

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL034091</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>05/18/2015</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE LIVING CENTER OF WINSTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2900 REYNOLDS PARK ROAD</b><br><b>WINSTON SALEM, NC 27107</b> |
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| D 000              | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and a complaint investigation on 5/11/15 -5/18/15.  | D 000         |   |                    |
| D 077              | <p>10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings<br/>(a) Adult care homes shall:<br/>(4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more;<br/>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times.</p> <p>The findings are:</p> <p>Observation on 05/11/15 at 9:00 am upon entrance to the facility revealed:<br/>-The sanitation score was 73 based on the inspection completed on 06/11/14.</p> <p>Review of the facility's current Environmental Health inspection report dated 06/11/14 revealed:<br/>-The inspection included demerits related to</p> | D 077         |   |                    |

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| Division of Health Service Regulation<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| D 077              | <p>Continued From page 1</p> <p>walls, floors and ceiling not being cleaned; lighting, ventilation, and moisture control, toilet, hand-washing, laundry and bathing facilities (no soap, hand towel or drying device); water supply; vermin control; Furnishings clean and in good repair and odor free, linen changed and properly handled, .</p> <p>Interview on 05/13/15 at 11:50 am with the Administrator revealed:<br/>-He started working at the facility in July 2014.<br/>-When he came to the facility they had the sanitation score of 73.<br/>-It was his understanding that the Resident Care Director (RCD) had contacted the local Environmental Health department and requested a follow-up visit.</p> <p>Interview on 05/12/15 at 9:20 am with the Environmental Health Supervisor revealed:<br/>-The last time the facility requested a follow-up inspection was 05/16/14.<br/>-They had received several complaints regarding the facility since May 2014.<br/>-Most complaints were related to cleanliness of the facility, needed repairs, and bedbugs.<br/>-The facility could have called at any time throughout the year to request a follow-up inspection.<br/>-Review of documentation in their computer system showed no call by the facility requesting a follow-up inspection.<br/>-The RCD may have verbally asked for a follow-up inspection when someone was on site for the compliant inspection, but that is not the protocol.<br/>-The person investigating does not schedule or make appointments for follow-up inspections.<br/>-On 05/11/14 the facility requested a follow-up inspection because the Administrator felt the</p> | D 077         |   |                    |

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| D 077              | <p>Continued From page 2</p> <p>initial findings on the report dated 05/09/14 (score 68) were inaccurate and the Inspector was not skilled and cited things incorrectly.</p> <ul style="list-style-type: none"> <li>-As of this date (05/12/15) no request had been made by the facility for a follow-up inspection.</li> <li>-The DHSR surveyor requested a follow-up survey due to conditions at the facility.</li> </ul> <p>Interview on 05/14/15 at 2:45 pm with the RCD revealed:</p> <ul style="list-style-type: none"> <li>-Last year in May 2014, she requested a follow-up inspection.</li> <li>-The Inspector came to the facility in June 2014 and had not returned for another inspection.</li> <li>-She made several attempts to request another follow-up inspection.</li> <li>-She was unable to recall the dates she requested the follow-up inspections.</li> <li>-The RCD said she did not write down the name of the person she talked with or the date she requested the follow-up inspection.</li> <li>-In February 2015, when the Inspector was in the facility for an unrelated issue she asked for a follow-up inspection, she was told they were short of staff, but would get around to it.</li> <li>-She must call and request to be put on the schedule for an inspection.</li> <li>-The RCD said she would call and request a follow-up inspection because the facility had made many updates and repairs.</li> <li>-She was confident the score would rise to the required 85 or above.</li> </ul> <p>Observations on 05/11/15 from 9:30 am to 11:00 am during initial tour of the facility revealed items cited on the 06/11/14 Environmental Health report were identified:</p> <ul style="list-style-type: none"> <li>-Handrail needing repair.</li> <li>-Initial hot water temperatures ranged between 98 to 146 degrees on 05/11/15 and corrected on</li> </ul> | D 077         |   |                    |

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| D 077              | <p>Continued From page 3</p> <p>05/11/15 to between 98 and 110 degrees with a plumber providing assistance.</p> <ul style="list-style-type: none"> <li>-Several air conditioning/heating units throughout the facility were inoperable.</li> <li>-A window identified as needing repair.</li> <li>-Several windows without blinds to provide privacy.</li> <li>-Several walls and ceilings appeared to have evidence of repairs in various stages of completion.</li> </ul> <p>On 05/12/15 the facility provided the following plan of protection:</p> <ul style="list-style-type: none"> <li>-A call shall be placed to the county health department for a re-inspect</li> <li>-A walk through of the building shall be done to assure all issued on the report have been addressed.</li> <li>-All issues shall be address as to increased sanitation grade to an 85.</li> <li>-Management shall monitor weekly to assure all areas are in compliance.</li> </ul> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 2, 2015.</p> | D 077         |   |                    |
| D 079              | <p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings</p> <p>(a) Adult care homes shall</p> <p>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;</p> <p>This Rule shall apply to new and existing facilities.</p>   | D 079         |   |                    |

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| D 079              | <p>Continued From page 4</p> <p>This Rule is not met as evidenced by:<br/>TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to maintain a clean and orderly environment, free of hazards, as related to bedbugs in multiple rooms throughout the facility biting and irritating residents, safe storage of oxygen cylinders and repair and maintenance of hand rails for resident safety and mobility.</p> <p>The findings are:</p> <p>A. Observation on 05/11/15 from 9:30 am to 11:00 am during initial tour of the facility revealed no obvious signs of bedbugs visible to the eye.</p> <p>Interview on 05/11/15 at 11:45 am the Administrator revealed:<br/>-He started working at the facility in July 2014.<br/>-The facility had bedbugs when he came to the facility.<br/>-The facility had a bedbug protocol in place when he started working at the facility.<br/>-He felt residents continually brought the bedbugs into the facility by going to shelters and dumpster's obtaining clothing.<br/>-The Administrator said he observed one resident (did not name) bring an old jacket into the facility.<br/>-He checked the jacket pocket and it was filled with bedbugs.<br/>-He had not discussed further treatment methods with the owner, but he felt that he was doing all that could be done.</p> <p>Interview on 05/13/15 at 2:50 pm with a personal care aide revealed:<br/>-She had worked at the facility for three months as a resident care aide<br/>-She was aware the facility had bedbugs.</p> | D 079         |   |                    |

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| D 079 | <p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-She was informed by residents and other staff.</li> <li>-She changed bed linen for residents.</li> <li>-She had never seen a bedbug.</li> <li>-She had seen bumps from bedbug bites on the residents.</li> <li>-The residents told her the the bumps were from bedbugs biting them.</li> </ul> <p>Interview on 05/13/15 at 10:23 am with a Medication Aide revealed:</p> <ul style="list-style-type: none"> <li>-She had seen bedbugs in the facility within the last couple of weeks.</li> <li>-About six months ago while working she received three bites/bumps in a row on her arm.</li> <li>-She showed them to the Resident Care Director (RCD) and was told to show them to the exterminator.</li> <li>-She showed the bumps to the exterminator during one his visits and he said the bites resembled the characteristic style of a bedbug bite.</li> <li>-After several days the bumps went away.</li> <li>-The staff said residents complain all the times about seeing or being bitten by bedbugs.</li> <li>-She did not recall any residents having bites from bedbugs which became infected or needed medical treatment other than an anti-itch cream provided by staff.</li> <li>-Residents had reported to her as recent as one week ago they saw bedbugs.</li> </ul> <p>Confidential interviews with 8 residents on the 500, 400, 300 and 100 halls revealed:</p> <ul style="list-style-type: none"> <li>-One resident said in April 2015 there was a fire on the second floor and all residents up there where moved downstairs. The day the fire happened she had to spend the night in the sunroom and the next morning she had six bites/bumps with three being in a row. She showed the bumps to the medication aide</li> </ul> | D 079 |  |  |
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| D 079              | <p>Continued From page 6</p> <p>supervisor. The supervisor said "I told you people there were bedbugs in the sunroom."<br/>                     -A second resident on the 500 hall said she saw two bedbugs crawling on the covers on her bed. She killed them and reported it to staff.<br/>                     -Three residents said they previously had seen bedbugs in their rooms and previously were bitten. The residents said within the last month they have not seen any bedbugs.<br/>                     -Four residents said when they were on the second floor they got bit often by the bedbugs. Since the fire, residents moved to the 500 hall and have not got bitten by the bedbugs.<br/>                     -Six residents said they had bedbugs upstairs and got bitten all the time. They received bites on their face, chest, and ears. The residents said the bites stung, itched and lasted for several of days.<br/>                     -One resident said she was bitten by bedbugs the whole 3 years that she lived at the facility.<br/>                     -One resident said 2-3 weeks ago she got bitten by bedbugs on the 500 hall. The resident recalled the facility sprayed the rooms upstairs (200 hall) for bedbugs. She was not sure if the 500 hall had been sprayed for bedbugs.</p> <p>Confidential interview with a staff member revealed:<br/>                     -The facility had bedbugs since she started working at the facility a little over one year ago.<br/>                     -The facility got sprayed, but it does not work.<br/>                     -The staff said that she had a great fear of taking bedbugs home to her family.<br/>                     -She said it was a nightmare working at the facility being afraid, and watching everything to ensure she did not pick up bedbugs or their eggs.<br/>                     -She felt very sorry for the residents because they continually complained about getting bit by the bedbugs.<br/>                     -She had not observed any bites that were severe enough for serious medical treatment.</p> | D 079         |   |                    |

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| D 079              | <p>Continued From page 7</p> <p>-She thought residents were annoyed continually getting bit by the bedbugs.</p> <p>Interview on 05/11/15 at 5:15 pm with a Medication Aide/Personal care aide revealed:<br/>-She had worked at the facility for 2 years.<br/>-In December 2014, she started hearing residents say they had bedbug bites.<br/>-She said every time residents reported seeing bedbugs the facility sprayed the area where the resident reported seeing the bugs.<br/>-She recalled two weeks ago the facility had the sunroom sprayed for bedbugs.</p> <p>Interview on 05/11/15 at 12:28 pm with a Supervisor revealed:<br/>-It had been 2-3 months since residents reported seeing bedbugs.<br/>-She checked mattresses weekly to see if bedbugs were in the facility.<br/>-If bedbugs were identified, staff was to follow the bedbug protocol.<br/>-The protocol was posted at various locations throughout the facility.</p> <p>Interview on 05/12/15 at 9:20 am with the Environmental Health Inspector revealed:<br/>-Since August 2014 they received 5 complaints this facility.<br/>-Two complaints were specifically related to bedbugs.<br/>-On 12/03/14 bedbug complaint they saw bedbugs in rooms on the 100 and 300 halls.<br/>-The Inspector checked two rooms (101 and 311) and identified bedbugs.<br/>-On 02/03/15 bedbug complaint was validated after visiting the facility.<br/>-During the visit the Inspector identified living and dead bedbugs in rooms 111, 218, 217, and 424 (the 500 hall was not open for resident living).</p> | D 079         |   |                    |

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| D 079              | <p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-The Inspector said her division and other government agencies had extensively provided consultation and training facility staff related to bedbug protocol.</li> <li>-It appears nothing was working because there are still reports of bedbugs at the facility.</li> <li>-She was not sure if the facility staff were following proper protocol or why the facility still had bedbugs.</li> <li>-The Inspector said it helped to spray the rooms because it got get rid of the bedbugs, but they are coming back or just moving from room to room.</li> <li>-The Inspector said the only treatment option left was heat treatment to get rid of the bedbugs.</li> </ul> <p>Interview on 05/12/15 at 1:40 pm with the housekeeper revealed:</p> <ul style="list-style-type: none"> <li>-He had worked at the facility for 5 months.</li> <li>-When cleaning rooms he had never seen bedbugs.</li> <li>-He had heard some residents say they had bedbugs.</li> </ul> <p>Interview on 05/12/15 at 2:00 pm with the Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> <li>-She was unaware the facility had bedbugs.</li> <li>-She was also unaware that residents had bites from bedbug.</li> </ul> <p>Review of the facility's bedbug protocol revealed:</p> <ul style="list-style-type: none"> <li>-The RCD or Administrator will be notified.</li> <li>-The RCD or Housekeeper will investigate.</li> <li>-Cleaning in Clorox and water will be completed.</li> <li>-Pest control will be contacted/treatment will be done within 24 hours.</li> <li>-Linen will be immediately put in dryer for 45 minutes.</li> <li>-Clothes will be bagged and sealed in 3mm-5mm trash bags with Nuevo strips for 14 days then washed, dried, and returned to the resident.</li> </ul> | D 079         |   |                    |

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| D 079              | <p>Continued From page 9</p> <p>Review of the facility's pest control invoices revealed:</p> <ul style="list-style-type: none"> <li>-On 01/28/15 treatment of rooms 202, 203,214, 216 and the medication rooms was for bedbugs.</li> <li>-On 02/03/15 treatment of rooms 111, 202, 205, 214, and 216 was for bedbugs.</li> <li>-On 03/24/15 treatment of rooms 303, 404, 406, 407, and the television room was for bedbugs.</li> <li>-On 04/07/15 treatment of rooms 203, 205 and 207 was for bedbugs.</li> </ul> <p>Interview on 05/12/15 at 12:40 pm with the pest control company representative revealed:</p> <ul style="list-style-type: none"> <li>-He repeatedly treated the facility for bedbugs.</li> <li>-He did generalized extermination treatments every quarter at the facility.</li> <li>-During that visit if staff wanted him to spray for bedbugs they just informed him.</li> <li>-He visited the facility last week on 05/05/15 for the quarterly generalized extermination treatment.</li> <li>-When he arrived facility staff told him that room 205 needed to be treated again for bedbugs.</li> <li>-He was unaware no residents were living on the second floor, he sprayed where staff had asked.</li> <li>-He had been treating bedbugs at the facility for some time.</li> <li>-The bedbugs were just not going away.</li> <li>-He was limited to treatment methods for bed bugs.</li> <li>-If the facility wanted more advanced treatment they would have to go to another pest control company.</li> <li>-When he sprayed he required that all things to be taken out of the rooms.</li> <li>-He did not treat furniture that was taken out.</li> <li>-To his knowledge, the furniture was later brought back to the room.</li> <li>-Sometimes if the rooms were not completely cleared out he sprayed the rooms anyway around</li> </ul> | D 079         |   |                    |

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| D 079              | <p>Continued From page 10</p> <p>the furniture or around whatever items were left in the room.</p> <p>-He thought the bedbug problem existed from the residents visiting family and friends and bring them back to the facility.</p> <p>-He said residents bring furniture from home and staff did not check the furniture for bedbugs.</p> <p>Observation during facility tour on 05/11/15 from 9:30 am-11:00 am revealed:</p> <p>-Multiple resident rooms on the 300 Hall had boxsprings and mattresses wrapped in a plastic covering.</p> <p>-Multiple resident rooms on the 400 Hall had boxsprings and mattresses wrapped in a plastic covering.</p> <p>Interview with a resident on the 400 Hall on 05/11/15 at 10:45 am revealed:</p> <p>-He was admitted to the facility 03/03/15.</p> <p>-There had been bed bugs in his room during the first two weeks of his stay.</p> <p>-The facility had called an exterminator to come and treat the bed bug problem in his room.</p> <p>-He believed bedbugs were still active in the facility.</p> <p>B. Observations of Room 111 during the initial tour of the facility on 5/11/15 during 9:35 am and 11:00 am revealed:</p> <p>-An oxygen concentrator running at 1-1/2 liters per minute via attached nasal cannula which was laid on the floor.</p> <p>-4 free standing, small oxygen cylinders (unopened) standing in the space behind the opened room door.</p> <p>-One resident was asleep on his bed.</p> <p>-The resident using oxygen was not in the room.</p> <p>Observations of the Medical Records office at</p> | D 079         |   |                    |

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| D 079              | <p>Continued From page 11</p> <p>3:00 pm on 5/12/15 revealed:</p> <ul style="list-style-type: none"> <li>-An oxygen cylinder wire rack on the floor in the corner of the medical records office.</li> <li>-The rack contained 5 small oxygen cylinders, 5 medium oxygen cylinders and one medium cylinder on top of the rack leaning against the wall, but not inserted into the rack.</li> <li>-2 free standing medium oxygen cylinders beside the rack.</li> <li>-Three medium oxygen cylinders in rolling stands.</li> <li>-1 large oxygen cylinder in a floor stand.</li> <li>-10 cylinders were unopened with plastic guards intact and 6 cylinders were empty.</li> </ul> <p>Observations on 5/12/15 at 3:20 pm in the Supervisor's office revealed 2 small used oxygen cylinders standing unsupported along the wall.</p> <p>Interview with the Supervisor on 5/12/15 at 3:20 pm revealed:</p> <ul style="list-style-type: none"> <li>-The 2 small oxygen cylinders on the floor of her office were recently brought to her by staff.</li> <li>-Staff brought the cylinders to her and she would move them to the Medical Records office</li> <li>-All oxygen cylinders are stored in the Medical Records office, both full and empty.</li> <li>-She was not aware there was any cylinders in resident rooms except those currently being used.</li> </ul> <p>Observations on 5/12/15 at 3:30 pm with the Supervisor in the Medical Records Office revealed:</p> <ul style="list-style-type: none"> <li>-She placed the two empty oxygen cylinders on the floor beside the other cylinders.</li> <li>-She stated everyone knew to place the cylinders in the rack.</li> <li>-The Supervisor reported this was the only designated place for oxygen cylinders and this was the only rack for storage.</li> </ul> | D 079         |   |                    |

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| D 079              | <p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-She removed the leaning cylinder from the rack and inserted the cylinder into a rolling cylinder stand.</li> <li>-She placed the two empty cylinders into the rack and stated they needed more storage.</li> <li>-She was not aware of the oxygen cylinders stored in the resident's room.</li> </ul> <p>Observations in room 111 on 5/12/15 at 3:45 pm with the Supervisor revealed:</p> <ul style="list-style-type: none"> <li>-There were 4 small unopened oxygen cylinders standing unsupported behind the door.</li> <li>-There was one small empty oxygen cylinder standing unsupported behind the door.</li> </ul> <p>Interview with the resident in room 111 on 5/12/15 at 4:00 pm revealed the oxygen supplier had delivered cylinders on 5/11/15 and they usually stored them behind the door and either he changed them out himself, or staff would.</p> <p>C. Observations on the 100 Hall during the facility tour on 5/11/15 between 9:30 am and 11:00 am revealed the following:</p> <ul style="list-style-type: none"> <li>-A loosely connected 5 foot handrail between rooms 101-103.</li> <li>-The handrail had three brackets attached to wooden blocks for bracing.</li> <li>-The wooden blocks used screws to secure the brackets/blocks to the wall</li> <li>-All three bracket attachments were separated from the wall with gaps of space approximately 1/2" to 1" between wall surface and wooden blocks of each bracket.</li> <li>-There were three screws backed out and not penetrating into the wall.</li> </ul> <p>Additional observations made during the same time frame revealed:</p> | D 079         |   |                    |

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| D 079              | <p>Continued From page 13</p> <ul style="list-style-type: none"> <li>-A missing 5-6 foot section of handrail on the opposite wall.</li> <li>-There was no evidence of any brackets or bracing for handrail attachment.</li> </ul> <p>Interview with the part time maintenance worker on 5/12/15 revealed:</p> <ul style="list-style-type: none"> <li>-He was aware of the missing handrail and the loosely attached handrail.</li> <li>-He was employed by the owners of the business and only helped out at the facility as needed.</li> <li>-He kept forgetting to bring the new brackets to attached the missing handrail, but had purchased them.</li> <li>-The residents try to sit or rest on the handrails and would separate the rails from the walls.</li> <li>-The previous maintenance worker left last week.</li> <li>-The part time maintenance worker reported he was aware of the missing handrail and the broken handrail for at least a week.</li> <li>-He also stated he had a list of items for repair in the building, but had completed the current list and would add the handrails to the next list.</li> </ul> <p>The handrails were repaired and replaced on 5/13/15.</p> <p>_____</p> <p>The facility provided the following Plan of Protection on 5/12/15:</p> <ul style="list-style-type: none"> <li>-The oxygen provider has been called to provide ample racks for cylinder storage.</li> <li>-Expected delivery date of the oxygen storage was 5/12/15.</li> <li>-Coordination with the oxygen provider to ensure no oxygen cylinders will be left of the premises without proper storage racks.</li> <li>-Supervisor shall ensure all tanks are stored appropriately daily.</li> <li>-We coordinate with the pest control company to</li> </ul> | D 079         |   |                    |

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| D 079              | Continued From page 14<br><br>provide a better solution to eradicate any and all bedbug issues.<br>-The pest control provider has been contacted.<br>-The building will be immediately be asses to identify areas and location of bedbugs.<br>-Working in tandem with the pest control provider, we shall make sure all means are implement to eliminate pest issues.<br>-Staff will continue to monitor and report bedbugs to management.<br><br>THE DATE CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 2, 2015.   | D 079         |   |                    |
| D 080              | 10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall<br>(6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure bathrooms on the 500 hall (#501, #502, #503, #504, and #510) had individual clean towels, hand drying device, and soap.<br><br>The findings are:<br><br>Observations on 05/11/15 from 9:30 am to 11:00 am during the initial tour of the facility of rooms on the 500 (#501, #502, #503, #504 and #510) hall revealed: | D 080         |   |                    |

