

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on April 9, 2015, April 10, 2015, April 13, 2015, April 14, 2015 and April 15, 2015.	D 000		
D 067	<p>10A NCAC 13F .0305(h)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are:</p> <p>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation and interview, the facility failed to assure a sounding device on the front door for 4 of 4 sampled Residents(#4, #5, #9, #10) who wandered or were disoriented.</p> <p>The findings are:</p> <p>Observation of the facility's front door on 4/9/15 at 1pm revealed no sounding device was activated when the door was opened. -A touch key pad was located inside the facility beside the door frame.</p>	D 067		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 067	<p>Continued From page 1</p> <ul style="list-style-type: none"> -A switch case was located above and to the right of the front door. -The cover casing over the switch was pulled open and the switch was in neutral position. -5 residents walked out the front door to smoke. -Staff members walked in and out the front door. -3 visitors entered through the front door. <p>Review of resident FL-2 forms revealed 4 of 4 residents listed as "intermittently disoriented " under the orientation category.</p> <p>Review of resident Care Plans revealed least 4 of 4 residents listed as "sometimes disoriented" under the orientation category.</p> <p>Confidential staff interviews revealed there were at least 4 identified wanderers in the facility.</p> <ul style="list-style-type: none"> -The policy for supervision of identified wanderers or disoriented residents included 15 minute checks. -These residents were also included in hourly checks. -Staff tried to chart in an area where they could monitor the residents. -The front door did not have a sounding device. - Staff were supposed to let a supervisor or alert another staff member if they could not do 15 minute checks. -Sometimes there was a lack in communication between staff on the 15 minute checks but staff did the best they could. -Staff did not feel the residents were safe because some residents knew how to disarm the locking mechanism after watching staff. <p>Interview with the Administrator on 4/15/15 at 11:40am revealed:</p> <ul style="list-style-type: none"> -There was no sounding device on the front door. -The Administrator was not aware there was a 	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 067	<p>Continued From page 2</p> <p>need for a sounding device in this facility.</p> <ul style="list-style-type: none"> -There had been an ongoing issue with the front door since 9/2014 when she became the Administrator. -The Administrator was aware there were identified wanderers in the facility. -She visited the facility randomly on 2nd and 3rd shifts to check on residents and staff. -The Administrator lived on campus and had been to the facility on off hours to see if residents were outside. -All the doors were locked at 8pm and anyone coming or going through the front door would have to know the code. -The side doors alarmed all shifts when anyone attempted to open them without a code. -The Administrator called her maintenance man immediately. <p>Interview with the maintenance man on 4/15/15 at 12 noon revealed:</p> <ul style="list-style-type: none"> -The front door had several issues. -The hydraulic mechanism needed to be replaced. -The "crash bar/push bar" on the front door was new. -He had to make adjustments on the push bar. -He was installing a sounding device. -The front door was only 6 months old. <p>Observation on 4/15/15 at 2pm revealed a shrill sound whenever the front door was opened.</p> <p>_____</p> <p>The Plan of Protection dated 4/20/15 included the following:</p> <ul style="list-style-type: none"> -The facility has installed a new door on the front entrance and has placed a sounding device to make staff aware when someone enters or exists -This was completed within 20 minutes of being 	D 067		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(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 067	Continued From page 3 notified by the survey team. -The facility has also had the business office manager to magnify the front door entrance on the camera system in the front offices so the facility can further monitor all entrances and exits from the facility through the front door. -Once the alarm sounds to indicate that someone has either entered or exited the facility, the staff on duty must respond physically to see who has entered or exited to ensure that no identified wanderers have walked out of the facility. -This process will be monitored daily by the Resident Care Coordinators as well as by the Administrator daily to ensure the process is being followed correctly. -It is also a plan of the owner to install a wanderguard system to ensure residents that are identified as wanderers are kept safe from any type of harm. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 30, 2015.	D 067		
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 ensure the front door of the facility was maintained in a safe and operating condition. The findings are:	D 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 105	<p>Continued From page 4</p> <p>Observation of the front door of facility on 4/9/15 at 1pm revealed :</p> <ul style="list-style-type: none"> -The front door did not close completely, leaving a 1 and a 1/2 inch gap. -The front door remained ajar after residents, staff and visitors entered or exited. <p>Confidential resident interviews revealed they could not recall a time when the front door closed all the way.</p> <ul style="list-style-type: none"> -The front door was closed and locked after 8 pm. -Staff would have to know the code to open the front door after 8pm. -The residents did not have a problem with the front door not closing behind them. -They could come and go from facility anytime they wanted. -The door has been like that for a "long time." -Heard staff say that a hydraulic bar needed to be replaced. -They had not noticed that the front door remained ajar. -Staff thought the door was closing behind them. -Staff believed the door was 3-6 months old. -Residents were free to come and go except the identified wanderers. -Staff provided 15 minute checks on identified wanderers. -The front door had been painted 3-6months ago and it used to have a spring mechanism that kept it shut. -The switch next to the door operated a mag-lock. -Some residents knew how to turn the switch to the "disabled" mode. -There are at least 4 identified wanderers at the facility. -Staff recalled the front door had been worked on around 12/2014. -Staff member believed all staff was aware of this 	D 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 105	<p>Continued From page 5</p> <p>issue.</p> <ul style="list-style-type: none"> -The front door was locked at 8pm. -Visitors, staff, or residents would have to know the code to enter or exit through the front door after 8pm. <p>Interview with the Administrator on 4/5/15 at 11:40am revealed:</p> <ul style="list-style-type: none"> -The issue with the front door staying ajar had been an on-going problem as long as she had been the Administrator (Since September 2014). - The old door was in disrepair and the current door was 6 months old. -The "crash bar/push bar" mechanism was new in the door. -The maintenance man had to make adjustments to the 2 security features on the door. -The door had started locking people out of the facility when the door was disengaged. -The door was in proper working condition for a while after the adjustments. -The door was designed to be closed, but was kept open all day for the convenience of residents and visitors. -There had been no issues with the door remaining ajar. -The Administrator came to the facility periodically to see that the doors are all locked during off hours and to ensure the location of residents. -The front door was locked at 8pm and cannot be opened without a code. -The Administrator called the maintenance man immediately to repair the front door. <p>Observation at 12 noon revealed the maintenance man repaired the hydraulic bar and the door closed completely.</p>	D 105		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 6	D 270		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on interview and record review, the facility failed to provide supervision of 1 of 2 sampled Residents (#8) known to elope from the facility and 1 of 2 sampled residents (Resident #3) known to have behavior problems.