, dining room or his room.</p> <p>Observations on 2/5/15 at 12:10 pm revealed: Resident #8 was sitting in the dining room at a table. A surveyor asked the resident how he was doing. The resident responded, "What?" As the surveyor walked closer to the resident, the surveyor was approached by the Manager and told</p>	D 270		

Division of Health Service Regulation

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D 270	Continued From page 21 to back away from the resident because the resident would hit the surveyor with his cane if he was startled. Another staff stated, "He [Resident #8] will hit you". _____ Review of the facility's Plan of Protection revealed: -Resident #8 will be escorted by staff when he is out of his bedroom. -Resident #8 will be checked on every 30 minutes while in his bedroom. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record review, the facility failed to assure referral and follow up to meet the acute mental health care needs and chronic medical health care needs of 1 of 1 sampled resident (Resident #8) by not notifying the mental health provider or the resident's primary physician the resident's combative and aggressive behaviors; by not following up on a panic lab value; and by not assuring resident continued to receive a renal medication when	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 22</p> <p>discharged from the hospital.</p> <p>The findings are:</p> <p>Review of documentation dated 11/6/14 on a "Medical Progress Note" in Resident #8's record revealed Resident #8 was sent out to the hospital because the resident was having vomiting, sweating, fever and chills.</p> <p>Review of Resident #8's current FL2 signed by the physician and dated 11/14/14 revealed:</p> <ul style="list-style-type: none"> · Resident #8 was readmitted to the facility on 12/8/14. · The resident's diagnoses included acute Metabolic Encephalopathy, Dementia, Diabetes Mellitus and End Stage Renal Disease. · Inappropriate behavior was documented as history of combative behavior. · Hemodialysis was documented on the FL2 with no frequency included. · The requested level of care was Nursing Facility and the discharge plan was Skilled Nursing Facility. <p>There was no order for Renagel ((Renagel is used to control phosphorus levels in people with chronic kidney disease who are on dialysis).</p> <p>Review of Resident #8's initial FL2 signed by the physician and dated 8/25/14 revealed:</p> <ul style="list-style-type: none"> · The resident was originally admitted to the facility on 8/29/14. · Medication orders included Renagel 2400mg with meals. <p>a. On 2/5/15 at 11:35am revealed a resident approached the surveyor and stated, "Look where that man [Resident #8] hit me with his cane" . Observations of the left side of Resident #7's face revealed a row of sutures approximately 2-3cm</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 23</p> <p>long running perpendicular to the resident' s left ear.</p> <p>Subsequent interview on 2/5/15 at 1:10pm with Resident #7 revealed:</p> <ul style="list-style-type: none"> · Resident #7 walked by Resident #8's room. · Resident #8 was standing in his doorway with his cane. · Resident #7 said good morning to Resident #8 and, "He just hit me" . <p>Review of Resident #7' s assessment and care plan (DMA 3050R) dated 1/18/15 revealed the resident was oriented and memory was adequate.</p> <p>Review of documentation from the local hospital's emergency room dated 1/30/15 revealed:</p> <ul style="list-style-type: none"> · Patient is alert and oriented x 3. Respirations are unlabored. Skin is warm and dry, vascular status intact. · Laceration that is jagged and deep to the left ear. · Patient agreed to have laceration repaired. <p>Review of the Resident Log for Resident #7 revealed:</p> <ul style="list-style-type: none"> · An incomplete note dated 1/30/15 timed 7A was documented and not signed by staff. · The note in its entirety read, "Resident was hit with cane by another resident this morning, EMS (Emergency Management Service) responded on scene; area" · The note was not complete or signed by staff. <p>Interview with the facility's Administrator on 2/6/15 at 10:00am revealed he was aware of the incident and there was no documented report of the incident which occurred on 1/30/15 when Resident #8 hit Resident #7 with his cane.</p>	D 273		

