

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/09/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 3/2/2015 to 3/4/2015, 3/6/2015 and 3/9/2015.	D 000		
{D 072}	<p>10A NCAC 13F .0305(m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition. The findings are:</p> <p>Observation of the facility's yard on 03/09/15 from 1:28 p.m. to 2:35 p.m. revealed:</p> <ul style="list-style-type: none"> - Grass in the front, back, and both side yards was dried and straw colored with scattered areas of green weeds 1 to 1 and ½ feet tall. - The dried, straw colored grass was approximately 1 foot long and laid over in layers making the grass thick and difficult to walk in. - Brown weeds approximately 2 to 3 feet high were alongside the front left side of the building. - Wooden fence around the outside exit door of the kitchen had 3 and ½ missing wooden boards. - One of the boards was propped up on the side of the building. - At least 3 boards were warped and pulling 	{D 072}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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{D 072}	<p>Continued From page 1</p> <p>away from the fence with rusted nails sticking out.</p> <ul style="list-style-type: none"> - One of the gates was detached from the fence and propped up on the inside of the fence. - Multiple cigarette butts (too numerous to count) were in the dried grass near all 4 smoking areas outside of the facility. - The smoking areas included the front entrance area, side exit area, back exit area, and the smoking courtyard. - There was trash and debris in the yard around the facility including soda cans, paper torn from cigarette packs, chocolate syrup bottle, adult brief sticking out of plastic pack, plastic cup, and torn pieces of shingles and siding. - The storage building in the backyard of the facility had multiple items sitting outside the building such as a bedframe and mattresses, ripped and torn recliner, wooden door, broken geri-chair, bedside table, and a desk chair. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - They have tin cans to put cigarette butts in but most residents flick the cigarettes in the yard. - Grass has not been cut since last summer. <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> - Residents will not put their cigarette butts in the tin cans. - Residents throw their cigarette butts in the grass. - Housekeeping staff will clean up the cigarette butts. - The grass has not been cut since last summer. - The building behind facility is used for storage. - Staff did not know how long the furniture had been sitting outside the storage building. <p>Interview with a Housekeeper on 03/09/15 at 2:08 p.m. revealed:</p> <ul style="list-style-type: none"> - She was mostly responsible for cleaning the 	{D 072}		

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{D 072}	<p>Continued From page 2</p> <p>inside of the building.</p> <ul style="list-style-type: none"> - She would sweep the four outside smoking areas. - She cleaned spider webs around the outside doors and picked up the trash. - When the grass is cut low, she can sweep the cigarette butts out of the grass. - When grass is high and thick like it was currently she was unable to sweep them up or rake them up. - The grass has not been cut since July 2014. <p>Interview with the Facility Manager on 03/09/15 at 2:58 p.m. revealed:</p> <ul style="list-style-type: none"> - Administrator, who is the owner, was responsible for mowing the grass. - Administrator usually cuts the grass 4 to 5 times during the spring and summer. - Administrator usually starts back cutting the grass around mid-April or early May. - Lawnmower was messed up and the Administrator had ordered a part for it. - She did not know if the part had come in. - She went over the report from the survey in September 2014 with the Maintenance person. - Maintenance person was supposed to get with the Administrator about repairing the fence. - Maintenance person is responsible for cleaning and repairs to the outside of the building. - Housekeeper just raked up the cigarette butts in the yard last week. - Housekeeper was told about a month ago to pick up the trash outside the building. - Items in front of the storage building were supposed to be taken to the dump by the maintenance person about a month or two ago. - She has checked behind the maintenance person on some stuff but not everything. <p>Interviews with the Administrator on 03/09/15 at</p>	{D 072}		
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{D 072}	<p>Continued From page 3</p> <p>3:20 p.m. and 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> - He had problems this summer with his lawnmower and tractor used for mowing. - He just picked up a tire for the lawnmower today. - He usually cuts the grass every 2 weeks or as needed. - He last cut the grass this past summer but then the equipment broke down. - He has not talked with the Maintenance person about the fence because the Maintenance person has been real busy. - The Maintenance person also works at the sister facility. - The items in front of the storage building can only be taken to the dumpster one Saturday per month. - They have not been able to coordinate a time to do that. <p>Interview with the Maintenance Person on 03/09/15 at 4:55 p.m. revealed:</p> <ul style="list-style-type: none"> - He had seen the report from the previous survey and he was aware of the outside issues with the building and yard. - He knew the fence outside of the kitchen area needed repair but he had not decided if he was going to repair it or take the fence down. <p>Interview with the Administrator on 03/09/15 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> - He had recently spent \$20,000 repairing the roof of the building. - There was no money to do anything. - Last summer was the worst summer he ever experienced with lawn mowers breaking down. - There was 15 acres of land to mow at the facility. 	{D 072}		

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{D 074}	Continued From page 4	{D 074}		
{D 074}	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure walls, ceilings, and floors were clean and in good repair in 20 resident rooms and adjoining bathrooms, the men's shower room, hallways, 2 of 2 dining rooms, the kitchen, the activity room, and the smoking area off the activity room. The findings are:</p> <p>Observation of facility hallways and Resident rooms on the 100 hallway on 3/6/15 at 11:15 a.m. revealed:</p> <ul style="list-style-type: none"> - The bathroom in resident room #106 had yellow water stains in 2 of the ceiling tiles in the corner of the room. - The bathroom in resident room #108 had a large brown stain on the floor under the sink, and a buildup of grey dirt stains inside the sink. - The bathroom in resident room #112 had a large brown stain in front of the toilet. - The bathroom in resident room #110 had brown stains on the floor and along the baseboards surrounding the toilet. - The bathroom in resident room #116 had a large brown stain on the floor in front of the toilet and along the baseboards surrounding the toilet. Some of the baseboards were corroded and some parts were missing along the left side of the toilet. - The bathroom in resident room #120 had a 	{D 074}		

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{D 074}	<p>Continued From page 5</p> <p>large brown stain under the sink.</p> <ul style="list-style-type: none"> - In the each hallway in front of each doorway leading to the outside of the building, were large dulled dirt stains. - The hallways of the facility had built up brown dirt around the corners of the entryway to each resident room. - There were dirt stains along the walls and baseboard surrounding the laundry room. - The floor at the entry way to the laundry room had cracks with dirt inside the cracks. <p>Interview with the Housekeeper on 3/3/15 at 10:45am revealed:</p> <ul style="list-style-type: none"> - She has a cleaning schedule to clean each resident room daily. - She dusts along the windowsills and wipes down the bathroom, sweeps and mops each room and bathroom daily. - She does not deep clean or buff the floors, the maintenance man is responsible for doing that. <p>Interview with the Housekeeping supervisor on 3/9/15 at 1:15pm revealed:</p> <ul style="list-style-type: none"> - She monitors the cleaning of every hall and every resident room and shower room daily. - Housekeepers are required to dust window sills, dressers and night tables, in resident rooms and sweep and mop the room and clean bathroom commodes and sinks, and sweep and mop the floor on a daily basis. - They use a mildew spray on the resident bathroom floors, it is hard to get the brown stains up. The staff do the best they can to get the stains up off the floors but they don't come out. - She had reported the brown stains on resident bathroom floors to the maintenance man and to the facility Manager. She last spoke to the facility Manager about it last week. 	{D 074}		
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{D 074}	<p>Continued From page 6</p> <ul style="list-style-type: none"> - The previous maintenance man used to go into the residents' rooms and buff the floors on a regular basis, but that had not been done since the new guy started a while back. <p>Interview with the facility manager on 3/9/15 at 3:00pm revealed:</p> <ul style="list-style-type: none"> - The maintenance man comes to the facility on different days each week because he alternates back and forth to the sister facility and this facility. - When staff find problems at the facility they are supposed to put in a work order in the box at the nursing station. - Some staff just report the problems to her or to the resident care coordinator (RCC). - No one reported brown stains on the bathroom floors to her, they might have reported them to the housekeeping supervisor. - She does not have access to his work orders, he writes them in a book he has. - The maintenance man is responsible for replacing ceiling tiles and buffing floors at the facility. - The floors have not been buffed since May of last year, when they were being buffed 2 or 3 times a week. - When the floors were buffed on a regular basis the dirt spots in the hallways and in front of the doorways came clean. - Housekeeping is responsible for keeping her informed of the build-up of brown stains on the residents' bathroom floors. - She had not been aware of the brown spots on the floors. If she had she would have supplied her with some sort of bathroom floor cleanser to get rid of them. <p>Interview with the maintenance man on 3/9/15 at 4:35 revealed:</p>	{D 074}		
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{D 074}	<p>Continued From page 7</p> <ul style="list-style-type: none"> - He does not deep clean the floors. - He has not buffed or waxed the floors since he has worked at the facility. - Rain water is seeping in through the cracked foundation from the outside of the building into some of the bathrooms of the residents rooms causing baseboards in multiple bathrooms to have brown stains and dampness on the floors. - The brown spots on the bathroom floors in the resident's bathrooms will not come up. - He has been in the process of replacing ceiling tiles throughout the facility. <p>Interview with the Administrator on 3/9/15 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> - The maintenance man has a load on him with both this facility and the sister facility. - He gets pulled off some things to work on other things, he's very busy. - Having the floors buffed and cleaned has been priced and he cannot afford it right now, due to more pressing issues. - He was not aware of the condition of the resident bathrooms. - The maintenance man will replace the resident bathroom tiles one bathroom per month, he will pull the whole tile up and replace them starting with the floors in the worse condition first. <p>Observation in room #201 on 3/2/2015 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> -Brown discolored floor tile on the bathroom floor and brown dirt build up in the corners. -A missing narrow strip of sheet rock from the lower portion of the wall in the bathroom. -Broken tile was next to the bed in the bedroom -There was broken wood off the base of the entrance door. <p>Observation in room #203 on 3/2/2015 at 11:35</p>	{D 074}		
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{D 074}	<p>Continued From page 8</p> <p>a.m. revealed broken floor tile underneath the heater.</p> <p>Observation in room #205 on 3/2/2015 at 11:40 a.m. revealed: -Brown discolored floor tile was around the base of the toilet. -Brown and black stains were along the bottom of the wall. -Cracked floor tile was at the entrance to the room.</p> <p>Observation in room #207 on 3/2/2015 at 11:45 a.m. revealed: -Brown discolored floor tile was in the bathroom. -Brown and black stains along the bottom of the wall. -Cracked floor tile was at the entrance to the room.</p> <p>Observation in room #209 on 3/2/2015 at 11:50 a.m. revealed: -Brown dirt build up was on the floor in the corner of the room. -Brown and gray discolored floor tiles were in the bathroom. -Brown and black stains were along the bottom of the wall. -Cracked floor tile was in the corner of the bedroom.</p> <p>Observation in room #212 on 3/2/2015 at 11:55 a.m. revealed: -Cracked brown discolored floor tile was at the entrance to the room. -There was broken wood off the base of the entrance door. -Brown and gray discolored floor tiles were in the bathroom. -Brown dirt build up was on the floor in the corner</p>	{D 074}		

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{D 074}	<p>Continued From page 9 of the room.</p> <p>Observation in room #210 on 3/2/2014 at 12:00 p.m. revealed: -Cracked brown discolored floor tile was at the entrance to the room. -Broken floor tile was in front of the heater. -There was broken wood off the base of the entrance door. -Brown dirt build up was on the floor in the corner of the room. -Gray discolored floor tiles were in the bathroom.</p> <p>- Observation of room #211 on 3/2/2015 at 12:05 revealed: -There was a build-up of a black substance behind the bedroom door. -Two yellow stained ceiling tiles were in the bedroom. -The bathroom sink was dirty with a greying substance inside of the sink.</p> <p>Observation of Resident room #211 at 12:10 p.m. revealed: -There was a build -up of a black substance behind the bedroom door. -Two yellow stained ceiling tiles were in the bedroom. -The bathroom sink was dirty with a greying substance inside of the sink.</p> <p>A confidential interview with a resident revealed: -The sink in her bathroom needs to be cleaned. -She asked the housekeeper to clean it a few days ago and she did not clean it for her. -She reports having had a leak in her bedroom a couple of weeks ago, leaving stains on the ceiling tiles. -The way they mop the floors in the facility is not like anything she had seen before, there is dirt</p>	{D 074}		
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{D 074}	<p>Continued From page 10</p> <p>everywhere you look.</p> <p>-When she was admitted to the facility two years ago her family was told they were going to be replacing the floors, but that has not happened yet.</p> <p>-She had never lived in a place like this in her life.</p> <p>Observation of the men's shower room on 3/2/2015 at 12:30 p.m. revealed:</p> <p>-Brown discolored tiles were on the floor and on the walls in the 3 shower stalls.</p> <p>-There were broken tiles off the bottom of 2 sections of the lower wall visible upon entry into the shower room.</p> <p>-There were three brown stained ceiling tiles, and 4 missing ceiling tiles.</p> <p>Observation of the activity room on 3/2/2015 at 12:45 p.m. revealed:</p> <p>-Brownish, black dirt build up was on the floor along the wall.</p> <p>-There was black discoloration at the base of the door leading to the smoking area.</p> <p>Observation of the smoking area next to the activity room on 3/2/2015 at 12:50 p.m. revealed:</p> <p>-A red brick patio with missing bricks and loose bricks over an approximate 5 by 5 foot area presenting a fall hazard.</p> <p>-The benches for residents to sit on had thick brown and black stains.</p> <p>Observation of the kitchen on 3/2/15 at 10:45 a.m. revealed:</p> <p>The green tiled walls by the sink had dark brown grease stains.</p> <p>-The white area above the four walls had brown and orange dried food stains.</p> <p>-The corners of the tiled floor had black dried scum and dirt.</p>	{D 074}		

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{D 074}	<p>Continued From page 11</p> <ul style="list-style-type: none"> -The baseboards had black dried scum. -The wall behind the three compartment sink had brown dried food stains. -The floor behind the three compartment sink had black dried dirt stains. <p>Interview with the Dietary Supervisor on 3/2/15 at 10:45 a.m. revealed:</p> <ul style="list-style-type: none"> -Dietary staff swept and mopped the kitchen after meals. -"I had just started cleaning the walls this past Friday (2/27/15)." <p>Observation of the smaller dining room, which contained the reach in freezer, on 3/2/15 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -The wooden baseboards on the side of the reach-in-freezer had red stains. -The floor was dirty with black and grey dried dirt. -Greater than 20 tiles were indented, cracked and had dark brown stains. -Eight ceiling tiles had brown dried stains. <p>Observation of the larger dining room on 3/2/15 at 11:08 a.m. revealed:</p> <ul style="list-style-type: none"> -All four walls had orange and brown dried stains. -Eight ceiling vents had black dried stains which covered the vents. -The floors at the entrance of the dining room had white tile with black dried and stained dirt. <p>Interview with the Dietary Supervisor on 3/2/15 at 10:58 a.m. revealed anytime repairs needed to be done, she contacted Maintenance man.</p> <p>Interview with the Dietary Supervisor on 3/6/15 at 12:04 p.m. revealed after the last meal and as needed, dietary aides cleaned the floors in the kitchen and the dining room.</p>	{D 074}		

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{D 074}	<p>Continued From page 12</p> <p>Interview with a Medication Aide on 3/6/15 at 4:27 p.m. and a Personal Care Aide on 3/9/15 at 2:23 p.m. revealed they did not have a problem with the cleanliness of the facility and none of the residents had complained of the cleanliness of the facility.</p> <p>Interview with the facility Manager on 3/6/15 at 2:00 p.m. revealed: -The Dietary Supervisor was responsible for making sure staff cleaned the kitchen. -The kitchen should be cleaned daily. -The dining room should be swept and mopped after each meal. -The Manager checked the cleanliness of the kitchen twice daily. -The Manager was not aware the floors and walls in the dining room and kitchen needed to be cleaned. If she was aware, she would have made sure dietary staff and housekeeping cleaned the areas which needed to be cleaned.</p> <p>Interview with the facility Manager on 3/9/15 at 5:13 p.m. revealed: -The Manager expected dietary staff to clean the walls in the kitchen and dining room twice weekly. -The Manager was not aware the walls had not been cleaned.</p> <p>Interview with the Maintenance Man on 3/9/15 at 5:09 p.m. revealed: -He repaired anything which needed to be repaired. -The Maintenance Man was aware the ceiling and floor tiles in the facility needed to be replaced and he was in the process of replacing all ceiling and floor tiles.</p> <p>Interview with the Administrator on 3/9/15 at 5:13 p.m. revealed:</p>	{D 074}		