</p> <p>The findings are:</p> <p>1. Review of Resident #8's current FL-2 dated 1/8/15 revealed diagnoses included Bipolar Disorder, Diabetes, Hypertension, Anemia, Chronic Kidney Disease, and orientation status "intermittently disoriented."</p> <p>Review of Resident #8's current Care Plan signed and dated on 11/10/14 revealed: -Resident #8 was identified as a wanderer. -Resident #8 had a history of mental illness and was sometimes disoriented. -Resident #8 was currently receiving medications for mental illness. -Referrals had been made for mental health. -"Resident likes to sit outside in the smoking area. Resident is not a smoker. Staff has to constantly guide resident to appropriate areas of the facility."</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 7</p> <p>According to Resident Register, Resident #8 was admitted to the facility on 8/14/12.</p> <p>Review of Resident #8's most recent health provider assessment dated 2/3/15 revealed the following:</p> <ul style="list-style-type: none"> -The resident's short term memory was impaired. -Resident #8 was oriented to person and place, but not time or situation. -Resident #8 had reported to the health care worker that the resident just wanted to get out of here. The resident felt something crawling on her and heard a ringing in her head. -Staff denied problems or concerns and did not observe Resident #8 having hallucinations or delusions. <p>Review of Resident #8's incident report dated 2/5/15 revealed:</p> <ul style="list-style-type: none"> -On 2/4/15 at 3pm Resident #8 was reported walking on the side road beside the facility near the church. -Staff went to pick up Resident #8 and asked her where she was going. She told them she was just walking. - Resident was returned to the facility and placed on 15 minute checks to ensure that she did not leave the facility. -The family member was informed of incident "once they came to the facility." No time was listed when the family member was contacted. -The physician was notified on 2/5/15; no time was listed. <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> -Resident #8 eloped from the facility on 2/4/15. -"Resident #8 had walked behind the jeep going toward the apartments. -The resident was at the local gas station. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Staff went and picked her up a little after 3:30pm. -Another resident had returned from the local neighborhood store and stated that Resident #8 was at the local gas station. -Resident #8 told staff she had a lot on her mind. -After the staff brought Resident #8 back to the facility the resident was placed on 15 minute checks and an incident report was completed. -When Resident #8 was brought back to the facility, she was assigned to staff on second shift. -When the resident returned back to the facility, she was calm. -Resident #8 was in bed no later than 8:30pm and was calm. -The next day the case worker (Guardian) came by and asked questions. <p>Facility Elopement policy revealed:</p> <ul style="list-style-type: none"> -Check the building, call the police and provide a picture of the resident. -Call the power of attorney or the family, document everything in progress and note in the chart, and notify the administrator. -Notify the doctor. <p>Observation of Resident #8 on 4/14/15 at 8:05am revealed:</p> <ul style="list-style-type: none"> -The resident was seen in hallway near the dining room. -Resident #8 was then seen walking down the hall to her bedroom. <p>Observation on 4/14/15 at 10:47am revealed Resident #8 was sitting on front porch with other residents.</p> <p>Observation on 4/14/15 at 11am revealed Resident #8 was seen entering the facility from the front porch.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 9</p> <p>Interview with Resident Care Coordinator on 4/15/15 at 10:34 am revealed: -Resident #8 eloped on 2/4/15. -"Resident #8 went out the front door (no date) between 3-3:30pm and went down the driveway to the side street. - Resident #8 told staff she was just walking because it was pretty outside. -The resident was calm. -"The resident was in the building. I was getting ready to go home that day when I saw Resident #8 walking." -"After bringing Resident #8 back I left."</p> <p>Confidential staff interview revealed: -On 2/4/15 Resident #8 was on the property and on hourly checks. -Resident #8 exited the facility on 2/4/15 and was back within one hour. - Resident #8 was then placed on 15 minute checks. -Staff member did not believe Resident #8 was competent to go off on her own. -A staff member thought Resident #8 knew what happened. -"Resident #8 is very quiet and to herself. She went past the store on 2/4/15." -"Resident #8 comes and goes from the facility." -On 2/4/15 Resident #8 was in the smoking area to the side of the building -During the change of shift Resident #8 walked out the front door, past the truck, towards the apartments, toward the local neighborhood store, and then stopped by the local daycare. -Resident #8 walked about a mile. -Resident #8 was not mentally stable. -"Resident #8 was in the smoking area and got by us when we were clocking in and out." -"Resident #8 is not with it enough to go walking</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 270	<p>Continued From page 10 out by herself."</p> <p>Confidential resident interview revealed:</p> <ul style="list-style-type: none"> -Resident #8 seldom came out and smoked. -The resident goes in and out the front. -That is the only door Resident #8 can get out of; the front door is a new door. -The front door used to close but now it does not work properly. -"Resident #8 is kind of in and out. Most of the time she is with it." -"Resident #8 just walked off when no staff was around." -"I was on the front porch when Resident #8 came out the front door and walked off towards the apartments." -Staff brought Resident #8 back to the facility. -Someone told staff that Resident #8 had walked away from the facility. -Resident #8 is not capable of going walking off by herself; the staff is aware. -Now the staff keep a close eye on her. The staff don't want her to go out and get run over." <p>Observation on 4/14/15 at 5:15pm of the area surrounding facility revealed:</p> <ul style="list-style-type: none"> -The front of the facility was separated from the main road by a parking lot and a grassy area containing shrubs approximately three to four feet high and marshy terrain. -This grassy area located next to the main road was approximately 50 yards in diameter. -On one side of the facility was an entrance road to the facility and a small road that was at least fifty yards in length. -There was a ditch approximately 4-5 feet deep between the entrance road and the woods near a local church. -On the right side of the facility was a long parking lot leading into the area of apartments. 	D 270		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 11</p> <ul style="list-style-type: none"> -The parking lot of the apartments was separated from a side road leading to the local store by grassy areas and shrubbery. -Behind the apartments was a wooded marshy area six feet high with several tall skinny trees approximately fifty feet tall. -The local gas station was located right off the main road and the furthest from the facility. -There was a busy four lane road in front of the facility with a deep ditch (4-5 feet) on both sides of the street. There were no sidewalk on the side of the street closest to the facility. -The distance between the facility and the local gas station is approximately a half mile. <p>Interview with the Administrator on 4/13/15 at 4:10pm revealed Resident #8 was still on the facility property that included the apartments and the RCC brought Resident #8 back to the facility but the Administrator could not recall the details.</p> <ul style="list-style-type: none"> -It was around shift change. -Staff got written up for not doing rounds. -Resident #8 does not usually go anywhere and she did not say she was going for a walk. -There have been no other incidents since February 2015. -Resident #8 will be on continuous 15 minute checks during all shifts. <p>Interview with Resident #8's former health provider on 4/14/15 at 10:25 am revealed:</p> <ul style="list-style-type: none"> -The provider was not aware Resident #8 had eloped. -Staff should know Resident #8's locations at all times as she is not safe to be out by herself. -They should be aware that the resident is not competent to make her own decisions. -The last time the provider had seen Resident #8 was on 2/23/15. -The facility did not mention elopement. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 12</p> <ul style="list-style-type: none"> - Resident #8 does not smoke. -The resident had never been a wanderer or wandered off before. -Half hour checks would be appropriate for Resident #8. <p>Interview with Resident #8's mental health provider on 4/14/15 at 2:46pm revealed:</p> <ul style="list-style-type: none"> -Resident #8 was seen by their practice for the first time on 4/6/15. -"I would have liked to have been made aware of Resident #8's elopement at our first visit. -Resident #8's mood goes up and down. -Resident #8 has to be with staff because of her special needs mentally. -She would get lost by herself. If Resident #8 wants to go outside staff needs to be with her. -Resident #8 comes and goes in her mind. -She is intermittently disoriented. -Before elopements facilities usually do 1-2 hour checks on residents. -Resident #8 is not capable of signing in and out. -She has mental retardation from her assessment. -At least the primary care physician and a mental health provider need to be notified of any elopement. -The facility should also be monitoring doors and hallways continuously and make sure they document." <p>Interview with Resident #8's current health provider on 4/15/15 at 11:55am revealed:</p> <ul style="list-style-type: none"> -The provider started providing service for Resident #8 on 3/15/15. -She had not received any information concerning elopement. -Resident #8 was not very well oriented. -Mental retardation was a factor for the resident and the resident had problems with 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 13</p> <p>comprehension.</p> <p>-Resident #8 was not focused, seemed confused at times, and was not capable of going out on her own.</p> <p>-Resident #8 would sit on the porch of the facility and smoke without problems.</p> <p>-Resident #8's mini mental status was oriented to the town and the president.</p> <p>Review of Resident #8's Documentation on Petition for Adjudication of Incompetence revealed Resident #8 was deemed as incompetent by the Superior Court in Craven County, N.C. on 1/10/14.</p> <p>Based on observation, interview, and record review, Resident #8 was non interviewable.</p> <p>2. Review of Resident #3's current FL-2 dated 4/6/15 revealed:</p> <p>-The resident's diagnoses included hypotension and Type II Diabetes Mellitus.</p> <p>-An order for Celexa 20 milligrams (mg) one tablet by mouth daily (used to help treat depression).</p> <p>Record review revealed Resident #3 had a prior FL-2 dated 11/6/14 which included an order for Celexa 20 mg take one tablet by mouth daily.</p> <p>The Resident Register revealed Resident #3 was admitted to the facility on 4/5/12.</p> <p>Review of Resident #3's Care Plan dated 4/2/15 revealed:</p> <p>-The resident had a history of mental illness and the resident had been seen by mental health.</p> <p>-Resident #3 was a "very pleasant" resident.</p> <p>-There was no other documentation about the resident's behavior.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 14</p> <p>Review of Resident #3's February 2015, March 2015 and April 1-13, 2015 Medication Administration Records (MARs) revealed the resident had received Celexa 20 mg one tablet daily.</p> <p>Interview with Resident #3 on 4/14/15 at 8:34 a.m. revealed the resident had never done anything inappropriate to a resident or had ever seen anyone do anything inappropriate to residents.</p> <p>Further interview with Resident #3 on 4/15/15 at 11:41 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident goes to the female hall to visit Resident #6 1-2 times weekly around lunch time. -Resident #3 was last in Resident #6's room two weeks ago. -Resident #3 talked to Resident #6 and watched television (TV) with the resident. -The resident never inappropriately touched himself while in the presence of other residents. <p>A confidential resident interview revealed:</p> <ul style="list-style-type: none"> -One day between the week of April 5-11, 2015 between 8:30-8:45 p.m., the resident was in the smoking area near the TV lounge and observed Resident #3 sitting by Resident #6. Resident #6 was sitting in a wheel chair. Both residents were watching TV. -Resident #3 had the right hand on Resident #6's right knee. -Resident #6 was leaning towards the left away from Resident #3, which was unusual. Resident #6 looked uncomfortable around Resident #3. -When the resident had left the smoking area and got up and walked inside the TV room, Resident #3 snatched the hand from Resident #6's knee. -The resident told Resident #3 "I saw what you were doing. You need to keep your hands to 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 15</p> <p>yourself and leave the resident alone." -Resident #3 left the room. -Resident #6 told the resident that Resident #3 needed to keep hands to self. -The resident did not report the incident to any staff. "I should have told someone, but I didn't."</p> <p>Telephone interview with Resident #3's Primary Care Physician on 4/15/15 at 12:17 p.m. revealed: -Resident #3 was first seen by the provider's office on 3/6/15. -There was no documentation of the resident having inappropriate sexual behaviors in the resident's record. -Resident #3's judgement and insight are impaired.</p> <p>Telephone interview with Resident #3's mental health provider on 4/15/15 at 12:34 p.m. revealed: -The provider started seeing Resident #3 on 3/2/15. -The mental health company had been seeing Resident #3 since July 2014. -There was no documentation of Resident #3 having inappropriate sexual behaviors in the resident's file.</p> <p>Interview with the Administrator on 4/15/15 at 5:06 p.m. revealed: -The Administrator was not aware Resident #3 had put a hand on Resident #6's knee. -If the Administrator would have known about it, the Administrator would have investigated the incidence, talked to the resident and called the resident's primary care physician. Confidential resident interview revealed Resident #3 was observed in Resident #6's room standing behind Resident #6 and masturbating.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 16</p> <ul style="list-style-type: none"> -This occurred within the last month. -Resident #6 was wheelchair bound. -The roommate was asleep in her bed. -The occurrence was reported to the current Resident Care Coordinators. -One of the RCCs immediately came down and removed Resident #3 from the room. <p>Confidential resident interview revealed she saw Resident #3 go in Resident #4's room a month ago and several aides had asked Resident #3 not to go down the women's hall.</p> <ul style="list-style-type: none"> -Resident #4 asked Resident #3 to leave her room. -This happened before Resident #4 was discharged from facility. <p>Confidential staff interview revealed Resident #3 was observed to walk down the women's hall often.</p> <ul style="list-style-type: none"> -"Resident #3 is strange and I believe sexually perverse." -Other residents had complained to this staff member about Resident# 3 but could not recall specific names. -Staff tried to keep an eye on Resident #3. -Resident #3 did not resist when corrected and was easily re-directed. <p>Confidential staff interviews revealed Resident #6 was not "with it."</p> <ul style="list-style-type: none"> -You could have limited conversation with Resident #6 but not with the resident's roommate. -Everybody loved Resident #6 and most residents' called the resident "grandma." -Resident # 3 was often observed watching TV with Resident # 6 in her room on a regular basis. <p>Interview with Resident Care Coordinator (RCC) on 4/14/15 at 1pm revealed Resident #3 goes</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 17</p> <p>into Resident #6's room to visit and watch TV on a regular basis.</p> <p>-The RCC did not know anything about inappropriate sexual behavior and Resident #3.</p> <p>-The RCC did not go into Resident Resident #6's room to remove Resident #3.</p> <p>-The RCC did not have problems with Resident #3 and stated no other residents complained about Resident #3.