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| D 080              | <p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-The five rooms occupied by residents on the 500 hall had adjoining bathrooms.</li> <li>-The 3 bathrooms used by the residents had paper towel dispensers and soap dispensers.</li> <li>-Both dispensers (paper towel and soap) were empty.</li> <li>-No paper towel, individual clean towels, or hand drying device was observed in the 3 bathrooms used by residents.</li> <li>-There was no bar soap or liquid soap available for hand washing.</li> <li>-There was no soap, paper towel or hand drying device in the common bathroom on the 500 hall.</li> </ul> <p>Interviews on 05/11/15 9:30 am to 10:30 am with 5 residents on the 500 hall revealed:</p> <ul style="list-style-type: none"> <li>-All 5 residents said soap was never put in the bathrooms.</li> <li>-One resident said that she purchased her own hand soap from the store and kept in her room.</li> <li>-Two residents said they washed their hands using just water.</li> <li>-One resident dried her hands on her clothes.</li> <li>-One resident said facility staff did not put paper towel in the bathroom because her roommate put paper towel in the toilet and stopped up the toilet.</li> <li>-The resident said it was not fair that everyone was punished because of her roommate.</li> <li>-One resident said when she washed her hands she shucked them in the air until they dried. The facility gave wash cloths and bath towels for showers, but not to dry their hands.</li> <li>-All 5 residents said it would be nice to have paper towel to dry their hands after washing them.</li> </ul> <p>Interview on 05/12/15 at 05/12/15 at 10:20 am with a housekeeper revealed:</p> <ul style="list-style-type: none"> <li>-Housekeepers were responsible for putting paper towel and soap in the bathrooms for</li> </ul> | D 080         |   |                    |

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| D 080              | <p>Continued From page 16</p> <p>residents to use.</p> <p>-He did not have paper towels and soap for the dispensers currently installed in the bathrooms on the 500 hall.</p> <p>He had not informed the Administrator, but had planned to ask for new dispensers so he could use what was in other common bathrooms.</p> <p>-If residents wanted to wash their hands using soap and paper towel they go to the common bathrooms on the 400, 300, and 100 halls.</p> <p>-The towel dispenser in the common bathrooms had paper and residents could go there to wash their hands.</p> <p>Interview on 05/12/15 at 10:40 am with the Administrator revealed:</p> <p>-The 3 bathrooms used by residents that live on the 500 hall should have soap and paper towel.</p> <p>-He did not know why housekeeping was not putting power towel and soap in the bathrooms for residents.</p> <p>-He did mention again that the arrangements on the 500 hall was supposed to be temporary, however the resident had been there since April 11, 2015.</p> <p>-He will make sure paper towels are put in the bathrooms used by residents on the 500 hall.</p> | D 080         |   |                    |
| D 083              | <p>10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care home shall:</p> <p>(9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy;</p> <p>This Rule shall apply to new and existing facilities.</p>   | D 083         |   |                    |

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| D 083              | <p>Continued From page 17</p> <p>This Rule is not met as evidenced by:<br/>Based on observations and interviews, the facility failed to assure privacy curtains, drapes or window coverings were in 1 of 5 resident rooms on the 500 hall (room 510).</p> <p>The findings are:</p> <p>Observations on 05/11/15 from 9:30 am to 11:00 am during the initial tour of the facility revealed:<br/>-Room 510 had three residents in the room.<br/>-The window in the room where the residents slept was uncovered and it was very visible for people outside to see inside the bedroom.<br/>-The bathroom in room 510 did not have shades or covering.<br/>-It was easy for people outside to see inside the bathroom.<br/>-Both windows were 3 and ½ feet wide by 4 and ¾ feet long.<br/>-Both windows face a parking lot and the porch where residents stand and socialize.<br/>-The toilet and sink in the bathroom are directly in front of the window.</p> <p>Interview on 05/11/15 at 10:33 am with two residents in room 510 revealed:<br/>-They have lived in the room for 5 or more weeks.<br/>-There had never been blinds on the window in the bedroom and the bathroom.</p> <p>Interview on 05/12/15 at 10:20 am with a housekeeper revealed:<br/>-The previous housekeeping supervisor was responsible for ensuring windows had blinds and were covered.<br/>-The housekeeping supervisor left last Friday and was not available for interview.</p> | D 083         |   |                    |

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| D 083              | Continued From page 18<br><br>Interview on 05/12/15 at 10:40 am with the Administrator revealed:<br>-Residents in room 510 were temporarily sleeping in the room.<br>-The residents had a permanent room upstairs.<br>-The residents had been in the room since April 11, 2015.<br>-He was unaware that housekeeping had not put blinds or some type of covering on the windows in room 510.<br>-He will make sure blinds are put up right away.   | D 083         |   |                    |
| D 087              | 10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:<br>(1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following:<br>(A) at least one pillow with clean pillow case;<br>(B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and<br>(C) clean bedspread and other clean coverings as needed;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to provide or maintain at least one pillow | D 087         |   |                    |

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| D 087              | <p>Continued From page 19</p> <p>with clean pillow case, a clean top and bottom sheets on the bed and a clean bedspread or other coverings as needed for 17 of 50 beds observed.</p> <p>The findings are:</p> <p>Observations made on the 100 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 pm revealed the following:<br/>-In resident occupied rooms 101, 103, 104, 110, 111, one bed in each room had a bottom sheet only.<br/>-In resident occupied rooms 108 and 109, one bed in each room had a flat bottom sheet and no top sheet.</p> <p>Observations made on the 200 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 pm revealed the following:<br/>-There was evidence of fire damage and ongoing repairs.<br/>-There were no residents residing on this floor.</p> <p>Observations made on the 300 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 pm revealed the following:<br/>-In resident occupied rooms 304 and 306, both beds had no top or bottom sheets<br/>-In resident occupied room 301, both beds had flat sheet only<br/>-In resident occupied room 305, two beds had fitted bottoms sheets only<br/>-In resident occupied room 311, both beds had no bottom sheets<br/>-In resident occupied rooms 305, 304, and 306, there were no pillow cases on the resident's pillows.</p> <p>Interviews with two residents who reside on the</p> | D 087         |   |                    |

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| D 087              | <p>Continued From page 20</p> <p>300 hall revealed:<br/>-The beds get made sooner or later.<br/>-The beds frequently do not have sheets until later in the day.</p> <p>Observations made on the 400 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 pm revealed the following:<br/>-In resident occupied rooms 404, 407, 414, and 424, the resident's pillow had no casing.<br/>-In resident occupied rooms 404, 407, 408, and 414, all of the beds did not have top and bottom sheets.</p> <p>Interviews with 3 personal care aides on 5/11/15 and 5/12/15 revealed:<br/>-Each personal care aide was responsible for changing bed linens for the residents on their assigned bath day, which is scheduled three times weekly.<br/>-The personal care aides are responsible for doing both the house linens and resident laundry on the scheduled bath day.<br/>-One aide reported there was not enough linen to make the beds up unless the laundry was kept up.<br/>-Two aides stated there was enough linen to make the changes as needed.<br/>-The 3 care aides are aware of the need for a top sheet, bottom sheet and pillow case for each resident bed.</p> <p>Observations made during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 noon revealed:<br/>-At least 15 resident beds observed did not have a complete linen set (fitted bottom sheet, flat top sheet, pillow case and spread) but had parts of the set.<br/>-The 400 Hall laundry room had one fitted sheet</p> | D 087         |   |                    |

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| D 087              | Continued From page 21<br><br>and 2 flat sheets on storage shelf rack.<br>-There were wet clothes in the washer.<br>-The 300 Hall laundry room had 5 new fitted sheets and no fitted or flat sheets on on the shelf.<br>-Both washers were full of wet laundry.<br>-The dryer was full of laundry in the process of drying.<br>-An aide took laundry out of the dryer and loading into a laundry basket.<br><br>[Refer to Tag 206 10A NCAC13F.0604(2)(b) Personal Care and Staffing.]   | D 087         |   |                    |
| D 090              | 10A NCAC 13F .0306(b)(4) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:<br>(4) a wall or dresser mirror that can be used by each resident;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to furnish a wall or dresser mirror in 5 of 5 residents' rooms that could be used by each resident (Rooms #501, #502, #503, #504, and #510).<br><br>The findings are:<br><br>Observations on 05/11/15 from 9:30 am to 11:00 am during the initial tour of the facility revealed:<br>-No mirrors were observed in the 5 rooms on the | D 090         |   |                    |

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| D 090              | <p>Continued From page 22</p> <p>500 hall.</p> <ul style="list-style-type: none"> <li>-There were three rooms with 3 residents and two rooms with 2 residents.</li> <li>-Each room did have a mirror in the bathroom.</li> </ul> <p>Interviews on 05/11/15 from 9:30 am to 10:30 am with 5 residents on the 500 hall revealed:</p> <ul style="list-style-type: none"> <li>-They had moved down stairs due to a fire upstairs.</li> <li>-They lived on the 500 hall for 5 or more weeks.</li> <li>-They did not have a lot things downstairs that they had in the rooms upstairs.</li> <li>-There was a mirror above the sink in the bathroom.</li> <li>-One resident said the bathroom was semi-private and shared by six people so it would be nice to have a mirror in the room.</li> <li>-One resident wished she had a mirror in the room.</li> <li>-The other residents did not really care about not having a mirror.</li> </ul> <p>Interview on 05/12/15 at 10:40 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-The 13 residents on the 500 hall were temporarily living there.</li> <li>-He thought repairs to the second floor would have been completed by now.</li> <li>-The residents had a permanent room upstairs.</li> <li>-Since the arrangements were temporary he did not think the rooms had to have all the required things, like mirrors.</li> <li>-He will make sure mirrors were obtained right away or take the ones from upstairs.</li> </ul> | D 090         |   |                    |
| D 091              | <p>10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And</p>   | D 091         |   |                    |

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| D 091 | <p>Continued From page 23</p> <p>Furnishings<br/>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:<br/>(5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising;<br/>(6) additional chairs available, as needed, for use by visitors;<br/>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations and interviews, the facility failed to provide a minimum of one comfortable chair for each resident in 5 of 5 resident bedrooms (Rooms #501, #502, #503, #504, and #510).</p> <p>The findings are:</p> <p>Observations on 05/11/15 from 9:30 am to 11:00 am during the initial tour of the facility of rooms on the 500 (#501, #502, #503, and #510) hall revealed:<br/>-Room #501 had three residents and no chairs.<br/>-Room #502 had three residents and no chairs.<br/>-Room #503 had two residents and no chairs.<br/>-Room #504 had two residents and no chairs.<br/>-Room #510 had three residents and no chairs.</p> <p>Interviews on 05/11/15 9:30 am to 10:30 am with 5 residents on the 500 hall revealed:<br/>-They had lived on the 500 hall for 5 or more weeks.<br/>-There had been no chairs in the room since they moved.<br/>-When in the room they had to sit on the bed, because there were no chairs.<br/>-One resident said when family visited they sat on</p> | D 091 |  |  |
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| D 091              | <p>Continued From page 24</p> <p>her bed.</p> <p>-Three residents said if they had a chair in the room to sit in, stead of on the bed that would be great.</p> <p>-The other residents did not care about not having a chair.</p> <p>Interview on 05/12/15 at 10:40 am with the Administrator revealed:</p> <p>-The 13 residents on the 500 hall were temporarily living there.</p> <p>-He thought the repairs to the second floor would have been completed by now.</p> <p>-He did not know how much longer the repairs were going to take.</p> <p>-The residents had a permanent room upstairs.</p> <p>-Since the arrangements were temporary he did not think the rooms had to have all the required things, like chairs.</p> <p>-He will make sure chairs were obtained right away or take the ones from upstairs.</p> | D 091         |   |                    |
| D 093              | <p>10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:</p> <p>(8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation and interview, the facility</p>  | D 093         |   |                    |

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| D 093              | <p>Continued From page 25</p> <p>failed to ensure a bedside lamp or a light overhead of residents' beds with the switch within reach of person lying on bed for 24 of 25 resident rooms observed.</p> <p>The findings are:</p> <p>Observations of resident occupied rooms on the 100 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 1:00 pm of revealed the following:</p> <ul style="list-style-type: none"> <li>-Room 101 with three residents had a table lamp on the floor near the bathroom and no overhead light switch within reach of the beds.</li> <li>-Room 104 with two residents and no bedside table lamp and no overhead light switch within reach of the beds.</li> <li>-Room 105 with one resident and no bedside table lamp and no overhead light switch within reach of the bed.</li> <li>-Room 107 with one resident and no bedside table lamp and no overhead light switch within reach of the bed.</li> <li>-Room 110 with two residents and no bedside table lamp and no overhead light switch within reach of the beds.</li> <li>-Room 111 with two residents and no bedside table lamp and no overhead light switch within reach of the beds.</li> </ul> <p>Observations on the 200 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 1:00 pm revealed there were no residents residing on the second floor.</p> <p>Observations of resident occupied rooms on the 300 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 1:00 pm revealed the following:</p> <ul style="list-style-type: none"> <li>-Room 301, no bedside table lamp and no</li> </ul> | D 093         |   |                    |

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| D 093              | <p>Continued From page 26</p> <p>overhead light switch within reach of the beds.<br/>-Room 302, no bedside table lamp and no overhead light switch within reach of the beds.<br/>-Room 305, no bedside table lamp and no overhead light switch within reach of the bed.<br/>-Room 306, no bedside table lamp and no overhead light switch within reach of the bed.<br/>-Room 311, no bedside table lamp and no overhead light switch within reach of the bed.</p> <p>Observations of resident occupied rooms on the 400 Hall during the initial tour of the facility on 5/11/15 between 9:30 am and 1:00 pm revealed the following:<br/>In rooms 400, 402, 404, 407, 408, 409, 414, 416, 421, 422, 423, 424, 425, and 427, there was no bedside table lamp, nor were the beds positioned as to allow the resident lying in bed to reach the overhead light switch.</p> <p>Interview with 4 residents on 5/11/15 revealed:<br/>-One resident would like a bedside table lamp but had not requested one from staff<br/>-3 residents did not care whether they had lamps at bedside or not, stating the door to the hall way is usually open and they can see to go to the bathroom most of the time.<br/>-4 residents did not remember if they have ever had bedside lamps or not.<br/>-1 resident who moved from the 200 Hall after the fire thought she had a lamp in her room when she was on the 200 Hall.</p> <p>Interview with a resident on 5/11/15 at 10:35 am revealed:<br/>-He had never had a bedside table or lamp in his room.<br/>-He would like to have one, but has not asked for one.<br/>-He has to get up to turn the light on in the middle</p> | D 093         |   |                    |

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| D 093              | Continued From page 27 of the night.  | D 093         |   |                    |
| D 105              | <p>10A NCAC 13F .0311(a) Other Requirements</p> <p>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.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, interview, and record review, the facility failed to assure a radiator heater on the second floor was maintained in a safe and operating condition resulting in water damage to the ceiling to a resident room (Room 104) on the first floor.</p> <p>The findings are:</p> <p>Observation on 5/11/15 at 10:30 am of room 104 revealed:</p> <ul style="list-style-type: none"> <li>- Two residents resided in the room.</li> <li>- Two beds were located in the room; one bed adjacent to the outside wall and the second bed adjacent to the center wall.</li> <li>- The bed adjacent to the outside wall had two mattresses on it.</li> <li>- The ceiling board above the bed adjacent to the outside wall had multiple water stain marks along the outside wall edge and in the various area throughout a 4 foot by 8 foot section of ceiling over the resident's bed located on the outside wall. (No water was observed dripping).</li> <li>- The bathroom between room 104 and room 102 had bubbles in the paint along the wall adjacent to room 104.</li> </ul> | D 105         |   |                    |

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| D 105              | <p>Continued From page 28</p> <p>Observation on 5/12/15 at 4:30 pm of room 104 revealed:</p> <ul style="list-style-type: none"> <li>- The bed originally observed adjacent to the outside wall was now located at the center wall and the other bed was not in the room.</li> <li>- The ceiling had a 4 foot by 4 foot section of ceiling board missing from the corner of the ceiling adjacent to the outside wall and center wall.</li> <li>- The bed had a 4 foot by 4 foot section of ceiling board lying across the end of the bed and small white fragments spread on the mattress.</li> <li>- Where the ceiling tile was originally fastened, 1 inch by 4 inch furring strips were exposed.</li> <li>- A two gallon plastic waste basket was placed approximately 5 feet from the inside wall and 2 ½ feet from the outside wall and water was dripping in the waste basket.</li> </ul> <p>Interview on 5/12/15 at 5:10 pm with one of the residents from room 104 revealed:</p> <ul style="list-style-type: none"> <li>- She was awakened at 4:20 am (on 5/12/15) with water dripping on her bed.</li> <li>- She was assisted by staff (alerted by her roommate) in removing her wet bed clothes and dressed for the day.</li> <li>- Staff transferred her to a wheelchair after dressing and she was transported to the sitting area outside the dining area.</li> <li>- The ceiling tile had not fallen at this time.</li> </ul> <p>The Resident Care Director (RCD) was instructed to make sure the room was blocked off and that nobody occupied the room. The RCD was also instructed to evaluate the rooms adjoining room 104 for safety of the residents.</p> <p>Interview on 5/12/15 at 5:40 pm with the RCD revealed:</p> <ul style="list-style-type: none"> <li>- The resident in room 102 did not use the</li> </ul> | D 105         |   |                    |

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| D 105              | <p>Continued From page 29</p> <p>bathroom between room 102 and 104.</p> <ul style="list-style-type: none"> <li>- Staff assisted the resident with toileting and bathing in the common bath area.</li> <li>- The RCD locked the bathroom door from the room 104 side and locked the hall door for room 104.</li> </ul> <p>Interview on 5/12/15 at 5:55 pm with the RCD revealed:</p> <ul style="list-style-type: none"> <li>- She was aware that a section of ceiling had fallen in room 104, earlier in the day.</li> <li>- She stated no resident was in the room when the section of ceiling fell.</li> <li>- Housekeeping staff had gone in the room around 8:00 am to mop up the dripping water and discovered the section of ceiling tile had fallen.</li> </ul> <p>Interview on 5/12/15 at 6:10 pm with the second resident residing in room 104 revealed:</p> <ul style="list-style-type: none"> <li>- She was in bed at 4:15 am.</li> <li>- She was awakened by her roommate at approximately 4:20 am.</li> <li>- She observed her roommate's nightgown was wet and water was dripping from the ceiling.</li> <li>- She alerted the staff member who was in the hall that water was wetting her roommate.</li> <li>- She routinely gets up at 4:30 am so she got up, got dressed, and exited the room about the same time staff were assisting her roommate out of the room.</li> <li>- The ceiling tile was intact when she exited the room.</li> </ul> <p>Interview on 5/12/15 at 6:30 pm with the night shift Medication Aide/Supervisor (MA/S) revealed:</p> <ul style="list-style-type: none"> <li>- She was working on the night of 5/11/15 and morning of 5/12/15 when the residents in room 104 alerted staff for water dripping from the ceiling in the room.</li> <li>- She stated "the room looked like it was raining".</li> </ul> | D 105         |   |                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE LIVING CENTER OF WINSTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2900 REYNOLDS PARK ROAD</b><br><b>WINSTON SALEM, NC 27107</b> |
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| D 105              | <p>Continued From page 30</p> <ul style="list-style-type: none"> <li>- The resident next to the wall (where the water was dripping) was assisted out of bed, changed into dry clothes, transferred to her wheelchair and removed from the room.</li> <li>- The resident was not very wet.</li> <li>- The roommate was up and dressed when she got to the room.</li> <li>- The MA/S set a trashcan under the dripping water.</li> <li>- She notified housekeeping for clean up around 7:00 am or 7:30 am.</li> <li>- The ceiling was intact when she and the residents left room 104.</li> </ul> <p>Observation on 5/13/15 at 11:00 am revealed:</p> <ul style="list-style-type: none"> <li>- The room on the second floor above room 104 was vacant.</li> <li>- Water was pooled on the right hand side of the room (room 213).</li> <li>- A radiator heater was observed in the center of the outside wall underneath a window.</li> <li>- A control valve beneath the radiator was observed to be actively dripping water.</li> </ul> | D 105         |   |                    |
| D 113              | <p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p>  | D 113         |   |                    |