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{D 074}	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The Administrator expected dietary staff to keep the kitchen cleaned. -If the Administrator had been aware the kitchen and dining room were not cleaned he would have made dietary staff clean the kitchen and dining room. <p>Interview with the resident who lived in Room #101 on 3/2/15 at 11:16 a.m. revealed:</p> <ul style="list-style-type: none"> -Housekeeping cleaned the facility daily. -The resident's room was cleaned daily or every other day. <p>Observation of the floor in Room #101 on 3/2/15 at 11:34 a.m. revealed the corners of the baseboards on three walls had black dried stains.</p> <p>Observation of the private bathroom in Room #101 on 3/2/15 at 11:34 a.m. revealed:</p> <ul style="list-style-type: none"> -There were three stained (brown and green) tiles on the floor around the base of the toilet. -There was one stained brown tile under the sink. -The wall on the right side of the toilet had dried brown stains. <p>Observation of the private bathroom in Room #103 on 3/2/15 at 11:36 a.m. revealed the floor had three stained yellow tiles.</p> <p>Interview with the resident who lived in Room #103 on 3/2/15 at 3:36 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident did not have any problems with the cleanliness of the facility. -The bathrooms are cleaned daily by staff. <p>Observation on 3/2/15 at 11:53 a.m. revealed a Housekeeper was on each resident halls (2) cleaning.</p> <p>Observation of Room #109 at 11:58 a.m.</p>	{D 074}		

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{D 074}	<p>Continued From page 14</p> <p>revealed the floor had two tiles stained black on the floor.</p> <p>Observation of the private bathroom in Room #109 on 3/2/15 at 11:58 a.m. revealed three dried brown stained tiles were around the base of the toilet.</p> <p>Observation of Room #111 on 3/2/15 at 12:00 p.m. revealed the corners of the floor had built-up dried black scum.</p> <p>Observation of the private bathroom in Room #111 on 3/2/15 at 12:00 p.m. revealed: -The entrance to the bathroom floor had built-up black scum in the corners of the tile. -There were six stained brown tiles on the floor around the base of the toilet. -The walls and baseboards had brown dried stains on all four walls. -There were two broken ceiling tiles. -All 15 ceiling tiles were dried and stained brown.</p> <p>Observation of Room #117 on 3/2/15 at 12:05 p.m. revealed there was one cracked tile on the floor by the air conditioner.</p> <p>Observation of the private bathroom in Room #117 on 3/2/15 at 12:05 p.m. revealed there were three brown stained tiles on the floor around the base of the toilet.</p> <p>Observation of Room #119 on 3/2/15 at 12:06 p.m. revealed: -There was a black dry stain on the left wall. -The corner of the floor by the air conditioner (located in the wall) was a dried brown stain.</p> <p>Observation of the private bathroom in Room #119 on 3/2/15 revealed:</p>	{D 074}		

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{D 074}	Continued From page 15 -Four gray stained tiles were around the base of the toilet. -There was a brown dried stain on the right wall which was by the sink. -There was a gray dry streak on the bottom of the wall which was the wall on the left side of the toilet. Interview with the resident who lived in Room #119 on 3/2/15 at 12:10 p.m. revealed a "lady" cleaned the resident's room and bathroom daily after lunch.	{D 074}		
{D 105}	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building in a safe and operating condition. The findings are: Observation of the outside of the facility's building on 03/09/15 from 1:28 p.m. to 2:35 p.m. revealed: - Spider webs were noted around the outside of the building near the residents' windows. - The vinyl siding of the outside of the left side of the building was covered with a thick green substance. - Two long black wires were draped down in front of the dining room/kitchen windows on the outside of the building. - A metal gray box on the corner of the building near the kitchen had two wires running from it	{D 105}		

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{D 105}	<p>Continued From page 16</p> <p>with one wire exposed and not connected to anything while the other wire was sticking in the ground.</p> <ul style="list-style-type: none"> - The brick patio area to the smoking courtyard had multiple missing bricks on the right side as you enter the smoking porch. - The area missing bricks was approximately 4 to 5 feet in diameter and exposed the dirt where the bricks had been. - There were at least 8 loose bricks laying around the edge of the area of missing bricks. - The right side of the smoking courtyard porch had at least 10 bricks that were sticking up and uneven causing trip hazards. - Multiple nails (too numerous to count) were sticking down from the ceiling of the roof over the smoking porch. - Wooden benches on the smoking porch were worn with black stains. - The wooden exit door to the smoking courtyard had large area of black scratch and scuff marks on bottom half of door. - This exit door had a hole near the bottom approximately 4 inches in diameter. - This exit door had strips of wood pulling away from the bottom of the door exposing sharp and jagged edges. - The white metal support beams around the edges of the roof of the building had multiple areas of rust all around the building. - The lower 4 to 5 feet of the white stucco walls on the outside of the building had cracks running down the walls. - The white stucco walls had thick layer of dark brown dirt and a green substance. - The brick areas of the outside of the building also had cracks running down the bricks. - The black metal hand rail attached to the cement ramp at the side exit/smoking area was loose and would rock approximately 6 inches 	{D 105}		

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{D 105}	<p>Continued From page 17</p> <p>back and forth when touched.</p> <ul style="list-style-type: none"> - A white PVC pipe was sticking out of the ground in the yard near the fence by the kitchen exit area. - A second white PVC pipe was under water in a dug out trench near the fence by the kitchen exit area. - The trench was filled with water and extended down the yard in front of the right side of the building for approximately 20 feet. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - Housekeeper usually cleans the spider webs. - The metal hand rail outside the side exit/smoking area has been loose for years. <p>Confidential interview with a second resident revealed:</p> <ul style="list-style-type: none"> - Bricks in the smoking courtyard have been that way for a long time. - Sometimes residents' wheelchairs will get stuck on the bricks that are sticking up. - The exit door to the smoking courtyard has been that way for a long time. - Resident would like for the benches to be cleaned because of the stains. <p>Interview with a Housekeeper on 03/09/15 at 2:08 p.m. revealed:</p> <ul style="list-style-type: none"> - She was mostly responsible for cleaning the inside of the building. - She would sweep the four outside smoking areas. - She cleaned spider webs around the outside doors and picked up the trash. <p>Interview with the Facility Manager on 03/09/15 at 2:58 p.m. revealed:</p> <ul style="list-style-type: none"> - Last week they were using both washers and water started coming up through some of the 	{D 105}		

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{D 105}	<p>Continued From page 18</p> <p>drains.</p> <ul style="list-style-type: none"> - They contacted a plumber who came last week and temporarily repaired the pipes. - They think a delivery truck may have run over the original pipes, causing the problem. - She went over the report from the survey in September 2014 with the Maintenance person. - Maintenance person is responsible for cleaning and repairs to the outside of the building. - There is a box for work orders at the nurses' station where staff will document any issues that maintenance person needs to repair. - She did not know if any of the issues cited on the previous survey had been documented on work orders. - She did not know why the needed repairs from the previous survey had not been completed. - She has checked behind the maintenance person on some stuff but not everything. <p>Interviews with the Administrator on 03/09/15 at 3:20 p.m. and 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> - Maintenance person also works at the sister facility. - He was not aware of a problem with the plumbing pipes to the laundry room. - They have a power washer but they have not power washed the building in 4 to 5 years. - A lot of damage to the building came from the roof leaking which was repaired about 7 months ago. - The cracks in the building need plastering. - The bricks were put in the smoking courtyard to keep it from getting muddy but they can take them up if they need to. - The wires hanging outside the kitchen window were old television wires that were no longer used and could be removed. - The wires hanging from the box on the corner near the kitchen were old telephone wires no 	{D 105}		
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{D 105}	Continued From page 19 longer used and could be removed. Interview with the Maintenance Person on 03/09/15 at 4:55 p.m. revealed: - He had seen the report from the previous survey and he was aware of the outside issues with the building. - He was not aware the metal hand rail in the side porch was loose. - Plumber came to the facility last week and did a temporary fix on the pipe in the yard that was connected with the laundry room for the washing machines. - Plumber will come back on Monday, 03/16/15, to permanently fix the pipe and it will be covered. - Maintenance person indication he would put some tape up or rope off the area with the trench until the plumber came back for the permanent repair. - He had not worked on the mold on the building and had not cleaned or painted the outside of the building. - He had not worked on repairing the cracks in the outside walls of the building. Interview with the Administrator on 03/09/15 at 4:40 p.m. revealed: - He had recently spent \$20,000 repairing the roof of the building. - There was no money to do anything.	{D 105}		
{D 131}	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health	{D 131}		

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{D 131}	<p>Continued From page 20</p> <p>Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 6 sampled staff (Staff A) had the second step of the tuberculosis (TB) skin test in compliance with control measures adopted by the Commission for Health Services. The findings are:</p> <p>Review of Staff A's personnel record revealed:</p> <ul style="list-style-type: none"> - He was hired on 6/3/13 as a Medication Aide. - Staff A had a 1st step TB skin test given on his hire date of 6/3/13 and read as negative on 6/5/13. - There was no documentation of a second TB test. - There was documentation of a TB screen on 8/13/13 with no further documentation. - Interview with Staff A on 3/9/15 at 1:30pm revealed: <ul style="list-style-type: none"> - He has never had a positive TB test. - He never had a second TB test done. <p>Interview with facility Manager on 3/6/15 at 10:30am revealed:</p> <ul style="list-style-type: none"> - She did not realize it had not been done. - She will make sure it is done as soon as possible <p>Interviews with the Administrator 3/9/15 at 3:45pm revealed, he did not comment when asked about the required second TB test.</p>	{D 131}		
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{D 150}	Continued From page 21	{D 150}		
{D 150}	<p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>(a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.</p> <p>(b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review.</p> <p>This Rule is not met as evidenced by: Based on record review, and interview, the facility failed to assure the 80-hour personal care training and competency evaluation program was completed within six months of hire for 2 of 3 staff sampled (Staff A, and C). The findings are:</p> <p>A. Review of Staff A's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff A was hired as a Medication Aide on 6/3/2013 - There was n 	{D 150}		

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{D 150}	<p>Continued From page 22</p> <p>o documentation of the Personal Care Services (PCS) 80- hour training in Staff A's personnel record.</p> <ul style="list-style-type: none"> - Staff A's job duties included personal care tasks for residents. <p>An interview with Staff A on 3/9/15 at 1:30pm revealed:</p> <ul style="list-style-type: none"> - He has not had any personal care training. - He does not provide personal care task to the residents. - He administered medications only. - The only times he has touched a resident had been assisting to pick up one of the larger resident up off of the floor following a fall. <p>Refer to the interview with the facility Manager on 3/6/15 at 10:30am.</p> <p>Refer to the interview with Administrator on 3/9/15 at 3:45pm.</p> <p>B. Review of Staff C's personnel record revealed:</p> <ul style="list-style-type: none"> - Date of hire: 2/9/11. - Staff C was hired as a PCA. - No documentation of the PCS 80 hour training in Staff C's personnel record. - Staff B's job duties included personal care tasks for residents. <p>Observation on 3/6/15 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff C assisted in the transfer of a resident from the wheel chair to the bed. - Staff C provided incontinence care to a resident with the assistance of a medication aide. <p>An interview with Staff C on 3/6/15 at 1:10pm revealed:</p> <ul style="list-style-type: none"> - He had not received the any PCA training. - He does provide patient care assistance to 	{D 150}		
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{D 150}	<p>Continued From page 23</p> <p>the residents at the facility.</p> <ul style="list-style-type: none"> - He changes diapers, give showers, shaves residents, and whatever else their personal needs are. <p>Refer to the interview with the facility Manager on 3/6/15 at 10:30am.</p> <p>Refer to the interview with Administrator on 3/9/15 at 3:45pm.</p> <p>_____</p> <p>An interview with the facility Manager on 3/6/15 at 10:30am revealed:</p> <ul style="list-style-type: none"> - The PCA training has not been done for anyone without a certified nursing assistant (CNA). - She is aware it is needed, she hired a nurse from the pharmacy to teach the class 3 weeks ago, because she could not find a training class in this area. - The nurse told her she ordered a manual and she has not heard anything since then. <p>An interview with Administrator on 3/9/15 at 3:45pm revealed:</p> <ul style="list-style-type: none"> - The nurse is in the process of getting manuals to teach PCA training. - The nurse is checking with the Department's office on what the requirements of the class are. 	{D 150}		
D 176	<p>10A NCAC 13F .0601 Management Of Facilities</p> <p>10A NCAC 13F .0601Management Of Facilites</p> <p>(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</p>	D 176		

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D 176	<p>Continued From page 24</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, and interview, the Administrator and Manager failed to assure that all required duties were carried out in the facility related to the rule areas of resident rights, providing personal care and supervision, health care, medication administration, death reporting requirements, health care personnel registry, physical environment, housekeeping and furnishings, test for tuberculosis, personal care training and competency, and nutrition and food service. The findings are:</p> <p>Interview with the Manager (Staff F) on 3/6/2015 at 3:00 p.m. revealed: -She had been employed at the facility since 1998. -She was the supervisor in charge and worked collaboratively with the Resident Care Coordinator to manage the facility operations and resident care. -She had received an Administrator in training certificate but was unable to locate it. -The Administrator did not come to the facility often, but was on call as needed.</p> <p>1. Based on observation and interview, the</p>	D 176		

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D 176	<p>Continued From page 25</p> <p>facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition. [Refer to Tag D072 10A NCAC 13F .0305(a) Physical Environment]</p> <p>2. Based on observation and interview, the facility failed to assure walls, ceilings, and floors were clean and in good repair in 20 resident rooms and adjoining bathrooms, the men's shower room, hallways, 2 of 2 dining rooms, the kitchen, the activity room, and the smoking area off the activity room. [Refer to Tag D074 10A NCAC 13F .0306(a) Housekeeping and Furnishings]</p> <p>3. Based on observation and interview, the facility failed to maintain the building in a safe and operating condition. [Refer to Tag D105 10A NCAC 13F .0311(a) Other Requirements]</p> <p>4. Based on record review and interviews, the facility failed to assure 1 of 6 sampled staff (Staff A) had the second step of the tuberculosis (TB) skin test in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag D131 10A NCAC 13F .0406(a) Test for Tuberculosis]</p> <p>5. Based on record review, and interview, the facility failed to assure the 80-hour personal care training and competency evaluation program was completed within six months of hire for 2 of 3 staff sampled (Staff A, and C). [Refer to Tag D150 10A NCAC 13F .0501(a)(b) Personal Care Training and Competency]</p> <p>6. Based on observation, interview, and record review the facility failed to provide supervision of 13 sampled residents (#1, #3, #4, #8, #9, #16, #18, #19, #20, #21, #22, #23, and #24) caught</p>	D 176		

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D 176	<p>Continued From page 26</p> <p>smoking in their rooms, including resident (#3) whose roommate (#7) was on continuous oxygen via nasal cannula at 4 Liters/minute and resident (#1) who used oxygen in his room as needed. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]</p> <p>7. Based on observation, interview, and record review the facility failed to notify the physician for 3 of 6 sampled residents (#1, #2, and #6), regarding oxygen and smoking behavior (#1), and aggressive and assaultive behaviors toward staff and residents (#6). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]</p> <p>8. Based on observation and interview, the facility failed to assure the refrigerator in the kitchen and the freezer in the dining room were cleaned and dietary staff were following sanitation and safety guidelines. [Refer to Tag D283 10A NCAC 13F .0904(a) Nutrition and Food Service]</p> <p>9. Based on observation, interview, and record review, the facility failed to assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance. [Refer to Tag D338, 10A NCAC 13F .0909 Residents' Rights.]</p> <p>10. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#7) observed during the medication pass which included errors with the administration of inhalers for breathing problems and a stool softener and 4 of 4 diabetic residents (#9, #10, #11, #12)</p>	D 176		

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D 176	<p>Continued From page 27</p> <p>sampled related to the residents receiving insulin approximately 2 hours prior to their supper meal on 03/03/15. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]</p> <p>11. Based on observation, interview, and record review, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 3 of 4 residents (#7, #13, #14) observed during the 8:00 a.m. medication pass on 03/03/15 and 3 residents (#9, #16, #17) who received medications prior to observation of the 8:00 a.m. medication pass on 03/03/15. [Refer to Tag D366 10A NCAC 13F .1004(i) Medication Administration]</p> <p>12. Based on interviews, and record review, the facility failed to report to the North Carolina Health Care Personnel Registry allegations of abuse of a resident (#4) by a staff member, and neglect of a resident (#1) by a staff member who failed to remove oxygen prior to going out to the smoking area to ensure the resident's safety. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]</p> <p>13. Based on observation, interview and record review, the facility failed to ensure a written report was submitted to the Division of Health Service Regulation regarding the death of 1 resident (#1) who died as a result of an accident. [Refer to Tag D441 10A NCAC 13F .1208(a) Death Reporting Requirements]</p> <p>14. Based on observation, interview and record review, the facility failed to assure residents were treated with respect, consideration and dignity by</p>	D 176		