</p> <p>Interview with RCC on 4/15/15 at 10:45 am revealed she had never heard anything about inappropriate sexual behavior involving Resident #3 and did not know that Resident # 3 visits the women's hall.</p> <p>Confidential staff interview revealed no problems with Resident #3 and stated Resident #3 did not visit the women's hall.</p> <p>Interview with Resident # 6 on 4/15/15 at 9:45am revealed no man visited her room.</p> <p>-The resident was not afraid of anybody.</p> <p>-The resident liked living at the facility.</p> <p>Resident #6's roommate was not interviewable.</p> <p>Interview with the Administrator on 4/15/15 at 10:25pm revealed she did not know about any inappropriate sexual behavior involving Resident #3</p> <p>-Resident #3 goes into the room of Resident #6 to visit and watch TV on a regular basis.</p> <p>-The Administrator denied having either RCC report this incident to her.</p> <p>-The Administrator said if she had known about the incident she would have removed Resident #3 from Resident # 6's room.</p> <p>-The Administrator would keep Resident #3 under close supervision now that the incident had been</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	<p>Continued From page 18 brought to her attention.</p> <p>The Plan of Protection received 4/14/15 included the following:</p> <ul style="list-style-type: none"> -The facility will assess any and all residents who are potential wanderers or at risk for elopement. - Once identified, those residents will be placed on 15 minute checks. - The facility is also installing a wanderguard alarm on the front door to enable staff to hear the door opening and closing that will require automatic staff response. -The facility doors are locked at 9pm nightly. - Once residents are identified as wanderers or elopement risk, they will automatically be placed on a 15 minute documented check. - Door alarms installed on front door on 4/15/15 to alert staff of exiting and entering residents, staff and visitors that will have to be visibly monitored by staff to ensure no resident is endangered or at any other future risk for elopement. - The scheduled staff on the floor responsible for completion of the 15 minute checks will also be responsible for completing or monitoring the exit and entrance of residents etc...as they enter or exit the door based on the alarm. - This process will be monitored by the RCC's daily and the Administrator will monitor the RCC's to ensure that his process is being followed daily. <p>The Plan of Protection received on 4/22/15 included the following:</p> <ul style="list-style-type: none"> -The facility would place the residents of suspect on an hourly checks and would also increase the supervision to every 15 minutes to ensure that there are no inappropriate behaviors present. -The facility would also notify the resident's family, primary care physician, as well as the local mental health provider to receive any guidance necessary. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19 - The hourly and 15 minute checks would be done by the Personal Care Aide staff. The Resident Care Coordinators will do daily checks to ensure this is being completed and will also be responsible for contacting families, physicans and mental health providers. -The Administrator will complete weekly checks to ensure that the process is being completed. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 15, 2015.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure referral and follow-up to meet the chronic and acute health needs of a resident related to increased behaviors.(Resident #7). The findings are: Review of Resident # 7 current FL-2 dated 7/14/14 revealed diagnoses of Hypertension, Developmental Delay, Mood Disorder with Depression, Dermatitis and Prader-Willi-Syndrome. (People with Prader-Willi	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 273	<p>Continued From page 20</p> <p>Syndrome typically have mild to moderate intellectual impairment and learning disabilities. Behavioral problems are common, including temper outbursts, stubbornness, and compulsive behavior such as picking at the skin. Sleep abnormalities can also occur)</p> <p>-Medications included Risperdal 2 mg by mouth at bedtime.</p> <p>-Ativan 0.5mg every 4 hours as needed for agitation/anxiety.</p> <p>Review of Resident #7's nurses notes dated 9/6/14 revealed an incident occurred on 9/6/14 between Staff C and Resident # 7.</p> <p>Review of Resident #7's nurses noted dated 2/10/15 revealed Resident # 7 hit another resident on 2/10/15.</p> <p>Interview with Resident #7's health care provider on 4/15/15 at 12:10pm revealed visits with Resident #7 since 3/2015.</p> <p>-The last recorded visit was on 3/3/15.</p> <p>-Resident # 7 did not mention an altercation with a resident or staff.</p> <p>-The health provider had not been notified that Resident # 7 hit a resident on 2/10/15.</p> <p>-The health care provider was unaware of incident on 9/6/14.</p> <p>- Resident # 7 had a "short fuse".</p> <p>-No incident reports had been faxed to the local health care provider regarding Resident # 7's behaviors</p> <p>- The health care provider wanted to be notified of any increased behaviors and altercations between Resident # 7 and staff or between Resident #7 and other residents because the information could possibly change his medication management and possible referrals.</p>	D 273		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(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 273	<p>Continued From page 21</p> <p>Confidential family interview revealed concern that Resident #7 was a threat to himself and others.</p> <ul style="list-style-type: none"> -Resident # 7 had a violent past. -The family had been threatened by Resident # 7. -Resident #7 had threatened to burn down the family's home. -The police had been called on Resident #7 before because he had stalked a female in town before. -Resident #7's behaviors had increased in the past 6 months. -Resident #7 did not tell family about the incidents on 9/6/14 and 2/10/15. -The family wanted to be called if Resident #7 went out of facility per police or to the hospital. -Resident #7 was not allowed to come back home because of his violent behavior. - Resident # 7 had emotional outbursts. -He would scream, curse, and then go outside to smoke. -Resident # 7 got very upset when the monthly funds were late and when meal times were running late. -Resident #7 often tried to interfere with issues involving other residents. <p>Confidential staff interview revealed Resident # 7 had an emotional outburst in the dining room with a kitchen staff who is no longer employed at the facility.</p> <ul style="list-style-type: none"> -Resident #7 was like a child when he didn't get his way as far as his increased temper. <p>During an observation and interview with Resident #7 on 4/9/15 at 1:15pm the following were revealed:</p> <ul style="list-style-type: none"> -Resident #7 stated he thought he got along with the other residents. -"I feel safe I just don't like it here." 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 273	<p>Continued From page 22</p> <ul style="list-style-type: none"> -Denied having problems with anyone at facility. -Got visibly irritated when asked specifics about staff and resident interactions and refused to discuss the matter further. -"I 've got a learning disability, I'm handicapped, I'm disabled." -Resident #7 pointed to a package of incontinent briefs and remarked that he could walk and do alot for himself but liked the staff to changed his incontinent brief. -Resident #7 was walking unassisted and shaving his head over the bathroom sink. <p>Interview with Resident #7's roommate on 4/9/15 at 1:10Pm revealed he got along with Resident #7.</p> <p>Confidential resident interviews revealed they were not afraid of Resident #7 or anybody else at the facility.</p> <p>Interview with Resident #7's mental health provider on 4/14/15 at 2:10pm revealed July 3, 2014 as last documented visit with Resident #7, but resident stayed active in their system x 3 years.</p> <ul style="list-style-type: none"> -No one from the facility had notified their practice about the 2/10/15 incident. -Now that the local provider was aware of family's concern, an attempt would be made to re-establish care with Resident # 7. <p>Interview with the Administrator on 4/15/15at 10:25pm revealed there had been some changes in health care providers at the facility.</p> <ul style="list-style-type: none"> -The administrator could not recall if any provider was notified after latest altercation involving Resident # 7. -The administrator thought it would have been a good idea to have contacted the resident's health 	D 273		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 273	Continued From page 24 VIOLATION SHALL NOT EXCEED MAY 30, 2015.	D 273		