Division of Health Service Regulation

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D 273	<p>Continued From page 24</p> <p>A confidential staff interview revealed:</p> <ul style="list-style-type: none"> · Resident #8 raised his cane to hit this staff member but the staff member quickly got out of the way. · The resident asked for toilet tissue and the staff did not have any. · The staff told the resident she would bring him some tissue when she came back up the hall. · The resident started yelling cussing and that he wanted it now and raised his cane to hit staff. <p>Another confidential staff interview revealed the resident had never hit this staff member but heard the resident had hit other staff.</p> <p>Review of the Resident #8's Resident Log revealed the following documentation:</p> <ul style="list-style-type: none"> · On 9/8/14, the resident became aggressive and combative when the Medication Aide (MA) went to give him his bedtime meds. · Resident proceeded to fuss and kick at the MA who quickly moved to the side and the MA landed in the closet. · The resident then shut and locked the door and stood between MA and the locked exit door. <p>Review of the Resident #8's Resident Log revealed the following documentation:</p> <ul style="list-style-type: none"> · On 9/28/14, when MA went to give the resident his medications, the resident began to yell, jumped up out of his chair and as the MA was leaving the room, Resident #8 hit the MA in the back with his fist. · The resident then came into the hallway with his cane and attempted to hit the MA with his cane. · The MA ran down the hall into a bathroom and shut the door. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 273	<p>Continued From page 25</p> <p>Interview with the Administrator on 2/6/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> · The Administrator was aware of only 2 incidents involving Resident #8. · One with Resident #7 and one with Resident #5. · The incident involving Resident #7 had not been reported to the resident' s family or the County Department of Social Services. <p>Review of a progress note dated 12/19/14 documented by the therapist from Resident #8' s mental health provider revealed, "Pt. [patient] was very agitated today, has hit some of his peers includes some staff members. Pt finally calm down after several intervention and promise not [to] hit his peers" .</p> <p>A subsequent note documented by the same therapist on 12/23/14 revealed, "F/U [follow up] from last week pt. [patient] is doing well, however still has some agitation but doing well".</p> <p>Interview on 2/6/15 at 12:15pm with the therapist who had written the note on 12/19/14 revealed:</p> <ul style="list-style-type: none"> · The therapist meant to write "trying" to hit, instead of "has hit" in the note dated 12/19/14. · He did not hit anybody. · The incident occurred in the dining room. · The resident was standing in a boxing stance (as demonstrated by the provider) in front of another resident and trying to hit the other resident. · Resident #8 then went towards a medication aide. · When the resident saw the therapist, he stopped, because he likes the therapist. · Interventions included sitting the resident down; telling him to take deep breaths; and 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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D 273	<p>Continued From page 26</p> <p>walking him down the hall and back to his room.</p> <ul style="list-style-type: none"> · Before the resident was discharged to the hospital [in November 2014], the therapist had never seen combative behaviors in the resident. But when he came back [from the hospital 11/8/14], he had this [combative] behavior. · The therapist had never been contacted for behaviors of Resident #8 trying to fight or hit other residents. <p>Interview with the nurse at Resident #8's physician office on 2/6/15 at 11:40am revealed there was no documentation the facility had contacted the physician regarding Resident #8's combative behavior.</p> <p>b. Review of a document in Resident #8' s record labeled Fax revealed:</p> <ul style="list-style-type: none"> · The Fax was addressed to the facility from the resident's dialysis unit. · The Fax was dated 1/27/15. · Boxes checked on the Fax sheet were Urgent, For Review, Please Comment and Please Reply. · A handwritten note on the Fax documented, "Please review the following panic lab report/alert for á K+ 7.4 along with dietary guidelines for a low potassium diet. *á K+ is dangerously high and could result in Death." <p>Review of a copy of the above document in Resident #8' s record labeled Fax revealed:</p> <ul style="list-style-type: none"> · A typed note had been documented at the bottom of the document and signed by Resident #8's primary provider. · The note was dated 1/28/15. · Please find out right away if the Potassium level was addressed at dialysis. Also, I don' t see a low potassium diet here. Did they send a diet and can you provide it? [please call us with the 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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D 273	<p>Continued From page 27</p> <p>answer and don' t wait for fax response]</p> <p>Interview with the Administrator on 2/5/15 revealed:</p> <ul style="list-style-type: none"> · The elevated lab value had been faxed to the physician' s office. · The facility had not contacted dialysis regarding the potassium being addressed there. <p>Interview on 2/6/15 at 12:00pm with the nurse at the Resident's dialysis facility revealed:</p> <ul style="list-style-type: none"> · The facility had not contacted the dialysis facility regarding the Resident' s elevated potassium level. · Normally, the dialysis would help with washing out some of the potassium but the resident had missed some sessions. · When he doesn't come, the facility does not call to say he is not coming. We have to call them to find out where the resident is. · One time he was late getting here and when we called to find out where he was, they had stopped at the bank. We have a schedule to keep. · When we called the facility about the panic lab level and the low potassium diet, they told us they could not control what the resident ate. It was his right to eat what he wanted to eat. <p>c. Interview on 2/6/15 at 12:00pm with the nurse at the Resident's dialysis facility revealed:</p> <ul style="list-style-type: none"> · We can tell he has not been getting his phosphorus binding medicine because his phosphorus level is high. · He should get that medicine with every meal. · The resident came in one day with a whole sleeve of butterfingers, which the staff had stopped to the store on the way and got them for him. They are loaded of phosphorus and he is diabetic and should not have that sugar. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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D 273	<p>Continued From page 28</p> <p>Review of the resident's current FL2 dated 11/14/14 from hospital discharge revealed no order for Renagel.</p> <p>Review of Resident #8's January 2015 and February 2015 Medication Administration Records revealed no entry or documentation of administration of Renagel and no other phosphorus-binding medication.</p> <p>Interview with the Administrator on 2/10/15 at 11:20am revealed he did not know why the previous Administrator or Resident Care Coordinator did not notify the resident's doctor that the resident needed the medication.</p> <p>The facility provided a Plan of Protection: -The resident's physician will be notified immediately. -The facility will follow the physician's orders.</p> <p>DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 11, 2015.</p>	D 273		
D 285	<p>10A NCAC 13F .0904(a)(4) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.</p>	D 285		