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D 176	<p>Continued From page 28</p> <p>making residents stand in line to receive a plated meal, by failing to assure 1 of 2 Residents (#9) who ate in the room was provided a bedside table, and by allowing 1 of 1 Staff (C) to disrespect residents. [Refer to Tag D911 G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)]</p> <p>15. 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 personal care and supervision, health care, medication administration, health care personal registry reporting, and residents' rights. [Refer to Tag D912 G.S. 131D-21(2) Declaration of Resident Rights]</p> <p>16. Based on interview and record review the facility failed to remove oxygen from 1 of 1 sampled resident (#1) wearing oxygen prior to going out in the smoking area who ultimately caught on fire and later died. [Refer to Tag D914 G.S. 131D-21(4) Declaration of Resident Rights (Type A1 Violation)]</p> <p>17. Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 2 of 2 employees (Staff D and Staff E) hired after 10/1/13 before the employees began working. [Refer to Tag D992 G.S. 131D-45 Examination and Screening for Controlled Substances]</p> <p>_____</p> <p>Review of the facility's plan of protection dated 3/6/2015 revealed:</p>	D 176		

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D 176	Continued From page 29 -Management will sit down with the administrator for an in-service. -Manager will study the DHSR rules and regulations book for Assisted Living facilities. -Immediately develop a plan of correction for the areas cited that are out of compliance. -Review and develop policies and procedures for areas of non-compliance. -Monitor the facility's daily operation on a daily basis. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 08, 2015.	D 176		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview, and record review, the facility failed to provide supervision of 13 sampled residents (#1, #3, #4, #8, #9, #16, #18, #19, #20, #21, #22, #23, and #24) caught smoking in their rooms, including resident (#3) whose roommate (#7) was on continuous oxygen via nasal cannula at 4 Liters/minute and resident (#1) who used oxygen in his room as needed. The findings are:	D 270		

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D 270	<p>Continued From page 30</p> <p>Observation during the tour of the facility on 3/2/2015 from 10:00 - 11:00 a.m. revealed all bedroom doors had a sign which read "No smoking" and a larger no smoking symbol on Room #201 bedroom door in which Resident #7 had continuous oxygen.</p> <p>A. Interview with the Manager on 3/4/2015 at 3:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 wore the portable oxygen in his room after discharge from the hospital on 1/5/2015 and mostly laid in bed and did not smoke as much as usual. -Resident #1 had been smoking in his room daily in the bathroom. "You could smell it coming from underneath the door." -There was a can of cigarette butts in his bathroom. -Resident #1 couldn't get himself in and out to smoke as easily as he used to because he had no energy. -The Manager would take Resident #1's cigarettes and lighter away from him when she suspected he was smoking in his room, put them at the Nurses station, and the Medication Aide or the Activity Director would give them back to him if he asked. -Staff were aware of the smoking policy and fire safety policy upon hire. -There was not a specific policy for oxygen use. -There is no policy regarding consequences for smoking in the building except for confiscating their cigarettes and lighter, but they always find ways to get more or the staff gives them back after a period of time. -Residents are observed every 30 minutes by staff and there is a log where staff sign they have done 30 minute resident checks. -Two personal care aides and a medication aide are scheduled on first and second shift, and 2 	D 270		
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D 270	<p>Continued From page 31</p> <p>personal care aides on third shift.</p> <p>Review of Resident #1's record revealed: -An incident report dated 1/7/2015 stating Resident #1 "had just returned from a doctor's appointment when he requested to be taken outside. Shortly thereafter a staff member saw flames coming from (Resident #1's) face. (Resident #1) was attempting to lite a cigarette with his oxygen on. His face looked to be burned. 911 was called. Emergency Medical Services arrived quickly."</p> <p>Interview with the the personal care aide on 3/4/2015 at 12:00 p.m. revealed: -On 1/7/2015 after Resident #1 got back from his physician's appointment the transporter told him Resident #1 wanted to get some fresh air and to keep an eye on him. -The transporter brought Resident #1 out to the smoking area. -He was aware Resident #1 had oxygen on and went outside to the smoking area to ask Resident #1 if he was alright and Resident #1 told him yes. -Resident #1 was not smoking at that time but there were other residents in the smoking area. -He walked out of the smoking area through a different exit door from the activity room leading into a hallway and walked around the facility through the day room and down 2 more hallways before returning to the activity room. -He said something to the Activity Director who was sitting in her office off the activity room and turned his head to the window in the activity room facing the smoking area and he saw Resident #1's face was on fire. -He put the fire out on Resident #1's face with his hands.</p> <p>B. Interview with the Manager and the Resident</p>	D 270		

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D 270	<p>Continued From page 32</p> <p>Care Coordinator (RCC) present on 3/3/2015 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #3's "smoking in the bedroom is a problem 24/7." - "We have spoken to him and he has promised not to smoke in the room." -Resident #3 "throws the cigarette on the floor when you catch him or puts it out in the urinal. " -Resident #3 "smokes in bed and falls asleep burning holes in the sheets and the bedding." - "We have confiscated his cigarettes and lighter." - "We have spoken to him about the safety and dangers to other residents and himself with oxygen in the room." -Resident #3 manages to get cigarettes and a lighter from other residents and does it again. -Resident #3's room has not been changed because he does damage to the doors in his room with his electric wheelchair requiring them to be replaced. -Resident #3 "would trash another room". -Resident #3 had been issued a discharge notice but no place will take him because of his behaviors. -Resident #3 was sent to the hospital for disoriented behavior on 3/1/2015 and the facility will not be accepting him back. "We cannot meet his needs." <p>Interview with a Personal Care Aide (PCA) on 3/3/2015 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -She had caught Resident #3 smoking "frequently" in his room approximately "every 3 days". -Resident #3 will throw his cigarette on the floor if you catch him. -She stated she has told Resident #3 "You are going to blow us up with oxygen in the room." -Resident #7 does not like him smoking in the room and will ring the bell for help if he sees him. 	D 270		

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D 270	<p>Continued From page 33</p> <ul style="list-style-type: none"> -Resident #3 will just throw the cigarette at Resident #7 if he is mad enough. -Resident #3 falls asleep smoking and the sheets have been burned. <p>Interview with Resident #7 on 3/6/2015 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #7 did not get along with Resident #3. "We don't like each other." -Resident #3 smoked in their bedroom every day and he would ring his call bell for staff assistance. -"He can't do that because I am on oxygen." -Resident #3 had come over to him with his fists raised and they have had a physical altercation in the past. <p>Interview with the Medication Aide on 3/3/2015 at 5:45 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #3 smokes in his room with a roommate with an oxygen tank and he had caught him several times. -The PCA's mostly discover if Resident #3 has been smoking in his room. <p>Interview with the Medication Aide on 3/2/2014 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #3, #4, #8 have been caught smoking in their rooms. -Resident #3 gets caught smoking in his room approximately every other day, the last time being 2/26/2015. -Staff have confiscated his cigarettes and give him cigarettes at certain times during the day to go out and smoke. <p>Review of the available staff shift notes revealed:</p> <ol style="list-style-type: none"> 1. Resident #1 was noted to be smoking in his room on 8/1/2014, 10/1/2014, and 1/6/2015. 2. Resident #3 was noted to be smoking in his 	D 270		

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D 270	<p>Continued From page 34</p> <p>room or in the building on: 12/2/2014, 12/3/2014, 12/22/2014, 1/3/2015 (smoking twice in his room), 1/6/2015, 1/9/2015 (smoking twice in room), 1/10/2015, 1/16/2015, 1/29/2015, 1/31/2015, 2/16/2015, and 2/21/2015.</p> <p>-On 12/2/2014 Resident #3 was smoking in his room and set the alarm on Resident #7's oxygen off at 1:25 a.m., 2:42 a.m. again, 3:21 a.m. again, 4:00 a.m. again, 5:55 a.m. again.</p> <p>-On 12/17/2014 Resident #3 "is turning Resident #7's oxygen off."</p> <p>-On 12/18/2014 Resident #3 "is still messing with Resident #7."</p> <p>-On 12/20/2014 Resident #3 "was in his room trying to fight Resident #7. Resident #3 told Resident #7 he is going to hit him so hard he is going to have a heart attack."</p> <p>-On 1/9/2015 Resident #3 was "smoking in his room around 10:00 p.m. till 8:00 a.m."</p> <p>- On 2/16/2015 "His roommate is on oxygen. I took his cigarettes and lighter."</p> <p>-On 2/21/2015 Resident #3 "was caught smoking in the room while Resident #7 is on oxygen."</p> <p>3. Resident #4 was noted to be smoking in the activity room on 12/6/2014, 12/10/2014, 12/29/2014, 12/30/2014, 1/6/2015, 1/15/2015, and 2/10/2015.</p> <p>- On 12/10/2014 "When she (Resident #4) was caught she put it out on the furniture and almost set the place on fire."</p> <p>-On 12/30/2014 Staff "Took the lighter and cigarettes" from Resident #4.</p> <p>-On 1/2/2015 Resident #4 was noted to be coming down the hallway smoking a cigarette.</p> <p>- On 1/21/2015 Resident #4 "was smoking in the building twice today. I took her lighter and put it in her cubby hole."</p> <p>-On 1/27/2015 Resident #4 was "caught smoking in the building once again."</p>	D 270		

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D 270	<p>Continued From page 35</p> <p>1/29/2015 Resident #4 was "smoking in facility."</p> <p>4. On 1/28/2015 Resident #8 "was caught smoking in his room. He told me that it was too cold to go outside to smoke. I took his cigarettes and put them in his cubby hole." -On 2/26/2015 Resident #8 was smoking in his room.</p> <p>5. On 12/17/2014, and 1/10/2015 Resident #9 was noted to be smoking in her room.</p> <p>6. Resident #16 was noted to be smoking in his room with no date recorded.</p> <p>-7. On 12/7/2014 Resident #18 was noted to be smoking in her room.</p> <p>8. On 1/29/2015 Resident #19 was noted to be "smoking in the facility".</p> <p>9. On 2/8/2015 Resident #20 was noted to be "smoking in the front door".</p> <p>10. Resident #21 "Smokes in her room. Housekeeper found ashes around her toilet seat." with no date recorded.</p> <p>11. On 12/4/2014, Resident #22 was noted to be smoking in his room. "He will not give up his lighter or cigarettes." -On 12/23/2014, Resident #22 was caught smoking in his room. -Resident #22 was "smoking in his room and throwing the butts in his toilet which has caused it to be clogged. Reported by the housekeeper. " with no dated recorded.</p> <p>12. On 2/26/2015 Resident #24 was caught smoking in his room.</p>	D 270		

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D 270	<p>Continued From page 36</p> <p>Interview with a Personal Care Aide (PCA) on 3/9/2015 at 1:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #16 had been caught smoking in his room. -Resident #24 has been caught smoking in his room on the third shift (11:00 p.m. - 7:00 a.m.) and staff monitors his cigarettes by giving him 2 a day, but he picks up cigarettes out of the can. "Can't keep an eye on him." -Resident #3 smokes in his room daily with a roommate with oxygen which she recognized was dangerous. -Resident #3's cigarettes have been taken away from him but he calls his family to bring him more. -Resident #18, #20, #21, #22 have been caught smoking in their rooms mostly on second shift (3:00 p.m. - 11:00 p.m.) heard by report. -When residents are caught or suspected of smoking in their rooms the Manager and the Resident Care Coordinator are made aware and it is written on the shift notes. <p>Interview with Staff C on 3/9/2015 at 1:45 p.m. revealed:</p> <ul style="list-style-type: none"> -He had caught Resident #8 smoking in his room several times. -He had caught Resident #4 several times approximately every 2 weeks lighting a cigarette inside at the doorway before she gets outside. -When residents get caught or are suspected of smoking we reinforce the rules, take their cigarettes and lighter and put them at the medication station in a cubby, but they find a way to get more cigarettes. <p>Interview with the transporter on 3/4/2015 at 3:20 p.m. revealed "There are a bunch of residents that smoke in their rooms, especially when it is cold outside."</p>	D 270		

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D 270	<p>Continued From page 37</p> <p>Observation on 3/9/2015 at 2:00 p.m. of room # 120 with the Medication Aide revealed: -Resident #8 coming out of his bathroom and Resident #23 sitting on the bed. -The bathroom and the room outside the bathroom smelled like smoke.</p> <p>Interview with the Medication Aide on 3/9/2015 at 2:00 p.m. in room# 120 revealed: -The bathroom smelled like "some kind of narcotic or crack" had been smoked in the bathroom, not a cigarette. -He reported his suspicion to the Manager and the Resident Care Coordinator (RCC). -Resident #21 had been caught smoking several times on first shift (7:00 a.m. - 3:00 p.m.) and "some on second shift". -Resident #20 had been caught smoking and ashes have been found on Resident #22's toilet seat. -Resident #17 and Resident #18's rooms have smelled like smoke. -When a resident is caught smoking inside the building or suspected of smoking it is reported to the RCC and the Manager and it is documented in the shift notes.</p> <p>Interview with the Manager on 3/9/2015 at 3:30 p.m. revealed: -She had not had a chance to talk to Resident #8 and Resident #23 yet about the smoke smell reported in room# 120 at 2:00 p.m. -She thought Resident #8 would be honest when she asked him about whether he had been smoking something other than cigarettes in his room. -" I guess I will have to discharge them if they say they did it." -She had caught Resident #8 smoking cigarettes</p>	D 270		

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D 270	<p>Continued From page 38</p> <p>before in his room. -Resident #8 gets caught every 1- 2 days usually on the off shifts. -Resident #8's room usually smells like smoke.</p> <p>Interview with the Business Office Manager (BOM) on 03/09/15 at 3:40 p.m. revealed: -They have to keep the door locked for the common bathroom located between her office and the front entrance. -"Residents will go in there and smoke." -BOM would not give names of residents when asked but she stated it was "different residents".</p> <p>Interview with the Administrator on 03/09/15 at 3:55 p.m. revealed: -He was aware residents were smoking in the facility. -They don't have enough staff to supervise residents 24 hours a day. -He stated the residents are adults. - We tell them not to do it and restrict their cigarettes.</p> <p>_____ Review of the facility's plan of protection dated 3/3/2015 revealed: -The facility will not accept back a resident that is smoking around oxygen -If he does come back he will be moved into a different room. -The facility manager will check each room every 15 minutes. -Re-educate staff on the smoking policy,. -Facility manager will monitor smoking areas every 15 minutes along with the Resident Care Coordinator and Supervisors. -Supervisors will also ensure the safety of the residents. -If a resident is caught smoking in their room 3 or</p>	D 270		

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D 270	Continued From page 39 more times they will be discharged. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 08, 2015.	D 270		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, interview, and record review the facility failed to notify the physician for 3 of 6 sampled residents (#1, #2, and #6), regarding oxygen and smoking behavior (#1), and aggressive and assaultive behaviors toward staff and residents. The findings are:</p> <p>1. Review of the Resident #1's Resident Register revealed he was admitted on 6/4/2003.</p> <p>Review of Resident #1's last FL-2 dated 7/11/2014 revealed: -Diagnoses included: Organic Brain Syndrome, Organic Seizure Disorder, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, History of Atrial Fibrillation, and Gastro-Esophageal Reflux Disease. -Resident #1 was semi-ambulatory with the use of a wheelchair.</p>	D 273		

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D 273	<p>Continued From page 40</p> <p>-Oxygen was ordered with the frequency and amount unspecified.</p> <p>Interview with the Manager on 3/4/2015 at 1:00 p.m. revealed:</p> <p>-She had not called to clarify the frequency or amount of oxygen ordered on the FL-2 for Resident #1.</p> <p>-Resident #1 had a previous order for oxygen at 2 Liters/minute by nasal cannula.</p> <p>-She was unable to locate an oxygen order in Resident #1's record except for oxygen being checked on the FL-2 dated 7/11/2014.</p> <p>-Resident #1 had an oxygen concentrator and several portable tanks in his room but he rarely used them.</p> <p>Interview with the medical supply representative on 3/4/2015 at 11:30 a.m. revealed:</p> <p>-He received a physician's order on 5/13/2014 for home oxygen 2 Liters/minute via nasal cannula and home oxygen equipment.</p> <p>-The company delivered an oxygen concentrator, 2 portable oxygen tanks on 5/13/2014 and the complete portable oxygen system, including the 1 oxygen tank, the cart, a regulator, and a concentrator on 8/3/2014.</p> <p>-He had not received any further physician's orders or requests for oxygen supplies from the facility for Resident #1.</p> <p>-Resident #1's oxygen supplies were picked up from the facility on 1/14/2015 when he received information from the facility Resident #1 had died.</p> <p>Review of Resident #1's medical records revealed:</p> <p>-Resident #1 was evaluated at the pulmonology specialty clinic on 5/15/2014 for follow from hospitalization for flare up of COPD.</p> <p>-On 5/15/2014 notes stated "Caregiver states he</p>	D 273		