D 282	<p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the floor in the walk-in-cooler were free of rust and protected from contamination.</p> <p>The findings are:</p> <p>Observation of the floor in the reach-in-cooler on 4/9/15 at 2:10 p.m. revealed: -The edges of the floor by the wall had brown rust stains. -The center of the floor had three large brown rust patches.</p> <p>Interview with the Cook on 4/9/15 at 2:10 p.m. revealed two years ago the floor in the walk-in-freezer had been painted.</p> <p>Interview with another Cook on 4/9/15 at 2:41 p.m. revealed: -The floor in the walk-in-cooler had been rusty at least for one month since he had been working at the facility. - " We try to clean the floor as best as we can."</p>	D 282		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/15/2015
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(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 282	Continued From page 25 Interview with the Administrator on 4/13/15 at 5:45 p.m. revealed: -She had been working at the facility for the past 6-7 months. -The floors in the walk-in-cooler are cleaned daily by dietary staff. -She was aware of the rusted floor inside of the walk-in-cooler and floor had been rusted before she had started working at the facility. The paint had worn off on the floor. The floor had not been painted for the past 6-7 months. -The racks are pulled from the walls in the walk-in-cooler weekly and staff cleaned the floor. The Dietary Supervisor was not available for interview.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure a Cook followed sanitation and safety guidelines by not opening a package with his teeth to be used in preparing the resident's meals. The findings are: Observation on 4/14/15 at 9:16 a.m. revealed: -The Cook was standing at the entrance door to the kitchen, had shook a silver package and was	D 283		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 283	<p>Continued From page 26</p> <p>opening the package with his teeth. -The Cook had turned and went back into the kitchen. -It was unsure what the Cook was opening with his teeth.</p> <p>Interview with the Cook on 4/14/15 at 9:17 a.m. revealed: -The Cook denied opening anything with his teeth. -"I don't know what you are talking about." -He had some chips earlier during the day.</p> <p>Further interview with the same Cook on 4/15/15 at 7:45 a.m. revealed: -The Cook had training on sanitation and safety guidelines at a prior job 8 months ago. -He had not received training on sanitation and safety guidelines while working at the facility.</p> <p>Interview with the Administrator on 4/14/15 at 9:20 a.m. revealed: -The Cook should not have been using his mouth to open up anything with his teeth to cook for the residents. -She was not aware he had opened something with his mouth to cook for the residents. -Whether the Cook denied opening anything with his teeth to cook or prepare for the residents was inappropriately. - "He will get written up for this."</p> <p>Interview with the Administrator on 4/14/15 at 9:30 a.m. revealed: -The Administrator went to go and talk to the Cook. -The Cook denied opening anything with his teeth to use while cooking for the residents. -Because of the Cooks' behaviors, she believed the Cook was lying</p>	D 283		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 283	Continued From page 27 Further interview with the Administrator on 4/15/15 at 8:26 a.m. revealed: -The Cook was hired to work at the facility on 2/13/15. -The Cook had completed the state food service orientation on 2/13/15. -The Cook had food handling training, but she was unsure when. -The Dietary Supervisor trained the Cook on safe food handling.	D 283		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that every resident be free from mental and physical abuse, neglect, and exploitation as related to a resident being choked by a staff member after an altercation between them. The findings are: Based on interview and record review, the facility failed to assure that every resident be free from mental and physical abuse, neglect, and exploitation as related to Resident #7 being choked by a staff member after an altercation between them. [Refer to Tag D914 G.S. 131D-21(4) Resident Rights]	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 427	Continued From page 28	D 427		
D 427	<p>10A NCAC 13F .1106 Settlement Of Cost Of Care</p> <p>10A NCAC 13F .1106 Settlement Of Cost Of Care</p> <p>(a) If a resident of an adult care home, after being notified by the facility of its intent to discharge the resident in accordance with Rule .0702 of this Subchapter, moves out of the facility before the period of time specified in the notice has elapsed, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure 1 of 1 Residents (#1) received a refund within 14 days after being discharged from the facility.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 9/11/14 revealed the resident's diagnoses included bipolar disorder, anxiety and chronic pain. The resident had chronic use of opiates.</p> <p>Review of Resident #1's record revealed: -The Resident Register revealed the resident was admitted to the facility on 5/1/14. -The resident was discharged from the facility on 3/23/15.</p> <p>Telephone interview with Resident #1's</p>	D 427		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 427	<p>Continued From page 29</p> <p>Responsible Party on 4/9/15 at 5:16 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was discharged from the facility on 3/23/15 and the resident had not received a refund from the facility as of 4/9/15. -Resident #1 was owed a refund for 1 week and 1 day from the facility. -When the resident was discharged from the facility, the Responsible Party was told by the Administrator the resident would receive a refund within 14 days. The Administrator did not say if the refund would be received within 14 calendar days or business. -The Responsible Party had called the facility, between 4/6/15 to 4/9/15, and the Administrator was not available. <p>Review of Resident #1's business file revealed the discharge documentation had been faxed to corporate on 3/25/15.</p> <p>Interview with the Administrator on 4/13/15 at 5:10 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 paid rent for the month of March 2015, so the resident was due a refund. -When a resident is discharged from the facility, the resident will receive a refund within 14-30 days. -Corporate would send the refund to the resident. -The Administrator had spoken with the Business Manager and she revealed she had submitted the information to corporate which included the discharge information so Resident #1 could receive a refund. -The Business Manager said the resident probably would not receive a refund, because the resident owed money for medications. <p>Review of Resident #1's contract under the "Resident's Personal Fund Policies" signed by the</p>	D 427		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 427	<p>Continued From page 30</p> <p>resident on 5/1/14 included "If a resident gives notification to leave the home, personal funds balance will be refunded 14 days from the date of notice."</p> <p>Interview with the Administrator on 4/15/15 at 8:37 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 submitted a discharge notice on 3/13/15, because the resident was not satisfied with living at the facility and the resident's Responsible Party agreed to pick up the resident on 3/23/15. The Responsible Party and the Administrator agreed to have the rest of the 14 days waived. -The Administrator called corporate on 4/14/15 for the cost of care refund for Resident #1. -The Corporate Business Manager revealed she did not see the discharge documentation for Resident #1. The Corporate Business Manager told her to re-submit the discharge documentation and she would send the check to Resident #1 on 4/14/15. -After the Business Manager sent the information to corporate for a refund, corporate was responsible for sending the refund to the resident. -Resident #1 should have received a refund by 4/7/15. <p>Observation on 4/15/15 at 9:45 a.m. revealed the Administrator called the corporate Business Manager, but the Business Manager was not available.