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| D 113              | <p>Continued From page 31</p> <p>This Rule is not met as evidenced by:<br/>TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure the hot water temperature for 2 of 8 sink fixtures and 2 of 8 shower fixtures in the common bathrooms and resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F, with hot water temperatures ranging from 98 degrees F to 148 degrees F.</p> <p>The findings are:</p> <p>A. Observations of the facility during the initial tour on 05/11/2015 from 9:30 am to 11:00 am revealed:</p> <ul style="list-style-type: none"> <li>-The hot water temperature on the 100 Hall ranged from 98 degrees F to 109 degrees F.</li> <li>-The hot water temperature on the 300 Hall ranged from 98 degrees F to 112 degrees F.</li> <li>-The hot water temperature on the 400 Hall ranged from 138 degrees F to 142 degrees F.</li> <li>-The hot water temperature on the 500 Hall ranged from 124 degrees F to 128 degrees F.</li> </ul> <p>Observation during initial tour on 05/11/15 at 9:58 am revealed:</p> <ul style="list-style-type: none"> <li>- Two residents in the middle section of 400 hall were making instant coffee in their rooms from their sink fixtures.</li> <li>-Signs warning of hot water temperatures were observed on some bathroom doors of residents on the 400 hall.</li> </ul> <p>Confidential interview with two residents on a hall with elevated hot water temperatures revealed:</p> <ul style="list-style-type: none"> <li>-The water has been "too hot in that sink."</li> <li>-The resident had lived at the facility since March</li> </ul> | D 113         |   |                    |

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| D 113              | <p>Continued From page 32</p> <p>2015.</p> <p>-When the water was too hot some residents adjusted the hot water temperature in the sink by maneuvering the valve at the base of the sink.</p> <p>-Both residents were concerned about a confused resident getting burned by the hot water coming from the sink.</p> <p>-Both residents stated that they had informed the staff of the hot water temperatures at least twice.</p> <p>Interview on 05/15/15 at 12:15 pm with a resident revealed:</p> <p>-Water temperatures on the 400 hall were so hot he sustained a burn that required home health treatment from coffee spilled on him.</p> <p>-The resident across the hall gave him the coffee.</p> <p>-He was not sure what that resident name was.</p> <p>A second recheck of water temperatures on the 400 hall on 05/11/2015 at 12:18 pm revealed:</p> <p>-The common bath temperature was 142 degrees F.</p> <p>-At 12:21 pm, room 423, hot water temperature at the sink was 146 degrees F.</p> <p>A third recheck of water temperatures on the 400 hall on 05/11/15 at 4:10 pm revealed:</p> <p>-The common bathroom sink temperature was 110 degrees F.</p> <p>-At 4:15 pm, room 423, hot water temperature at the sink was 112 degrees F.</p> <p>Refer to review 05/11/15 of the facility's hot water temperature log.</p> <p>Refer to interviews with the Administrator on 05/11/15 at 10:48 am and 12:55 pm.</p> <p>Refer to calibration of thermometers on 05/11/15 at 11:09 am.</p> | D 113         |   |                    |

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| D 113              | <p>Continued From page 33</p> <p>B. Observations on 05/11/15 from 9:30 am to 10:30 am of the 500 hallway during the tour of the facility revealed;</p> <ul style="list-style-type: none"> <li>-At 9:43 am, in room 501-502 (adjoining bathroom), the hot water temperature was measured in the bathroom sink faucet at 128 degrees F.</li> <li>-At 10:05 am, in room 503-504 (adjoining bathroom), the hot water temperature was measured in the bathroom sink faucet at 124 degrees F.</li> <li>-At 10:37 am, in room 510, the hot water temperature was measured in the bathroom sink faucet at 126 degrees F.</li> </ul> <p>Observation on 05/11/15 from 9:30 am to 10:30am revealed:</p> <ul style="list-style-type: none"> <li>-Signed were posted on bathroom doors throughout the facility including the 500.</li> <li>-The sign told residents to ask for staff assistance when turning on the hot water.</li> <li>-The sign did not warn residents that the water was hot and residents could get burned.</li> <li>-The signs were not dated and it could not be determined how long they had been posted.</li> <li>-No signs were posted on the bathroom doors for rooms 501, 501, 501, 504, and 510.</li> <li>-No sign was posted on the door to the residents' common bath/shower room on the 500 hall.</li> </ul> <p>Interviews on 05/11/15 at 9:45 am with two residents from rooms 501-502 revealed;</p> <ul style="list-style-type: none"> <li>-One resident said the water was hot, but she was able to adjust to her comfort levels.</li> <li>-She did not need staff assistance when showering, she was able to adjust water temperatures.</li> <li>-The resident said she had never gotten burned because she was aware how to add in cold water.</li> </ul> | D 113         |   |                    |

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| D 113              | <p>Continued From page 34</p> <p>Interview on 05/11/15 at 9:55 am with a third resident regarding rooms 501-502 revealed:<br/>-The water was "real hot."<br/>-She mixed a little hot water with a lot of cold water.<br/>-Staff did not assist her with showers; she adjusted her own water temperatures.</p> <p>Interview on 05/12/15 at 11:58 am with two residents from rooms 503-504 revealed:<br/>-One resident had lived at the facility for 3 years.<br/>-She bathed herself in her bathroom and a couple of times she got burned on her stomach by the hot water splashing.<br/>-She had not shared getting burned by the hot water with staff.<br/>-She tried to be very careful when turning on the water and tried to remember to add in cold water.<br/>-The second resident said the water was hot, she did not get burned if she remembered to turn on more cold water, then hot water.</p> <p>There were no residents available for interview in room 510.</p> <p>Interview on 05/11/15 at 11:10 am with a medication aide/supervisor and a medication/resident aide revealed:<br/>-Residents were assisted with their showers by staff turning on the water and setting temperature.<br/>-There was signs already posted throughout the facility instructing residents to ask for staff assistance when turning on the hot water.<br/>-Last year the facility was cited for high hot water temperatures, so the signs were posted and left up to remind resident to ask for assistance in case the hot water temperatures were hot again.<br/>-Both staff were unaware that no signs were posted on the residents' common shower/bath</p> | D 113         |   |                    |

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| D 113              | <p>Continued From page 35</p> <p>room door and resident semi-private bathroom doors on the 500 hall.</p> <p>Observation on 05/11/15 at 12:15 pm of the 400 and 500 halls revealed:<br/>-A second sign was posted near the original warning residents of the hot water temperatures.<br/>-Signs were were posted on the bathroom doors and the common shower/bathroom warning residents of the hot water and to ask for staff assistance when turning on the water.</p> <p>A second recheck of hot water temperatures using the facility's thermometers and the surveyor thermometer revealed:<br/>-At 12:27 pm, the hot water temperature in rooms 501-502 semi-private bathroom sink was 133 degrees F using the facility's thermometer and 135 degrees F using the surveyor's thermometer.<br/>-At 12:31 pm, the hot water temperature in rooms 503-504 semi-private bathroom sink was 131 degrees F using the facility's thermometer and 132 degrees F using the surveyor's thermometer.<br/>-At 12:45 pm, the hot water temperature in the common shower/bath shower was 130 degrees F using both the facility's thermometer and the surveyor's thermometer.</p> <p>A third recheck of hot water temperatures on the 500 hall on 05/1/2015 revealed:<br/>-At 4:15 pm common shower/bath bathroom sink hot water temperature was 106 degrees F.</p> <p>The maintenance supervisor was no longer employed at the facility as of last Friday, May 8th, and was not available for interview.</p> <p>Refer to review 05/11/15 of the facility's hot water temperature log.</p> | D 113         |   |                    |

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| D 113              | <p>Continued From page 36</p> <p>Refer to interviews with the Administrator on 05/11/15 at 10:48 am and 12:55 pm.</p> <p>Refer to calibration of thermometers on 05/11/15 at 11:09 am.</p> <p>_____</p> <p>Review on 05/11/15 of the facility's weekly hot water temperature logs for March 2015 through May 2015 revealed:</p> <ul style="list-style-type: none"> <li>-There were no water temperature checks done for the 500 Hall.</li> <li>-In March, 2015 hot water temperatures on the 400 hall ranged from 106 to 110 degrees F.</li> <li>-In April, 2015 hot water temperatures on the 400 hall ranged from 107 to 110 degrees F.</li> <li>-On May 6, 2015 the hot water temperature on the 400 hall was 110.</li> <li>-There was no documentation of a designated or specific faucet hot water obtained from, or the time.</li> </ul> <p>Interview on 05/11/15 at 10:48 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-He was unaware of the elevated hot water temperatures.</li> <li>-The maintenance supervisor checked hot water temperatures weekly and documented temperatures in a book.</li> <li>-Last year they were cited for hot water temperatures, so signs were put up to warn residents of the hot water temperatures and to ask for staff assistance when turning on the hot water.</li> <li>-The signs were never taken down from the 100, 200, 300, and 400 halls.</li> <li>-During that time no residents lived on the 500 hall, so there was no need to post signs.</li> <li>-He was unaware if the maintenance supervisor checked hot water temperatures on the 500 hall.</li> </ul> | D 113         |   |                    |

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| D 113              | <p>Continued From page 37</p> <ul style="list-style-type: none"> <li>-Signs will be immediately posted on the 500 hall bathroom doors.</li> <li>-He will call a contract plumber.</li> </ul> <p>Interview with the Administrator on 05/11/15 at 12:55 pm revealed:</p> <ul style="list-style-type: none"> <li>-He had turned the water temperature valves down around 12:00 noon that day.</li> <li>-There was a second tank for the 400 and 500 hall.</li> <li>-When the hot water temperature checks were done, it was on random rooms with no documentation of which rooms.</li> <li>-He was not aware of the time of day when the hot water temperature checks were completed.</li> <li>-The Maintenance Director was responsible for the hot water temperature checks but he resigned from the facility on 05/08/15.</li> <li>-It would take "awhile" for the 400 and 500 Hall hot water tank to cool down.</li> <li>-He had contracted a plumbing service and they were on the way to facility to fix the unknown problem.</li> </ul> <p>Calibration of thermometers on 05/11/15 at 11:09 am revealed:</p> <ul style="list-style-type: none"> <li>-The facility had a meat digital cooking thermometer and two surveyors' had mercury thermometers.</li> <li>-All three thermometers were put in ice water for calibration.</li> <li>-The facility's thermometer calibrated at 32 degrees F.</li> <li>-Two surveyors' thermometers (mercury thermometers) calibrated as follows: one thermometer measured 32 degrees F, and one thermometer measured 30 degrees F, needing to add +2 points to readings (this thermometer was used on the 500 hall hot water temperatures).</li> </ul> | D 113         |   |                    |

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| D 113              | <p>Continued From page 38</p> <p>On 05/11/2015, the Administrator submitted a Plan of Protection as follows:<br/>                     -The hot water heater shall be turned down and plumbing contractor will be called to assess excessive temperature.<br/>                     -Signs have been placed in the affected areas to advise residents to check with staff prior to using the hot water.<br/>                     -Water temperatures will be checked weekly in multiple rooms and various halls.<br/>                     -500 Hall will be added to the weekly temperature log.<br/>                     -Maintenance personnel to document room number in monitoring report.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 18, 2015.</p> | D 113         |   |                    |
| D 163              | <p>10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks</p> <p>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation.</p> <p>This Rule is not met as evidenced by:</p>                         | D 163         |   |                    |

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| D 163              | <p>Continued From page 39</p> <p>TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to obtain physican certification and ensure non-licensed staff met the requirements for training and competency validation prior to performing wound care for greater than stage 2 wound for 1 resident (Resident #2) with a stage 4 sacral wound.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 11/14/14 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was admitted to the facility 11/23/14.</li> <li>-Diagnoses that included paraplegic, decubiti, colostomy, foley, osteomyelitis and methicillin-resistant staphylococcus aureus (MRSA) a infection that is caused by a strain of staph bacteria that's becomes resistant to antibiotics.</li> <li>-Resident was documented to have a small decubiti on sacral area.</li> <li>-Resident's ambulatory status was documented as non-ambulatory.</li> </ul> <p>Review of Resident #2's record revealed an order dated 11/24/14 by the nurse practitioner for Home Health (HH) services which begin on 11/24/14.</p> <p>Review of HH skilled nurse visits documentation revealed:</p> <ul style="list-style-type: none"> <li>-HH skilled nurse visits three times weekly for dressing changes.</li> <li>-HH wound care is as follows: <ul style="list-style-type: none"> <li>Wound care aseptic technique</li> <li>Irrigate wound with normal saline</li> <li>Flagyl 250 mg (a antibiotic used to control wound odor) crushed and applied to wound bed</li> <li>Pack gauze into tunneling area and wound bed</li> </ul> </li> </ul> | D 163         |   |                    |

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| D 163              | <p>Continued From page 40</p> <p>Cover with ABD pads and secure with tape.<br/>Change dressing 2 times daily and as needed.<br/>-HH documented sacral wound stage 4 (A full thickness of the skin and subcutaneous tissue is lost. Able to see muscle or bone) measurement 10 cm X 9 cm X 3 cm depth.<br/>-HH documented on 11/24/14 Resident #2 could not perform own dressing changes.</p> <p>Interview on 5/12/15 at 9:00 am with the HH nurse revealed:<br/>-She had seen Resident #2 for the past 6 months for wound care 3 times weekly.<br/>-She was aware of the order for wound care dressing changes to Resident #2 sacral area two times daily.<br/>-She instructed a Medication Aide (MA) to perform wound care dressing changes in the afternoon and on the days HH was not in the facility<br/>-The MA watched her several times perform wound care dressing change then completed a return demonstration.<br/>-It was her belief, due to the MA's return demonstration of wound care for Resident #2, the MA was trained to do the stage 4 dressing on Resident #2's sacral area.</p> <p>Interview on 5/12/15 at 3:00 pm with Resident #2 revealed:<br/>-Sometime I have do my own dressing "I don't have a choice."<br/>-I have to change the dressing in the afternoons and on weekends when staff is not here to do it.<br/>-I can not do the packing, " I just try to keep the dressing dry.</p> <p>Interview on 5/12/15 at 3:30 with the facility Licensed Health Professional Support (LHPS) nurse revealed:</p> | D 163         |   |                    |

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| D 163              | <p>Continued From page 41</p> <ul style="list-style-type: none"> <li>-She completed a LHPS evaluation for Resident #2 on 12/13/14.</li> <li>-She was not aware of the stage 4 wound to Resident #2's sacral area.</li> <li>-She never assessed Resident #2's wound.</li> <li>-She had not completed an LHPS evaluation for March 2015 for Resident #2.</li> </ul> <p>Review of Resident #2 Licensed Health Professional Support (LHPS) evaluation dated 12/13/14 revealed:</p> <ul style="list-style-type: none"> <li>-LHPS by registered nurse was signed.</li> <li>-Task included transfers, care of colostomy and care of foley catheter all documented as self.</li> <li>-No documentation of wound care or dressing changes identified as a LHPS tasks.</li> </ul> <p>Review of Resident #2's facility care plan revealed:</p> <ul style="list-style-type: none"> <li>-The care plan signed by facility licensed health care provider and dated 11/24/14.</li> <li>-No documentation of wound care on Resident #2's care plan.</li> <li>-No documentation of a physician order certifying a non-licensed personnel to be competency validated to perform other task to meet Resident #2's needs for wound care on stage 4 wound.</li> </ul> <p>Interview on 5/13/15 at 11:15 am with the facility's nurse practitioner revealed:</p> <ul style="list-style-type: none"> <li>-She made a referral to HH for Resident #2's wound to sacral area.</li> <li>-She had never seen or assessed the wound to Resident #2's sacral area.</li> <li>-She was not aware the facility staff completed dressing change for Resident #2's stage 4 wound.</li> <li>-She was aware HH could not come everyday to the facility to perform wound care dressing change to Resident #2's sacral wound.</li> </ul> | D 163         |   |                    |

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| D 163              | <p>Continued From page 42</p> <p>-She was not aware of the requirements or how the HH nurse instructed staff to complete a stage 4 wound care dressing change.</p> <p>Interview on 5/12/15 at 1:00 pm with a Medication Aide revealed:</p> <ul style="list-style-type: none"> <li>-She worked day shift 7-3 as a MA.</li> <li>-She watched the HH nurse perform wound care dressing change to Resident #2's sacral wound.</li> <li>-She performed wound care and dressing change on the days the HH nurse was not in the facility.</li> <li>-She said Resident #2 did his own dressing changes in the afternoons and the days when no one was available.</li> <li>-She said Resident #2 preferred only her or the HH nurse to perform wound care dressing changes.</li> <li>-She was unaware if a physican had completed and signed a temporary certification for a non licensed staff competency to perform wound care on a stage 4 wound.</li> </ul> <p>Review of MA's personnel record revealed:</p> <ul style="list-style-type: none"> <li>-LHPS skills validation dated 11/3/14 and signed by a registered nurse.</li> <li>-Documented and validated by registered nurse "to care for a pressure ulcers up to and including stage 2."</li> </ul> <p>Interview on 5/13/15 at 11:00 am with the Resdient Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>-She was aware HH was in the facility 3 times weekly for Resident #2's wound care dressing change.</li> <li>-She was aware the HH nurse had showed one of the MA how to perform wound care dressing change to Resident #2 on days HH was not in the facility.</li> <li>-She was aware HH could not come everyday to perform wound care for Resident #2 due to</li> </ul> | D 163         |   |                    |

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| D 163              | <p>Continued From page 43</p> <p>Resident #2's insurance.<br/>-She was unaware the MA could not perform wound care to a stage 4 wound without a physican certification that a non-licensed personnel can be competency validated to perform other task on a temporary basis to meet the resident's needs.</p> <p>Refer to Tag 0932, G.S 131D-4.4A (b). Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for wound care for Resident #2 with a stage 4 sacral wound.</p> <p>_____</p> <p>On 5/12/15, the Administrator submitted a Plan of Protection as follows:<br/>-Staff will only be allowed to perform LHPS tasks for which they have been validated.<br/>-We will consult with the doctors that had staged wounds, in order to determine appropriate level of care.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 18, 2015.</p> | D 163         |   |                    |
| D 176              | <p>10A NCAC 13F .0601 Management Of Facilities</p> <p>10A NCAC 13F .0601Management Of Facilites</p> <p>(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter.</p>   | D 176         |   |                    |