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D 273	<p>Continued From page 41</p> <p>refuses to use oxygen and smokes 1 pack of non-filter Camel cigarettes daily." -On 5/15/2014 nebulizer treatments were ordered. -On 5/15/2014 there was no documentation of oxygen treatment or orders. -On 7/11/2014 Resident #1 was seen by a primary care physician at the clinic. -On 7/11/2014 Resident #1 received a new FL-2, there was no documentation of oxygen use in the notes from this visit. -On 12/17/2014 was Resident #1's next visit to the specialty clinic with documentation "Still smoking, and also does not want to stop... and does not use oxygen."</p> <p>Review of Resident #1's physician's orders revealed: -On 12/17/2014 "Discontinue oxygen as he is not using it". -Resident #1 was to follow up in 9 months.</p> <p>Review of Resident #1's hospital record dated 12/29/2014 revealed: -Resident #1 was sent to the hospital for complaint of shortness of breath. -Admitting diagnosis included COPD exacerbation and Dementia. -Resident #1 was discharged on 1/5/2015 with a transfer summary including medications which did not include physician's order for oxygen. -A case management note on 1/5/2015 at 3: 44 p.m. states "Patient does not need oxygen at home" and the facility Medication Aide was notified of that.</p> <p>Interview with the Medication Aide on 3/6/2015 at 4:30 p.m. revealed he received the call from the case manager at the hospital regarding Resident #1 not needing home oxygen but did not tell</p>	D 273		

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D 273	<p>Continued From page 42</p> <p>anyone, including the Manager or the Resident Care Coordinator (RCC).</p> <p>Interview with the Manager on 3/4/2015 at 3:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 went to the specialty clinic in December 2014 and his oxygen had been discontinued because she informed them Resident #1 was not using it. -She had not received an order for oxygen after discharge from the hospital on 1/5/2015 and assumed because the transfer summary referred to the resident having been on home oxygen before that it was continued. -She did not call the physician to clarify oxygen orders for Resident #1. -Resident #1 wore the portable oxygen in his room after discharge from the hospital on 1/5/2015 and mostly laid in bed and did not smoke as much as usual. -Staff C told her on the morning of 1/7/2015 Resident #1 was short of breath. -Resident #1 "could hardly breathe". -The Manager put oxygen on Resident #1 by nasal cannula at 2 Liter/minute per an old order. -The Manager did not call the physician regarding Resident #1's respiratory distress, for an oxygen order, or call 911. -Resident #1 wore oxygen to his appointment at the specialty clinic on 1/7/2015. -The Manager would take Resident #1's cigarettes and lighter away from him when she suspected he was smoking in his room, put them at the Nurses station, and the Medication Aide or the Activity Director would give them back to him if he asked. -Staff have been trained on the dangers of oxygen use and smoking. -The Manager did not inform Resident #1's physician of Resident #1 smoking in his room at 	D 273		
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D 273	<p>Continued From page 43</p> <p>the facility on a daily basis.</p> <p>Interview with the nurse at the pulmonology specialty clinic on 3/9/2014 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 came to his last appointment on 1/7/2015 wearing oxygen by nasal cannula at 3 Liters/minute. -The oxygen is not removed or adjusted without a physician's order. -She did not see an order for oxygen for Resident #1 in their records. -Resident #1 did not have a primary care physician at the clinic and was "unassigned" which may have been due to noncompliance with his appointments. -The last time Resident #1 had an assigned primary care physician was 2 years ago. <p>Interview with Resident #1's physician at the specialty clinic on 3/9/2015 at 2:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was not ordered oxygen by him or the clinic. -Resident #1 had been on oxygen after pulmonary function tests done on 9/27/2011. -Resident #1 was getting the oxygen from somewhere else. -The facility had never called with concerns for Resident #1's respiratory status, smoking in his room, or for oxygen orders. -Resident #1 had been seen at the specialty clinic for 3 years. -Resident #1 had oxygen via nasal cannula on at 3 Liters/minute at the 1/7/2015 visit which he had not had on at the previous visits. -If a patient comes in with oxygen we do not change it since it is ordered somewhere else. -Resident #1 smoked 2-3 packs of cigarettes per day. -Resident #1 was counseled at every visit on 	D 273		

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D 273	<p>Continued From page 44</p> <p>stopping smoking and the dangers of oxygen use while smoking.</p> <p>-Resident #1 didn't want to stop smoking and stated "The Lord would help him."</p> <p>2. Review of Resident #6's current FL-2 dated 10/14/14 revealed:</p> <p>-The resident's diagnoses included intellectual disability, glaucoma, epilepsy without mention of intractable epilepsy, depressive disorder, schizophrenia and seizure disorder.</p> <p>-The resident was semi ambulatory with a wheel chair.</p> <p>-An order for Lexapro 10 milligrams (mg) 1 by mouth daily (used to help treat depression and anxiety disorder).</p> <p>-An order for Namenda XR 14 mg by mouth daily (used to help treat dementia).</p> <p>-An order for Depakote SOD ER 500 mg 1 by mouth twice daily (used to help treat seizures and bipolar disorders).</p> <p>-An order for Clonazepam 0.5 mg 1 by mouth three times daily.</p> <p>-An order for Ambien 10 mg 1 by mouth at bedtime (used to help treat insomnia).</p> <p>Review of Resident #6 record revealed a subsequent order dated 11/5/14 to change to Clonazepam 0.5 mg 1 tab by mouth three times daily as needed for anxiety.</p> <p>Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 9/27/13.</p> <p>Review of Resident #6's current Care Plan dated 10/14/14 revealed:</p> <p>-The resident was oriented.</p> <p>-There was no documentation of Resident #6's behaviors.</p>	D 273		

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D 273	<p>Continued From page 45</p> <p>Review of Resident #6's Medication Administration Records (MARs) revealed: -For January 2015, Clonazepam was administered 32 times. -For February 2015, Clonazepam was administered 30 times. -From March 1-9, 2015, Clonazepam was administered 7 times.</p> <p>Review of Resident #6's progress notes revealed the resident was seen by the primary care physician on 10/21/14.</p> <p>Review of the progress note entry dated 10/9/14 by Resident #6's mental health provider revealed: -Add Seroquel 25 milligrams by mouth twice daily (used to help treat schizophrenia and bipolar disorder.) -"Continue all other medications and management. Return to clinic in 4 weeks." -Call the mental health providers cell phone if any problems in the meantime.</p> <p>Review of Resident #6's progress notes entry dated 11/8/14 at 3:55 p.m. by a Personal Care Aide (PCA) revealed: -The PCA heard Resident #6 and another resident making a lot of noise, screaming and fighting in the activity room. -The PCA yelled for the two residents to stop fighting, but the residents would not stop fighting. -The PCA got the Medication Aide (MA)/Supervisor (SIC). The SIC broke up the fight. -The resident who was fighting with Resident #6 revealed Resident #6 said bad things and hit the resident in the chest. -Resident #6 complained of the head hurting and denied hitting the resident in the chest.</p>	D 273		

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D 273	Continued From page 46 Review of Resident #6's progress notes entry dated 11/8/14 at 4:00 by the SIC revealed: -The resident refused to go and receive "medical treatment" after being hit on the head. -The resident only wanted to receive medications for a headache. The SIC gave the resident Tylenol 325 mg 2 tablets by mouth to treat the headache. -The resident did not complain of any more headaches when asked by the SIC at 5 p.m. Review of Resident #6's progress notes entry dated 11/16/14 at 8:30 (unknown if a.m. or p.m.) by another PCA revealed: -Resident #6 was trying to hit the PCA. -The PCA moved and the resident hit the wall and fell on the floor. -The resident continued to try to kick the PCA. Review of Resident #6's progress note entry dated 12/7/14 at 8 a.m. by a MA revealed: -Resident #6 was in line for breakfast and started kicking the other residents' wheel chairs and cursing residents for no reason. -The MA attempted to keep Resident #6 from kicking the other residents' wheel chairs by standing between Resident #6 and the other residents, but resident #6 kicked the MA. The resident stood up and "punched" the MA in the face, chest and stomach. -The MA called the facility Manager and the Manager "handled the situation." -Resident #6 is still irritated at 2 p.m. Interview with the MA on 3/6/15 at 10:11 a.m. who documented the entry in the progress notes on 12/7/14 at 8: a.m. revealed: -On 12/7/14 at 8 a.m., Resident #6 came to the medication room to get medications.	D 273			

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D 273	<p>Continued From page 47</p> <ul style="list-style-type: none"> -There was a line of residents waiting to receive medications. Resident #6 did not want to wait in line to receive medications. The resident started kicking other resident wheel chairs. -The MA stood in front of Resident #6's wheel chair to stop the resident from kicking the other resident wheel chairs. -Resident #6 started swinging the residents' arms at the MA and hit the MA in the chest, face and abdomen. -The MA sent a PCA to get the facility Manager. -The MA had never observed Resident #6 hit residents. -The MA faxed to the resident's primary care physician the resident's behaviors. -He did not know the response from the primary care physician. -The MA was unaware Resident #6 had a mental health provider. <p>Review of Resident #6's progress notes entry dated 3/2/15 by a MA revealed:</p> <ul style="list-style-type: none"> -During the med pass, Resident #6 came to the medication room for medications. -The MA told the resident the resident would receive the medication after the other residents who were in line first received their medications. -Resident #6 started calling the MA names and cursing at the MA. -The MA asked the resident if the resident wanted to take medications when time to give the resident the medications and the resident starting kicking the MA. -Resident #6 kicked the MA in the groin. -The MA grabbed the resident's legs until another staff assisted the MA from getting away from the resident. The Resident Care Coordinator (RCC) told the MA to let the resident's legs go, but the MA told the RCC he could not because the resident was kicking. 	D 273		
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D 273	<p>Continued From page 48</p> <p>-A PCA came to relieve the MA.</p> <p>Interview with the MA on 3/2/2015 at 11:45 a.m. who documented the entry in the progress notes on 3/2/15 revealed:</p> <ul style="list-style-type: none"> -Resident #6 has a "bad attitude." -Resident #6 tries to fight people and kicks them almost daily. -Resident #6 kicked me this morning below the belt and it is painful still. -Resident #6 hurts other residents by kicking them. -Resident #6 forgets what he does an hour later. -Resident #6's behavior has gotten worse lately. -He has told the Resident Care Coordinator and the Administrator and documents in the shift notes. - "I wish his psychiatrist would adjust his medications. I don't know why he won't." <p>Interview with the same MA on 3/9/15 at 1:52 p.m. revealed:</p> <ul style="list-style-type: none"> -Sometimes Resident #6 will refuse a Clonazepam dosage if the resident know the medication will calm the resident down. The resident calls the medication a "nerve pill." -If the resident refuses the Clonazepam, the MA documents the refusal in the shift notes and informs the RCC. -The facility Manager calls the resident's primary care physician and tells the Transporter to give the information to the physician. <p>Confidential interview with a resident on 3/2/2015 revealed:</p> <ul style="list-style-type: none"> -Resident #6 kicked staff as they were walking by. -If a resident touched Resident #6 the resident will curse at the resident, call the resident names, and tell the resident to "go f ... your mother." 	D 273		

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D 273	<p>Continued From page 49</p> <p>-There are not many days where Resident #6 will not tell you to "go fyou mother." -"It got on my nerves so bad I could hardly stand it." -"Some days it makes you not want to eat." -"I am scared. I stay in my room most of the time." -"He has kicked me and knocked the skin off my arm shortly after I got here 2 years ago." -"I pray for everyone here."</p> <p>Observation on 3/6/15 at 11:40 a.m. revealed: -Resident #6 was arguing with a resident. -In the dayroom near the dining room, Resident #6 had swung the arms and had cursed at a PCA. -The PCA moved away from the resident.</p> <p>Interview with the resident who got into the altercation with Resident #6 on 3/6/15 at 11:40 a.m. revealed Resident #6 was saying bad things about the resident's family. So, the resident kicked Resident #6.</p> <p>Interview with the MA on 3/6/15 at 12:33 p.m. who witnessed Resident #6 arguing with a resident on 3/6/15 at 11:40 a.m. revealed: -The MA gave Resident #6 a Clonazepam dosage after the resident had yelled earlier during the day at 11:40 a.m. -The medicine Resident #6 is using is not working for the resident. The resident's Clonazepam changed from three doses daily to as needed three times daily, when we first told the doctor about the resident's behavior. "It should not have changed."</p> <p>Interview with the Transporter on 3/6/15 at 11:45 a.m. revealed: -Resident #6 blocked the doorway in the dayroom</p>	D 273		

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D 273	<p>Continued From page 50</p> <p>daily, which is a fire hazard.</p> <p>-Resident #6 curses, swings the residents' arms at staff, uses racial slang and will not move when staff try to move the resident out of the doorway.</p> <p>Interview with a MA on 3/6/15 at 4:27 p.m. revealed:</p> <p>-Resident #6 curses residents, but Resident #6 does not hit other residents.</p> <p>-Resident #6's physician was made aware about the behaviors either November 2014 or December 2014, but the physician changed the medications to as needed.</p> <p>-The MA told the facility Manager. The facility Manager told Resident #6's physician about the resident's behavior (November 2014 or December 2014), but the resident has not changed. The behavior is still the same.</p> <p>-The MA had not told the physician about the resident's behaviors. "I could tell him."</p> <p>Telephone interview with Resident #6's mental health provider on 3/9/15 at 1:10 p.m. revealed:</p> <p>-The provider was not aware of Resident #6's current behaviors. No one at the facility had contacted the provider about the residents' behaviors.</p> <p>-The provider is aware of Resident #6's past behaviors (kicking, yelling, name calling).</p> <p>-When Resident #6 was at the last appointment, no one complained about the resident's behavior. The provider could not remember the last time he saw the resident nor was he able to give information about when he was first contacted about the resident's behaviors, because he did not have the Resident #6's file with him.</p> <p>-The provider revealed if Resident #6 had gotten worst with the behavior since the last appointment, he would have wanted to have known. He would like to see Resident #6 as soon</p>	D 273		

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D 273	<p>Continued From page 51 as possible.</p> <p>Review of Resident #6's progress notes revealed: -Entry dated 1/20/15 revealed Resident #6 was seen by the primary care physician for a follow-up. -Entry dated 1/28/15 revealed Resident #6 was seen by the mental health provider. Follow-up in months.</p> <p>Telephone interview with Resident #6's primary physicians nurse on 3/9/15 at 2:10 p.m. revealed: -Resident #6 was last seen by the primary care physician on 1/20/15. -There was no documentation about Resident #6's behaviors in the resident's file. -The facility should have notified Resident #6's primary care physician if the resident had behavior problems. -The nurse would contact Resident #6's primary care physician to see if the physician had any documentation about Resident #6's behaviors. -The nurse did not call back by the end of the survey.</p> <p>Interview with the RCC on 3/9/15 at 2:42 p.m. revealed: -The RCC does not know why the MAs did not contact Resident #6's mental health provider. -The MA's document Resident #6's behaviors in the shift note or write the note in the communication log and it leave on the RCC's desk or the facility Manager's desk. -The MA's or the RCC should have contacted the mental health provider sooner. She could not provide a reason to why she had not contacted Resident #6's mental health provider or physician. -The RCC had observed Resident #6 yelling, cursing and swinging. She just tells staff not to get in the resident's space.</p>	D 273		

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D 273	<p>Continued From page 52</p> <ul style="list-style-type: none"> -The RCC just contacted the Resident #6's mental health provider on today (3/9/15) and the provider increased the Clonazepam to 1 mg three times daily with scheduled dosages. -The provider wanted to see the resident on Wednesday (3/11/15) after 9 a.m. -There was no documentation of calling Resident #6's mental health provider. -The RCC had not been checking to make sure the MA's had contacted Resident #6's physician. -The RCC checked the residents' MARs three times monthly to make sure staff are documenting the medications. -Resident #6 had gotten worse since the Clonazepam had changed to as needed. -Resident #6 had last seen the mental health provider on 1/28/15 and was to follow-up in 4 months. <p>Observation and interview with Resident #6 on 3/9/15 at 3:09 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident was sitting in the day room watching television. -Resident #6 get in fights with other residents when the residents talk about Resident #6. -Staff are nice. -The resident did not want to talk anymore. <p>Interview with the facility Manager on 3/9/15 at 3:36 p.m. revealed:</p> <ul style="list-style-type: none"> -If a resident had behavior problems, the MA should try to get in touch with the resident's physician the same day. -The RCC and the facility Manager checked behind the MAs twice weekly to make sure staff are documenting correctly on the MARs. -If the MA could not get in touch with the physician, the RCC or the facility Manager should try to get in touch with the physician. -The facility Manager had not contacted Resident 	D 273		

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D 273	<p>Continued From page 53</p> <p>#6's physician about the resident's current behaviors. -The facility Manager was not aware Resident #6's physician had not been contacted.</p> <p>Interview with the Administrator on 3/9/15 at 4:14 p.m. revealed: -If a resident has behavioral problems the RCC should notify the resident's physician. -The RCC should keep contacting the physician until there is a response. -He was not aware Resident #6's primary care physician and mental health provider had not been contacted due to the resident behaviors.</p> <p>_____</p> <p>Review of the facility's plan of protection dated 3/9/2015 revealed: -Call the physician now and inform him of Resident #6's behavior and actions. -The physician called back and adjusted Resident #6's medication and will see the patient 3/11/2015. -Monitor resident daily and inform staff to monitor also. -Redirect resident if and when he becomes agitated. -Administer as needed medications as ordered. -Notify the physician as needed. -Will notify the physician on any resident status or change in status. -Will call the physician about any orders, or medication changes that are not clear.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 08, 2015.</p>	D 273		