</p> <p>Observation and interview with the Administrator on 4/15/15 at 11:51 a.m. revealed:</p> <ul style="list-style-type: none"> -The Administrator read a text from the Owner dated 4/15/15 which revealed Resident #1 was sent a personal refund on 4/14/15. -The Administrator called Resident #1's Responsible Party to inform them the resident's 	D 427		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 427	Continued From page 31 refund check was mailed to the resident on 4/14/15.	D 427		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on interview and record review the facility failed to ensure Health Care Personal Registry was notified within 24 hours after an allegation was made that a staff member (Staff C) grabbed a resident around the neck after being hit in the head by that resident(Resident #7).</p> <p>The findings are:</p> <p>Review of Resident # 7 current FL-2 dated 7/14/14 revealed diagnoses of Hypertension, Developmental Delay, Mood Disorder with Depression, Dermatitis and Prader-Willi-Syndrome. (People with Prader-Willi syndrome typically have mild to moderate intellectual impairment and learning disabilities. Behavioral problems are common, including temper outbursts, stubbornness, and compulsive behavior such as picking at the skin. Sleep abnormalities can also occur) -Medications included Risperdal 2 mg by mouth at bedtime. -Ativan 0.5mg every 4 hours as needed for</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 32</p> <p>agitation/anxiety.</p> <p>Interview with Resident #1 on 4/10/15 at 10:10am revealed Resident #7 informed her that Staff C grabbed Resident #7 by the neck on 9/6/14.</p> <ul style="list-style-type: none"> -Resident #1 stated Staff C and Resident #7 were in a heated argument on 9/6/14. -Resident #7 came out of the medication room and told Resident #1 that Staff C had grabbed him around his throat. -Resident #1 reported the incident to the Administrator but said "nothing was done." <p>Interview with Resident #7's roommate on 4/9/15 at 1:10pm revealed he did not know about any problems between staff and Resident #7. Resident would not talk about staff and kept going off topic.</p> <p>During observations and interview with Resident #7 on 4/9/2015 at 1:15pm the following was revealed:</p> <ul style="list-style-type: none"> -Resident #7 was observed walking unassisted and shaving his head over the bathroom sink. -The resident was observed to be irritated when asked for an interview. -The resident pointed to a package of incontinent products. -The resident remarked he could not do anything for self and liked for staff to change his incontinent briefs. -The resident stated he got along with roommate. -The resident stated, " I feel safe; I just don ' t like being here. " -The resident stated having no problems with anyone in the facility. -The resident, observed to be more irritated, stated, " I ' ve got a learning disability, I ' m handicapped, I ' m disabled! " 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 33</p> <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> - Resident #7 and staff C had been arguing on 9/6/14 after Resident #7 was corrected for trying to intervene into other residents' concerns that day. -Resident # 7 came into the medication room and hit Staff C. -"When I stood up and turned around they were locked up." -Resident # 7's back was up against the paper towel machine. -Staff C was trying to get his hands off her. -" Resident #7 will listen to me so I pulled him off her." -"I gently used my hands around his waist to pull him off of her." -Resident #7 didn't resist. - He said he would tell people that Staff C choked him. - Resident #7 went back to his room. -"I gave him a couple of cigarettes." - "He went ranting and raving about it to residents." - Resident #1 was walking by when he was talking about the incident to other residents. -Staff C was encouraged to go to the hospital. -Staff C said she was okay but couldn't believe Resident #7 hit her on the back of the head. -"A nurse's note was filled out. I don't believe he was sent out." -"I think the Administrator was called . Staff C went home shortly after charting." -Resident #1 was telling other residents about it. - Resident # 7 was red all over. - "He wouldn't let us look at his neck after he calmed down and put on a button-up shirt." - "I know the Administrator was aware." -The supervisor and the family were called. - "At no time was I ever called in to explain what I saw." 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 34</p> <p>- "I don't have any problems with him. I haven't seen any tense moments between them since then."</p> <p>- "The steps we were to follow are: Call the Supervisor in charge, take vital signs, and send the residents for a medical incident or accident. For increased resident behaviors we call the supervisor in charge, call family, and if it's really bad we call mobile crisis."</p> <p>Confidential staff interviews revealed Staff C was seen choking Resident #7.</p> <p>- Staff was certain the Administrator and any staff working that day knew about the incident.</p> <p>- Staff was afraid of retaliation.</p> <p>- "Staff C had Resident # 7 by the throat with her left hand. Resident #7 was trying to swing at Staff C , trying to get out of it. The current Administrator was called at the time of the incident."</p> <p>Confidential staff interview revealed staff members were trained on de-escalation techniques.</p> <p>- Staff member knew that Resident #7 hit Staff C in the back of the head.</p> <p>- Resident #7 had been calling Staff C bad names prior to the incident.</p> <p>- Another staff member had to pull Resident #7 off of staff C.</p> <p>- Other staff asked Staff C if she wanted to press charges but she said no.</p> <p>- The Administrator was called.</p> <p>- Staff C completed an incident report and left the facility.</p> <p>Interview with Staff C on 4/13/15 at 3:30pm revealed:</p> <p>- Resident #7 came into the medication room on 9/6/14 and threatened to hit Staff C.</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 35</p> <ul style="list-style-type: none"> -Staff C asked Resident #7 to leave but he would not. -"Resident # 7 hit me upside the head with his fist. He called me a bad name and told me he didn't like me." -"I was a Medication aide then." -"I still cannot think of exactly what set him off." -"Earlier that day right before shift change he had been arguing with another resident and we asked Resident # 7 to stay away from the other resident." -Resident # 7 did not like that. -"I never saw any marks on his neck." -"Since that time we have had no problems." -"I didn't hit him or grab him around his neck. The other staff who pulled him off of me didn't go anywhere near his neck either." - Resident # 7 would not let anybody see his neck after that. -Staff C completed an incident report. -Staff C contacted her supervisor by phone. -Staff C said the Administrator was aware. -Staff C said she called the Doctor -Staff C called Resident # 7's family. <p>Review of Resident #7's Nurses Note dated 9/6/14 revealed:</p> <ul style="list-style-type: none"> - Patient was cussing the Supervisor in charge today. -Resident was told to stay out of other residents' business. - Resident came into the nursing station and hit the Supervisor in charge (SIC) on the side of the neck. -The Administrator was notified. -Talked to resident's mom and stepbrother about what happened. -MD was notified also. 	D 438		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 36</p> <p>Review of Incident report dated 9/6/14 revealed: -Resident #7 came into the nurse's station and hit Staff C in the neck. -The plan of treatment was to watch the resident closely. -Resident # 7 was talking to Staff C when the incident occurred. -The mother and step-brother were notified. -The incident report was completed by Staff C.</p> <p>Phone interview with Resident # 7's family on 4/14/15 at 2:47pm revealed she had been called after the incident on 9/6/14. -The family member was told by staff at the facility that the resident had hit Staff C in the throat. -The family member could not recall if Resident #7 saw mental health professionals or not. -The family member did not see Resident #7 following the incident. -The family member does not see Resident #7 on a regular basis due to the residents' behaviors.