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| D 176              | <p>Continued From page 44</p> <p>The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by:<br/>TYPE A1 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas including housekeeping and furnishings, water temperatures, health care, medication administration, staff qualifications, staffing, personal care and supervision, infection prevention, reporting of accidents and incidents, health care personnel registry, and resident rights.</p> <p>The findings are:</p> <p>Interview on 5/13/15 at 9:30 am with the Resident Care Coordinator (RCD) revealed:<br/>-She works day shift in the facility.<br/>-Her staff comes to her with issues and problems that occur in the facility.<br/>-The Administrator is responsible for the day to day operations of the facility.<br/>-If the Administrator is not in the facility then she is in charge of day to day operations of the the facility.</p> <p>Interview on 5/13/15 at 9:35 am with the</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 45</p> <p>Adminstrator revealed:<br/>-He works day 9-5 Monday through Friday in the facility.<br/>-He is on call 24/7 for facility issues and concerns.<br/>-He was responsible for the day to day operations of the facility.<br/>-If he is out the the RCD is responsible for the day to day operations,<br/>-He reports to the owner of the facility weekly and as needed.</p> <p>Interview on 5/13/15 at 1:15 pm with the owner of the facility revealed:<br/>-She is in the facility usually every other week.<br/>-She is on conference call with the Administrator and the RCD on Fridays.<br/>-The Administrator is in charge of the day to day operations of the facility and if he is not in the facility the RCD is in charge.<br/>-She was unaware when the last Resident Council meeting was held.<br/>-She was unaware of the current facility census.</p> <p>Noncompliance was identified in the following rules areas:</p> <p>A. Based on record review, observations and interviews, the facility failed to ensure residents were free from neglect by failing to recognize its role in caring for individuals with communicable infections and those with diminished mental capacity; addressing the special care needs and interventions for the monitoring and reporting of communicable infections; and by failing to make available and implement preventative measures to protect other residents from transmission of a communicable disease and failed to ensure residents were free of abuse as evidenced by</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 46</p> <p>abuse of 1 resident (Resident #2) by Staff K. [Refer to Tag 338, 10A NCAC 13F. 0909 (Type A1 Violation).</p> <p>B. Based on interviews, record reviews, and observations, the facility failed to provide supervision or monitoring related to safety for 4 residents of 8 residents sampled, 4 residents who left the facility frequently and were known to have guardians or the inability to make safe decisions (Residents #1, #3, #5, and #16) and failed to provide additional supervision for 1 resident who attempted suicide. (Resident #5). [Refer to Tag 0270, 10A NCAC 13F.0901(b) (Type A2 Violation).]</p> <p>C. Based on observations, interviews and record reviews the facility failed to assure the hot water temperature for 2 of 8 sink fixtures and 2 of 8 shower fixtures in the common bathrooms and resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F with hot water temperatures ranging from 98 degrees F to 148 degrees F. [Refer to Tag 113, 10A NCAC 13F.0311(d) (Type A2 Violation).]</p> <p>D. Based on observations, interviews, and record reviews the facility failed to obtain physican certification and ensure non-licensed staff met the requirements for training and competency validation prior to performing wound care for greater than stage 2 wound for 1 resident (Resident #2) with a stage 4 sacral wound. [Refer to Tag 0163, 10A NCAC 13F.0504(c) (Type A2 Violation).]</p> <p>E. Based on observation, interview and record review, the facility failed to assure prescribed medications (Megace, Cipro, Diflucan, Combivir, Valtrex, Kaletra, Zolof, Naproxen, Omeprazole</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 47</p> <p>and Nystatin) were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 8 residents (#4, #10 and #17). [Refer to Tag 0358, 10A NCAC 13F.1004(a) (Type A2 Violation).]</p> <p>F. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for wound care for 1 Resident (Resident #2) with a stage 4 sacral wound. [Refer to Tag 0932, G.S 131D-4.4A (b) (Type A2 Violation).]</p> <p>G. Based on record reviews and interviews, the facility failed to assure notification of health department, health care providers or the resident's guardian regarding residents' behaviors for 3 of 3 sampled residents (Residents #6, #16 and #17) regarding behaviors. [Refer to Tag 0273, 10A NCAC 13F.0902(b) (Type A2 Violation).]</p> <p>H. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. [Refer to Tag 0077, 10A NCAC 13F.0306(a)(4) (Type B Violation).]</p> <p>I. Based on observations, interviews and record reviews, the facility failed to maintain a clean and orderly environment, free of hazards, as related to bedbugs in multiple rooms throughout the facility biting and irritating residents, safe storage of full and empty oxygen cylinders and repair and maintenance of hand rails for resident safety and mobility. [Refer to Tag 0079, 10A NCAC 13F.0306(a)(5) (Type B Violation).]</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 48</p> <p>J. Based on record review and interviews the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when a resident whereabouts were unknown (Resident #1). [Refer to Tag 0328, 10A NCAC 13F.0906(f)(4) (Type B Violation).]</p> <p>K. Based on interviews, and record reviews the facility failed to report to the North Carolina Health Care Personnel Registry (HCPR) an allegation of abuse by one staff (Staff K) resulting in an injury of a resident (Resident #2). [Refer to Tag 438, 10A NCAC 13F.1205 (Type B Violation).]</p> <p>L. Based on observation and interview, the facility failed to assure bathrooms on the 500 hall (#501, #502, #503, #504, and #510) had individual clean towels, hand drying device, and soap. [Refer to Tag 0080, 10A NCAC 13F.0306(a)(6).]</p> <p>M. Based on observations and interviews, the facility failed to assure privacy curtains, drapes or window coverings were in 1 of 5 resident rooms on the 500 hall (room 510). [Refer to Tag 0083, 10A NCAC 13F.0306(a)(9).]</p> <p>N. Based on observations and interviews, the facility failed to provide or maintain at least one pillow with clean pillow case, a clean top and bottom sheets on the bed and a clean bedspread or other coverings as needed for 17 of 50 beds observed. [Refer to Tag 0087, 10A NCAC 13F.0306(b)(1).]</p> <p>O. Based on observation and interview, the facility failed to furnish a wall or dresser mirror in 5 of 5 residents' rooms that could be used by each resident (Rooms #501, #502, #503, #504,</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 49 and #510). [Refer to Tag 0090, 10A NCAC 13F.0306(b)(4).]</p> <p>P. Based on observations and interviews, the facility failed to provide a minimum of one comfortable chair for each resident in 5 of 5 resident bedrooms (Rooms #501, #502, #503, #504, and #510). [Refer to Tag 0091, 10A NCAC 13F.0306(b)(5).]</p> <p>Q. Based on observation and interview, the facility failed to ensure a bedside lamp or a light overhead of residents' beds with the switch within reach of person lying on bed for 24 of 25 resident rooms observed. [Refer to Tag 0093, 10A NCAC 13F.0306(b)(8).]</p> <p>R. Based on observation, interview, and record review, the facility failed to assure the building and and plumbing equipment were maintained in a safe and operating condition resulting in a ceiling board collapsing in a resident room (Room 104). [Refer to Tag 0105, 10A NCAC 13F.0311(a).]</p> <p>S. Based on interview and record review, the facility failed to assure 1 of 6 sampled staff (Staff A) had been competency validated by return demonstration prior to performing Licensed Health Professional Support (LHPS) tasks. [Refer to Tag 0161, 10A NCAC 13F.0504(a)].</p> <p>T. Based on observation, interview and record review, the facility failed to assure any assigned housekeeping tasks (house and resident laundry) were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm. [Refer to Tag 0206, 10A NCAC 13F.0604(2)(b).]</p> <p>U. Based on interviews the facility to ensure</p> | D 176         |   |                    |

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| D 176              | <p>Continued From page 50</p> <p>resident care and services were provided regarding access to a telephone made available for residents to privately make and receive calls. [Refer to Tag 0324, 10A NCAC 13F.0906(d)(1).]</p> <p>V. Based on observation, interview and record review, the facility failed to assure an accurate reconciliation record for one controlled medication (Hydrocodone/Acetaminophen 10-325) prescribed for 1 of 5 sampled residents with controlled medication (Resident #4). [Refer to Tag 0392, 10A NCAC 13F.1008(a).]</p> <p>W. Based on interview and record review, the facility failed to notify the resident's guardian for 1 of 3 sampled residents (Resident #4) who required hospitalization. [Refer to Tag 454, 10A NCAC 13F.1212(e).]</p> <p>X. Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed before the staff began work at the facility for 2 of 10 sampled staff (Staff A and Staff D). [Refer to Tag 0992, G.S. 131D-45.]</p> <hr/> <p>On 5/13/15, the Administrator submitted a Plan of Protection as follows:<br/>-I will meet with management team to assess day to day operations of facility policy and procedures in regard to complying with State rules and Regulations.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED June 18, 2015.</p> | D 176         |   |                    |

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| D 206              | Continued From page 51   | D 206         |   |                    |
| D 206              | <p>10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staff</p> <p>The following describes the nature of the aide's duties, including allowances and limitations:</p> <p>(B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to assure any assigned housekeeping tasks (house and resident laundry) were limited to occasional, non-routine tasks between 7:00 am and 9:00 pm.</p> <p>The findings are:</p> <p>Review of the facility census for 5/11/15 revealed there were 67 residents currently residing in the facility.</p> <p>Observations during the initial tour of the facility on 5/11/15 between 9:30 am and 12:00 noon revealed:</p> <ul style="list-style-type: none"> <li>-At least 15 resident beds observed did not have a complete linen set (fitted bottom sheet, flat top sheet, pillow case and spread) but had parts of the set.</li> <li>-The 400 Hall laundry room had one fitted sheet and 2 flat sheets on storage shelf rack.</li> </ul> | D 206         |   |                    |

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| D 206              | <p>Continued From page 52</p> <ul style="list-style-type: none"> <li>-There were wet clothes in the washer.</li> <li>-The 300 Hall laundry room had 5 new fitted sheets in a bag on the floor and no fitted or flat sheets on on the shelf.</li> <li>-Both washers were full of wet laundry.</li> <li>-The dryer was full of laundry in the process of drying.</li> <li>-A Personal Care Aide took laundry out of the dryer and loaded the contents into a laundry basket.</li> </ul> <p>Five resident interviews on 5/12/15 revealed:</p> <ul style="list-style-type: none"> <li>-Two residents said the staff did their laundry or the residents could do their own, but had to wait until late evening before the washer or dryer was available.</li> <li>-All five residents said their bed linens were changed at least weekly and mostly with a complete set of bed linen, but sometimes only a flat sheet on the bottom and a blanket but not a spread.</li> </ul> <p>Interview with the Supervisor on 5/11/15 at 3:00 pm revealed:</p> <ul style="list-style-type: none"> <li>-All care staff on duty each shift was responsible for resident care, linen changes on bath days and all resident laundry for their assigned residents.</li> <li>-Each nursing assistant (NA) was assigned halls and should take care of resident needs first.</li> <li>-All residents are assigned bathing days, either Monday, Wednesday, Friday, or Tuesday, Thursday Saturday, and each of the three shifts are responsible for designated residents bathing and laundry.</li> <li>-The Supervisor stated all resident beds are changed and linens washed on assigned bathing days even if the resident refused a bath.</li> <li>-Some residents will change their own beds and linen was left in the room for them to use.</li> <li>-All bed linen was stored in the laundry rooms.</li> </ul> | D 206         |   |                    |

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| D 206              | <p>Continued From page 53</p> <p>-All resident laundry was returned to the resident on the same day.</p> <p>Review of the facility's bathing schedule and care aide assignments revealed a starred and bold typed statement at the bottom of each shift assignment sheet stating "*Remember shower includes nails clipped and cleaned, shaves, linen changes, dirty laundry washed and returned to resident!*."</p> <p>Interviews with 3 NAs who work either first or second shifts on 5/12/15 between 2:00 pm and 3:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-There were usually two aides per shift assigned to halls for resident care.</li> <li>-House laundry and resident laundry was done daily depending on bath schedule.</li> <li>-The aides are responsible for getting the laundry washed, dried, folded and stored correctly during their shift.</li> <li>-One aide stated they ran out of linens daily until the laundry was caught up, so beds are not made up right away.</li> <li>-All three NAs stated they did laundry all shift long, intermittently while caring for residents, but the washers and dryers run continuously.</li> <li>-The Medication Aides usually did not help with routine resident care and laundry.</li> <li>-The facility had housekeepers, but no staff person dedicated to laundry services.</li> <li>-One aide reported they just got 10 new fitted sheets yesterday (Monday, 5/11/15).</li> </ul> <p>Interview with the Administrator on 5/15/15 at 3:10 pm revealed:</p> <ul style="list-style-type: none"> <li>-All staff on every shift have the responsibility for house and resident laundry.</li> <li>-He had not ever hired a person for laundry services.</li> </ul> | D 206         |   |                    |

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| D 206              | Continued From page 54<br><br>-He did have several housekeepers but they are not responsible for laundry services; only the personal care staff was responsible for laundry.<br>-He did not consider laundry services as housekeeping tasks.  | D 206         |   |                    |
| D 270              | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on interviews, record reviews, and observations, the facility failed to provide supervision or monitoring related to safety for 4 residents of 8 residents sampled, 4 residents who left the facility frequently and were known to have guardians or the inability to make safe decisions (Residents #1, #3, #5, and #16) and failed to provide additional supervision for 1 resident who attempted suicide (Resident #5).<br><br>The findings are:<br><br>A. Review of Resident #5's current FL-2 dated 08/28/2014 revealed diagnoses included Depression and Mental Disability.<br><br>Review of Resident #5's current Resident Register signed and dated on 09/09/2014 revealed: | D 270         |   |                    |

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| D 270              | <p>Continued From page 55</p> <p>-Resident #5 was admitted to the facility on 09/09/2014.</p> <p>-Resident #5 was her own guardian.</p> <p>-The personal information section documented that Resident #5 was forgetful at times and needed reminders.</p> <p>Review of Resident #5's record revealed:</p> <p>-Hospital Emergency Department documentation Resident #5 was struck by a vehicle while out of the facility on 01/16/2015.</p> <p>-Hospital Emergency Department documentation Resident #5 had a attempted suicide while out of the facility on 04/18/2015.</p> <p>Review of Resident #5's nurse's notes for the months of March, April and May 2015 revealed:</p> <p>-On 05/08/2015 at 8:45 pm, the resident returned to facility then left again without signing out.</p> <p>-On 05/08/2015 at 11:00 pm when doing rounds, the resident window was up and it appears that she climbed out of the window.</p> <p>-On 05/04/2015 at 7:00 pm, Resident #5 had unsteady gait, foul odor to breath, slurred speech and she was vomiting.</p> <p>-On 04/25/2015 at 10:00 pm, a local hospital called to inform the facility they had the resident for possible admission due to suicidal threats and had been brought to the local emergency department by the local police department.</p> <p>-On 04/06/2015 at 8:35 pm, Resident #5 had a foul odor to her breath and unsteady gait.</p> <p>-On 03/25/2015 at 3:00 pm, Resident #5 had walked away from the facility stating she was going to kill herself. The local police department was called and Resident #5 was taken to the hospital for evaluation.</p> <p>Review of the facility's incident reports for the months of May, April and March 2015 revealed</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 56</p> <p>there were no incident reports for Resident #5 available for review.</p> <p>Review of the facility's Midnight Census Report revealed Resident #5 was missing from the facility:</p> <ul style="list-style-type: none"> <li>-One time from so far in May 2015.</li> <li>-Sixteen times for the month of April 2015.</li> <li>-Two times for the month of March 2015.</li> </ul> <p>Interview with Resident #5 on 05/11/2015 at 3:30 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was aware she was to sign out but forgets.</li> <li>-Her boyfriend helped to remind her; he is a resident as well.</li> <li>-She was struck by a vehicle while walking at the intersection next to the facility.</li> <li>-"I do go out a lot at night when I am not supposed to."</li> <li>-"I go to the woods with my boyfriend to have sex because we can't do it in the rooms because of our roommates."</li> <li>-"I crawl out of my bedroom window to meet him."</li> <li>-"I can't tell a person no when it comes to sex."</li> <li>-"I think I am pregnant because I feel something kicking inside of me but my parents have told me I had my tubes tied."</li> </ul> <p>Observation of Resident #5's behavior revealed:</p> <ul style="list-style-type: none"> <li>-She was very fidgety and had a fast pace walk.</li> <li>-Clothing was mismatched.</li> </ul> <p>Interview with Resident #5's Psychiatrist on 05/14/2015 at 1:05 pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5 was a very difficult patient to manage due to her cognitive deficits.</li> <li>-Resident #5 was promiscuous with no impulse control.</li> <li>-Resident #5 was doing better than when she first arrived at the facility because she was first</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 57</p> <p>accusing everyone of rape.<br/>-"I changed her medicines during that time."<br/>-"It's just crazy that she is her own guardian but I am amazed at the people that are their own guardians at that place."</p> <p>Interview with Administrator on 05/13/2015 at 3:30 pm revealed:<br/>-He was aware that Resident #5 does not sign out every time.<br/>-It was very difficult for him to "police that behavior".<br/>-If Resident #5 was missing on midnight rounds, the staff just make a note of it in the record and sign out the resident on the sign out log.<br/>-Resident #5 leaves the facility multiple times on a daily basis.<br/>-Resident #5 attempted suicide while attending a day program facility with her boyfriend because the two got into a disagreement.<br/>-There was no responsible person, only a emergency contact person for Resident #5.</p> <p>Interview with Resident #5's emergency contact person on 05/18/215 at 9:45 am revealed:<br/>-Resident #5 suffered from a congetial Syndrome.<br/>-Resident #5 began living in group homes when in her 20's..<br/>-Resident #5's behavior had been the same at other facilities where she had resided in the past.<br/>-They had visited the facility twice since admission on 09/09/2014.<br/>-Most of the contact was done over the phone and mailing care packages to Resident #5 because they live out of town.<br/>-One concern was that Resident #5 had been missing for 2 days and the facility did not contact them during that time.<br/>-Stated "I am ok with her being her own guardian</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 58</p> <p>because we just can't do it at our age. I would not be opposed if the state wanted to take over guardianship though."</p> <p>-She was aware that Resident #5 had a history of leaving the facility and "it's only under God's grace that she has survived this long."</p> <p>Interview on 05/14/15 at 9:45 am with the Activity Director revealed:</p> <p>-Resident #5 frequently left the facility.</p> <p>-She was really worried about Resident #5 because the resident had the mentality of "child" and did not make good decisions.</p> <p>-She observed that most people took advantage of Resident #5.</p> <p>Interview on 05/15/15 at 2:45 pm with the RCD revealed:</p> <p>-She previously contacted someone from the local Department of Social Services to get Resident #5 a guardian.</p> <p>-She felt that Resident #5 was not good at making decisions causing several incidents like: being struck by a vehicle, attempted suicide, and drinking alcohol.</p> <p>-She felt Resident #5 had caused Resident #3 to make bad decisions, like leaving the facility and staying out all night.</p> <p>-She thought it would be best for Resident #5 to have a guardian to make decisions for her.</p> <p>Review of Resident #5's record and interviews with 5 staff at various times during the survey revealed:</p> <p>-All staff were knowledgeable that Resident #5 had attempted to commit suicide in 03/2015.</p> <p>-All staff were aware the resident left the facility through her window and left without signing out or informing staff.</p> <p>-Staff were not aware of how long Resident #5</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 59</p> <p>may be out of the facility or where the resident went when out of the facility.</p> <ul style="list-style-type: none"> <li>-Staff did not think Resident #5 was able to make safe decisions regarding the resident's well-being or health or able to understand consequences from her behaviors while away from the facility.</li> <li>-There was no increase in supervision or monitoring of Resident #5 following the resident's attempt to commit suicide in 03/2015 or with knowledgeable of Resident #5 leaving the facility through her bedroom window.</li> <li>-There were no measures implemented to monitor or check for safety when Resident #5 was at or away from the facility.</li> <li>-Staff thought it was the resident's right to come and go from the facility as the resident wanted, without staff being aware.</li> </ul> <p>B. Review of Resident #1's current FL2 dated 03/25/15 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included chronic schizophrenia disorder, type manic.</li> </ul> <p>Review of the care plan dated 04/04/14 revealed:</p> <ul style="list-style-type: none"> <li>-Social/mental health history: the resident was currently receiving medications for mental illness/behavior, had a history of mental illness,</li> <li>-The resident had positive social skills and continued to hear voices.</li> <li>-Needed extensive assistance with eating, and supervision with toileting, bathing, dressing, and grooming.</li> </ul> <p>Review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-The resident's court appointed guardian was a county Department of Social Services.</li> <li>-He had a guardian since 2012.</li> </ul> <p>Review of Resident #1's record revealed a note signed by the Resident Care Director (RCD) and</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 60</p> <p>Resident #1 on 01/07/14 as follows:<br/>-Resident #1 must sign out and give a return time.<br/>-If Resident #1 does not return within 1 hour of the time she signs out, staff were to notify the police and the guardian.<br/>-If the whereabouts of Resident #1 are unknown the person in charge will immediately notify the resident's responsible person, law enforcement and the county Department of Social Services.</p> <p>Continued review of the notes in Resident #1's record revealed:<br/>-On 11/30/14 at 10:00 pm - Resident appeared to be intoxicated, was very irritated.<br/>-On 12/17/14 at 1:30 am - Resident returned (no signed-out time).<br/>-On 03/12/15, at 2:00 pm - Resident still not back at facility.<br/>-On 03/13/15 at 4:30 pm - Resident still has not returned back to the facility, missing person report done.<br/>-On 04/11/15 at 9:30 pm - Resident signed out at 12:45 pm and has not returned.<br/>-On 04/23/15 on 3pm to 11 pm shift - Resident signed out at 3:00 pm and did not return at 6:00 pm as stated.<br/>-On 05/11/15 on 11pm to 7am shift- Resident signed out at 3:00 pm and did not return by 11:00 pm as stated.</p> <p>Review of the facility's census reports from March 2015 through May 2015 revealed Resident #1 was on therapeutic (TL) (not in the building by the end of third shift) as follows:<br/>-March 1, 2, 6, 9, 10, 11, 12, 13, 26, and 27th, 2015;<br/>-April 8, 15, 18, and 23rd, 2015;<br/>-May 1, 2, 5, 6, 7, 10, 11, 12, 13, and 14th, 2015.</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 61</p> <p>Review of the facility's sign-out/sign-in sheets from March through May 2015 revealed for Resident #1:</p> <ul style="list-style-type: none"> <li>-Times documented on the sign-out/sign-in register did not include am or pm, therefore it could not be determined the time of day the resident was signing-out/signing-in.</li> <li>-Signed-out 4 days in March, 2015, did not sign-in;</li> <li>-Signed-out 4 days in April, 2015, did not sign-in;</li> <li>-Signed-out 6 days in May, 2015, did not sign-in;</li> <li>-On 03/06/15 at 5:30 signed-out - signed-in at 1:00;</li> <li>-On 03/09/15 at 10:50 signed-out - signed-in at 1:20;</li> <li>-On 03/14/15 no sign-out time - signed in at 11:30;</li> <li>-On 04/01/15 signed-out at 10:40 - signed-in at 7:00;</li> <li>-On 04/05/15 signed-in at 7:00;</li> <li>-On 04/14/15 signed-out at 1:45 - signed-in at 4:55, signed-out at 8:00 - signed-in at 9:55, signed-out at 10:50 - signed-in at 6:05.</li> <li>-On 05/08/15 signed-out at 7:20 - signed-in at 8:00, signed-out at 8:36 - sign-in at 1:00.</li> <li>-On 05/11/15 signed-in at 7:00</li> </ul> <p>Review of Resident #1's March 2015 Medication Administration Record (MARs) revealed:</p> <ul style="list-style-type: none"> <li>-In March 2015, staff circled their initials 12 times indicating the resident's medication was not administered.</li> <li>-Staff documented on the back of the MARs the resident was on leave of absence (LOA).</li> </ul> <p>Review of Resident #1's April 2015 MARs revealed:</p> <ul style="list-style-type: none"> <li>-In April 2015, staff circled their initials seven times indicating the resident's medication was not administered.</li> </ul> | D 270         |   |                    |