Division of Health Service Regulation

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D 285	<p>Continued From page 29</p> <p>This Rule is not met as evidenced by: Based on observations, review of menu, and interviews, them facility failed to maintain a 3 day supply of perishable foods.</p> <p>The findings are: Observation of non-perishable foods on hand on 2/3/15 at 9:50 a.m. revealed: -Three gallons of milk which had just been purchased from a local retailer still in the bags on top of the chest freezer. -Three heads of iceberg lettuce which had just been purchased from a local retailer on the food prep table in preparation for the lunch meal. -Seven medium size tomatoes. -One bunch of bananas which consisted of 7 bananas. -Two 5 pound tubs of margarine. -Three bags of shredded cheese. -Two 5 pound bags of white potatoes. -Two 5 pound bags of yellow onions. -One 10 ounce bag of garlic cloves -One 10 pound package of frozen hamburger. -Four 10 pound packages of raw frozen chicken. -Six dozens of eggs. -Two packages of ham meat, one approximately 4 pounds and one approximately 2 pounds which had just been purchased from a local retailer on the food prep table in preparation for the lunch meal.</p> <p>Interview with the cook on 2/3/15 at 10:00 a.m. revealed: -He had been working as the cook for 8 weeks. -He had not been aware of any food truck delivering food to the facility since he was hired 8 weeks ago. -He believed the manager and the food company had to work out arrangements.</p>	D 285		