</p> <p>Interview on 4/14/15 at 2pm with a Mental Health professional revealed Resident #7 was seen once a month since 2/2015 to manage his medications and was not aware of the allegation regarding the incident between Staff C and Resident #7 and was not notified about the incident. Resident #7 had not spoken about the incident in their sessions together.</p> <p>-Interview with the Administrator on 4/14/15 at 3:30pm revealed she was the Administrator at the time of the incident on 9/6/14 but was out of town. Staff C called the Administrator about the incident. -"There was a lot of commotion in the background during that phone call." -"When I first started here there was chaos in the</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 37</p> <p>facility."</p> <p>- "It seemed like staff were against the residents and staff against staff."</p> <p>- "I have worked very hard to change the culture of the community."</p> <p>- "My policy is zero tolerance to verbal, mental, or physical abuse to residents"</p> <p>- "If I believed at any point Staff C had put her hands on Resident #7 that would have meant suspension of Staff C pending an investigation."</p> <p>- "I talked to Resident #7 when I got back into town and he wouldn't even say that he put his hands on Staff C."</p> <p>- "He was not happy with being told to stay out of other resident's business."</p> <p>- "I was not aware that I needed to report this particular incident to the Health Care Personal Registry."</p> <p>- " No one did a physical assessment on Resident #7 after the incident because we were thinking only Staff C got hurt."</p> <p>- "I did not believe Staff C put her hands on Resident #7 or that there was a need to ask any further questions. I just heard yesterday through staff gossip that Staff C hit Resident #7."</p> <p>- The administrator advised Staff C not call the police but to document and complete an incident report.</p> <p>- Resident #7's Doctor was not notified.</p> <p>- Resident #7's family was notified.</p> <p>- Staff C and the Administrator were signed up to take the state 1068 training this month about abuse, neglect, and exploitation in facilities</p> <p>- The Administrator held regular meetings on such topics as Resident Rights, OSHA and blood-borne pathogens.</p> <p>Interview with the Administrator on 4/15/15 at 10:25pm revealed she could not recall if Resident #7 was being seen by a mental health provider at</p>	D 438		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	<p>Continued From page 38</p> <p>the time of the incident.</p> <p>-The administrator could not recall if a physician or mental health provider was notified about the incident.</p> <p>-No documentation was provided showing notification of a health care provider.</p> <p>Interview with facility's local health care provider on 4/15/15 at 12:10pm revealed visits with Resident #7 since 3/2015.</p> <p>-The local health care provider was unaware of incident on 9/6/14.</p> <p>-No incident reports received from facility regarding Resident # 7's behaviors.</p> <p>-The local health care provider wanted to be notified of any increased behaviors regarding Resident #7 because the information could possibly change his medication management and possible referrals.</p> <p>The plan of correction included the following:</p> <p>-If there is an allegation of a staff physically, verbally, emotionally, or mentally abusing a resident, the facility has a no tolerance policy on this.</p> <p>-If these things are suspected the employee will be suspended pending a formal investigation and the family, law enforcement, DSS, and the Health Care Personnel Registry will be notified .</p> <p>-Notify the mental healthcare provider as necessary.</p> <p>-The initial notification of the Health Care Registry will be within 24 hours of the incident and will be followed by a 5 day working report to include all of the facilities' actions and investigation notes on the incident.</p> <p>CORRECTION DATE FOR THE TYPE A2</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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 438	Continued From page 39 VIOLATION SHALL NOT EXCEED MAY 15, 2015.	D 438		
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: Based on observation, interview and record review, the facility failed to assure all residents receive care and services which are adequate, appropriate, and in compliance with federal and state laws and rules and regulations as related to the facility having a sounding device on the front door for wanderers and disoriented residents, elopement, resident and staff behaviors and contacting the Health Care Personnel Registry.</p> <p>The findings are:</p> <p>1. Based on observation and interview, the facility failed to assure a sounding device on the front door for a population of at least 4 identified wanderers and residents known to be disoriented. [Refer to Tag D067, 10A NCAC 13F. 0305 (h)(4). (Type B Violation)]</p> <p>2. Based on interview and record review, the facility failed to provide supervision of 1 of 2 sampled residents (Resident #8) known to elope from the facility and 1 of 2 sampled residents (Resident #3) known to have behavior problems. [Refer to Tag D270, 10A NCAC 13F. 0901 (b).</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D912	Continued From page 40 (Type A2 Violation) 3. Based on observation, interview, and record review, the facility failed to assure referral and follow-up to meet the chronic and acute health needs of a resident related to increased behaviors. [Refer to Tag D273, 10A NCAC 13F. 0902 (b). (Type B Violation)] 4. Based on interview and record review the facility failed to ensure the Department of Health Care Personal Registry was notified within 24 hours after an allegation was made that a staff member (Staff C) grabbed a resident around the neck after being hit in the head by that resident. [Refer to Tag D438, 10A NCAC 13F. 1205. (Type A2 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 A2 VIOLATION Based on interview and record review, the facility failed to assure that every resident be free from mental and physical abuse, neglect, and exploitation as related to Resident #7 being choked by a staff member after an altercation between them. The findings are: Review of Resident # 7's current FL-2 dated 7/14/14 revealed diagnoses of Hypertension,	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D914	<p>Continued From page 41</p> <p>Developmental Delay, Mood Disorder with Depression, Dermatitis and Prader-Willi-Syndrome. (People with Prader-Willi syndrome typically have mild to moderate intellectual impairment and learning disabilities. Behavioral problems are common, including temper outbursts, stubbornness, and compulsive behavior such as picking at the skin. Sleep abnormalities can also occur)</p> <p>-Medications included Risperdal 2 mg by mouth at bedtime. -Ativan 0.5mg every 4 hours as needed for agitation/anxiety.</p> <p>An interview with Resident #1 on 4/10/15 at 10:10am revealed Resident #7 informed her that Staff C grabbed Resident #7 by the neck on 9/6/14. -Resident #1 stated Staff C and Resident #7 were in a heated argument on 9/6/14. -Resident # 7 came out of the medication room and told Resident #1 that Staff C had grabbed him around his throat. -Resident #1 reported the incident to the Administrator but said "nothing was done."</p> <p>Interview with Resident #7's roommate on 4/9/15 at 1:10pm revealed he did not know about any problems between staff and Resident #7. Resident would not talk about staff and kept going off topic.</p> <p>Interview with Resident #7 on 4/9/15 at 1:15pm revealed he did not want to talk about staff and was hard to keep on topic. Resident refused to talk about staff x 2 attempts.</p> <p>Confidential staff interview revealed: -Resident #7 and staff C had been arguing on 9/6/14 after Resident #7 was corrected for trying</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D914	<p>Continued From page 42</p> <p>to intervene into other residents' concerns that day.