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{D 283}	Continued From page 54	{D 283}		
{D 283}	<p>10A NCAC 13F .0904(a)(2) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the refrigerator in the kitchen and the freezer in the dining room were cleaned and dietary staff failed to follow sanitation and safety guidelines:</p> <p>The findings are:</p> <p>1. Observation of the refrigerator during the tour on 3/2/15 at 10:40 a.m. revealed the refrigerator had white dried food crumbs at the bottom of the refrigerator.</p> <p>Observation of the smaller dining room on 3/2/15 at 11:00 a.m. revealed: -One of the vent slates located at the bottom on the outside of the freezer was loosed and the vent had gray dust. -Inside of the freezer on the bottom shelf were scattered light and dark brown food crumbs.</p> <p>Interview with the Dietary Supervisor on 3/6/15 at 12:04 p.m. revealed: -The refrigerator and the freezer are cleaned every Tuesday and was last cleaned on 2/24/15. -The Dietary Supervisor was aware the refrigerator and the freezer needed to be cleaned.</p> <p>Interview with the facility Manager on 3/6/15 at</p>	{D 283}		

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{D 283}	<p>Continued From page 55</p> <p>2:00 p.m. revealed: -The Dietary Supervisor was responsible for making sure staff cleaned the kitchen. -The inside and outside of the freezer should be cleaned as needed by dietary staff. -The Manager checked the cleanliness of the kitchen twice daily. -The Manager was not aware the refrigerator and the freezer needed to be cleaned. If she was aware, she would have made sure dietary staff cleaned the refrigerator and freezer.</p> <p>Observation of the refrigerator and freezer on 3/9/15 at 3:15 p.m. revealed: -One of the vent slates located at the bottom on the outside of the freezer was still loosed and the entire vent had gray dust. -The inside of the refrigerator and freezer were cleaned.</p> <p>Interview with the Administrator on 3/9/15 at 5:13 p.m. revealed: -The Administrator expected dietary staff to clean the refrigerator and freezer twice weekly. -The Administrator was not aware the refrigerator and the freezer had not been cleaned as expected.</p> <p>2. Observation upon entrance into the kitchen on 3/2/15 at 10:40 a.m. revealed: -Staff G, Dietary Aide, was plating the lunch meal and his hair was hanging over the food. -Staff G did not have on a hairnet on his head nor was the hair restrained.</p> <p>Interview with Staff G on 3/2/15 at 10:40 a.m. revealed the hairnets did not fit his head.</p> <p>Interview with the Dietary Supervisor on 3/2/15 at 10:40 a.m. revealed she would talk to Staff G and</p>	{D 283}		

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{D 283}	<p>Continued From page 56</p> <p>make sure he put a hairnet on his head.</p> <p>Observation on 3/2/15 at 10:45 a.m. revealed Staff G had put a hairnet on his head and his hair was restrained.</p> <p>Observation of the dinner meal on 3/2/15 at 5:00 p.m. revealed: -Staff G had a hairnet on his head. -Staff G had plated a slice of bread on the resident ' s plate with his hands without using gloves.</p> <p>Interview with the Dietary Supervisor on 3/3/15 at 12:08 p.m. revealed: -Dietary staff should use gloves or serving utensils when plating meals. -The Dietary Supervisor was not aware Staff G was plating meals with his hands without using gloves</p> <p>Observation of the preparation of the lunch meal on 3/6/15 at 12:00 p.m. revealed: -Staff G was plating the meal and was placing hush puppies on the resident ' s plates with his hands without using gloves. -Staff G had plated 5 plates and then he put on gloves shortly after the observation.</p> <p>Interview with the Dietary Supervisor who had been going in and out of the kitchen on 3/6/15 at 12:02 p.m. revealed she would talk to Staff G and advise him to wear gloves.</p> <p>Interview with the facility Manager on 3/9/15 at 3:36 p.m. revealed Dietary staff know to follow sanitation and safety guidelines.</p>	{D 283}		

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{D 338}	Continued From page 57	{D 338}		
{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: Based on observation, interview, and record review, the facility failed to assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance. The findings are:</p> <p>Cross refer to Tag D911, G.S. 131D-21(1) Declaration of Residents' Rights.</p> <p>1. Based on observation, interview and record review, the facility failed to assure residents were treated with respect, consideration and dignity by making residents stand in line to receive a plated meal, by failing to assure 1 of 2 Residents (#9) who ate in the room were provided a bedside table and 1 of 1 Staff (C) treated residents with respect, consideration and dignity.</p> <p>Cross refer to Tag D914, G.S. 131D-21(4) Declaration of Residents' Rights.</p> <p>2. Based on interview and record review the facility failed to remove oxygen from 1 of 1 sampled resident (#1) wearing oxygen prior to going out in the smoking area who ultimately caught on fire and later died.</p>	{D 338}		

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D 358	Continued From page 58	D 358		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#7) observed during the medication pass which included errors with the administration of inhalers for breathing problems and a stool softener and 4 of 4 diabetic residents (#9, #10, #11, #12) sampled related to the residents receiving insulin approximately 2 hours prior to their supper meal on 03/03/15. The findings are:</p> <p>1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 27 opportunities during the 8:00 a.m. and 11:00 a.m. medication passes on 03/03/15.</p> <p>Review of Resident #7's current FL-2 dated 11/13/14 revealed: - Diagnoses included chronic airway obstruction, acute and chronic respiratory failure, type II diabetes without complications, dementia, and agitation.</p>	D 358		

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D 358	<p>Continued From page 59</p> <ul style="list-style-type: none"> - Order for ProAir HFA inhaler, inhale 2 puffs 4 times a day. - Order for Spiriva Handihaler, inhale 1 capsule once daily. - Order Advair HFA, inhale 2 puffs twice daily. - (ProAir, Spiriva, and Advair are inhalers used to treat and prevent breathing problems due to airway diseases.) - Order for Colace 100mg once daily. (Colace is a stool softener.) <p>Observation during the 8:00 a.m. medication pass on 03/03/15 revealed:</p> <ul style="list-style-type: none"> - Medication aide administered 8 different oral medications to Resident #7 at 8:49 a.m. that had been prepared in advance. - ProAir, Spiriva, Advair, and Colace were not observed to be administered to Resident #7 during the 8:00 a.m. medication pass. - ProAir inhaler was laying on the resident's bedside table. - Medication aide stated the resident self-administers the ProAir. - Medication aide did not ask the resident if he had used the inhaler that morning. - Medication aide then initialed the 8:00 a.m. dose for ProAir on the medication administration record as being administered to the resident. - Medication aide also initialed the 8:00 a.m. doses of Advair and Colace as being administered. <p>Review of the March 2015 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> - ProAir was scheduled to be administered at 8:00 a.m., 12:00 noon, 5:00 p.m., and 8:00 p.m. - No documentation the ProAir inhaler was to be self-administered. - Spiriva was scheduled to be administered at 8:00 a.m. 	D 358		

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D 358	<p>Continued From page 60</p> <ul style="list-style-type: none"> - Advair was scheduled to be administered at 8:00 a.m. and 8:00 p.m. - Colace was scheduled to be administered at 8:00 a.m. and 8:00 p.m. <p>Interview with the medication aide on 03/03/15 at 9:43 a.m. revealed:</p> <ul style="list-style-type: none"> - He usually administered the Spiriva and Advair to the resident during the 8:00 a.m. medication pass when he received his other morning medications. - He "just overlooked" the Spiriva and Advair on the MARs and forgot to administer them. - He looked in the medication cart and stated Colace was not administered because there was no bubble card for the morning dose of Colace in the cart. - When he prepoured the medications, he punched out the ones in cards marked for morning. - He did not notice there was no morning card for Colace and that it had been omitted during the prepouring process. - He stated there were cards for the bedtime dose and an "as needed" dose of Colace but he would have to order a card for the morning dose. - He did not offer to give a Colace to the resident from either of the supply cards on hand. - He thought the resident had an order to self-administer the ProAir inhaler. - Staff initials the MAR for the ProAir each day even though they don't administer it. - He does not usually ask the resident when he uses the ProAir inhaler. - He did not know how many puffs the resident used for the ProAir inhaler or how often. <p>Observation on 03/03/15 at 9:44 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #7 was in his room wearing oxygen at 4 liters per minute. 	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/09/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 61</p> <ul style="list-style-type: none"> - Medication aide administered the 8:00a.m. dose of Advair at 9:45 a.m. and the Spiriva at 9:46 a.m. - He did not administer any ProAir or Colace. <p>Interviews with Resident #7 on 03/03/15 at 9:47 a.m. and 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - He has chronic breathing problems and is short of breath at times. - He wears his oxygen all the time. - He used the ProAir inhaler on his bedside table early that morning. - He could not give a specific time. - He used the ProAir inhaler whenever he needed it about 3 times a day. - He always used 3 puffs of the ProAir each time he used the inhaler. - Staff usually gave him the Spiriva and Advair each day. - He was unsure about receiving Colace but denied any current problems with constipation. <p>Review of Resident #7's record revealed:</p> <ul style="list-style-type: none"> - A handwritten note dated 07/28/14. - Note indicated resident may keep ProAir inhaler at bedside due to shortness of breath per MD. - No staff signature on the note. - No physician's signature on the note. - No signed physician's order for the resident to self-administer the ProAir inhaler. <p>Review of hospital forms in Resident #7's record revealed:</p> <ul style="list-style-type: none"> - Visit on 10/29/14 for chronic obstructive pulmonary disease. - Visit on 11/19/14 for obstructive chronic bronchitis with exacerbation and shortness of breath. - Visit on 12/32/14 for dyspnea (difficulty 	D 358		

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D 358	<p>Continued From page 62</p> <p>breathing), chronic obstructive pulmonary disease, and constipation.</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/03/15 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware staff was prepouring medications. - Staff had been trained to read the MARs and should make sure all scheduled medications are administered. - Staff should have used a Colace capsule from one of the resident's other bubble cards until they could order another morning dose card. - She could not find a signed physician's order for Resident #7 to self-administer the ProAir inhaler. - She would contact the physician to clarify. <p>Review of a physician's order dated 03/03/15 revealed staff should administer the ProAir inhaler 2 puffs 4 times daily instead of resident doing it himself.</p> <p>2. Interview with the second shift medication aide on 03/03/15 at 3:40 p.m. revealed:</p> <ul style="list-style-type: none"> - He had already checked blood sugars and given sliding scale insulin to 4 diabetic residents. - Blood sugars and insulins were scheduled to be administered at 4:00 p.m. - He has one hour before or after the scheduled time to administer the insulin. - He always checked the blood sugars and gave insulin to the residents at 3:00 p.m. - Supper was usually served around 4:45 p.m. - 5:00 p.m. - He did not realize it was a problem to give the insulin two hours before the residents were supposed to eat supper. - He thought since it was scheduled at 4:00 p.m. 	D 358		

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D 358	<p>Continued From page 63</p> <p>he could do it one hour before the scheduled time.</p> <ul style="list-style-type: none"> - He gave insulin to Residents #9, #10, #11, and #12 at 3:00 p.m. that day. - It took him about 15 minutes to administer the insulin to the four residents. <p>A. Review of Resident #9's record revealed:</p> <ul style="list-style-type: none"> - Current FL-2 dated 11/26/14 included diagnoses of uncontrolled diabetes mellitus type II without complications, morbid obesity, osteomyelitis of ankle and leg, and cellulitis of foot. - Order on FL-2 dated 11/26/14 for fingerstick blood sugars (FSBS) 4 times a day before meals and at bedtime. - Order dated 02/25/15 for Novolog sliding scale insulin before meals and at bedtime: <70 = give 120ml orange juice and retest in 30 minutes if still <70 call MD; 70 - 150 = 0 units; 151 - 200 = 4 units; 201 - 250 = 8 units; 251 - 300 = 12 units; 301 - 350 = 14 units; 351 - 400 = 16 units; >400 = 16 units and call MD. (Novolog is rapid-acting insulin that lowers blood sugar. According to the manufacturer, Novolog should be administered within 5 to 10 minutes of the start of a meal due to an onset of action in 10 - 20 minutes after administration.) <p>Review of Resident #9's blood sugar log and medication administration record for March 2015 revealed:</p> <ul style="list-style-type: none"> - FSBS and Novolog sliding scale insulin were scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. - Resident's FSBS was 238 before supper on 03/03/15. - Staff documented administering 8 units of Novolog insulin. 	D 358		

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D 358	<p>Continued From page 64</p> <p>Interview with the medication aide on 03/03/15 at 3:40 p.m. revealed he had already checked Resident #9's blood sugar and administered her 8 units of Novolog insulin at 3:00 p.m.</p> <p>Review of Resident #9's blood sugar log revealed:</p> <ul style="list-style-type: none"> - FSBS ranged from 145 - 342 in March 2015. - FSBS ranged from "Lo" (less than 20 according to the manufacturer) - 386 in February 2015. <p>Interview with Resident #9 on 03/03/15 at 4:28 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff checked her FSBS at 3:00 p.m. and gave insulin to her at that time. - It was normal for staff to check her blood sugar and give insulin around 3:00 p.m. each day. - Her FSBS was usually high. - She usually felt shaky and nervous when her FSBS was low. - The last time it was low was about a month ago. - She currently felt okay and was waiting for staff to deliver her supper tray. - She usually ate supper in her room because of problems with her feet and legs. <p>Observation on 03/03/15 revealed staff delivered the supper meal to Resident #9 to her room at 5:18 p.m.</p> <p>Refer to interview with the Facility Manager on 03/03/15.</p> <p>B. Review of Resident #10's current FL-2 dated 01/05/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included diabetes mellitus and glaucoma. - Order for fingerstick blood sugars (FSBS) 4 	D 358		

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D 358	<p>Continued From page 65</p> <p>times a day.</p> <ul style="list-style-type: none"> - Order for Humalog sliding scale insulin: <70 = give 120ml orange juice and retest in 30 minutes if still <70 call MD; 70 - 150 = 0 units; 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 400 = 14 units; >400 = 14 units and call MD. (Humalog is rapid-acting insulin that lowers blood sugar. According to the manufacturer, Humalog should be administered within 15 minutes of a meal because of a rapid onset of action of 15 minutes.) <p>Review of Resident #10's blood sugar log and medication administration record for March 2015 revealed:</p> <ul style="list-style-type: none"> - FSBS and Humalog sliding scale insulin were scheduled to be administered at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. - Resident's FSBS was 213 before supper (4:00 p.m.) on 03/03/15. - Staff documented administering 6 units of Humalog insulin. <p>Interview with the medication aide on 03/03/15 at 3:40 p.m. revealed he had already checked Resident #10's blood sugar and administered him 6 units of Humalog insulin at 3:00 p.m.</p> <p>Review of Resident #10's blood sugar log revealed:</p> <ul style="list-style-type: none"> - FSBS ranged from 84 - 358 in March 2015. - FSBS ranged from 29 - 416 in February 2015. <p>Interview and observation of Resident #10 on 03/03/15 at 4:12 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident was sitting in chair in hallway eating a honey bun and drinking a soda. - He reported another resident gave it to him. - Staff checked his FSBS at 3:00 p.m. and gave insulin to him at that time. 	D 358		

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D 358	<p>Continued From page 66</p> <ul style="list-style-type: none"> - It was normal for staff to check his blood sugar and give insulin around 3:00 p.m. each day. - His FSBS would sometimes get low. - He currently felt okay and was waiting for supper. <p>Observation on 03/03/15 revealed Resident #10 was served supper at 5:05 p.m.</p> <p>Refer to interview with the Facility Manager on 03/03/15.</p> <p>C. Review of Resident #11's current FL-2 dated 05/07/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included type 2 diabetes, diabetic neuropathy, and diabetic foot ulcer. - Order for fingerstick blood sugars (FSBS) twice a day. - Order for Humulin R sliding scale insulin: 200 - 239 = 2 units; 240 - 279 = 4 units; 280 - 299 = 6 units; 300 - 349 = 8 units; > 350 = 8 units and call MD; >450 - go to ER. (Humulin R is short-acting insulin that lowers blood sugar. According to the manufacturer, the injection of Humulin R should be followed by a meal within approximately 30 minutes of administration.) <p>Review of Resident #11's blood sugar log and medication administration record for March 2015 revealed:</p> <ul style="list-style-type: none"> - FSBS and Humulin R sliding scale insulin were scheduled to be administered at 8:00 a.m. and 4:00 p.m. - Resident's FSBS was 339 before supper on 03/03/15. - Staff documented administering 8 units of Humulin R insulin. <p>Interview with the medication aide on 03/03/15 at 3:40 p.m. revealed he had already checked</p>	D 358		
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D 358	<p>Continued From page 67</p> <p>Resident #11's blood sugar and administered him 8 units of Humulin R insulin at 3:00 p.m.</p> <p>Review of Resident #11's blood sugar log revealed:</p> <ul style="list-style-type: none"> - FSBS ranged from 196 - 339 in March 2015. - FSBS ranged from 73 - 408 in February 2015. <p>Interview with Resident #11 on 03/03/15 at 4:24 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff checked his FSBS at 3:00 p.m. and gave insulin to him at that time. - It was normal for staff to check his blood sugar and give insulin at 3:00 p.m. each day. - He knows when is FSBS is low because he can feel it. - Low FSBS makes him feel hungry so he will get something to eat. - He feels like his FSBS sometimes gets low while he is waiting for his meals. - He currently felt okay and was waiting for supper. <p>Observation on 03/03/15 revealed Resident #11 was served supper at 5:04 p.m.</p> <p>Refer to interview with the Facility Manager on 03/03/15.</p> <p>D. Review of Resident #12's record revealed:</p> <ul style="list-style-type: none"> - Diagnoses on current FL-2 dated 11/13/14 included diabetes mellitus. - Order dated 12/19/14 for fingerstick blood sugars (FSBS) 4 times a day. - Order dated 03/02/15 for Humalog sliding scale insulin: 120 - 149 = 3 units; 150 - 199 = 5 units; 200 - 249 = 10 units; 250 - 299 = 12 units; 300 and > = 15 units; 500 and > = call MD. (Humalog is rapid-acting insulin that lowers blood sugar. According to the manufacturer, Humalog 	D 358		