Division of Health Service Regulation

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D 285	<p>Continued From page 30</p> <ul style="list-style-type: none"> -The manager buys the food once a week and brings it to the facility. -He sometimes had to make substitutions for foods. -If they needed anything the kitchen staff would go out and buy it and get reimbursed. -A food truck was supposed to have come yesterday but did not show up. -The food truck was scheduled to come today. -Staff went out this morning to purchase the ham and lettuce for today's lunch and also bought the milk. -Staff had to go out at least weekly to buy nonperishable foods for meals on th menu. -He did not have access to food receipts. <p>Confidential interview 9 residents during the lunch meal revealed:</p> <ul style="list-style-type: none"> -Sometimes asked for seconds but they would not have more to give us seconds. -The food was usually good. -Facility never ran out of food. -We get good snacks most of the time. 	D 285		
D 306	<p>10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water with meals.</p>	D 306		

Division of Health Service Regulation

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D 306	<p>Continued From page 31</p> <p>The findings are:</p> <p>Observation of the lunch meal on 2/3/15 at 12:15 p.m. revealed no water was served to any residents including residents who had meals in their rooms.</p> <p>Interview with 5 residents on 2/3/15 at 12:30 p.m. revealed the staff do not serve or offer water at meal and they get their water from the water dispenser in the dining room.</p> <p>Interview with the cook on 2/3/15 at 12:35 p.m. revealed water was not put on the tables and the residents would get water if they wanted it from the water dispenser in the dining room.</p> <p>Interview with a personal care aide working in the dining room on 2/3/15 at 12:40 p.m. revealed water was not served to the residents but was available from the water dispenser located in the dining room or served to the resident(s) if they requested water.</p> <p>Observation of the lunch meal on 2/4/15 at 12:15 p.m. revealed all residents were served water.</p>	D 306		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 32</p> <p>Based on observations and interview, the facility failed to assure residents were treated with dignity and basic rights in having toilet paper and paper towels in 4 of 4 residents' common bathrooms at all times for residents use and assuring 1 of 1 resident received a regular diet and snacks as ordered by the resident's physician.</p> <p>The findings are:</p> <p>Interview with Resident #4 on 2/3/15 at 10:02am revealed:</p> <ul style="list-style-type: none"> · The resident used to get double portions but they were stopped. · The portions are so small, "I don't get enough to eat". · They don ' t give me anything but diabetic snacks. "I want something with sugar in it sometimes". · I' m diabetic but I stopped taking Metformin because my blood sugar is between 60 to 80. <p>Review of Resident #4's current FL2 dated 10/28/14 revealed an order for regular diet.</p> <p>Review of the Physician's Order sheet, last signed by the physician on 11/3/14 revealed, "May have double portions."</p> <p>Interview with the dietary aide on 2/5/15 at 11:30 am revealed the aides give out the snacks.</p> <p>Review of the diet list in the kitchen revealed the resident was listed under the regular diets.</p> <p>Observations throughout the survey revealed Resident #4' s name was included on a list of Diabetics posted in the dining room.</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 33</p> <p>Interview with a personal care aid on 2/5/15 at 11:35am revealed, "We thought since he was diabetic, he had to have diabetic snacks."</p> <p>Interview with the nurse at Resident #4's physician office on 2/6/15 at 11:40am revealed the physician's response was:</p> <ul style="list-style-type: none"> · Resident #4's diabetes is controlled. · The resident can discuss his concerns about his diet with the physician at his upcoming appointment in March 2015. <p>Resident can continue the current diet. (The resident's current diet order was Regular.)</p> <p>Observation of the men's bathroom (#1) on right side of north hall on 2/3/15 at 10:20 a.m. revealed:</p> <ul style="list-style-type: none"> -No toilet paper in the bathroom. -No paper towels in the bathroom. -No tissue paper of any kind for residents' use. -No cloth towels or any other items for residents to dry their hands with. <p>Observation of the men's bathroom (#2) on right side of north hall on 2/3/15 at 10:35 a. revealed:</p> <ul style="list-style-type: none"> -No toilet paper in the bathroom. -No paper towels in the bathroom. -No tissue paper of any kind for residents' use. -No cloth towels or any other items for residents to dry their hands with. <p>Observation of the women's bathroom on right side of south hall on 2/3/15 at 10:45 a.m. revealed:</p> <ul style="list-style-type: none"> -No toilet paper in the bathroom. -No paper towels in the bathroom. -No tissue paper of any kind for residents' use. -No cloth towels or any other items for residents to dry their hands with. 	