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| D 270 | <p>Continued From page 62</p> <p>-Staff documented on the back of the MARs the resident was on LOA.</p> <p>Review of Resident #1's May 2015 MARs revealed:<br/>-In May 2015, staff circled their initials six times as not administering the resident's medications.<br/>-Staff documented on the back of the MARs the resident was on LOA.</p> <p>Review of local police "Field contact remarks" revealed:<br/>-On 07/25/13 - An officer stated he spoke with the resident about loitering for prostitution.<br/>-Over the past several days, he noticed the resident loitering in the area of the liquor store, beckoning to vehicles, and once exiting a vehicle.<br/>-The officer noted the resident was in a facility due to mental illness.<br/>-The officer warned the resident to stop her behavior or face prosecution.<br/>-On 08/24/13 - An officer stated while walking in a designated area, he talked with the resident, she was on foot.<br/>-The resident advised the officer she was walking the area in order to get exercise.<br/>-She later stated to the officer she was also in the area to visit a friend.<br/>-During the conversation the officer noticed the resident was holding \$15 in cash.<br/>-The resident told the officer due to her mental illness she lived in an assisted living facility.<br/>-The resident left the area walking.</p> <p>Review of a local police report dated 03/13/15 revealed:<br/>-The resident was reported missing.<br/>-The resident last signed out on 03/11/15 at 7:00 pm.<br/>-Staff stated to the officer the resident usually left</p> | D 270 |  |  |
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| D 270              | <p>Continued From page 63</p> <p>the facility, but was back by 3:00 am.</p> <ul style="list-style-type: none"> <li>-The RCD told the officer she observed the resident getting out of a car in the parking lot near the facility.</li> <li>-The RCD told the officer that Resident #1 usually signed-out, but returned in the early morning hours.</li> <li>-On 03/14/15 the officer followed-up with the facility regarding Resident #1's whereabouts.</li> <li>-Staff at the facility told the officer that Resident #1 had just returned to the facility 10 to 15 minutes ago.</li> <li>-The resident told the officer she could leave the facility whenever she wanted to and she could stay away from the home as long as she wanted.</li> <li>-The officer documented hearing staff tell Resident #1 "to call the facility when she knows she is not coming home right away, otherwise the facility will have to follow procedures in reference to reporting her as a missing person at high risk"</li> </ul> <p>Review of a local police report dated 05/12/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's guardian called and filed a missing persons report.</li> <li>-The RCD told the officer this was an ongoing issue with Resident #1.</li> <li>-The RCD told police officer Resident #1 had previously stated to her she needed to get away from the facility for a while to be around normal people like herself.</li> </ul> <p>Continued review of Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-No documentation of supervision related to Resident #1 continually leaving the facility and her whereabouts unknown.</li> <li>-No communication with the resident's guardian when the resident was not in facility at the agreed upon time.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 64</p> <p>-No documentation of attempts to keep Resident #1 from leaving the facility.</p> <p>Interview on 05/11/15 at 9:23 am with one of Resident #1's roommates revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 always heard voices.</li> <li>-Some nights the resident woke up screaming there are "demons" in her head.</li> <li>-The resident said that "demons" were telling her to do things.</li> <li>-Resident #1 usually stayed away from the facility and did not sleep in her bed 2-3 times a week.</li> <li>-She was not sure where the resident went or what the resident did when she was out of the facility.</li> <li>-She believed the Resident #1 had an alcohol problem and maybe did drugs.</li> <li>-Resident #1 was usually not violent or argumentative; she mostly slept when in the facility.</li> </ul> <p>Interview on 05/14/15 at 4:56 pm with Resident #1's second roommate revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had never stayed away from the facility this long before.</li> <li>-Resident #1 has been gone 1 to 3 days before, but never this long.</li> <li>-The roommate was worried something had happened to Resident #1.</li> </ul> <p>Interview on 05/12/15 at 3:50 pm with Resident #1's guardian revealed:</p> <ul style="list-style-type: none"> <li>-She was a court appointed guardian from the Department of Social Services.</li> <li>-She was not in the county where Resident #1 lived.</li> <li>-A lot of communication was made with Resident #1 and facility staff over the phone.</li> <li>-In the past, she had several discussions with Resident #1 and facility staff about the resident</li> </ul> | D 270         |   |                    |

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| D 270 | <p>Continued From page 65</p> <p>not leaving the facility.</p> <ul style="list-style-type: none"> <li>-Last year, she had a discussion and an agreement was signed with the Resident Care Director (RCD) with stipulations what to do if the resident was missing for 1 hour.</li> <li>-She did not want Resident #1 out of the building at all, but she was afraid the resident would go out anyway, so she agreed to a 9:00 pm curfew.</li> <li>-Per the agreement, if the resident was gone 1 hour past curfew, the facility staff were to call the police and report the resident missing.</li> <li>-The facility was also supposed to call her and inform her the resident was out past curfew.</li> <li>-As of this date (05/12/15) she had not received any phone calls from facility staff regarding Resident #1 not in building by curfew.</li> <li>-She visited the resident in March 2015, unannounced and found the resident was not in the facility.</li> <li>-She suspected there were many times the resident was not in the building and facility staff did not inform her the resident was missing.</li> <li>-The guardian said at 5:45 pm last night (05/11/15) someone from the facility left a message on her voice mail at work, not the call center hotline as per the agreement.</li> <li>-The message was that Resident #1 had been missing since 3:00 pm Sunday evening (05/10/15).</li> <li>-When she talked with the RCD this morning she found out that they did not call the police, and according to staff the resident had been missing or not seen by facility staff since 3:00 pm Sunday.</li> <li>-She felt Resident #1 really needed to be in a secure facility to keep the resident from leaving.</li> <li>-She was afraid the resident was prostituting.</li> <li>-She previously asked Resident #1 if she was prostituting, the resident said no, but then stated "she needed to get her sex on."</li> <li>-The resident was always having sex in the</li> </ul> | D 270 |  |  |
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| D 270              | <p>Continued From page 66</p> <p>woods.</p> <p>-In 2013, the resident was escorted back to the facility by the police because she was pacing the street back and forth like she was prostituting.</p> <p>-The guardian said the RCD informed her that she had seen Resident #1 getting in and out of cars.</p> <p>-She realized Resident #1 was difficult to supervise, which was why she gave the resident a curfew time.</p> <p>-Once facility staff called and told her Resident #1 had stayed out overnight, but the incident had happened 5 days earlier.</p> <p>-The RCD informed her that Resident #1 was usually out of the facility between the hours of 12:00 noon, and 11:00 pm.</p> <p>-She was unaware the resident was out of the building for 1 to 3 times per week, and had missed medications.</p> <p>-She expected some type of supervision from facility staff, if nothing else, to inform her of noncompliance with agreement.</p> <p>Interview on 05/12/15 at 4:20 pm with the Nurse Practitioner (NP) revealed:</p> <p>-She was aware Resident #1 was gone for days at a time.</p> <p>-It had been more than 1 year since she saw Resident #1.</p> <p>-When she comes to the facility, the resident was never in.</p> <p>-Even when the resident made appointments to see her, when she got there Resident #1 was gone.</p> <p>-She signed the FL2's and renewed medications, but had not physically seen Resident #1 since last year.</p> <p>-She was not sure what the facility could do for Resident #1, because they could not physically restrain the resident.</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 67</p> <p>Interview on 05/12/15 at 5:21 pm and 05/14/15 at 2:45 pm with Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's guardian had requested the resident be back in the facility by 9:00 pm.</li> <li>-If the resident was not in the facility by 9:00 pm staff was to call the resident's guardian.</li> <li>-The guardian requested facility staff call the police, but they did not want to call the police so, they called the guardian when the resident was not back in the facility by curfew time 9:00 pm.</li> <li>-Resident #1 left the facility 2-3 times daily.</li> <li>-Most nights the resident was back in the building by 11:00 pm.</li> <li>-Once or twice a week Resident #1 stayed out until 1:00 to 3:00 am.</li> <li>-She could not confirm the resident's guardian had been contacted for times past 9:00 pm.</li> <li>-Several months ago she found out that Resident #1 was sneaking outside the facility through the basement door and staying out all night.</li> <li>-She had the basement door locked, then later found out that Resident #1 was staying out, then knocking on certain residents' windows and they would open the door for her; or the resident would come in through the window.</li> <li>-She found this information out when inquiring why so many window screens were getting torn up.</li> <li>-Since a burglary at the facility, all doors are locked at 11:00 pm.</li> <li>-Resident #1 had been missing in March 2015 for three days.</li> <li>-This is the second time Resident #1 has been missing for more than 24 hours.</li> <li>-She was unsure what Resident #1 did when she was out of the facility.</li> <li>-She suspected the resident walked the streets to obtain money.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 68</p> <ul style="list-style-type: none"> <li>-She had not seen the resident on the street soliciting men for money, but she did see the resident getting in and out of various cars in the neighborhood.</li> <li>-Resident #1 was knowledgeable about things around her, like directions and how to get around from one place to another, therefore she was not worried about the resident on the streets.</li> <li>-However the resident did sometimes say that "demons" were inside of her head telling her what to do.</li> <li>-The demons "raped her and tore up her stomach and female parts."</li> <li>-She had also heard from the police and other residents that Resident #1 walked the streets as a prostitute.</li> <li>-The facility did not have a policy regarding supervision of residents.</li> <li>-She had never thought that Resident #1 needed supervision as far as continuous watching and unable to come and go safely.</li> <li>-The facility was unable to provide that type of service to Resident #1.</li> <li>-Previously Resident #1's guardian had talked about moving resident, but nothing had transpired since the conversation.</li> </ul> <p>Interview on 05/12/15 at 4:30 pm with the psychiatrist revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was a very difficult person.</li> <li>-He was aware that Resident #1 was never in the facility.</li> <li>-Someone from mental health visited the facility twice weekly, and reported the resident was always out.</li> <li>-He visited the facility twice a month to see residents, and Resident #1 was never there.</li> <li>-He previously treated Resident #1 for mental health, and was well aware the resident had difficulty being in one location for long periods of</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 69</p> <p>time.</p> <ul style="list-style-type: none"> <li>-He ordered medications to treat mental illness, but was not concerned the medications were not administered daily.</li> <li>-He said Resident #1 was a "prostitute and usually worked the streets."</li> <li>-He said because the resident was on the streets, there was always the potential for something bad to happen due to the company that she communicated with.</li> <li>-He believed it was impossible to keep the resident from going out when she wanted to go.</li> <li>-The only alternative that he could think of was to put Resident #1 in a more secure living unit for her own safety.</li> <li>-He said no one from that facility had ever contacted him regarding Resident #1 being missing or not taking her medications.</li> <li>-No one at the facility had called or asked to discuss methods or options as far as supervision for Resident #1.</li> </ul> <p>Interview on 05/14/15 at 9:45 am with the Activity Director revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 usually left and stayed gone over night.</li> <li>-This was the longest time the resident had ever stayed away.</li> <li>-Resident #1 was a drinker and may be somewhere drunk.</li> <li>-There was a big window in her office and she has often watched Resident #1 walk up the hill to the path that leads away from the facility.</li> <li>-She had never shared this with anyone.</li> </ul> <p>Confidential interviews with three staff members revealed:</p> <ul style="list-style-type: none"> <li>-Two staff wondered why everyone was so upset about Resident #1 being gone from the facility.</li> <li>-It was a continual pattern for Resident #1 to be</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 70</p> <p>gone 3 nights a week, return two nights to get what the resident called "rest," and to leave again repeating the same pattern.</p> <ul style="list-style-type: none"> <li>-Three staff said Resident #1 was pretty smart with her thinking, she dressed nice and took care of herself, but the resident had mental problems.</li> <li>-The resident was too trusting of people and does not make good decisions regarding people she should not get involved with.</li> <li>-The resident said she had "demons" living inside of her and they told her do things.</li> <li>-They did not make her hurt herself or others, but Resident #1 said "they made her drink alcohol, they raped her and hurt her insides."</li> <li>-Three staff said Resident #1 was prostituting on the street.</li> <li>-They could not confirm they had actually seen her prostituting, but others have seen her.</li> <li>-The resident basically did what she wanted to do.</li> <li>-They did rounds every two hours, but mainly to make sure the building was safe.</li> <li>-They did not specially look for residents when they were missing or gone from the facility.</li> <li>-They did a head count of residents at the end of each shift and reported to the next shift the resident that was not in the building.</li> <li>-If they noticed, for example, Resident #1 was not in her room they reported to the oncoming shift.</li> <li>-If Resident #1 was not identified for 24 hours they called the guardian.</li> <li>-One staff said Resident #1 was smart and knows how to play the system.</li> <li>-The staff said that Resident #1 will come to the facility take a shower, ask for medications, and then will leave again.</li> <li>-When approached by staff asking where she had been, the resident will say to staff "I was here, you gave me medications."</li> <li>-One staff said last week, Resident #1 returned to</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 71</p> <p>the facility stating she was "afraid that she was pregnant in her tubes because her stomach was getting bloated."</p> <p>Interview and observation on 05/18/15 at 2:15 pm with Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was laying in her bed.</li> <li>-The resident's legs and feet were involuntary shaking.</li> <li>-The resident said she left the facility because of Mother's Day and she was feeling sad.</li> <li>-She was aware of her curfew, but thought it was 11:00 pm.</li> <li>-She was aware that she should not stay away without letting someone know.</li> <li>-She did not call the facility because she did not have the telephone number, and it was not listed in the phone book.</li> <li>-She went to a boyfriend's house.</li> <li>-She was not prostituting.</li> <li>-People from the mental health agency said that she was leaving and doing things because she was in the street.</li> <li>-She stayed at the boyfriend's house the whole time.</li> <li>-She was not concerned about missing her medications because she was drinking beer, smoking "crack" and "weed."</li> <li>-The resident said about one month ago she stayed gone for several days with a guy.</li> <li>-She left the facility almost daily but was back in the early morning hours (between 1:00 and 3:00 am).</li> <li>-Resident #1 said sometimes she felt that she needed to get out of the facility.</li> <li>-The resident said she heard "demons" talking to her in her head.</li> <li>-They were talking to her when the surveyors walked into the room.</li> <li>-The demons do bad things to her every night.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 72</p> <ul style="list-style-type: none"> <li>-Every night the "demons" stick sticks into her back causing very bad pain.</li> <li>-They raped her and tore up stomach and female parts.</li> <li>-They did sex things to her when she was out at her boyfriend's house.</li> <li>-Resident #1 said in a previous situation 5 to 6 "demons" had her eating her own feces, and believing she was "chomping on birds."</li> <li>-The resident said she did not think that she needed to live at the facility, or needed a guardian, and she could care for herself.</li> </ul> <p>Interview on 05/18/15 at 2:20 pm with home health nurse revealed:</p> <ul style="list-style-type: none"> <li>-She visited the facility monthly to give Resident #1 her injection (medication for mental illness).</li> <li>-If she did not call to tell the resident that she was coming, the resident was not at the facility.</li> <li>-She had a pretty good relationship with Resident #1 and felt the resident does not need to be alone.</li> <li>-Resident #1 cannot take care of herself and did not make good decisions, especially when it comes down to the people the resident assumed are her friends.</li> <li>-The resident did not make good judgement calls.</li> <li>-She tried to tell the resident it was not good for her to be out of the facility so long without taking her medications, but the resident could not comprehend the importance of routinely taking medications.</li> <li>-She has witnessed that Resident #1 usually was out of the facility for 2-3 days at a time, but never this long before.</li> <li>-The resident has told her that "demons live inside her and messed-up her body in her stomach and vaginal area."</li> <li>-The nurse said Resident #1 was mentally unfit or sound to live alone.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 73</p> <p>Review of the facility's "house rules" revealed:<br/>-The facility had a curfew in place.<br/>-For safety reasons residents' were required to be in the facility by 9:00 pm when the doors are locked.</p> <p>Review of the facility's "Missing residents" policy revealed:<br/>-A resident will be considered missing when he/she is not in the facility and we cannot verify their whereabouts; and in addition, there is reason to be concerned for the resident's safety.<br/>-If the facility discovers a resident is missing we will:<br/>-Notify the supervisor and all other staff immediately.<br/>-Perform a hasty search of the building and the immediate areas outside the building.<br/>-If the resident is not found, we will immediately notify:<br/>-Local law enforcement - Call 911.<br/>-The resident ' s family member/responsible person.<br/>-The County Department of Social Services.</p> <p>Based on interviews and record review, the facility failed to monitor or oversee when Resident #1 left or was away from the facility to help ensure the resident's safety. On numerous occasions the resident was out of the facility overnight or until the early morning hours, and no one at the facility knew where the resident was going, what the resident planned to do, who the resident was with, or when the resident planned to return.</p> <p>C. Review of Resident #3's current FL2 from 2014 revealed diagnoses included mild/moderate mental retardation and mood disorder.</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 74</p> <p>Review of Resident #3's care plan from 2014 revealed the resident needed extensive assistance with eating, and supervision was needed with toileting, bathing, dressing, and grooming.</p> <p>Review of Resident #3's record revealed the resident's court appointed guardian was the Department of Social Services of another county.</p> <p>Review of a police report from April 2015 the resident had left the facility for 2 days and was brought back to the facility by the police.</p> <p>Review of the facility's census reports from December 2014 through May 2015 revealed the following dates Resident #1 was on therapeutic leave (TL) (not in the building by the end of third shift)as follows:<br/>-December 14, 16, 21, 24, 25, and 27th, 2014;<br/>-January 17, 18, and 24th, 2015;<br/>-March 24, 25th, 2015;<br/>-April 3, 4, 6, 7, 8, 9, 10, 13, 14, 18, 23, 26th, 2015;<br/>-May 11, 2015.</p> <p>Review of the facility's sign-out/sign-in sheets from March 2015 through May 2015 for Resident #3 revealed:<br/>-Resident #3 signed-out 23 times and did not sign-in.<br/>-3 times the writing was not legible and sign-out/sign-in times not be read.<br/>-Documentation on the sign-out/sign-in sheet under the column titled name of responsible person Resident #3 wrote: AA store, AA meeting, self &amp; Guardian, church, store, taking a walk, other documentation which was not legible.</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 75</p> <p>Review of Resident #3's April 2015 MARs revealed:<br/>-In April 2015 staff circled their initials eight times indicating the resident's medications was not administered.<br/>-Staff documented on the back of the MARs the resident was on LOA.</p> <p>Review of Resident #3's May 2015 MARs revealed:<br/>-In May 2015 staff circled their initials three times as not administering the resident's medications.<br/>-Staff documented on the back of the MARs the resident was on LOA.</p> <p>Interview on 05/14/15 with Resident #3's guardian:<br/>-He became Resident #3's guardian recently.<br/>-Shortly after becoming Resident #3's guardian, the local police called to inform him Resident #3 was missing from the facility.<br/>-They reported the resident had been gone for three days.<br/>-After that incident, he had a talk with Resident #3 about not leaving the facility.<br/>-Until this conversation, no one at the facility had informed him that Resident #3 left the facility.</p> <p>Interview on 05/12/15 at 1:00 pm with Resident #3 revealed:<br/>-In April 2015 he did not have a guardian and frequently left the facility staying out overnight.<br/>-Sometimes when he left the facility, he and his girlfriend (a resident at the facility) slept on a mattress in the woods.<br/>-Sometimes he was at a family member's house.</p> <p>Interview on 05/12/15 at 5:21 pm and 05/14/15 at 2:45 pm with RCD revealed:<br/>-When Resident #3 had a guardian he did not</p> | D 270         |   |                    |

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| D 270 | <p>Continued From page 76</p> <p>leave the facility.</p> <p>-When Resident #3 realized no one was appointed as his guardian, the resident started leaving the facility.</p> <p>-When she approached the resident about not leaving the facility, he told staff that he was grown and did what he wanted.</p> <p>-The facility did nothing further in regards to the resident leaving the facility, during the time the resident did not have a named guardian.</p> <p>-Staff rounds every 2 hours, but do not go from room to room checking on the residents.</p> <p>-Rounds were mostly for staff to identify safety issues, like smoke in the building.</p> <p>-At the end of each shift staff were do a head count with staff coming duty for the next shift.</p> <p>-If a resident was reported missing for three shifts, then it was reported to her and the guardian, if a resident had a guardian.</p> <p>-There was never a discussion about monitoring Resident #3 leaving the facility, because there was no way to keep the resident from leaving.</p> <p>Interview on 05/14/15 at 1:43 pm with another NP visiting the facility revealed:</p> <p>-She saw Resident #3 two weeks ago.</p> <p>-She was new and had not been informed that sometimes the resident left the facility and did not get medications.</p> <p>Based on record review and interview, Resident #3 needed monitoring and supervision related to the resident leaving the facility during the time period the resident was without a guardian. The resident was allowed to freely roam the streets, spend nights on a mattress in the woods, and staff did not know the resident's whereabouts or if he was safe.</p> <p>D. Review of Resident #16's current FL2 dated</p> | D 270 |  |  |
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| D 270              | <p>Continued From page 77</p> <p>05/08/14 revealed:<br/>-Diagnoses of schizophrenia.<br/>-Disorientation was constant.</p> <p>Review of Resident #16's record revealed the resident's court appointed guardian was a county Department of Social Services.</p> <p>Review of the care plan dated 03/19/14 in Resident #16's record revealed:<br/>-Documentation on the social/mental health history: the resident was verbally abusive, had disruptive behavior/socially inappropriate, injurious to others and property; the resident had history of substance abuse, developmental disabilities, and mental illness.</p> <p>Review of the facility Census report for January 2015 through May 2015 revealed the resident was on therapeutic leave and out of the facility:<br/>-On January 9th, 2015;<br/>-On April 01, 02, 21, 22, 23, 24, and 25th, 2015;<br/>-On May 08 and 11th, 2015.</p> <p>Review of the sign-out/sign-in register for March 2015 through May 2015 for Resident #16 revealed:<br/>-Signed-out, 1 time in March 2015, did not sign-in.<br/>-Signed-out 9 times in April 2015, did not sign-in.<br/>-Signed-out 6 times in May 2015, did not sign-in.</p> <p>Review of Resident #16's record revealed:<br/>-No documentation of supervision for Resident #16.<br/>-No documentation of communication with Resident #16's guardian to ensure the resident can leave the facility.</p> <p>Observation on 05/13/15 at 11:15 am revealed:</p> | D 270         |   |                    |