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D 358	<p>Continued From page 68</p> <p>should be administered within 15 minutes of a meal because of a rapid onset of action of 15 minutes.)</p> <p>Review of Resident #12's blood sugar log and medication administration record for March 2015 revealed:</p> <ul style="list-style-type: none"> - FSBS and Humalog sliding scale insulin were scheduled to be administered at 7:00 a.m., 11:00 noon, 4:00 p.m., and 8:00 p.m. - Resident's FSBS was 193 before supper on 03/03/15. - Staff documented administering 5 units of Humalog insulin. <p>Interview with the medication aide on 03/03/15 at 3:40 p.m. revealed he had already checked Resident #12's blood sugar and administered him 5 units of Humalog insulin at 3:00 p.m.</p> <p>Review of Resident #12's blood sugar log revealed:</p> <ul style="list-style-type: none"> - FSBS ranged from 109 - 302 in March 2015. - FSBS ranged from 99 - 325 in February 2015. <p>Interview with Resident #12 on 03/03/15 at 4:20 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff usually checked his FSBS at 3:00 p.m. or 3:30 p.m. and gave insulin to him at that time. - His FSBS would sometimes get low. - He felt lightheaded, jumpy, and he could not focus when his FSBS was low. - He currently felt okay and was waiting for supper. <p>Observation on 03/03/15 revealed Resident #12 was served supper at 5:06 p.m.</p> <p>Refer to interview with the Facility Manager on 03/03/15.</p>	D 358		

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D 358	<p>Continued From page 69</p> <hr/> <p>Interview with the Facility Manager on 03/03/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> - Facility's policy was to check blood sugars and give insulin just prior to the meals. - The one hour before and one hour after timeframe rule does not apply to insulin. - Staff had diabetes training and should be aware of this. - She was unaware staff was doing the blood sugar and administering insulin two hours before supper was served at 5:00 p.m. - She will have staff check on the four residents that received insulin at 3:00 p.m. - Medication staff would be re-educated on the administration of insulin. <hr/> <p>Review of the facility's plan of protection dated 03/03/15 revealed:</p> <ul style="list-style-type: none"> - Facility Manager will monitor each medication pass. - In-service will be held for all medication aides on the importance of insulin and how it works. - The in-service will be arranged on 03/04/15 to be given by staff from primary pharmacy provider. - Scheduled times for all residents' blood sugar checks will be changed to be closer to all meal times. - There will be an in-service on medication administration. - Insulin will be administered as ordered. - Facility Manager and Resident Care Coordinator will monitor randomly 3 times a week to assure insulin is administered properly. - Facility Manager and Resident Care Coordinator will medication orders, MARs, and medication carts monthly. 	D 358		

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D 358	Continued From page 70 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2015.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 3 of 4 residents (#7, #13, #14) observed during the 8:00 a.m. medication pass on 03/03/15 and 3 residents (#9, #16, #17) who received medications prior to observation of the 8:00 a.m. medication pass on 03/03/15. The findings are: 1. Observation of the 8:00 a.m. medication pass on 03/03/15 revealed: - Medication aide administered prepoured medications to Resident #13 at 8:26 a.m. - Medication aide did not document administration of Resident #13's medications on the medication administration record (MAR).	D 366		

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D 366	<p>Continued From page 71</p> <ul style="list-style-type: none"> - Medication aide then administered prepoured medications to Resident #14 at 8:28 a.m. - Medication aide did not document administration of Resident #14's medications on the MAR. <p>Interview with the medication aide on 03/03/15 at 8:30 a.m. revealed:</p> <ul style="list-style-type: none"> - He stated he was finished administering medications for the residents on the green hall. - He then walked away to the other medication cart. - Surveyor intervened and asked medication aide when he documents on the MAR. - He stated he usually documented after he observed each resident take their medication. - He stated he forgot to document the medications for Resident #13 and Resident #14. <p>Observation of the medication aide on 03/03/15 at 8:32 a.m. revealed the medication aide documented the administration of 8:00 a.m. medications for Resident #13 and Resident #14.</p> <p>Refer to interviews with the Resident Care Coordinator on 03/03/15 and the Facility Manager on 03/03/15.</p> <p>2. Review of Resident #7's current FL-2 dated 11/13/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included chronic airway obstruction, acute and chronic respiratory failure, type II diabetes without complications, dementia, and agitation. - Order for ProAir HFA inhaler, inhale 2 puffs 4 times a day. - Order for Spiriva Handihaler, inhale 1 capsule once daily. - Order Advair HFA, inhale 2 puffs twice daily. - (ProAir, Spiriva, and Advair are inhalers used 	D 366		

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D 366	<p>Continued From page 72</p> <p>to treat and prevent breathing problems due to airway diseases.)</p> <ul style="list-style-type: none"> - Order for Colace 100mg once daily. (Colace is a stool softener.) <p>Observation of the 8:00 a.m. medication pass on 03/03/15 revealed:</p> <ul style="list-style-type: none"> - Medication aide administered a cup of prepoured medications to Resident #7 at 8:49 a.m. - No other medications were observed to be administered to Resident #7 at that time. - ProAir, Spiriva, Advair, and Colace were not observed to be administered to Resident #7 during the 8:00 a.m. medication pass. - ProAir inhaler was laying on the resident's bedside table. - Medication aide stated the resident self-administers the ProAir. - Medication aide did not ask the resident if he had used the inhaler that morning. - Medication aide initialed the 8:00 a.m. dose of ProAir, Advair, and Colace on the medication administration record (MAR) as if they were administered to the resident. - Medication aide did not document anything on the MAR for the 8:00 a.m. dose of Spiriva and no explanation for the omission was documented. <p>Interview with the medication aide on 03/03/15 at 9:43 a.m. revealed:</p> <ul style="list-style-type: none"> - He usually administered the Spiriva and Advair to the resident during the 8:00 a.m. medication pass when he received his other morning medications. - He "just overlooked" the Spiriva and Advair on the MARs and forgot to administer them. - He looked in the medication cart and stated Colace was not administered because there was no bubble card for the morning dose of Colace in 	D 366		

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D 366	<p>Continued From page 73</p> <p>the cart.</p> <ul style="list-style-type: none"> - He did notice that he had documented the ProAir, Advair, and Colace as being administered. <p>Observation on 03/03/15 at 9:44 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #7 was in his room wearing oxygen at 4 liters per minute. - Medication aide administered the 8:00a.m. dose of Advair at 9:45 a.m. and the Spiriva at 9:46 a.m. - He then initialed the MAR for the administration of Spiriva. <p>Refer to interviews with the Resident Care Coordinator on 03/03/15 and the Facility Manager on 03/03/15.</p> <p>3. Interview with the medication aide on 03/03/15 at 8:54 a.m. revealed:</p> <ul style="list-style-type: none"> - He had completed giving all of the 8:00 a.m. medications to all residents. - He did not currently need to use the MAR books. <p>Review of the MAR books for both medication carts on 03/03/15 starting at 9:00 a.m. revealed:</p> <ul style="list-style-type: none"> - Resident #9's 8:00 a.m. medications had not been documented as administered. - Resident #9 was scheduled to receive 19 different medications at that time. - Resident #16's 8:00 a.m. medications had not been documented as administered. - Resident #16 was scheduled to receive 6 different medications at that time. - Resident #17's 8:00 a.m. medications had not been documented as administered. - Resident #17 was scheduled to receive 9 different medications at that time. 	D 366		

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D 366	<p>Continued From page 74</p> <p>Interview with the medication aide on 03/03/15 at 9:35 a.m. revealed:</p> <ul style="list-style-type: none"> - He had not had a chance to initial the MARs for Residents #9, #16, and #17. - Resident #9 received all of her medications that morning. - Resident #16 received all of his medications that morning. - Resident #17 had refused all of her medications that morning. - He stated he would go back and document on the MARs now. <p>Refer to interviews with the Resident Care Coordinator on 03/03/15 and the Facility Manager on 03/03/15.</p> <hr/> <p>Interview with the Resident Care Coordinator (RCC) on 03/03/15 at 1:25 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff had been trained to document on the MARs after they observe the resident take the medication before going to the next resident. - She was unaware staff was not following this procedure. <p>Interview with the Facility Manager on 03/03/15 at 1:30 p.m. revealed:</p> <ul style="list-style-type: none"> - Staff was supposed to initial the MARs after they give and observed each resident take their medications. - She was unaware staff was not following this procedure. 	D 366		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry</p>	D 438		

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D 438	<p>Continued From page 75</p> <p>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record review, the facility failed to report to the North Carolina Health Care Personnel Registry allegations of abuse of a resident (#4) by a staff member, and neglect of a resident (#1) by a staff member who failed to remove oxygen prior to going out to the smoking area to ensure the resident's safety. The findings are:</p> <p>1. Review of Resident #1's record revealed: -An incident report dated 1/7/2015 stating Resident #1 "had just returned from a doctor's appointment when he requested to be taken outside. Shortly thereafter a staff member saw flames coming from (Resident #1's) face. (Resident #1) was attempting to lite a cigarette with his oxygen on. His face looked to be burned. 911 was called. Emergency Medical Services arrived quickly."</p> <p>Interview with the Resident Care Coordinator (RCC) on 3/3/2015 at 11:00 a.m. revealed: -She did not know what happened and had not done an investigation. -"Resident #1's face was black and burned around his mouth." -Resident #1 had a nasal cannula on and a portable oxygen tank hanging off the back of his chair. -Resident #1 should not have been in the</p>	D 438		
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D 438	<p>Continued From page 76</p> <p>smoking area with oxygen on.</p> <p>Interview with the Manager on 3/3/2015 at 11:30 a.m. revealed: -Staff had been educated by management on of the dangers of oxygen use and smoking as a fire hazard. -Resident #1 should not have been in the smoking area with oxygen on. -She had not done an investigation of the incident. -There were other residents outside in the smoking area at the time of the occurrence.</p> <p>Interview with the Personal Care Aide (Staff C) on 3/4/2015 at 12:00 p.m. revealed: -The transporter told him on 1/7/2015 after Resident #1 got back from his physician's appointment Resident #1 wanted to get some fresh air and to keep an eye on him because he had oxygen on and he brought Resident #1 out to the smoking area. -He was aware Resident #1 had oxygen on and went outside to the smoking area to ask Resident #1 if he was alright and Resident #1 told him yes. -Resident #1 was not smoking at that time but there were other residents in the smoking area. -He left Resident #1 in the smoking area with the oxygen on, walked around the facility, and after returning he saw Resident #1's face was on fire in the smoking area where he had left him. -He was aware Resident #1 was a heavy smoker, usually went out to the smoking area to smoke, and he had been noncompliant with the smoking policy by smoking in his room. -He was aware of the dangers of oxygen use and smoking as a fire hazard.</p> <p>Interview with the Manager on 3/6/2015 at 11:00 a.m. revealed:</p>	D 438		

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D 438	<p>Continued From page 77</p> <ul style="list-style-type: none"> -Staff C had not been reported to the Health Care Personnel Registry (HCPR) for neglecting to remove Resident #1's oxygen prior to going out in the smoking area. -She did not know if Resident #1 died as a result of his facial burns or if that contributed. -She was aware of the Health Care Personnel Registry (HCPR) but was not aware of the HCPR reporting requirements. <p>2. Review of current FL2 for Resident #4 dated 5/14/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included human immunodeficiency virus, unspecified urinary incontinence, depressive disorder, depressive psychosis, - Her admission date to the facility was 5/1/14. <p>Interview with Resident #4 on 3/2/15 at 1:30pm revealed:</p> <ul style="list-style-type: none"> - In February 2015 (she did not remember the exact date) she reported having a consensual sexual relationship with Staff A to her doctor, from October 2014 through February 2015. - The relationship ended when she told her doctor about it. - A law enforcement officer and 2 social workers met with her at the facility to ask her questions about her relationship with staff A. - She had not discussed this with anyone prior to this date. <p>Interview with the MTC on 3/3/15 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - He scheduled and drives Resident #4 to all of her medical appointments. - On November 5, 2014, on the way to the appointment, Resident #4 told him Staff A would climb into her window at night after his shift was over and the two of them would have unprotected 	D 438		

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D 438	<p>Continued From page 78</p> <p>sex.</p> <ul style="list-style-type: none"> - When they got back to the facility from the appointment, he immediately reported to the facility Manager and RCC that Resident #4 was saying she was having a sexual relationship with Staff A. <p>Interview with the facility Manager on 3/2/15 at 4:05 pm revealed:</p> <ul style="list-style-type: none"> - She was first made aware of an accusation of a sexual relationship between Staff A and Resident #4, by the medical transportation coordinator (MTC) in November 2014, she's was not sure of the date. - The MTC drove Resident #4 to a doctor appointment and Resident #4 told him she had been involved in a consensual sexual relationship with Staff A and it had been going on for 2 weeks. - Upon his return to the facility that day the MTC reported the information to her. - She immediately met with Resident #4 and the Resident Care Coordinator (RCC) upon Resident #4's return to the facility that day. - She was not sure Resident #4 was telling the truth. - There had never been any accusations made about Staff A since he started working at the facility. - She did not mention anything to Staff A, in November 2014. - She did not document any of the allegations or conversations with Resident #4 or any staff in November 2014. - She did not report the accusation to HCPR in November 2014. - Staff A continued to work at the facility and administer medications to Resident #4 and other residents, without further mention. - She did not discuss this matter with the Administrator in November 2014. At that time 	D 438		

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D 438	<p>Continued From page 79</p> <p>she knew she had to report it.</p> <ul style="list-style-type: none"> - On February 5, 2015 a social worker called to inform her Resident #4 had told her physician she had a sexual relationship with Staff A and the local law enforcement would also be contacting the facility Manager that day. - The first time she notified the Administrator of the allegation was February 5, 2015. - The next day on February 6, 2015 she suspended Staff A and sent a 24 hour report to HCPR. - On February 9, 2015 she sent the 5 day report to HCPR. - The facility does not have a policy on when and how to report allegations of abuse neglect or exploitation. <p>Interview with the RCC on 3/3/15 at 10:00am revealed:</p> <ul style="list-style-type: none"> - The first time she heard of the allegation of misconduct involving Staff A and Resident #4 was sometime last year. - The facility manager told her, Resident #4 told the MTC when he was taking her to an appointment. - She did not speak with Resident #4 or Staff A regarding this issue at that time. - She does know that Staff A was suspended around February 5, 2015. - There was an investigation with law enforcement, the facility manager, Adult Protective Services (APS), Department of Social Services (DSS) and HCPR. <p>Review of Resident #4's record revealed:</p> <ul style="list-style-type: none"> - There was no documentation regarding the reported allegation of Resident #4 in November 2014 or February 2015. - There was no documentation of the allegation having been reported to the Health Care 	D 438		

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D 438	<p>Continued From page 80</p> <p>Personnel Registry in November 2014 or February 2015.</p> <p>Observation of a separate staff folder, for Staff A revealed:</p> <ul style="list-style-type: none"> - Fax confirmation of HCPR 24 hour initial report sent on 2/6/15. - Fax confirmation of HCPR 5- working day report sent on 2/9/15. - A copy of the facility policy on fraternization that says; " Employees will not date or have physical relationships with residents. Relationships between staff and residents will be of a professional nature only. Staff will not enter a resident ' s room unless it is necessary to complete tasks designated by the employee ' s job description. Employees are not authorized to be on the premises when they are not on the schedule. " - A note dated 2/9/15 titled Facility Investigation documenting her findings regarding the allegation. <p>Review of an office/clinic note from Resident #4's physician's office dated February 5, 2015 revealed:</p> <ul style="list-style-type: none"> - Resident #4 is in a rest home and reports having had sexual intercourse with a worker there. - The physician's social worker talked with Resident #4 and this matter would be referred to concerned authorities as soon as possible. <p>Interview with Staff A on 3/3/15 at 10:50 a.m. revealed:</p> <ul style="list-style-type: none"> - He received a call at home on 2/5/15 from the facility Manager saying Resident #4 had accused him of getting her pregnant and he was suspended until further notice. - This subject had not ever been mentioned to 	D 438		