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 34</p> <p>Observation of the bathroom adjacent to the day room at the end of the south hall on 2/3/15 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> -No toilet paper in the bathroom. -No paper towels in the bathroom. -No tissue paper of any kind for residents' use. -No cloth towels or any other items for residents to dry their hands with. <p>Interview with a resident on 2/3/15 at 10:25 a.m. revealed:</p> <ul style="list-style-type: none"> -Staff would give out toilet paper once a week or had to ask for it. -There had not been any paper towels in the bathrooms for months. -There was a resident living there who took all of the toilet paper and paper towels out of the bathrooms all the time so the staff stopped putting toilet paper and paper towels in the bathrooms and started giving the residents a roll of toilet paper to keep in their rooms and to take with them to the toilet. - "It is not good we have to carry toilet paper around but that is what we have to do." <p>Interview with a housekeeper on 2/3/15 at 10:30 a.m. revealed:</p> <ul style="list-style-type: none"> -He was "...making his way up the hall giving out toilet paper to residents and putting paper towels in the bathrooms." -There was a resident who took the toilet paper and paper towels out of the bathrooms and he gave each resident a roll of toilet paper to keep in their room. <p>Interview with another resident on 2/3/15 at 11:05 a.m. revealed:</p> <ul style="list-style-type: none"> -There were no paper towels in the bathrooms. -He dried his hands on his shirt. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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D 338	<p>Continued From page 35</p> <p>-He keeps his own roll of toilet paper in his room because there was a guy there who took all the toilet paper and paper towels out of the bathrooms.</p> <p>-He had to ask staff for toilet paper when he needed it.</p> <p>Follow up observations of the facility's bathrooms on 2/3/15 after the housekeeper finished making his way up the hall revealed:</p> <p>Observation of the men' s bathroom (#1) on right side of north hall on 2/3/15 at 11:15 a.m. revealed:</p> <p>-No toilet paper in the bathroom.</p> <p>-No paper towels in the bathroom.</p> <p>-No tissue paper of any kind for residents' use.</p> <p>-No cloth towels or any other items for residents to dry their hands with.</p> <p>Observation of the men's bathroom (#2) on right side of north hall on 2/3/15 at 11:20 a.m. revealed:</p> <p>-No toilet paper in the bathroom.</p> <p>-No paper towels in the bathroom.</p> <p>-No tissue paper of any kind for residents' use.</p> <p>-No cloth towels or any other items for residents to dry their hands with.</p> <p>Interview with the Administrator on 2/3/15 at 3:40 p.m. revealed:</p> <p>-There was a resident there who took the toilet paper and paper towels out of the bathrooms all the time.</p> <p>-This resident took the toilet paper and paper towels back to his room and hoarded it by stuffing the rolls of toilet paper and paper towels into sleeves of his garments in his closet.</p> <p>-The facility had tried different types of toilet paper dispensers but that same resident would</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 36</p> <p>get all of the toilet paper out of the bathrooms by taking the dispensers apart or rolling off the toilet paper from the dispensers.</p> <p>-The facility had tried to remedy the issue by giving each resident a roll of toilet paper he or she could take to the toilet as needed.</p> <p>-It was an ongoing issue.</p> <p>Interviews with 10 residents on 2/3/15 revealed they had to dry their hands on their clothes or when they got back to their rooms.</p> <p>Observation of the men's bathroom (#1) on right side of north hall on 2/4/15 at 1:30 p.m. revealed:</p> <p>-No toilet paper in the bathroom.</p> <p>-No paper towels in the bathroom.</p> <p>-No tissue paper of any kind for residents' use.</p> <p>-No cloth towels or any other items for residents to dry their hands with.</p> <p>Observation of the men's bathroom (#2) on right side of north hall on 2/4/15 at 1:35 p.m. revealed:</p> <p>-No toilet paper in the bathroom.</p> <p>-No paper towels in the bathroom.