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| D 270              | <p>Continued From page 78</p> <ul style="list-style-type: none"> <li>-A trail leading along a path in a thicket of woods.</li> <li>-Multiple beer bottles and other debris was observed on both sides of the path in the thicket of woods.</li> <li>-Approximately 279 feet from the facility in the thicket of the woods was observed one full sized mattress.</li> <li>-The mattress was dirty with spots, ragged, and torn, with ¼ of the top missing and the brown cushion insides uncovered and hanging out.</li> <li>-The mattress leaned against a tree covering two bicycles.</li> <li>-About 5 feet from the mattress behind another patch of trees was a twin mattress that was navy blue and grey.</li> <li>-The mattress was solid with no open areas observed.</li> <li>-The mattress was leaned against some trees.</li> <li>-Approximately 10 feet away a second mattress was observed.</li> <li>-The mattress was twin sized, navy in color on the one side and grey on the other side.</li> <li>-The mattress was leaning against some trees.</li> <li>-No holes or tips were observed, but the mattress was covered with dead leaves and sticks.</li> </ul> <p>Confidential interviews on 05/13/15 with five residents who were observed walking the path through the woods revealed:</p> <ul style="list-style-type: none"> <li>-Surveyors were asked by the residents "aren't you afraid? "</li> <li>-The big mattress was the love nest and used mostly by residents #3, #5, #6, #9, and #18.</li> <li>-The other mattress was used by Resident #16.</li> <li>-Resident #16 slept in the woods almost every night.</li> <li>-Resident #16 complained about it being hot in the facility and slept in the woods.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 79</p> <p>Interview on 05/15/15 at 11:25 am with Resident #16 revealed:</p> <ul style="list-style-type: none"> <li>-He slept in the woods as often as could.</li> <li>-He slept on a mattress in the foods.</li> <li>-Facility staff was aware that he slept in the woods because most times they signed him out.</li> <li>-Some nights he did not sleep in the woods, sometimes he spent the night at his girlfriend's house.</li> <li>-He walked 20 miles to the Walmart and his girlfriend met him and took him to her house, which was about 10 minutes from the Walmart.</li> <li>-He had a guardian, but was unaware that he needed to inform his guardian where he was going.</li> <li>-Facility staff knew and he thought that was good enough.</li> </ul> <p>The RCD had to leave and was not available for interview.</p> <p>Interview on 05/15/15 at 5:20 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-He was unaware of the "sleeping and nesting" arrangements in the woods.</li> <li>-He was unaware that Resident #16 slept in the woods.</li> <li>-He was unaware that Resident #16 spent nights away from the facility with a girlfriend.</li> <li>-No one at the facility had discussed with him that they allowed Resident #16 to sleep in the woods or visit a girlfriend without contacting the guardian.</li> <li>-This will be corrected right away.</li> </ul> <p>Telephone interview on 05/15/15 at 12:10 pm with Resident #16's guardian revealed:</p> <ul style="list-style-type: none"> <li>-This conversation with the surveyor, this was the first time she heard that Resident #16 was "camping" in the woods on a mattress.</li> </ul> | D 270         |   |                    |

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| D 270              | <p>Continued From page 80</p> <ul style="list-style-type: none"> <li>-She had not given permission for the resident to leave the facility.</li> <li>-She did not want the resident to leave the facility.</li> <li>-She did not want the resident to leave the facility at any time with anyone, except her.</li> <li>-Every time Resident #16 left the facility she wanted to know.</li> </ul> <p>Interview with three medication aides on 05/15/15 from 4:42 pm to 4:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #16 asked us (staff) to help him sign out because he can't see that well at night.</li> <li>-Resident #16 tells us he is going to his girlfriend's house or that he will be out all night.</li> <li>-Sometimes he's gone all night and comes back in the morning.</li> <li>-They were unaware of the guardian and they should contact the guardian.</li> <li>-One staff said she worked during the day and he signs out at night, so I mostly see him in the morning after he gets back.</li> <li>-Another staff said Resident #16 was usually back here (facility) bright and early in the morning.</li> <li>-A third staff said he goes to the woods in the daytime, but I don't know about him going up there at night.</li> </ul> <p>Confidential interviews with 4 residents revealed:</p> <ul style="list-style-type: none"> <li>-One resident said that Resident #16 spent one night per week in the woods.</li> <li>-Three residents said they observed Resident #16 leaving the facility with his blanket going into the woods around 9:00 pm 2-3 nights per week sleeping in the woods.</li> <li>-Two residents said Resident #16 and his girlfriend don't stay in the woods all night, they go up there during the day time.</li> <li>-One resident said that Resident #16 slept in the woods 3-4 nights per week.</li> </ul> | D 270         |   |                    |

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| D 270 | <p>Continued From page 81</p> <p>-The resident drinks alcohol "up there" (in the woods).</p> <p>-One resident said he observed Resident #16 and his girlfriend going "up there" (the woods) around 11:00 pm and in the morning she doesn't come back with him.</p> <p>Communication with the Nurse Practitioner on 05/18/15 at 1:00 pm, to discuss Resident #16's behavior and anger revealed:</p> <p>-She was not available and a message was left, and prior to exiting the survey had not call back.</p> <p>Based on interview and record review Resident #16 needed to be supervised and not allowed to sleep in the woods without any safety procedures in place. Staff allowed the resident out of the facility without any knowledge of what the resident was doing or concern for the resident's safety, although it was known the resident had a guardian and was unable to make good judgement decisions.</p> <p>_____</p> <p>On 05/13/2015, the Administrator submitted a Plan of Protection as follows:</p> <p>-The Executive Director will have a documented one on one with residents with a witness to do a facility contract review.</p> <p>-Resident Care Director will do level of care evaluations.</p> <p>-Staff will be inserviced on appropriate sign out procedures.</p> <p>-Administrator will review documentation of sign out sheet every 2 hours for the next 3 weeks.</p> <p>-When Administrator is not present, other management will review the sign out log.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 18, 2015</p> | D 270 |  |  |
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| D 273              | <p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by:<br/>TYPE A2 VIOLATION</p> <p>Based on record reviews and interviews, the facility failed to assure notification of health department, health care providers or the resident's guardian regarding residents' behaviors for 3 of 3 sampled residents (Residents #6, #16 and #17) regarding behaviors.</p> <p>The findings are:</p> <p>A. Review of Resident #6's current FL2 dated 01/28/15 revealed:<br/>-Diagnoses of schizoaffective disorder, hepatitis, communicable infection, and altered mental status.</p> <p>Review of Resident #6's care plan dated 01/24/15 revealed:<br/>-The resident needed extensive assistance with eating, bathing, and grooming.<br/>-The resident required limited assistance with toileting and dressing.<br/>-The resident required supervision with transferring.<br/>-Based on the social/mental health history the resident was currently receiving medication for mental illness/behavior, and mental health services (no required contact person listed).</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 83</p> <p>Continued review of Resident #6's record revealed:<br/>-The resident was his own responsible person and did not have a legal guardian.</p> <p>Confidential interview with a medication aide revealed:<br/>-She was aware Resident #6 had a communicable infection.<br/>-She was aware the resident freely had sexual encounters with at least 5 other female residents.<br/>-One of the female residents previously told her that she was afraid because Resident #6 had a communicable infection, and the resident got tested.<br/>-She was aware that Resident #6 had many had sexual encounters with other residents on a mattress in the woods.<br/>-Sometimes the sexual encounters were in Resident #6's room, but most times in the woods.<br/>-She did not stop the residents or talk with the residents to offer any type of protection because she did not want to violate the residents' rights.<br/>-She was sure Resident #6 did not use protection when having sexual encounters with female residents because the female residents told her they did not use protection.</p> <p>Interview on 05/13/15 at 10:45 am with one of the female residents revealed:<br/>-She had lived at the facility for several months, she was unable to recall.<br/>-She had many sexual encounters with Resident #6, as recent as last night.<br/>-No protection was used, she had never used protection when she was with Resident #6.<br/>-She was unaware that she should use protection.<br/>-Ass far as she knows Resident #6 does not have</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 84</p> <p>a sexually transmitted disease (STD).<br/>-He never told her that he had an STD.</p> <p>Interview on 05/14/15 at 9:00 am with Resident #6 revealed:<br/>-The only STD that he was aware of was communicable infection.<br/>-The resident was unaware what it meant to have hepatitis.<br/>-When having sexual encounters he did not tell his partners that he a communicable infection.<br/>-He showed one condom that was in his wallet and said he had no more condoms to use.<br/>-He named 4 female residents that he had sexual encounters with.<br/>-His girlfriend was a resident, but he did not have sexual encounters with her.<br/>-He did not use protection (condoms) when having sex.<br/>-He sometimes had sexual encounters in his room, and asked the roommate to leave.<br/>-Most sexual encounters were on a mattress in the woods.</p> <p>Interview on 05/14/15 at 9:54 am with a second medication aide revealed:<br/>-Resident #6 a communicable infection and had frequent sexual encounters with 5 female residents.<br/>-The encounters were sometimes in Resident #6's room or on a mattress in the woods.<br/>-She had not seen residents on the mattress in the woods, but residents had told her that was where they were going.<br/>-When the encounters were in Resident #6's room, his roommate left the room.<br/>-She could not validate the nonuse of protection, but a couple of residents two female residents said they did not use protection.<br/>-She did not share resident's diagnoses with</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 85</p> <p>other residents, because it is private and only the resident could tell.</p> <ul style="list-style-type: none"> <li>-The facility did not have condoms to offer residents.</li> <li>-Staff did not get involved or discuss residents' sexual encounters because it was against residents rights.</li> </ul> <p>Telephone interview on 05/14/15 at 12:15 pm with the Nurse Practitioner (NP) revealed:</p> <ul style="list-style-type: none"> <li>- She had not seen Resident #6 since April 1, 2015.</li> <li>-She was aware of Resident #6 's diagnoses.</li> <li>-No one at the facility had made her aware the resident was sexually active without using protection.</li> <li>-She had not discussed sexual behaviors with Resident #6.</li> </ul> <p>Interview on 05/14/15 at 2:45 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of Resident #6 's diagnoses.</li> <li>-She was aware the resident had many sexual encounters with female residents living at the facility.</li> <li>-She was unaware of any role the facility would have with reporting or notifying the health department of residents with STD's such as communicable infection, being sexually active and not telling other residents who were partners and not using condoms.</li> </ul> <p>Interview on 05/15/15 at 1:30 pm with a third female resident revealed:</p> <ul style="list-style-type: none"> <li>-She had unprotected sex Resident #6, almost daily.</li> <li>-No partner had mentioned to her having an STD.</li> <li>-She would wanted to know if she needed to protect herself.</li> </ul> | D 273         |   |                    |

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| D 273              | <p>Continued From page 86</p> <p>B. Review of Resident #17's current FL2 dated 12/04/14 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included intellectual development disorder and communicable infection.</li> </ul> <p>Interview on 05/12/15 with Resident #17 revealed:</p> <ul style="list-style-type: none"> <li>-He came back to live at the facility in 2014.</li> <li>-He had a guardian.</li> <li>-They had sex almost daily, as recent as this morning and did not use condoms.</li> <li>-His girlfriend was aware that he had a communicable infection.</li> <li>-He had been with other residents at the facility, but currently his girlfriend, a resident of the facility, was the only resident that he was sexually involved with.</li> <li>-He did not use condoms, he said that he had condoms, but none were shown or surveyor observation.</li> <li>-When with other female residents he did not use condoms.</li> <li>-He could not recall if he told his partners that he had a communicable infection.</li> </ul> <p>Interview on 05/12/15 at 1:27 pm with Resident #17's girlfriend, a resident at the facility revealed:</p> <ul style="list-style-type: none"> <li>-Resident #17 was her boyfriend.</li> <li>-They had sexual encounters almost daily.</li> <li>-She was aware Resident #17 had a communicable infection.</li> <li>-She did not use protection or condoms when engaged with sexual relations with Resident #17.</li> <li>-She did not respond to why she did not use protection, but stated now she was very scared that she had a communicable infection.</li> <li>-She has periods of nausea, throwing up, and headaches.</li> <li>-She feels like her immune system is shutting down, like she needs a "boost."</li> </ul> | D 273         |   |                    |

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| D 273              | <p>Continued From page 87</p> <ul style="list-style-type: none"> <li>-She had aches and pains all over her body with flu like symptoms.</li> <li>-She sometimes was light headed and passed out.</li> <li>-During her last hospital visit last month she thought a test was ran that showed she had a communicable infection and medications were ordered.</li> <li>-Review of Resident #17's girlfriend's record could validate a test for a communicable infection or medications ordered.</li> </ul> <p>Interview on 05/13/15 at 10:48 am with a second female resident revealed:</p> <ul style="list-style-type: none"> <li>-She had lived at the facility for several months, she was unable to recall.</li> <li>-About one month ago she had sex with Resident #17 and did not use protection.</li> <li>-Resident #17 did not tell her or discuss that he had an STD.</li> <li>-She thinks and hopes she was pregnant by Resident #17.</li> </ul> <p>Interview on 05/14/15 with Resident #17's guardian:</p> <ul style="list-style-type: none"> <li>-He became Resident #17's guardian less than one month ago.</li> <li>-Resident #17 had couple of days when he was missing from the facility.</li> <li>-After that he had a talk with Resident #17 about using protection due to having a communicable infection.</li> <li>-He did not ask facility staff to let him know about Resident #17's sexual activity, because he was new and had never had this type of situation before.</li> <li>-He was unaware that Resident #17 was sexually active and not using protection.</li> <li>-He was also unaware this information needed to be shared with the health department.</li> </ul> | D 273         |   |                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE LIVING CENTER OF WINSTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2900 REYNOLDS PARK ROAD</b><br><b>WINSTON SALEM, NC 27107</b> |
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| D 273              | <p>Continued From page 88</p> <p>Interview on 05/15/15 at 9:30 am with a medication aide/supervisor revealed:<br/>-She was aware that residents had communicable infections and sexually active without using protection, but was unaware that she should report the information.<br/>-She thought this was private information and she could not discuss or tell anyone.</p> <p>Telephone interview on 05/14/15 at 11:40 am with the Communicable Disease Nurse at the local County Health Department revealed:<br/>-Anyone that has a communicable infection, and who were not using condoms, should be reported to the State Disease Intervention (DIS) team.<br/>-A person will be sent to the facility to talk with the HIV residents who were noncompliant with using condoms.<br/>-Anyone that has a communicable infection should inform their sexual partner they have a communicable infection and wear condoms.</p> <p>Interview on 05/14/15 at 1:43 pm with another NP visiting the facility revealed:<br/>-She had seen Resident #17 two weeks ago.<br/>-She was unaware the resident had a communicable infection or that he was engaged in unprotected sexual activity.<br/>-She will order another communicable infection test for Resident #17, and for residents named as sexual partners.</p> <p>Based on record review and interview Residents #6 and #17 sexual conduct should have been followed-up by reporting to the Department of Public Health Communicable disease section to protect the other residents, and the facility should have intervened, provided referral to help educate residents, and provided condoms.</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 89</p> <p>C. Review of Resident #16's current FL2 dated 05/08/14 revealed:<br/>-Diagnoses of syncope, seizure disorder, schizophrenia, hypertension, chronic back pain, and constipation.<br/>-Disorientation was constant.<br/>-The resident was ambulatory, continent of bladder and bowel.</p> <p>Review of Resident #16's record revealed the resident had a court appointed guardian from the Department of Social Services.</p> <p>Review of the care plan dated 03/19/14 in Resident #16's record revealed:<br/>-Social/Mental Health history: the resident was verbally abusive, had disruptive behavior/socially inappropriate, injurious to others and property; the resident had history of substance abuse, developmental disabilities, and mental illness.</p> <p>Review of notes in Resident #16's record revealed:<br/>-On 12/08/14 at 12:35 am - Resident #16 was in his room arguing with Resident #5. When asked to stop Resident #16 said "everyone can go to hell."<br/>-On 01/18/15 at 4:48 pm - Resident #16 was asked to stop pushing a resident and then pushed me. Resident #16 was asked to leave and would not stating that he "kick my ass."<br/>-On 01/21/15 at 5:30 pm - Resident #16 attempted to assault another resident by pushing him. Resident #16 stated he would hit me in the face if I kept talking to him.<br/>-On 02/20/15 at 3:20 pm - A resident accused Resident #16 of rape (The female resident would not come to the office as requested, so nothing was done).</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 90</p> <p>-02/27/15 (no time specified) - Resident #16 continually comes in my office to tell me that he is going to "kill, bash their skulls in" and other violent actions he wishes to do or will do if he gets a chance. The staff stated: "He definitely has anger problems."</p> <p>-On 03/10/15 at 7:00 pm - Resident #16 caught consuming alcohol.</p> <p>-On 03/14/15 at 10:15 pm - Resident #16 tried to fight staff because staff asked him not to light a cigarette.</p> <p>Review of documentation for the facility's Census report for January 2015 through May 2015 revealed the resident was on therapeutic leave (out of the facility) as follows:<br/>-On 01/9th, 2015;<br/>-On 04/01, 02, 21, 22, 23, 24, and 25th, 2015;<br/>-On 05/08 and 11th, 2015.</p> <p>Review of the sign-out/sign-in register for March 2015 through May 2015 for Resident #16 revealed:<br/>-Signed-out, 1 time in March, 2015, did not sign-in<br/>-Signed-out 9 times in April, 2015, did not sign-in<br/>-Signed-out 6 times in May, 2015, did not sign-in</p> <p>Review of Resident #16's record revealed:<br/>-No documentation of supervision for Resident #16.<br/>-No documentation of communication with Resident #16's guardian to ensure the resident can leave the facility.</p> <p>Observation on 05/13/15 at 11:15 am revealed:<br/>-A trail leading along a path in a thicket of woods.<br/>-Multiple beer bottles and other debris was observed on both sides of the path in the thicket of woods.</p> | D 273         |   |                    |

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| D 273              | <p>Continued From page 91</p> <ul style="list-style-type: none"> <li>-Approximately 279 feet from the facility in the thicket of the woods was observed one full sized mattress.</li> <li>-The mattress was dirty with spots, ragged, and torn, with ¼ of the top missing and the brown cushion insides uncovered and hanging out.</li> <li>-The mattress leaned against a tree covering two bicycles.</li> <li>-About 5 feet from the mattress behind another patch of trees was a twin mattress that was navy blue and grey.</li> <li>-The mattress was solid with no open areas observed.</li> <li>-The mattress was leaned against some trees.</li> <li>-Approximately 10 feet away a second mattress was observed.</li> <li>-The mattress was twin sized, navy in color on the one side and grey on the other side.</li> <li>-The mattress was leaning against some trees.</li> <li>-No holes or tips were observed, but the mattress was covered with dead leaves and sticks.</li> </ul> <p>Confidential interviews on 05/13/15 with five residents who were observed walking the path through the woods revealed:</p> <ul style="list-style-type: none"> <li>-Surveyors were asked by the residents "aren't you afraid? "</li> <li>-The big mattress was the love nest and used mostly by residents #3, #5, #6, #9, and #18.</li> <li>-The other mattress was used by Resident #16.</li> <li>-Resident #16 slept in the woods almost every night.</li> <li>-Resident #16 complained about it being hot in the facility and slept in the woods.</li> </ul> <p>Interview on 05/15/15 at 11:25 am with Resident #16 revealed:</p> <ul style="list-style-type: none"> <li>-He slept in the woods as often as could.</li> <li>-He slept on a mattress in the woods.</li> </ul> | D 273         |   |                    |