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D 438	Continued From page 81 him prior to 2/5/15. Interview with the Administrator on 3/9/15 at 3:45pm revealed: - He was not aware of the alleged sexual relationship involving Staff A and Resident #4 until February 5, 2015. - The facility Manager called him and reported the allegation to him the same day she suspended Staff A. _____ Review of the facility's plan of protection dated 3/6/2015 revealed: -Rreport to the Health Care Personnel Registry with employee neglect of resident on 1/7/2015. -Each allegation will be reported the the Health Care Personnel Registry by the facility manager as soon as she is made aware of resident abuse. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2015.	D 438		
D 441	10A NCAC 13F .1208 Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred.	D 441		

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D 441	<p>Continued From page 82</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a written report was submitted to the Division of Health Service Regulation regarding the death of 1 residents (#1) who died as a result of an accident. The findings are:</p> <p>Review of Resident #1's record revealed: -An incident report dated 1/7/2015 stating Resident #1 "had just returned from a doctor's appointment when he requested to be taken outside. Shortly thereafter a staff member saw flames coming from (Resident #1's) face. (Resident #1) was attempting to lite a cigarette with his oxygen on. His face looked to be burned. 911 was called. Emergency Medical Services arrived quickly."</p> <p>Interview with the Case Manager at the Burn Treatment Center on 3/9/2015 at 12:30 p.m. revealed: -Resident #1 was admitted on 1/7/2015 to the Burn Treatment Center for first and second degree facial burns and died on 1/14/2015 at 12:42 a.m. -The cause of death was cardiopulmonary collapse. -Resident #1 had respiratory failure and went into cardiac arrest.</p> <p>Interview with the Manager on 3/6/2015 at 11:00 a.m. -"I' ve never done a death report in 16 years. I don't know what one looks like." -She had not done a death report for Resident #1.</p> <p>Interview with the Administrator on 3/9/2015 at 4:30 p.m. revealed he was aware of there was a death reporting requirement but was unclear</p>	D 441		

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D 441	Continued From page 83 about the circumstances for when one needed to be filled out.	D 441		
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: Type B Violation</p> <p>Based on observation, interview and record review, the facility failed to assure residents were treated with respect, consideration and dignity by making residents stand in line to receive a plated meal, by failing to assure 1 of 2 Residents (#9) who ate in the room was provided a bedside table, and by allowing 1 of 1 Staff (C) to disrespect residents. The findings are:</p> <p>1. Review of staff qualifications revealed Staff C was hired as a Personal Care Aide on 2/9/2011.</p> <p>Confidential interview with a resident revealed: -Staff C "had a language all his own." -Staff C picked on certain residents including Resident #6 or "anybody he could". -Staff C "is not a Christian" and "is the one who starts it". -Staff C "aggravates everybody."</p> <p>Confidential interview with another resident</p>	D911		

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D911	<p>Continued From page 84</p> <p>revealed:</p> <ul style="list-style-type: none"> - "The way he talks to me I don't like it." - Staff, including Staff C, "cuss, smoke, and talk ugly to each other." <p>- Confidential interview with another resident revealed:</p> <ul style="list-style-type: none"> - "I avoid (Staff C). He doesn't like me and I don't like him." - "He left me on the commode one day for an hour." - "He has a sarcastic and smart mouth to me and all the residents." - "He does not treat residents with dignity and respect." <p>Confidential interview with another resident revealed:</p> <ul style="list-style-type: none"> - Staff C cursed at the resident all the time while providing incontinent care. - Staff C last cursed at the resident on 3/5/2015 while providing incontinent care. - The resident did not like Staff C cursing while providing incontinent care. - The resident had not reported the cursing to anyone. <p>Confidential interview with a staff revealed:</p> <ul style="list-style-type: none"> - Staff C "talks ugly to residents, all of them". - "I don't think he knows what he is doing." - "Most of the residents don't like him." - "He lines them up like in the military for snack." <p>Review of a communication note written by the Medication Aide on duty dated 5/18/2014 revealed:</p> <ul style="list-style-type: none"> - A resident was late coming to supper and let the Personal Care Aide know he would be late. - When the resident got to the dining room there was not a plate for him. 	D911		

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D911	<p>Continued From page 85</p> <ul style="list-style-type: none"> -Staff C had 2 sandwiches from the kitchen. -The Medication Aide told Staff C he would have to give up one of those sandwiches so the resident could have something to eat. -Staff C "got all mad, started fussing and cussing, and said before I give these sandwiches to anyone I will throw them away." -Staff C "walked over to the trash can and threw them away." -The Medication Aide called the Resident Care Coordinator "to let her know that (Staff C) can clock out and go home." -Staff C "just sat there so I grab his time card and clock him out." <p>Interview with the Manager on 3/6/2015 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> -She had received complaints about Staff C from residents. -There is a male and a female resident who had complained Staff C was "snatching them up" and being too rough. -Staff C used to work second shift until 3 months ago when an he took an opening on the first shift. -Since Staff C had been on first shift she had not had any resident complaints. -When she received resident complaints about Staff C she would speak to him and he would deny it. -She had not observed any inappropriate behavior by Staff C during his interactions with residents. -The Department of Social Services (DSS) Adult Home Specialist (AHS) investigated a complaint involving Staff C approximately 1 ½ years ago which was unsubstantiated. -She had suspended him for 2 weeks in the past for no findings. -She had observed profanity used between staff C and another staff and had to speak to them 	D911		

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D911	<p>Continued From page 86</p> <p>about it but "they were not cussing to the residents".</p> <ul style="list-style-type: none"> -Some of the residents use profanity at Staff C in a provocative manner and I have observed him respond appropriately. -Some residents think Staff C and I are related but that is not true. We grew up in the same neighborhood. -Whenever a resident complains about Staff C it comes to me under my door because the Resident Care Coordinator (RCC) and Staff C live together. -The incident with the sandwich was investigated with the conclusion the Medication Aide and Staff C were not getting along with no finding Staff C had been inappropriate. -The cook had made the sandwiches specially for 3 staff including Staff C before he left. -The Medication Aide could have asked one of the other 2 staff to give up their sandwich to the resident but he did not. -The Medication Aide could have called her to come in and make the resident a sandwich because there was food in the kitchen. -She did not know if the incident took place in front of the resident but stated the resident did get a sandwich to eat. <p>Interview with the Administrator on 3/9/2015 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -He was not aware of the incident with Staff C not giving a sandwich to the resident when asked to. -The food was not for staff but for the residents. <p>Observation of confidential comments from residents at the resident council meeting on 3/2/2015 12:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Some of the disrespectful staff had quit. -For the most part there has been some improvement, but there is still 1 or 2 that are still 	D911		

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D911	<p>Continued From page 87</p> <p>disrespectful.</p> <ul style="list-style-type: none"> -Residents are scared to speak up because if they report an incident with 1 staff member, other staff members will start treating them mean. -Residents have had run-ins with Staff C because he says whatever he wants and it is not so nice. <p>2. Review of Resident #9's current FL-2 dated 11/26/14 included diagnoses of uncontrolled diabetes mellitus type II without complications, morbid obesity, osteomyelitis of ankle and leg, cellulitis of foot, hypertension, tachycardia, leukocytosis, chronic pain, major depressive disorder, and cannabis abuse.</p> <p>Observation of Resident #9 on 03/03/15 at 5:18 p.m. revealed:</p> <ul style="list-style-type: none"> - Resident was lying in bed with a plate of food sitting on her chest/stomach area. - Resident was feeding herself. - Resident's beverage cup was sitting on top of the closed lid of her bedside commode that was pushed against the side of her bed. <p>Observation and interview of the medication aide on 03/03/15 at 5:20 p.m. revealed:</p> <ul style="list-style-type: none"> - There was only one bedside table in the facility. - It was used by the resident in the room next door who was currently at the hospital. - He offered no assistance to Resident #9. <p>Observation and interview with a personal care aide (PCA) on 03/03/15 at 5:20 p.m. revealed:</p> <ul style="list-style-type: none"> - There was only one bedside table in the facility that was used by another resident next door. - That resident was currently at the hospital. - Resident #9 usually ate in the dining room to her knowledge. - She offered no assistance to Resident #9. 	D911		

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D911	<p>Continued From page 88</p> <p>Interview with Resident #9 on 03/03/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> - She has an ulcer on her foot and needed to prop her feet up so she usually ate supper in her room while lying in bed. - She did not have a bedside table. - She usually ate from the plate while it was lying on her chest/stomach area. - When asked how she felt about eating this way, the resident stated, "it is fine" and put her head down and started back eating. <p>Interview with the Facility Manager on 03/03/15 at 5:45 p.m. revealed:</p> <ul style="list-style-type: none"> - She was unaware Resident #9 was eating in her room. - Staff should have cleaned and used the bedside table in the room next door since that resident was currently in the hospital. - The facility only has one bedside table to her knowledge because residents don't usually eat in their rooms. - She would order a bedside table for Resident #9. <p>Interview with a Personal Care Aide (PCA) on 3/6/15 at 2:23 p.m. revealed:</p> <ul style="list-style-type: none"> -The PCAs passed out meals to the residents who ate in the room. -If a resident ate in the room, she would get the meal from dietary and make sure the meal was covered. -The PCA had passed out meals to Resident #9 in the resident's room. The PCA last delivered meals to Resident #9's room on last Wednesday (2/25/15) or Thursday (2/26/15). -Resident #9 did not have a bedside table so, the PCA placed the resident's meal on the nightstand and put the nightstand closer to the bed. 	D911		

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D911	<p>Continued From page 89</p> <ul style="list-style-type: none"> -Resident #9 had not had a bedside table for the past 1-1 1/2 months. -Resident #9 had not complained about not having a bedside table. -The PCA had observed Resident #9 place the food on the bedside toilet. When the PCA had observed the resident put the food on the bedside toilet, the PCA removed the food from the toilet. The PCA encouraged the resident not to place the food on the commode. <p>Interview with Resident #9 on 3/6/15 at 11:45 a.m. revealed:</p> <ul style="list-style-type: none"> -If there was a bedside table to use, the resident would use the table. -When staff delivered the meal, staff had always set the meal and beverages on the night stand. -The resident placed the beverages on the toilet. <p>Observation of another resident, who ate meals in the room on 3/6/15 at 12:15 p.m., revealed the resident was using a bedside table.</p> <p>Interview with the Administrator on 3/9/15 at 3:44 p.m. revealed:</p> <ul style="list-style-type: none"> -The Administrator was not aware Resident #9 did not have a bedside table. -The Administrator would get a bedside table for Resident #9. <p>3. Observation of the dinner meal on 3/2/15 at 5:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Five residents were standing around the entrance door to the kitchen waiting on a dinner plate. -The residents received their dinner plate, took the plate to the table and sat down at the dining room table. -All of the residents were plated 1 cup chicken and rice, 1/2 cup of peaches, 1/2 cup of pickled 	D911		

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D911	<p>Continued From page 90</p> <p>beats and 1 slice of bread.</p> <p>Interview with the Cook on 3/2/15 at 5:00 p.m. revealed: -The Cook passed the plates to the residents at the kitchen door. -"They usually stand at the front door to get the meal."</p> <p>Interview with the Cook on 3/2/15 at 5:20 p.m. revealed the Cook did not know how long dietary staff had been passing the meals to the residents at the entrance to the kitchen door.</p> <p>Observation of the lunch meal on 3/3/15 at 12:00 p.m. revealed: -The residents sat down and staff bought the meal to the residents. -The residents were plated 1 cup of chicken pastries; ½ cup of green beans, ½ cup of yams and 1 slice of bread.</p> <p>Interview with the Dietary Supervisor on 3/3/15 at 12:08 p.m. revealed: -The residents should sit at the table and staff should bring the plated meals to the residents. -The Dietary Supervisor was aware staff had plated meals to residents and the residents had taken their food to the table. -The Cook who served the dinner meal on 3/2/15 passed plates to the residents during the meal, because staff did not come and assist him with placing the plated meal on the table. -The Dietary Supervisor revealed she would talk with the Dietary staff about not passing out plates to residents in a line.</p> <p>Observation of the lunch meal on 3/6/15 at 12:00 p.m. revealed: -The residents sat down and staff bought the</p>	D911		

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D911	<p>Continued From page 91</p> <p>meal to the residents. -The residents were plated 10-15 french fries, 3 ounce fried fish, 5 hushpuppies, ½ cup coleslaw and 1 cup vanilla pudding.</p> <p>Interview with the facility Manager on 3/6/15 at 2:00 p.m. revealed: -Four to five years ago the Cooks plated the meals and passed out the plates to the residents while the residents were seated in the dining room. -Currently, residents using the wheel chair sit in the dining room and staff bring the food. The non-wheel chair residents stand in line and staff pass out the meal plated to the residents. Residents had been standing in line for the past 2 ½ years to receive a meal, which was acceptable to the Manager.</p> <p>Interview with the Administrator on 3/9/15 at 4:25 p.m. revealed: -The Administrator was aware the residents were standing in line to receive a plated meal to take back to their seat in the dining room. -"If you ask the residents to sit down to receive a meal, they will continue to stand in line." -"The residents did not want to sit down to allow staff to bring the meals." -The Administrator was not aware the residents sat down to receive a meal when observed during the lunch meals on 3/3/15 at 12:00 p.m. and on 3/6/15 at 12:00 p.m.</p> <p>Confidential interview with a resident revealed the food is mainly on the table. Sometimes they received the meal standing in line. The resident did not have any problems standing in line to receive the food.</p> <p>Two confidential resident interviews revealed</p>	D911		
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D911	<p>Continued From page 92</p> <p>usually the residents stand in line to receive a meal. Sometimes staff bring the food to the table. The residents did not have a problem with waiting in line to receive a meal.</p> <p>Confidential interview with a staff revealed: -The residents who are in a wheel chair are seated in the dining room first. -The residents who do not use a wheel chair stand in line in the dining room and the kitchen staff pass the plate to the resident for all three meals. -No residents complained of standing in line to receive a meal.</p> <hr/> <p>Review of the facility's plan of protection dated 3/6/2015 revealed: -The facility has an in-service coming up on residents rights on 4/7/2015 with the Ombusman. -Each staff memeber has to attend. -Meet with the supervisors daily to make sure they are reporting all complaints from residents</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 23, 2015.</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> <p>This Rule is not met as evidenced by:</p>	D912		

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D912	<p>Continued From page 93</p> <p>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 management of the facility, personal care and supervision, health care, medication administration, health care personal registry reporting, and residents' rights. The findings are:</p> <ol style="list-style-type: none"> 1. Based on observation, and interview, the Administrator and Manager failed to assure that all required duties were carried out in the facility related to the rule areas of resident rights, providing personal care and supervision, health care, medication administration, death reporting requirements, health care personnel registry, physical environment, housekeeping and furnishings, test for tuberculosis, personal care training and competency, and nutrition and food service. [Refer to tag D176 10A NCAC 13F .0601 Management of Facilities (Type A2 Violation)] 2. Based on observation, interview, and record review the facility failed to provide supervision of 13 sampled residents (#1, #3, #4, #8, #9, #16, #18, #19, #20, #21, #22, #23, and #24) caught smoking in their rooms, including resident (#3) whose roommate (#7) was on continuous oxygen via nasal cannula at 4 Liters/minute and resident (#1) who used oxygen in his room as needed. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)] 3. Based on observation, interview, and record review the facility failed to notify the physician for 3 of 6 sampled residents (#1, #2, and #6), regarding oxygen and smoking behavior (#1), and aggressive and assaultive behaviors toward staff 	D912		

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D912	<p>Continued From page 94</p> <p>and residents (#6). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]</p> <p>4. Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 7 residents (#7) observed during the medication pass which included errors with the administration of inhalers for breathing problems and a stool softener and 4 of 4 diabetic residents (#9, #10, #11, #12) sampled related to the residents receiving insulin approximately 2 hours prior to their supper meal on 03/03/15. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]</p> <p>5. Based on interviews and record review, the facility failed to report to the North Carolina Health Care Personnel Registry allegations of abuse of a resident (#4) by a staff member, and neglect of a resident (#1) by a staff member who failed to remove oxygen prior to going out to the smoking area to ensure the resident's safety. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]</p> <p>6. Based on observation, interview and record review, the facility failed to assure residents were treated with respect, consideration and dignity by making residents stand in line to receive a plated meal, by failing to assure 1 of 2 Residents (#9) who ate in the room was provided a bedside table, and by allowing 1 of 1 Staff (C) to disrespect residents. [Refer to Tag D911 G.S. 131D-21(1) Declaration of Resident Rights (Type B Violation)]</p> <p>7. Based on interview and record review the</p>	D912		