</p> <p>-No tissue paper of any kind for residents' use.</p> <p>-No cloth towels or any other items for residents to dry their hands with.</p> <p>Interview with a resident on 2/5/15 at 10:15 a.m. revealed:</p> <p>-He did not have any toilet paper.</p> <p>-There was never any toilet paper or paper towels in the bathroom for months.</p> <p>- "I have to go get toilet paper from staff when you need it."</p> <p>- "I wipe with my hand."</p> <p>- "I rinse my hand off at the sink."</p> <p>- "I dry my hands with a towel in my bedroom."</p> <p>-There was resident there who always took the toilet paper and paper towels out of the bathroom</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 37 so staff residents they had to get it from them. Interview with another resident on 2/5/15 at 10:30 a.m. revealed: -There was not any toilet paper in the bathrooms for months. -There was a resident there who would take the toilet paper and paper towels out of the bathrooms. -Staff give her toilet paper when she needs it. -She had to carry the toilet paper roll and some paper towels with here because if she had to go in a hurry she could not make it back to her room to get those items. -She did not like having to carry toilet paper with her but that was what she had to do. -She thought it was embarrassing to carry a roll of toilet paper around. Observations of all residents' bathrooms on 2/10/15 between 10:00 a.m. and 10:20 a.m. revealed all bathrooms had paper towels and toilet paper. The facility provided a Plan of Protection as follows: -All residents will recieve toilet paper every morning before breakfast. -Bathrooms will be checked every 30 minutes by persoanl care aides and housekeeping to ensure there is toilet paper and paper towels in the residents' bathrooms. DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2015.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 438	<p>Continued From page 38</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry 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 review, the facility failed to report to the North Carolina Health Care Personnel Registry and investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #3).</p> <p>The findings are:</p> <p>Review of Resident #3' s last FL2 dated 9/29/14 revealed:</p> <ul style="list-style-type: none"> · Diagnoses included Rhabdomyelitis, Stroke, Urinary Tract Infection, Depression, Anemia, Hypertension, Gastro Esophageal Reflux Disease and Dementia without behavioral disturbance. · The resident was admitted on 9/29/14. · The resident was ambulatory with a walker. · The resident was intermittently disoriented. <p>Review of Resident #3's care plan dated 9/29/14 revealed the resident required supervision with transferring and ambulation.</p> <p>Review of Resident #3's Resident Log dated 1/26/15 at 9:15am revealed the Medication Aide (MA) was passing medication to resident when the resident complained of right hip hurting.</p> <p>Review of Resident #3's Resident Log dated 1/26/15 at 10:15am revealed an entry by the</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2015
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D 438	<p>Continued From page 39</p> <p>Administrator that Resident sent to ER for assessment due to complaint of hip pain.</p> <p>Review of the next and last entry into the Resident Log was documented on 2/2/15 [no time] and signed by an RN revealed, "Per med tech [name of medication aide], pt. [patient], was sent to ED 1/26/15, admitted to skilled nsg. facility from there [name of skilled nursing facility]".</p> <p>Review of Resident #3's Resident Log revealed no documentation of any incident occurring involving the resident.</p> <p>Interview with the MA on 2/10/15 at 10:15am who had worked the shift before the resident was sent to the hospital revealed:</p> <ul style="list-style-type: none"> · The MA did not know of anything that had happened to the resident on 1/25/15 to 1/26/15 on the 7p to 7a shift. · The MA did not see any injury to Resident #3's hip. · Resident #3 was moving "fine" and had no complaints. · If the resident had complained to the MA about pain, the MA would have assessed the resident, contacted the Administrator, completed an incident report, called the family and sent the resident out to the emergency room. <p>Interview with the personal care aide (PCA) on 2/10/15 at 10:20am who had worked the shift before the resident was sent to the hospital revealed:</p> <ul style="list-style-type: none"> · The PCA checked the resident closely at night. · There was no incident on 1/25/15 to 1/26/15 on the 7p to 7a shift. · Resident #3 was in her chair the whole night (resident normally sleeps in her chair). 	D 438		