</p> <p>-Resident # 7 came into the medication room and hit Staff C. "When I stood up and turned around they were locked up. Resident # 7's back was up against the paper towel machine. Staff C was trying to get his hands off her. Resident #7 will listen to me so I pulled him off her. I gently used my hands around his waist to pull him off of her. Resident #7 didn't resist. He said he would tell people that Staff C choked him. Resident #7 went back to his room. I gave him a couple of cigarettes. He went ranting and raving about it to residents. Resident #1 was walking by when he was talking about the incident to other residents. Staff C was encouraged to go to the hospital. Staff C said she was okay but couldn't believe Resident #7 hit her on the back of the head. A nurse's note was filled out. I don't believe he was sent out. I think we called the Administrator. Staff C went home shortly after charting. Resident #1 was telling other residents about it. Resident # 7 was red all over. He wouldn't let us look at his neck after he calmed down. He put on a button-up shirt. I know the Administrator was aware. The supervisor and the family were called. At no time was I ever called in to explain what I saw. I don't have any problems with him. I haven't seen any tense moments between them since then. The steps we were to follow are: Call the Supervisor in charge, take vital signs, and send the residents for a medical incident or accident. For increased resident behaviors we call the supervisor in charge, call family, and if it's really bad we call mobile crisis."</p> <p>Confidential staff interview revealed Staff C was seen choking Resident #7.</p> <p>-Staff was certain the Administrator and any staff working that day knew about the incident.</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D914	<p>Continued From page 43</p> <ul style="list-style-type: none"> -Staff was afraid of retaliation. -Staff were trained on de-escalation techniques. - Staff member knew that Resident #7 hit Staff C in the back of the head. - Resident #7 had been calling Staff C bad names prior to the incident. -Another staff member had to pull Resident #7 off of staff C. -Other staff asked Staff C if she wanted to press charges but she said no. -The Administrator was called. -Staff C completed an incident report and left the facility. <p>Interview with Staff C on 4/13/15 at 3:30pm revealed Resident #7 came into the medication room on 9/6/14 and threatened to hit Staff C. Staff C asked Resident #7 to leave but he would not. "Resident # 7 hit me upside the head with his fist. He called me a bad name and told me he didn't like me. I was a Medication aide then. Still cannot think of exactly what set him off. Earlier that day right before shift change he had been arguing with another resident and we asked Resident # 7 to stay away from the other resident. Resident # 7 did not like that. I never saw any marks on his neck. Since that time we have had no problems. I didn't hit him or grab him around his neck. The other staff who pulled him off of me didn't go anywhere near his neck. Resident # 7 would not let anybody see his neck after that."</p> <ul style="list-style-type: none"> -Staff C completed an incident report. -Staff C contacted her supervisor by phone. -Staff C said the Administrator was aware. -Staff C said she called the Doctor -Staff C called Resident # 7's family. <p>Review of Resident #7's Nurses Note dated 9/6/14 revealed the following:</p> <ul style="list-style-type: none"> - "Patient was cussing the Supervisor in charge 	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D914	<p>Continued From page 44</p> <p>today. Resident was told to stay out of other residents' business. Resident came into the nursing station and hit the Supervisor in charge (SIC) on the side of the neck. The Administrator (MS) was notified. Talked to resident's mom and stepbrother about what happened. MD was notified also."</p> <p>Review of Incident report dated 9/6/14 revealed: -Resident #7 came into the nurse's station and hit Staff C in the neck. -The plan of treatment was to watch the resident closely. -Resident # 7 was talking to Staff C when the incident occurred. -The mother and step-brother were notified. -The incident report was completed by Staff C.</p> <p>Phone interview with Resident # 7's family on 4/14/15 at 2:47pm revealed the family member had been called after the incident on 9/6/14. -The family member was told by staff at the facility that Resident #7 had hit Staff C in the throat. -Could not recall if Resident #7 saw mental health professionals or not. -The family member did not see Resident #7 following the incident. -The family member does not see Resident #7 on a regular basis due to his behaviors.</p> <p>Interview on 4/14/15 at 2pm with a Mental Health professional revealed Resident #7 was seen once a month since 2/2015 to manage his medications and was not aware of the allegation made by another resident regarding the incident between Staff C and Resident #7 and was not notified about the incident. Resident #7 had not spoken about the incident in their sessions together.</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
---	--

(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
D914	<p>Continued From page 45</p> <p>-Interview with the Administrator on 4/14/15 at 3:30pm revealed she was the Administrator at the time of the incident on 9/6/14 but was out of town. Staff C called the Administrator about the incident.</p> <p>"There was a lot of commotion in the background during that phone call. When I first started here there was chaos in the facility. It seemed like staff were against the residents and staff against staff. I have worked very hard to change the culture of the community. My policy is zero tolerance to verbal, mental, or physical abuse to residents. If I believed at any point Staff C had put her hands on Resident #7 that would have meant suspension of Staff C pending an investigation. I talked to Resident #7 when I got back into town and he wouldn't even say that he put his hands on Staff C. He was not happy with being told to stay out of other resident's business. I was not aware that I needed to report this particular incident to the Health Care Personal Registry. No one did a physical assessment on Resident #7 after the incident because we were thinking only Staff C got hurt. I did not believe Staff C put her hands on Resident #7 or that there was a need to ask any further questions. I just heard yesterday through staff gossip that Staff C hit Resident #7."</p> <p>- The administrator advised Staff C not call the police but to document and complete an incident report.</p> <p>-Resident #7's Doctor was not notified.</p> <p>-Resident #7's family was notified.</p> <p>-Staff C and the Administrator were signed up to take the state 1068 training this month about abuse, neglect, and exploitation in facilities</p> <p>-The Administrator held regular meetings on such topics as Resident Rights, OSHA and blood-borne pathogens.</p> <p>Interview with the Administrator on 4/15/15 at</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/15/2015	
NAME OF PROVIDER OR SUPPLIER RIVERSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562		
(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
D914	<p>Continued From page 46</p> <p>10:25pm revealed she could not recall if Resident #7 was being seen by a mental health provider at the time of the incident.</p> <p>-The administrator could not recall if a physician or mental health provider was notified about the incident.</p> <p>-No documentation was provided showing notification of a health care provider.</p> <p>Interview with Resident #7's health care provider on 4/15/15 at 12:10pm revealed visits with Resident #7 since 3/2015.</p> <p>-The local health care provider was unaware of incident on 9/6/14.</p> <p>-No incident reports received from facility regarding Resident # 7's behaviors.</p> <p>-The local health care provider wanted to be notified of any increased behaviors regarding Resident #7 because the information could possibly change his medication management and possible referrals.</p> <p>The plan of correction dated 4/20/15 included the following: If there is an allegation of a staff physically, verbally, emotionally, or mentally abusing a resident, the facility has a no tolerance policy on this. If these things are suspected the employee will be suspended pending a formal investigation and the family, law enforcement, DSS, and the Health Care Personnel Registry will be notified .The mental healthcare provider will be contacted as necessary.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 15, 2015.</p>	D914		