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D912	Continued From page 95 facility failed to remove oxygen from 1 of 1 sampled resident (#1) wearing oxygen prior to going out in the smoking area who ultimately caught on fire and later died. [Refer to Tag D914 G.S. 131D-21(4) Declaration of Resident Rights (Type A1 Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interview and record review the facility failed to remove oxygen from 1 of 1 sampled resident (#1) wearing oxygen prior to going out in the smoking area who ultimately caught on fire and later died. The findings are: Review of the Resident #1's Resident Register revealed he was admitted on 6/4/2003. Review of Resident #1's last FL-2 dated 7/11/2014 revealed: -Diagnoses included: Organic Brain Syndrome, Organic Seizure Disorder, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Hyperlipidemia, History of Atrial Fibrillation, and Gastro-Esophageal Reflux Disease. -Resident #1 was semi-ambulatory with the use of a wheelchair. -Oxygen was ordered without a frequency and amount unspecified. Review of Resident #1's Discharge summary	D914		

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D914	<p>Continued From page 96</p> <p>from the local hospital dated 5/6/2014 revealed:</p> <ul style="list-style-type: none"> -The principal diagnosis was acute chronic obstructive pulmonary disease (COPD) exacerbation with hypoxemia (abnormally low level of oxygen in the blood). -Resident #1 had a history of organic brain syndrome with a craniotomy due to head trauma in the past. -Resident #1 had short term memory loss. -Resident #1 had a tobacco use disorder with greater than 40 years of smoking history. -The importance of stopping smoking was explained to Resident #1 and he stated there was a high likelihood that he will go back to smoke cigarettes. -The physician explained to Resident #1 that he cannot smoke cigarettes and use oxygen at the same time, as that is a fire hazard. -Resident #1 "required assessment for home oxygen needs on discharge, pending reassurance by the patient that he will not smoke cigarettes while using oxygen therapy due to risk for fire hazard." -Resident #1 was discharged on 5/12/2014 with follow up recommended at the primary care medical clinic in 1 week. <p>Interview with the medical supply representative on 3/4/2015 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> -He received a physician's order on 5/13/2014 for home oxygen 2 Liters/minute via nasal cannula and home oxygen equipment. -On 5/13/2014 an oxygen concentrator was delivered and 2 portable oxygen tanks. -On 8/3/2014 the complete portable system including the 1 oxygen tank, the cart, a regulator, and a concentrator were delivered. -He received no further physician's orders for oxygen or requests for oxygen supplies from the facility for Resident #1. 	D914		

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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D914	<p>Continued From page 97</p> <p>-Resident #1's oxygen supplies were picked up from the facility on 1/14/2015 shortly after receiving notification Resident #1 had died.</p> <p>Review of Resident #1's physician's orders revealed on 12/17/2014 Resident #1 was evaluated at the pulmonary specialty clinic and an order to "Discontinue oxygen as he is not using it" was written.</p> <p>Review of Resident #1's hospital record dated 12/29/2014 revealed:</p> <p>-Resident #1 was sent to the hospital for complaint of shortness of breath.</p> <p>-Admitting diagnosis included COPD exacerbation and Dementia.</p> <p>-Resident #1 was discharged on 1/5/2015 with a transfer summary which did not include a physician's order for oxygen.</p> <p>-A case management note on 1/5/2015 at 3: 44 p.m. states "Patient does not need oxygen at home" and the Medication Aide at the facility was notified of that.</p> <p>Interview with the Medication Aide on 3/6/2015 at 4:30 p.m. revealed he received the call from the case manager at the hospital regarding Resident #1 not needing home oxygen but did not tell anyone, including the Manager or the Resident Care Coordinator (RCC).</p> <p>Review of Resident #1's physician's orders dated 1/7/2015 from the pulmonology specialty clinic revealed:</p> <p>-Post hospital visit from treatment for Pneumonia.</p> <p>-"He has to stop smoking to expect any improvement. He refuses to stop."</p> <p>-"Today he is stable and to continue current medications. Follow-up in 1 year."</p>	D914		

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D914	<p>Continued From page 98</p> <p>Interview with the nurse at the pulmonology specialty clinic on 3/9/2014 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 came to his last appointment on 1/7/2015 wearing oxygen by nasal cannula at 3 Liters/minute. -The oxygen is not removed or adjusted without a physician's order. -She did not see an order for oxygen for Resident #1 in their records. <p>Interview with Resident #1's physician at the specialty clinic on 3/9/2015 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was not ordered oxygen by him or the specialty clinic. -After reviewing Resident #1's records he had been on oxygen after pulmonary function tests done on 9/27/2011. -Resident #1 was getting the oxygen from somewhere else. -Resident #1 had been seen at the specialty clinic for 3 years. -Resident #1 had oxygen via nasal cannula on at 3 Liters/minute on the 1/7/2015 visit which he had not had on at the previous visits. -If a patient comes in with oxygen on it we do not change it since it is ordered somewhere else. -When Resident #1 was seen at the clinic in 12/17/2014 it was noted he did not use oxygen as prescribed. -Resident #1 smoked 2-3 packs of cigarettes per day. -Resident #1 was counseled at every visit on stopping smoking and the dangers of oxygen use while smoking. -Resident #1 didn't want to stop smoking and stated "The Lord would help him." -The facility had never called with concerns for Resident #1's respiratory status or for oxygen orders. 	D914		
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D914	<p>Continued From page 99</p> <p>Review of Resident #1's record revealed: -An incident report dated 1/7/2015 stating Resident #1 "had just returned from a doctor's appointment when he requested to be taken outside. Shortly thereafter a staff member saw flames coming from (Resident #1's) face. (Resident #1) was attempting to lite a cigarette with his oxygen on. His face looked to be burned. 911 was called. Emergency Medical Services arrived quickly."</p> <p>Interview with the Resident Care Coordinator (RCC) on 3/3/2015 at 11:00 a.m. revealed: -She did not know what happened and had not done an investigation. -"I ran outside because people were yelling and the resident's face was on fire and a staff member was putting out the flames." -"Resident #1's face was black and burned around his mouth." -Resident #1 had a nasal cannula on and a portable oxygen tank hanging off the back of his chair. -The RCC had never seen the oxygen tank on Resident #1's chair before. -She did not know if Resident #1's oxygen had been discontinued or not. -Staff were aware of the dangers of oxygen use and smoking as a fire hazard.</p> <p>Interview with the Manager on 3/3/2015 at 11:30 a.m. revealed: -Resident #1 went to the specialty clinic in December 2014 and his oxygen had been discontinued because she informed them Resident #1 was not using it. -She did not know why Resident #1's oxygen supplies had not been sent back to the medical supply company and stated she thought the RCC</p>	D914		

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D914	<p>Continued From page 100</p> <p>would have taken care of that.</p> <ul style="list-style-type: none"> -Resident #1 wore the portable oxygen in his room after discharge from the hospital on 1/5/2015 and mostly laid in bed and did not smoke as much as usual. -Resident #1 wore the oxygen to his appointment at the specialty clinic on 1/7/2015. -Resident #1 asked the transporter on the way back from the appointment to let him smoke. -The transporter refused and returned to the facility and brought Resident #1 into the activity room and left him there. -She had not done an investigation. -Staff had been educated by management on of the dangers of oxygen use and smoking as a fire hazard. <p>Interview with the transporter on 3/4/15 at 3:20 p.m. revealed:</p> <ul style="list-style-type: none"> -The transporter took Resident #1 to his physician's appointment at the specialty clinic on 1/7/2015 and Resident #1 had oxygen on with a nasal cannula. -Upon returning from the appointment he pushed Resident #1 to the activity room and Resident #1 asked him to push him outside into the smoking area for some fresh air before lunch. -The transporter told the Personal Care Aide (PCA/Staff C) in the activity room to keep an eye on Resident #1 because of the oxygen. -The transporter was aware of oxygen being a fire hazard. -Staff C told him "He said he had it." and would take over supervising Resident #1. -Shortly after the transporter left the activity room people were screaming and there was a boom. -He did not know Resident #1 had cigarettes and believed Resident #1's cigarettes had been confiscated by staff due to a recent hospital visit and held by the Business Manager. 	D914		

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D914	<p>Continued From page 101</p> <ul style="list-style-type: none"> -Resident #1 did not ask him if he could smoke. Interview with the Staff C on 3/4/2015 at 12:00 p.m. revealed: <ul style="list-style-type: none"> -On 1/7/2015 after Resident #1 got back from his physician's appointment, the transporter told him Resident #1 wanted to get some fresh air and to keep an eye on him. -The transporter brought Resident #1 out to the smoking area. -He was aware Resident #1 had oxygen on and went outside to the smoking area to ask Resident #1 if he was alright and Resident #1 told him yes. -Resident #1 was not smoking at that time but there were other residents in the smoking area. -He walked out of the smoking area through a different exit door from the activity room leading into a hallway and walked around the facility through the day room and down 2 more hallways before returning to the activity room. -He said something to the Activity Director who was sitting in her office off the activity room and turned his head to the window in the activity room facing the smoking area and he saw Resident #1's face was on fire. -He put the fire out on Resident #1's face with his hands. -He did not know who lit Resident #1's cigarette because Resident #1 did not have a lighter on him after the occurrence. -There was another resident outside he remembered being there who smoked but he did not think that resident was smoking when he went outside to check on Resident #1. -He asked the other resident if he lit Resident #1's cigarette and he stated he did not. -Resident #1 must have hid the cigarettes and a lighter since they are usually confiscated by staff when residents go to the hospital or to a doctor's appointment. 	D914		

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D914	<p>Continued From page 102</p> <ul style="list-style-type: none"> -He was aware Resident #1 was a heavy smoker, usually went out to the smoking area to smoke, and he had been noncompliant with the smoking policy by smoking in his room. -He was aware of the dangers of oxygen use and smoking as a fire hazard. -Residents are not supervised in the smoking areas at the facility. <p>Interview with the Activity Director on 3/3/2015 at 12:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Staff C had just left out of her office and several minutes later she heard him yelling. -Resident #1 had portable oxygen on that day (1/7/2015). -Resident #1 had not asked her for cigarettes or to smoke and usually wheels himself outside. -Staff do not supervise residents smoking outside the activity room. -There were residents in the activity room at the time of the occurrence. <p>Interview on 3/4/2015 at 12:30 p.m. with the resident identified by the Staff C who was outside with Resident #1 at the time of the occurrence revealed Resident #1 lit his own cigarette and his face caught on fire.</p> <p>Confidential interview with 1 resident revealed she did not witness the occurrence but believed Staff C "went out to light (Resident #1's) cigarette and he caught on fire."</p> <p>Confidential interview with another resident revealed:</p> <ul style="list-style-type: none"> -She was in the activity room and believed Staff C hooked up Resident #1's oxygen then pushed Resident #1 into the smoking area and he caught fire. -She saw the fire around his face and head. 	D914		

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D914	<p>Continued From page 103</p> <ul style="list-style-type: none"> -She was upset by the occurrence. -She was surprised more people were not burned. -Staff C "was just laughing." -She had never seen Resident #1 smoking with oxygen on before that. <p>Review of Resident #1's hospital record dated 1/7/2015 revealed:</p> <ul style="list-style-type: none"> -Resident #1 arrived at the hospital via ambulance at 10:52 a.m. -"Per EMS report patient was outside smoking a cigarette while wearing 3 Liters of oxygen via nasal cannula. Triangle shaped burn area noted to face and voice noted to have a raspy quality." -Primary diagnosis was facial burns. -Secondary diagnosis was respiratory distress. -At 11:06 a.m. blood pressure 188/144 (normal blood pressure is less than 120/80), heart rate 45 (normal is 60 - 100 beats per minute), respiratory rate 26 (normal 12 - 16 breaths per minute). -At 11:12 a.m. the physician called the Burn Center at another hospital seeking acceptance for transfer to the Burn Center intensive care unit. -Resident #1's pain level was noted at 11:13 a.m. to be severe 10/10. -At 11:18 a.m. Resident #1 was accepted for transfer. -Condition at 11:26 a.m. noted to be critical. -At 11:29 a.m. physician's note states, "Patient arrived with burns to mouth, face, and nose. Heavy soot to nares, carbonaceous sputum, active wheezing, and respiratory distress. Patient intubated on arrival for airway protection." Transfer for further treatment arranged. -At 11:38 a.m. blood pressure 66/32, pulse 75. -At 11:55 Resident #1 was discharged and transferred to the Burn Treatment Center by helicopter. 	D914		

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D914	<p>Continued From page 104</p> <p>Interview with the Case Manager at the Burn Treatment Center on 3/9/2015 at 12:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was admitted on 1/7/2015 to the Burn Treatment Center and died on 1/14/2015 at 12:42 a.m. -Resident #1 was treated for first and second degree burns to his face while at the Burn Center and had an existing pneumonia. -The cause of death was cardiopulmonary collapse. -Resident #1 had respiratory failure and went into cardiac arrest. -Resident #1's family was contacted and Resident #1 was changed to comfort care and expired shortly afterward. <p>Review of Staff C's staff qualifications revealed:</p> <ul style="list-style-type: none"> -Staff C was hired as a personal care aide (PCA) on 2/9/11. -Staff C did not have Licensed Health Care Professional Services (LHPS) validation checklist. -Staff C did not have the required 80 hours of personal care services training. -Staff C had the Health Care Personnel Registry check done 1/30/2014. <p>Interview with the Manager on 3/6/2015 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Staff C had not been reported to the Health Care Personnel Registry (HCPR) for neglecting to remove oxygen from Resident #1 prior to going out in the smoking area. -She was not aware of the HCPR reporting requirements. -She had not done an investigation. <p>_____</p> <p>Review of the facility's plan of protection dated 3/6/2015 revealed:</p>	D914		

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D914	Continued From page 105 -Staff will be in-serviced on resident rights within 24 hours. -The Ombudsman will in-service staff on resident rights on 4/7/2015. -There will be a staff meeting daily with all supervisors to make sure they are reporting all complaints from residents. -Facility manager will monitor daily. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 08, 2015.	D914		
{D992}	G.S.§ 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or	{D992}		

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{D992}	<p>Continued From page 106</p> <p>psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 2 of 2 employees (Staff D and Staff E) hired after 10/1/13 before the employees began working. The findings are:</p> <p>A. Review of Staff D's employment record revealed:</p> <ul style="list-style-type: none"> - Staff D was hired 1/22/15. - Staff D was hired as a Personal Care Aide. - There was no documentation of completion of controlled substance examination and screening. - Staff D was not available for interview. <p>Refer to interview with the facility Manager on 3/6/15 at 10:30am.</p> <p>Refer to interview with the Administrator on 3/9/15 at 3:45pm.</p> <p>B. Review of Staff E's employment record revealed:</p> <ul style="list-style-type: none"> - Staff E was hired on 5/28/14. - Staff E was hired as a Housekeeper. 	{D992}		
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{D992}	<p>Continued From page 107</p> <ul style="list-style-type: none"> - There was no documentation of completion of controlled substance examination and screening. <p>Staff E was not available for interview.</p> <p>Refer to interview with the facility Manager on 3/6/15 at 10:30 a.m.</p> <p>Refer to interview with the Administrator on 3/9/15 at 3:45 p.m.</p> <hr/> <p>Interview with the facility Manager on 3/6/15 at 10:30am revealed:</p> <ul style="list-style-type: none"> - She was aware of the rule requiring Staff at adult care homes to be screened for controlled substances. - After the last survey the Administrator ordered drug screen kits to the facility with no instructions on how to use them [she pulled out a box of unopened drug screen kits and set it on the table]. - She called the Administrator and informed him of what she received and explained, she did not know how to use them. - He told her he was calling the company where they were sent from and if they could not send someone out to the facility to explain how to use them, he was sending them back. - The kits are at the facility but they haven't used them because they don't know how. - So no one has been screened since that rule came in effect. <p>Interview with the Administrator on 3/9/15 at 3:45pm revealed:</p> <ul style="list-style-type: none"> - He is aware of it, but no they are not doing it. - He is aware of what they have to do, but they don't have the money to do it. 	{D992}		

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{D992}	Continued From page 108 - He did not have the money to buy it all and get it all in place.	{D992}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number HAL026046	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/9/2015
Name of Facility COUNTRYSIDE VILLA	Street Address, City, State, Zip Code 8100 DUNN ROAD WADE, NC 28395	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>D0164</u> Reg. # <u>10A NCAC 13F .0505</u> LSC _____	Correction Completed 11/21/2014	ID Prefix <u>D917</u> Reg. # <u>G.S. 131D-21(7)</u> LSC _____	Correction Completed 10/02/2014	ID Prefix <u>D934</u> Reg. # <u>G.S. 131D-4.5B. (a)</u> LSC _____	Correction Completed 11/24/2014
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date:	Signature of Surveyor:	Date:
Reviewed By _____ CMS RO	Reviewed By _____	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/19/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		