Division of Health Service Regulation

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D 438	<p>Continued From page 40</p> <ul style="list-style-type: none"> · The PCA was in and out of Resident #3's room that night because the PCA was washing the resident ' s clothes. · Resident #3 never told the PCA she had fallen and never complained of pain. · The resident said she was feeling "ok". Interview on 2/10/15 at 9:30am with the MA who worked the morning shift of 1/26/15 revealed: <ul style="list-style-type: none"> · The PCA told her the resident was complaining of pain in the right hip. · When the MA went in to administer the resident' s medications, the resident said her hip was hurting. · When the MA saw the resident's hip, the MA thought the resident's hip was broken because it was a large, swollen area and looked like a hematoma. · The MA could not remember if the off-going MA told her the resident fell or the PCA working the 7a-7p shift. · The resident was sent out to the emergency room. Interview on 2/10/15 at 9:35am with the PCA who worked the morning shift of 1/26/15 revealed: <ul style="list-style-type: none"> · The PCA went into the resident's room and asked the resident if she was "ok" and the resident said her hip was hurting. · It was a large area over her hip that "stuck out". · The PCA described the color as pink. · The resident told the PCA she had fallen. Interview with Resident #3's family member revealed: <ul style="list-style-type: none"> · The bruise on Resident #3's hips and leg did not look like a fall. · The family member had been called and told that Resident #3 reported to facility staff that she had fallen. 	D 438		
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Division of Health Service Regulation

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D 438	<p>Continued From page 41</p> <ul style="list-style-type: none"> · Resident #3 would not have been able to tell them that due to her severe short term memory loss. · According to the x-rays at the hospital, there was no fracture. · The family member had seen Resident #3 two days before; there was no bruise and the resident did not complain of pain. <p>Interview with the Administrator on 2/6/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> · He does not know what happened to cause the hip pain. · All he knew was the resident complained of pain and was sent out. <p>The Administrator did not report the injury of unknown origin to the NCHCPR nor conduct an investigation to determine what caused the injury.</p> <p>Review of documentation from the local hospital's emergency room dated 1/30/15 revealed:</p> <ul style="list-style-type: none"> · The resident was sent from the facility after a fall for evaluation of right hip pain with a large amount of discoloration on bony prominence. · The resident grimaced with movement of right leg. · The resident rated the pain as "9" on a one-to-ten scale with ten as the worst pain ever. Bruising discoloration and soft tissue fullness in the right hip region. · Findings included a large, superficial soft tissue focus without blood flow measuring 10.7x5.8x3.4cm and being consistent with a hematoma. <p>There is no evidence of acute fracture or dislocation involving the right hip.</p> <p>The facility provided a Plan of Protection: -The incident will be reported to the HCPR</p>	D 438		

Division of Health Service Regulation

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D 438	Continued From page 42 immediately. -The Administrator will conduct an investigation. DATE OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 12, 2015.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to report injuries to social services for 2 of 8 sampled residents who had hip pain and unexplained bruising of the hip (#3) and who had been injured another resident (#7) both requiring emergency department visits. The findings are: 1. Review of Resident #3's record revealed: -Resident #3 was sent out to the emergency department for hip pain on 1/26/15. Review of documentation from the local hospital's emergency room dated 1/30/15 revealed: · The resident was sent from the facility after a fall for evaluation of right hip pain with a large amount of discoloration on bony prominence.	D 451		