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| D 273              | <p>Continued From page 92</p> <ul style="list-style-type: none"> <li>-Facility staff was aware that he slept in the woods because most times they signed him out.</li> <li>-Some nights he did not sleep in the woods, sometimes he spent the night at his girlfriend's house.</li> <li>-He walked 20 miles to the Walmart and his girlfriend met him and took him to her house, which was about 10 minutes from the Walmart.</li> <li>-He had a guardian, but was unaware that he needed to inform his guardian where he was going.</li> <li>-Facility staff knew and he thought that was good enough.</li> </ul> <p>The RCD had to leave and was not available for interview.</p> <p>Interview on 05/15/15 at 5:20 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-He was unaware of the "sleeping and nesting" arrangements in the woods.</li> <li>-He was unaware that Resident #16 slept in the woods.</li> <li>-He was unaware that Resident #16 spent nights away from the facility with a girlfriend.</li> <li>-No one at the facility had discussed with him that they allowed Resident #16 to sleep in the woods or visit a girlfriend without contacting the guardian.</li> <li>-He was unaware of Resident #16's bouts with anger.</li> <li>-He was unaware that Resident #16 spent nights out of the facility sleeping in the woods and a girlfriend's house.</li> <li>-This will be corrected right away.</li> </ul> <p>Telephone interview on 05/15/15 at 12:10 pm with Resident #16's guardian revealed:</p> <ul style="list-style-type: none"> <li>-This conversation with the surveyor was the first time she heard that Resident #16 was camping in</li> </ul> | D 273         |   |                    |

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| D 273 | <p>Continued From page 93</p> <p>the woods on a mattress.</p> <ul style="list-style-type: none"> <li>-She had not given permission for the resident to leave the facility.</li> <li>-She did not want the resident to leave the facility.</li> <li>-She did not want the resident to leave the facility at any time with anyone, except her.</li> <li>-Every time Resident #16 left the facility she wanted to know.</li> <li>-For a year she asked the facility to provide her with the resident's current FL2, but the facility has not sent it to her.</li> </ul> <p>Interview with three medication aides on 05/15/15 from 4:42 pm to 4:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #16 asked us (staff) to help him sign out because he can't see that well at night.</li> <li>-Resident #16 tells us he is going to his girlfriend's house or that he will be out all night.</li> <li>-Sometimes he's gone all night and comes back in the morning.</li> <li>-They were unaware of the guardian and they should contact the guardian.</li> <li>-One staff said she worked during the day and he signs out at night, so I mostly see him in the morning after he gets back.</li> <li>-Another staff said Resident #16 was usually back here (facility) bright and early in the morning.</li> <li>-A third staff said he goes to the woods in the daytime, but I don't know about him going up there at night.</li> </ul> <p>Confidential interviews with 4 residents revealed:</p> <ul style="list-style-type: none"> <li>-One resident said that Resident #16 spent one night per week in the woods.</li> <li>-Three residents said they observed Resident #16 leaving the facility with his blanket going into the woods around 9:00 pm 2-3 nights per week sleeping in the woods.</li> <li>-Two residents said Resident #16 and his</li> </ul> | D 273 |  |  |
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| D 273              | <p>Continued From page 94</p> <p>girlfriend don't stay in the woods all night, they go up there during the day time.</p> <p>-One resident said that Resident #16 slept in the woods 3-4 nights per week.</p> <p>-The resident drinks alcohol "up there" (in the woods).</p> <p>-One resident said he observed Resident #16 and his girlfriend going "up there" (the woods) around 11:00 pm and in the morning she doesn't come back with him.</p> <p>Communication with the Nurse Practitioner on 05/18/15 at 1:00 pm, to discuss Resident #16's behavior and anger revealed:</p> <p>-She was not available and a message was left, prior to exiting the survey she did not call back.</p> <p>Based on interviews and record review Resident #16's leaving the facility should have been followed-up with his guardian before the resident was allowed to leave the facility. The resident should obvious signs of mental health intervention that was not followed up the physician and guardian.</p> <p>No plan of protection was provided.</p> <p>THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 18, 2015.</p> | D 273         |   |                    |
| D 324              | <p>10A NCAC 13F .0906 (d) Other Resident Care And Services</p> <p>10A NCAC 13F .0906 Other Resident Care And Services</p> <p>(d) Telephone.</p> <p>(1) A telephone shall be available in a location</p>  | D 324         |   |                    |

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| D 324              | <p>Continued From page 95</p> <p>providing privacy for residents to make and receive calls.</p> <p>(2) A pay station telephone is not acceptable for local calls; and</p> <p>(3) It is not the home's obligation to pay for a resident's toll calls</p> <p>This Rule is not met as evidenced by:<br/>Based on interviews the facility to ensure resident care and services were provided regarding access to a telephone made available for residents to privately make and receive calls.</p> <p>The findings are:</p> <p>Initial tour on 5/11/15 between 9:30 am and 11:30 am revealed:</p> <ul style="list-style-type: none"> <li>-Residents that resided on the 300 hall complained the resident telephone was not available for their use after 8 pm.</li> <li>-Residents said the second shift staff had taken the telephone and they locked it in a office to prevent some of the residents from calling 911.</li> <li>-Some of the residents get mad at staff and call the police.</li> <li>-Residents did not feel this was fair to all residents because of a few who misused the telephone.</li> </ul> <p>Interview on 5/12/15 at 8:35 am with first shift Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> <li>-She was aware staff on second shift took the phone in the resident's telephone room and locked it in an office.</li> <li>-She said some residents call 911 or the police for no reason at all.</li> <li>-Sometimes the police come out to the facility and we "don't really need them."</li> </ul> | D 324         |   |                    |

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| D 324              | <p>Continued From page 96</p> <p>Interview on 5/12/15 at 9:50 am with first shift Medication Aide (MA) revealed:<br/>--She heard second shift removed the resident telephone around 8:00 pm so the residents could not call 911.<br/>-She was not aware if the Resident Care Director (RCD) or the Administrator was aware of the residents not having a telephone to use after 8:00 pm.<br/>-The residents called the police and 911 on first shift, but the 911 operators usually called the facility back to see if they need to send someone.</p> <p>Interview on 5/12/15 at 10:15 am with the RCD revealed:<br/>-She was aware the staff on second shift were removing the telephone so the residents could not use it.<br/>-She received a call from one of the detectives at the police department reporting the residents had made unnecessary calls to 911 and the police department.<br/>-All residents know they could use the phone after 8:00 pm but had to ask staff to get the telephone out of the office.<br/>-She said in February 2015 they held a Resident Council meeting and discussed the phone with about 22 or 25 residents which were present for meeting.<br/>-She was unsure if all the residents were made aware of the telephone not available after 8:00 pm unless you ask staff for it.<br/>-A signed in roster or meeting notes for the Resident Council meeting conducted in February 2015 was not made available for review.<br/>-There were no signs posted in facility in regard to the telephone and the need to ask staff for the use of the telephone after 8:00 pm at night.</p> <p>Interview on 5/12/15 at 10:35 am with the</p> | D 324         |   |                    |

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| D 324              | Continued From page 97<br><br>Administrator revealed:<br>-He was unaware staff were removing the resident's telephone at night.<br>-He was aware the police called the facility to complain about the number of calls the residents made to 911.<br>-He was aware of the resident's right to be provided with a telephone to use in the facility.   | D 324         |   |                    |
| D 328              | <p>10A NCAC 13F .0906(f)(4) Other Resident Care and Services</p> <p>10A NCAC 13F .0906 Other Resident Care and Services<br/>(f) Visiting:<br/>(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.</p> <p>This Rule is not met as evidenced by:<br/>TYPE B VIOLATION</p> <p>Based on record review and interviews the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when a resident whereabouts were unknown (Resident #1).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 03/25/15 revealed:<br/>-Diagnoses included chronic schizophrenia disorder, type manic.<br/>-The resident was ambulatory.</p> | D 328         |   |                    |

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| D 328              | <p>Continued From page 98</p> <p>Review of Resident #1's Resident Register revealed the resident was admitted to the facility in 2013.</p> <p>Review of the care plan dated 04/04/14 revealed:<br/>-Documentation under social/mental health history: the resident was currently receiving medications for mental illness/behavior, had a history of mental illness,<br/>-The resident had positive social skills and continued to hear voices.<br/>-Needing extensive assistance with eating, and supervision with toileting, bathing, dressing, and grooming.</p> <p>Review of Resident #1's record revealed:<br/>-The resident had a court appointed Department of Social Services guardian since 2012.</p> <p>Review of a note in Resident #1's record signed by the Resident Care Director (RCD) and Resident #1 dated 01/07/14 revealed:<br/>-"If Resident #1 leave the facility she must sign out and give a return time. If Resident #1 do not return within 1 hour of the time she sign out and document that she will be returning. Staff is to notify police department and DSS on call number.<br/>-If the whereabouts of a resident are unknown and there is reason to be concerned about his/her safety, the person in charge in the home shall immediately notify the resident's responsible person, the law enforcement and the county department of social services. Rule 10A NCAC 13F .0906"</p> <p>Continued review of incident notes in Resident #1's record revealed staff documented:<br/>-On 11/30/14 at 10:00 pm - Resident appeared to be intoxicated, was very irritated.</p> | D 328         |   |                    |

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| D 328              | <p>Continued From page 99</p> <ul style="list-style-type: none"> <li>-On 12/17/14 at 1:30 am - Resident returned (no documentation when left).</li> <li>-On 03/12/15, at 2:00 pm - Resident still not back at facility (no documentation when left).</li> <li>-On 03/13/15 at 4:30 pm - Resident still has not returned back to the facility, missing person report done (according to the police report the resident left on 3/11/15).</li> <li>-On 04/11/15, 9:30 pm - Resident signed out at 12:45 pm and has not returned.</li> <li>-On 04/23/15, 3pm to 1 pm shift - Resident signed out at 3:00 pm and did not return at 6:00 pm as stated.</li> <li>-On 05/11/15, 11pm to 7am shift- Resident signed out at 3:00 pm on 05/10/15 and did not return by 11:00 pm as stated.</li> </ul> <p>Review of the facility's census reports from March 2015 through May 2015 revealed:</p> <ul style="list-style-type: none"> <li>-On the following dates by Resident #1's name, staff documented "TL" (therapeutic leave) in date column indicating the resident was not in the building:</li> <li>-March 1, 2, 6, 9, 10, 11, 12, 13, 26, and 27th, 2015;</li> <li>-April 8, 15, 18, and 23rd, 2015;</li> <li>-May 1, 2, 5, 6, 7, 10, 11, 12, 13, and 14th, 2015.</li> </ul> <p>Review of the facility's sign-out/sign-in sheets from March through May 2015 revealed:</p> <ul style="list-style-type: none"> <li>-Times documented on the sign-out/sign-in register did not include am or pm, therefore it could not be determined the time of day the resident was signing-out/signing-in.</li> <li>-March 3, 4, 10, 17, 25, 2015 Signed-out, did not sign-in;</li> <li>-April 4, 20, 26, 30, 2015 Signed-out, did not sign-in;</li> <li>-May 1, 2, 5, 6, 8, 10, 11, 2015 Signed-out, did not sign-in;</li> </ul> | D 328         |   |                    |

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| D 328              | <p>Continued From page 100</p> <ul style="list-style-type: none"> <li>-On 03/06/15 at 5:30 signed-out - signed-in at 1:00;</li> <li>-On 03/09/15 at 10:50 signed-out - signed-in at 1:20;</li> <li>-On 03/14/15 no sign-out time - signed in at 11:30;</li> <li>-On 04/01/15 signed-out at 10:40 - signed-in at 7:00;</li> <li>-On 04/05/15 signed-in at 7:00;</li> <li>-On 04/14/15 signed-out at 1:45 - signed-in at 4:55, signed-out at 8:00 - signed-in at 9:55, signed-out at 10:50 - signed-in at 6:05.</li> <li>-On 05/08/15 signed-out at 7:20 - signed-in at 8:00, signed-out at 8:36 - sign-in at 1:00.</li> <li>-On 05/11/15 signed-in at 7:00</li> </ul> <p>Review of a police report dated 05/12/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1's guardian called and filed a missing persons report.</li> <li>-According to staff at the facility the resident had been missing since 05/10/15.</li> <li>-The RCD told the officer this was an ongoing issued with Resident #1.</li> <li>-The RCD told police officer that Resident #1 had stated to her that she needed to get away from the facility for a while to be around normal people like herself.</li> </ul> <p>Interview on 05/12/15 at 3:50 pm with Resident #1's guardian revealed:</p> <ul style="list-style-type: none"> <li>-She did not want Resident #1 out of the building at all, but she was afraid the resident would go out anyway, so she agreed to a 9:00 pm curfew.</li> <li>-Per the agreement, if the resident was gone 1 hour past curfew, the facility staff were to call the police and report the resident missing.</li> <li>-The facility was to also call her and inform her if the resident was out past curfew.</li> <li>-As of this date (05/12/15) she had not received</li> </ul> | D 328         |   |                    |

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| D 328              | <p>Continued From page 101</p> <p>any phone calls from facility staff regarding Resident #1 not in the building by curfew.</p> <p>-The guardian said at 5:45 pm last night (05/11/15) someone from the facility left a message on her voice mail at work, not the call center hotline as per the agreement.</p> <p>-The message was that Resident #1 had been missing since 3:00 pm Sunday evening (05/10/15).</p> <p>-As per the previous agreement the facility staff were to call the police and report the resident missing.</p> <p>-When she talked with the RCD this morning she found out that they did not call the police and according to staff the resident had been missing or not seen by any staff since 3:00 pm Sunday.</p> <p>Interview on 05/12/15 at 5:21 pm and 05/14/15 at 2:45 pm with Resident Care Director (RCD) revealed:</p> <p>-Resident #1's guardian had requested the resident to be back in the facility by 9:00 pm.</p> <p>-If the resident was not in the facility by 9:00 pm staff was to call the resident's guardian.</p> <p>-The guardian requested facility staff call the police, but they did not want to call the police so they called the guardian when the resident was not back in the facility by curfew time 9:00 pm.</p> <p>-DSS had not been notified and the police was not notified within 24 hours of the resident identified as missing by facility staff.</p> <p>Confidential interviews with three staff members revealed:</p> <p>-It was a continual pattern for Resident #1 to be gone 3 nights a week, return two nights to get what the resident called "rest," and to leave again repeating the same pattern.</p> <p>-If Resident #1 whereabouts was unknown for 24 hours they were to call the guardian.</p> | D 328         |   |                    |

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| D 328              | <p>Continued From page 102</p> <p>Review of the facility's "house rules" revealed:<br/>-The facility had a curfew in place.<br/>-For safety reasons residents' were required to be in the facility by 9:00 pm when the doors are locked.</p> <p>Review of the facility's "Missing residents" policy revealed:<br/>-A resident will be considered missing when he/she is not in the facility and we cannot verify their whereabouts; and in addition, there is reason to be concerned for the resident's safety.<br/>-If the facility discovers a resident is missing we will:<br/>-Notify the supervisor and all other staff immediately.<br/>-Perform a hasty search of the building and the immediate areas outside the building.<br/>-If the resident is not found, we will immediately notify:<br/>-Local law enforcement - Call 911.<br/>-The residents family member/responsible person.<br/>-The County Department of Social Services.</p> <p>_____</p> <p>On 5/15/15 the facility provided the following plan of protection:<br/>-The Administrator and RCD will get the nurse practitioner and LHPS nurse involved in resident records review to determine the facility's ability to provide care and services to Resident #1.<br/>-The RCD will monitor care plans monthly to determine facility's ability to provide care and services, which include behavior and health issues.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 2, 2015.</p> | D 328         |   |                    |

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| D 338              | <p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights<br/>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by:<br/>TYPE A1 VIOLATION</p> <p>Based on record review, observations and interviews, the facility failed to ensure residents were free from neglect by failing to recognize its role in caring for individuals with communicable infections and those with diminished mental capacity; addressing the special care needs and interventions for the monitoring and reporting of communicable infections; and by failing to make available and implement preventative measures to protect other residents from transmission of a communicable disease and failed to ensure residents were free of abuse as evidenced by abuse of 1 resident (Resident #2) by Staff K.</p> <p>The findings are:</p> <p>A. Interviews with 9 residents at various times and dates during the survey revealed:<br/>-7 of the 9 residents frequently have sexual encounters at the facility or at an area with mattresses in the woods, located behind the facility.<br/>-2 of the 9 residents acknowledged they are aware they have a communicable infection.<br/>-7 of 7 residents who engage in sexual encounters do not use protection to prevent the transmission of sexually transmitted disease (STDs) or communicable infection</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 104</p> <ul style="list-style-type: none"> <li>-None of the residents have ever known condoms to be available at the facility for residents.</li> <li>-Facility staff, aides and management, are aware of the residents having sexual encounters because residents have told staff. In addition, one resident had complained to staff and management that he has to sleep on couches or other furniture in the facility because his roommate is having sex in his room.</li> </ul> <p>Interview on 05/14/15 at 2:45 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>-She was aware there were residents who had diagnoses that included a communicable infection.</li> <li>-She was aware there were residents with diagnoses of a communicable infection who had frequent sexual encounters with other residents at the facility.</li> <li>-She was aware residents had unprotected sex.</li> <li>-The facility did not get involved, did not offer or have condoms available for protection of the residents for fear of violating residents' rights.</li> <li>-All the residents identified by surveyors as having sexual encounters had mental disabilities, as far as not making good decisions, but two years ago the local ombudsman informed staff that residents had the right to have sexual encounters.</li> <li>-She had not talked to any of the residents with diagnoses of a communicable infection or sexually transmitted diseases about the importance of using protection and that they should inform any of their partners that they have a communicable infection.</li> <li>-The facility had never contacted the county health department or the residents' health care providers for guidance or assistance with interventions to help minimize the health risk of these residents.</li> </ul> | D 338         |   |                    |

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| D 338              | <p>Continued From page 105</p> <p>-She was unaware of any role the facility would have with reporting or notifying the health department of residents with STD's such as communicable infection, being sexually active and not telling other residents who were partners and not using condoms.</p> <p>-3 of the 9 residents involved in sexual encounters were deemed incompetent and had legal guardians. She thought the guardians of the 3 residents were aware the residents were having sex but she had not contacted the guardians and was not aware of any other staff who had contacted the guardian related to this issue.</p> <p>Observation, record review and interviews related to of the 2 residents with a diagnoses of a communicable infection revealed the following:</p> <p>1. Review of Resident # 20's current FL2 dated 01/28/15 revealed:<br/>-Included diagnoses of schizoaffective disorder, and communicable infection and hepatitis.</p> <p>Review of Resident # 20's care plan dated 01/24/15 revealed:<br/>-Documentation for the social/mental health history, the resident was currently receiving medication for mental illness/behavior, and mental health services (no required contact person listed).</p> <p>Review of Resident # 20's record revealed the resident was his own responsible person and did not have a legal guardian.</p> <p>Continued review of Resident # 20's record revealed no documentation of sexual behaviors.</p> <p>Interview on 05/14/15 at 9:00am with Resident # 20 revealed:</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 106</p> <ul style="list-style-type: none"> <li>-The resident knew of his diagnosis of a communicable infection.</li> <li>-When having sexual encounters, he did not tell his partner that he had a communicable infection.</li> <li>-Resident showed the surveyor one condom that was in his wallet, but stated he had no more to use.</li> <li>-He was unable to recall the last time he used a condom.</li> <li>-He had sex daily with female residents in the facility.</li> <li>-He identified 4 female residents he has had sex with.</li> <li>-He sometimes had sex in his room, and asked his roommate to leave.</li> <li>-Most sexual encounters were at an area in the woods that had a mattress.</li> <li>-Facility staff was aware that he had sexual encounters because his roommate left the room.</li> <li>-No one at the facility had discussed with him that he should use protection (condoms) when having sex or that he should tell his partner he had a communicable infection.</li> </ul> <p>Interview on 05/15/15 at 1:00 pm with Resident # 20's roommate revealed:</p> <ul style="list-style-type: none"> <li>-He had lived at the facility for five months.</li> <li>-He was tired of being asked to leave his room or sleeping in the hallway or common television room because his roommate (Resident # 20) was with a female resident.</li> <li>-Resident # 20, had a female resident in the room almost every night and sometimes even overnight.</li> <li>-He knew Resident # 20 to have sexual relations with at least 4 female residents since he had been Resident # 20's roommate.</li> <li>-He had heard about the area in the woods with the mattress where some residents had sex, but he had never been to the area.</li> </ul> | D 338         |   |                    |