Division of Health Service Regulation

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D 451	<p>Continued From page 43</p> <ul style="list-style-type: none"> · The resident grimaced with movement of right leg. · The resident rated the pain as "9" on a one-to-ten scale with ten as the worst pain ever. Bruising discoloration and soft tissue fullness in the right hip region. · Findings included a large, superficial soft tissue focus without blood flow measuring 10.7x5.8x3.4cm and being consistent with a hematoma. <p>There is no evidence of acute fracture or dislocation involving the right hip.</p> <p>Interview with the Administrator on 2/6/15 at 10 a.m. revealed:</p> <ul style="list-style-type: none"> -No accident/incident report was completed because his understanding was it was not an incident because no one knew what had happened to the resident. -He was told by the medication aide Resident #3 was having hip pain. -He did not know there was bruising on Resident #3's hip and leg. <p>No accident/incident report was received by the Department of Social Services for this incident.</p> <p>2. Reveiw of Resident #7's record revealed:</p> <ul style="list-style-type: none"> -Resident #7 was sent out to the emergency department for stitches on =====. <p>Interview with the Administrator on 2/6/15 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> -He was not aware of an incident report being completed for this incident. -The medication aides were suppose to document this information in the resident's record. -An incident report was not sent to the Department of Social Services for this incident. 	D 451		

Division of Health Service Regulation

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D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all residents were treated with respect and dignity related to not providing toilet tissue, paper towels and food in accordance with diet orders.</p> <p>The findings are:</p> <p>Based on observations and interview, the facility failed to assure residents were treated with dignity and basic rights in having toilet paper and paper towels in 4 of 4 residents' common bathrooms at all times for residents use and assuring 1 of 1 resident received a regular diet and snacks as ordered by the resident's physician. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].</p>	D911		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p>	D912		

Division of Health Service Regulation

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D912	<p>Continued From page 45</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with the rules and regulations as related to referral and follow up for acute needs, criminal background checks on staff, Health Care Personal Registry checks and reporting of incident, personal care, supervision, and residents' rights.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on observations, interviews and record review, the facility failed to provide personal care and grooming (finger nails and toenails were clean and cut and feet were washed) for 2 of 2 sampled residents who had been assessed as being totally dependent on staff for grooming, hygiene and bathing (Resident #1, #2). [Refer to Tag 0269, 10A NCAC 13F .0901 (a) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 5 sampled staff (Staff C, D, and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag 0137, 10A NCAC 13F .0407 (a) (5) Other Staff Qualifications (Type B Violation)]. 3. Based on interviews and review of personnel files, the facility failed to assure 5 of 5 sampled staff (Staff's A, B, C, D, and E), had a criminal background check prior to each staff 's working start date. [Refer to Tag 0139, 10A NCAC 13F 	D912		

Division of Health Service Regulation

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D912	<p>Continued From page 46</p> <p>.0407 (a) (7) Other Staff Qualifications (Type B Violation)].</p> <p>4. Based on interviews and record review, the facility failed to assure referral and follow up to meet the acute mental health care needs and chronic medical health care needs of 1 of 1 sampled resident (Resident #8) by not notifying the mental health provider or the resident' s primary physician the resident ' s combative and aggressive behaviors; by not following up on a panic lab value; and by not assuring resident continued to receive a renal medication when discharged from the hospital. [Refer to Tag 0273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)].</p> <p>5. Based on observation and interview, the facility failed to assure an administrator or administrator in charge was responsible for the total operation of the home, to meet and maintain the rules responsible to the Division of Health Service Regulation and the county department of social services. [Refer to Tag 0176, 10A NCAC 13F .0601 Management of Facilities (Type A2 Violation)].</p> <p>6. Based on interviews and record review, the facility failed to report to the North Carolina Health Care Personnel Registry and investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #3). [Refer to Tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].</p>	D912		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:</p>	D914		

Division of Health Service Regulation

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D914	<p>Continued From page 47</p> <p>4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure residents were free of mental and physical abuse and neglect.</p> <p>The findings are:</p> <p>Based on observations, interviews and record reviews, the facility failed to provide supervision of 1 of 1 sampled resident (Resident #8) with a documented history of combative behavior who assaulted staff, attempted to assault a resident and physically assaulted another resident. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].</p>	D914		