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| D 338              | <p>Continued From page 107</p> <p>-He had discussed with the Resident Care Director several times about his roommate's sexual encounters and how he was not able to sleep in his room, but nothing had been done.</p> <p>Interviews with 3 female residents identified by Resident # 20, as having had sex with Resident # 20, revealed:</p> <p>-No protection has been used when having sex. One resident did not understand what was meant by protection.</p> <p>-All of the residents have had sex with Resident # 20 many times and one resident currently has sex with Resident # 20 daily.</p> <p>-Three female residents were not aware of Resident # 20's diagnosis of communicable infection. One female resident stated "as far as she knows [Resident # 20's name] does not have communicable infection that I know of." Another resident stated she would want to know if a partner had a communicable infection and Resident # 20 has never mentioned to her that he had a communicable infection.</p> <p>-One resident had a legal guardian and one resident was identified as delusional by staff.</p> <p>Telephone interview on 05/14/15 at 11:15 am with the legal guardian of one of the female residents revealed:</p> <p>-The resident was legally deemed incompetent and had a court appointed guardian.</p> <p>-The guardian was aware the resident was engaging in sexual activity in the facility.</p> <p>-The RCD had informed the legal guardian that condoms were available to residents and were located in the medication room.</p> <p>-The RCD had informed the guardian that the facility provided condoms when residents asked for them.</p> | D 338         |   |                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE LIVING CENTER OF WINSTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2900 REYNOLDS PARK ROAD</b><br><b>WINSTON SALEM, NC 27107</b> |
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| D 338              | <p>Continued From page 108</p> <p>Telephone interview on 05/14/15 at 12:15 pm with the Nurse Practitioner (NP) revealed:<br/>-She had not seen Resident # 20 since April 1, 2015.<br/>-She was aware Resident # 20 had a communicable infection.<br/>-No one at the facility had made her aware the resident was sexually active without using protection.<br/>-She had not discussed sexual behaviors with Resident # 20.</p> <p>Continued telephone interview on 05/14/15 at 12:15 pm with the Nurse Practitioner (NP) revealed:<br/>-She was aware residents in the facility were engaging in sexual activity.<br/>-She had attempted to discuss sexual activity with some residents and advise to use condoms but some of the residents are difficult to talk to due to their diagnoses.</p> <p>Interview on 5/15/15 at 8:30 am with the RCD revealed:<br/>-She said the facility never provided condoms to residents.<br/>-She said she never told resident's guardians the facility had condoms in the medication room for the residents.</p> <p>2. Review of Resident #19's current FL2 dated 12/04/14 revealed diagnoses included mild/moderate mental retardation and communicable infection.</p> <p>Interview on 05/12/15 with Resident #19 revealed:<br/>-He came back to live at the facility in 2014.<br/>-He had a guardian.<br/>-Currently he had sex with his girlfriend, who was</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 109</p> <p>also a resident.</p> <ul style="list-style-type: none"> <li>-They had interactions almost daily and did not use condoms.</li> <li>-His girlfriend was aware that he had a communicable infection.</li> <li>-He had been with other residents at the facility, but currently his girlfriend was the only resident that he was sexually involved with.</li> <li>-He did not use condoms; he said he had condoms, but none were produced.</li> <li>-He could not recall if he told sexual partners he had a communicable infection.</li> </ul> <p>Interview on 05/14/15 with Resident #19's guardian:</p> <ul style="list-style-type: none"> <li>-He became Resident #19's guardian less than one month ago.</li> <li>-He had a talk with Resident #19 about using protection due to having a communicable infection.</li> <li>-No one at the facility had informed him Resident #19 was sexually active and not using protection.</li> </ul> <p>Interview on 05/14/15 at 1:43 pm with another NP visiting the facility revealed:</p> <ul style="list-style-type: none"> <li>-She had seen Resident #19 two weeks ago.</li> <li>-She was unaware the resident had a communicable infection or that he was engaged in unprotected sex.</li> <li>-She will order tests for the communicable infection for Resident #19, and other residents identified.</li> </ul> <p>Interview on 05/12/15 at 1:27 pm with the Resident #19 identified as his girlfriend revealed:</p> <ul style="list-style-type: none"> <li>-Resident #19 was her boyfriend.</li> <li>-They had unprotected sex almost daily.</li> <li>-She was aware Resident #19's diagnoses.</li> <li>-She did not respond to why she did not use protection, but stated now she was very scared</li> </ul> | D 338         |   |                    |

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| D 338              | <p>Continued From page 110</p> <p>that she may have the communicable infection.<br/>-I think I am pregnant because I feel something kicking inside of me but my parents have told me I had my tubes tied." "I do not use protection when having sex."</p> <p>Interview with the Activity Director and the RCD revealed:<br/>-The resident's girlfriend was not able to make good decisions due to her cognitive deficits.<br/>-Resident #19's girlfriend needed a guardian.<br/>-They were aware of the residents having unprotected sex and the residents' diagnoses.</p> <p>Interviews with 2 other female residents, identified as having had sex with Resident #19, at various times during the survey, revealed:<br/>-Both residents had sex with Resident #19 and no protection was used.<br/>-One resident was anticipating being pregnant. She was unaware if Resident #19 had a sexually transmitted disease.<br/>-The second resident said she had sex with Resident #19, but she used a condom. The resident was frequently tested for a CI by one of the local health agencies.<br/>-Both residents have court appointed legal guardians and deemed to be incompetent.</p> <p>Telephone interview on 05/14/15 at 11:15 am with the legal guardian of one of the female residents who was had had sex with Resident #19 revealed:<br/>-The female resident was legally deemed incompetent and had a court appointed guardian.<br/>-The guardian was aware the female resident was engaging in sexual activity in the facility.<br/>-The Resident Care Director (RCD) had informed the legal guardian that condoms were available to residents and were located in the medication</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 111</p> <p>room.</p> <p>-The RCD had informed the guardian that the facility provided condoms when residents asked for them.</p> <p>Additional interviews by facility staff regarding the availability of condoms and knowledge of residents having sexual relationships included the following:</p> <p>Interview on 5/14/15 at 12:00 pm with the Supervisor revealed:</p> <p>-She was employed at the facility for 1 year.</p> <p>-She was not aware of condoms being stored in the medication room.</p> <p>-She had never seen or distributed condoms to any residents since she had been employed at the facility.</p> <p>-The residents had never asked for condoms, but if they had she would have obtained condoms at the local health department.</p> <p>Interview on 05/14/15 at 9:54 am with Medication Aide on the second shift revealed:</p> <p>-She was aware of the sexual encounters of residents and the area in the woods that residents went to.</p> <p>-She had not seen the mattress, but residents had told her that was where they were going.</p> <p>-The facility did not have condoms to offer residents.</p> <p>-Staff did not get involved or discuss residents' sexual encounters because it was against residents rights.</p> <p>Interview on 5/15/15 at 8:30 am with the RCD revealed:</p> <p>-She said the facility never provided condoms to residents.</p> <p>-She said she never told resident's guardians the</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 112</p> <p>facility had condoms in the medication room for the residents.</p> <p>Policies and procedures provided by the facility included the following:</p> <p>Review of the facility's current Residents Rights policy revealed:<br/>"Residents are discouraged from visiting each other in rooms without good cause to assist in the overall therapeutic environment. (Example - semi-private rooms may need agreement from roommate - some facility areas are designated female only wing or male only areas) See a staff member if you wish to visit or have a need. You are always welcome to visit in common areas such as the lobby or library - or you may use any benches outdoors on the grounds."</p> <p>Review of the facility's current sexual activity of residents' policy revealed:<br/>-The ownership and management of this facility does not permit or support indiscreet sexual activity by residents of the facility.<br/>-The management is not authorized to act as law officials or act in any way that violates the individual rights of our residents and their right to privacy.<br/>-We try to make sure if anyone is having consensual sex they are capable of making this decision.<br/>-If an incident occurs without consent, we send the resident out for evaluation, contact our doctor to immediately begin prevention of another occurrence, along with contacting responsible parties to make them aware of situation.</p> <p>Information from the NC Division of Public Health and local county health department included:</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 113</p> <p>Telephone interview on 05/14/15 at 11:40 am with the Communicable Disease Nurse at the local County Health Department revealed:<br/>-Anyone testing positive with a communicable infection, and not using condoms, should be reported to the State Disease Intervention team.<br/>-A person from their agency would be sent to the facility to educate residents to protect themselves and the importance of using condoms.<br/>-Anyone who had a communicable infection should inform their sexual partner and wear condoms.</p> <p>Interviews on 05/15/15 with staff at the NC Division of Public Health and the local county health department revealed the county health department would be making an onsite visit to the facility.</p> <p>B. Review of Resident #2's current FL2 dated 11/14/14 revealed:<br/>-Resident #2 was admitted to the facility 11/23/14.<br/>-Diagnoses included paraplegic, decubiti, colostomy, foley, osteomyelitis and methicillin-resistant staphylococcus aureus MRSA (a infection that is caused by a strain of staph bacteria that's becomes resistant to antibiotics).<br/>-Documented small decubiti on sacral area.<br/>-Documented ambulatory status as non ambulatory.</p> <p>Review on 5/11/15 of Resident #2's record revealed:<br/>-A order upon admission to the facility for Home Health (HH) services on 11/24/14.<br/>-Documentation of stage 4 wound (A full thickness of the skin and subcutaneous tissue is lost. Able to see muscle or bone) measurement 10 cm X 9 cm X 3 cm depth.</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 114</p> <p>Interview on 5/11/15 at 9:30 am with Resident #2 revealed:</p> <ul style="list-style-type: none"> <li>-He lived in the facility for 6 months.</li> <li>-He said a few weeks ago Staff K pulled him out of the wheelchair.</li> <li>-They had gotten into a verbal altercation in which the Staff K put her hands on both his shoulders and he grabbed her by the arms.</li> <li>-Staff K started going backward and pulled him out of wheelchair on to the floor.</li> <li>-He had "cussed Staff K and called her a bitch."</li> <li>-He said the Administrator came after the incident occurred.</li> <li>-Resident #2 said he was laying on the floor and the Administrator asked if he needed help getting up, which he declined but the Administrator to hold the wheelchair.</li> <li>-He refused ER treatment at that time.</li> <li>-He said Staff K continued to work and was working on 5/11/15.</li> <li>-He reported the incident to management and the facility ombudsman.</li> <li>-The county adult home specialist came and talked with him, but he did not feel like she listened to him.</li> <li>-He called her supervisor but as of 5/11/15 had not heard back from her.</li> <li>-He felt like the staff were all together in this and he had another confrontation with another staff person in the kitchen after the first incident.</li> </ul> <p>Telephone interview on 5/11/15 at 3:50 pm with Resident #2's contact person revealed:</p> <ul style="list-style-type: none"> <li>-She talked to Resident #2 once or twice a month.</li> <li>-She was aware of the incident which occurred a few weeks ago.</li> <li>-Resident #2 had spoken to her about being pulled out of his wheel chair.</li> <li>-Resident #2 told her he was trying to defend</li> </ul> | D 338         |   |                    |

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| D 338              | <p>Continued From page 115</p> <p>himself.</p> <p>-She said Resident #2's sister came to the facility the day after the incident occurred but she does not know what happened.</p> <p>-She was aware after the altercation Resident #2 had additional injury to his sacral wound.</p> <p>-She thought all the staff appeared to stick up for each other.</p> <p>Attempted telephone interview on 5/11/15 and 5/12/15 with Resident #2's sister was unsuccessful.</p> <p>Telephone interview on 5/12/15 at 9:00 am with the Home Health nurse revealed:</p> <p>-She currently performed wound care to Resident #2 three times weekly.</p> <p>-She staged the wound to the sacral area as a stage 4.</p> <p>-She assessed the wound on 3/10/15 and found the wound had enlarged with more pronounced tunneling.</p> <p>-Resident #2 had told her of the altercation with the staff.</p> <p>Review on 5/13/15 of Resident #2's HH notes revealed:</p> <p>-Documented on 3/10/15 Resident #2's sacral wound, "had a small slit-type area, the area had significant depth of greater than half the length of a sterile q-tip."</p> <p>-Documented Resident #2 said he knew what had happened and explained he was "pushed out of wheel chair by staff."</p> <p>-Documented Resident #2 further discussed with the HH nurse "He had gotten into a verbal altercation with staff, ending up with her grabbing him with two hands and lifting him out his wheel chair and onto the floor."</p> <p>-Documented Resident #2 was not sent to ER for</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 116</p> <p>evaluation after incident.</p> <p>-Documentation HH completed the dressing change to Resident #2; she and Resident #2 went to the Administrator's office and requested Resident #2 be sent to ER for evaluation per physician request.</p> <p>-Documentation the altercation was reported to the HH nurse supervisor, the facility administrator, and the facility physician office.</p> <p>Review of Resident #2's record revealed:</p> <p>-Documentation Resident #2 was taken to the ER for evaluation of sacral area 3/10/15.</p> <p>-Resident #2 had orders to follow up at wound clinic and infectious disease physician.</p> <p>-Resident #2 returned to the facility 3/10/15.</p> <p>Interview on 5/11/15 at 3:35 pm with Staff K revealed:</p> <p>-She had been employed at the facility for 1 year as a Personal Care Aide (PCA) and a Medication Aide (MA).</p> <p>-She said on 3/6/15 she was walking down the hall and talking to another staff member and Resident #2 had told her to "Shut the [expletive deleted] up, no one wanted to hear that."</p> <p>-She told Resident #2, "No one is talking to you."</p> <p>-She and the other staff person walked down the 300 hall toward the medication room.</p> <p>-Resident #2 continued to cuss at her.</p> <p>-Resident #2 told her "He was going to slap the [expletive deleted] out of her."</p> <p>-She said Resident put up his hand to slap her and she placed both of her hands on his shoulders to prevent him from hitting her.</p> <p>-She said he grabbed her shirt and she tried to walk away but neither person would let go of each other.</p> <p>-Resident #2 fell out of his wheelchair onto the floor.</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 117</p> <p>-She said he had ripped her shirt and her breasts were exposed.</p> <p>-Staff went and got the Administrator; he arrived after the altercation and Resident #2 was already on the floor.</p> <p>Interview on 5/12/15 at 8:10 am with a resident on the 300 hall revealed:</p> <p>-He had seen the altercation with Resident #2 and Staff K on 3/6/15.</p> <p>-He Staff K and Resident #2 were arguing and cussing.</p> <p>-He said, "Staff K grabbed Resident #2 by his shoulders and pulled him out of the wheelchair."</p> <p>-Resident #2 gotten himself up off the floor.</p> <p>-He asked Resident #2 if he reported the altercation to the administrator or the Resident Care Director (RCD) and Resident #2 said, yes.</p> <p>Interview on 5/12/15 at 9:40 am with another resident on the 300 hall revealed:</p> <p>-She had seen the altercation between Resident #2 and Staff K.</p> <p>-Both Staff K and Resident #2 were arguing and cussing.</p> <p>-Staff K grabbed Resident #2's wheelchair and his shoulders.</p> <p>-She said Staff K turned the wheelchair over and Resident #2 fell on the floor.</p> <p>-Staff K did not have a torn shirt nor were her breasts exposed.</p> <p>-The Administrator came after the altercation and ask Resdient #2 if he need to go to the ER.</p> <p>Review on 5/11/15 of the facility incident reports revealed:</p> <p>-Incident report completed on 3/6/15 at 10:30 am by the RCD and signed by the Administrator.</p> <p>-Documented Resident #2 had an altercation with Staff K.</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 118</p> <ul style="list-style-type: none"> <li>-Documented Resident #2 had grabbed Staff K by her shirt.</li> <li>-Documented Resident #2 had tugged at the Staff K and fell out of wheelchair.</li> <li>-Documented Resident #2 stated, "He was fine and EMS was not called."</li> </ul> <p>Review of Staff K interview documented during the investigation by the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-Staff K documented the altercation had occurred with Resident #2 on 3/6/15.</li> <li>-Staff K documented she placed both hands on Resident #2's shoulders to prevent him from hitting her.</li> <li>-Staff K documented Resident #2 grabbed her shirt and was holding on to it while she held both his shoulders.</li> <li>-Staff K documented she was pulling away and Resident #2 fell in the floor.</li> <li>-Staff K documented Resident #2 tore her shirt and exposed her breast.</li> </ul> <p>Further review on 5/13/15 of interview by residents during the investigation of the allegation between Resident #2 and Staff K revealed:</p> <ul style="list-style-type: none"> <li>-One resident documented, "They both had each other by the shirt, they were tussling and Resident #2 lost his balance and fell out of wheelchair."</li> <li>-Another resident documented, "Resident #2 rolled his wheelchair next to Staff K and tried to grab her, she stayed back from him. He may had leaned over to far."</li> </ul> <p>Review of the facility policy on Harassment and Hostile Environment revealed:</p> <ul style="list-style-type: none"> <li>-Will not tolerate a hostile environment of any kind.</li> <li>-Prohibited conduct not limited to the use of physical conduct.</li> </ul> | D 338         |   |                    |

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| D 338              | <p>Continued From page 119</p> <p>-Policy was signed and dated 8/7/14 by the Staff K.</p> <p>Review of the facility policy and procedure agreement revealed:</p> <p>-No abusive language to residents or staff is permitted.</p> <p>-Employees must know resident rights which are posted in the community.</p> <p>-Profanity-bad attitudes-bad behavior will not be tolerated-misconduct may be grounds for immediate dismissal.</p> <p>-Signed and dated 8/7/14 by the Staff K.</p> <p>Interview on 5/12/15 at 10:30 am with the facility RCD revealed:</p> <p>-She was aware of the altercation on 3/6/15 with Resident #2 and Staff K.</p> <p>-She was not working that day but found out from staff what had happened.</p> <p>-She had contacted Resident #2's parole officer about the incident.</p> <p>-She refer all other questions about the altercation to the Administrator.</p> <p>Interview on 5/12/15 at 10:35 am with facility Adminsitrator reveled:</p> <p>-He was working on 3/6/15 when the altercation took place.</p> <p>-Staff came to his office and said "they are fighting."</p> <p>-He arrived at the 300 hall and found Resident #2 on the floor.</p> <p>-He said Staff K and Resident #2 were still engage in arguing.</p> <p>-He ask Resident #2 if he needed to go the ER.</p> <p>-He offered to help Resident #2 off floor but Resident #2 got himself into his wheelchair.</p> <p>-Staff K was "heated" and he sent her home the rest of that day.</p> | D 338         |   |                    |

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| D 338              | <p>Continued From page 120</p> <ul style="list-style-type: none"> <li>-He conducted an investigation and obtained interviews from the staff as well as from residents who had seen the altercation.</li> <li>-Resident #2 did not report being pulled out of the wheelchair till 2 days after the altercation.</li> <li>-The HH nurse informed him of the allegation Resident #2 was pulled out of his wheel chair by staff 3/10/15.</li> <li>-He had not, as of 5/12/15, reported the allegation of abuse by the staff to the Health Care Personnel Registry (HCPR).</li> <li>-He did not see the incident as an allegation, and was unaware of the need to report staff to the HCPR for suspected allegation.</li> <li>-He filed a report to the HCPR on 5/12/15 with the named staff and the allegation that occurred on 3/6/15.</li> </ul> <hr/> <p>The facility provided the following plan of protection on 05/15/15:</p> <ul style="list-style-type: none"> <li>-The Administrator will meet with all staff to inform them of residents rights concerning dignity and respect of residents.</li> <li>-The Administrator will immediately meet with Residents #3 and #6 to discuss safe sex practices and informing partners of their infection prior to relations.</li> <li>-Care plans will be reviewed with residents, physicians, Licensed Health Professional Support Nurse, guardians, RCD, and Administrator with documentation concerning sexual activity/protection.</li> <li>-If Residents #3 and #6 are not compliant with disclosure of the disease they will be discharged.</li> <li>-The Administrator will contact the local public health department to do an inservice and provide education on safe sex practices to all residents identified as sexually active.</li> <li>-All incidents regarding violation of residents</li> </ul> | D 338         |   |                    |

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| D 338              | Continued From page 121<br><br>rights reported reported to the Administrator and Resident Care Director (RCD) will be investigated.<br>-The facility's policy for residents rights will be reviewed and enforced.<br><br>THE DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 18TH, 2015.   | D 338         |   |                    |
| D 358              | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observation, interview and record review, the facility failed to assure prescribed medications (Megace, Cipro, Diflucan, Combivir, Valtrex, Kaletra, Zolof, Naproxen, Omeprazole and Nystatin) were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 8 residents (#4, #10 and #17).<br><br>The findings are:<br><br>A. Review of Resident #17's current FL2 dated 12/04/14 revealed:<br>-Diagnoses included a communicable infection. | D 358         |   |                    |

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| D 358              | <p>Continued From page 122</p> <p>Review of Resident # 17's FL2 dated 12/02/14 included the following medication orders:</p> <ul style="list-style-type: none"> <li>- Omeprazole 20mg twice daily (used to treat acid reflux)</li> <li>- Combivir 150-300 twice daily (an antiviral medication)</li> <li>- Valtrex 1gm once daily (used to treat infections caused by certain types of viruses)</li> <li>- Kaletra 200/50 2-tablets twice daily (an antiviral medication)</li> <li>- Zoloft 25mg once daily (used to treat depression)</li> <li>- Naproxen 500mg twice daily (used to treat inflammation and pain)</li> </ul> <p>(According to the manufacturers' recommendations, not taking antiviral medications as prescribed may result in the virus developing resistance to the medications.)</p> <p>A request on 05/14/15 at 2:58 pm by the surveyor to review Resident #17's Medication Administration Records (MARs) for December 2014 and January 2015 revealed:</p> <ul style="list-style-type: none"> <li>-Per the first shift medication aide/supervisor (MA), Resident #17 was in another setting for several months and returned to the facility the first week in December 2014.</li> <li>-When the resident returned his Medicaid was not approved.</li> <li>-The facility did not administer the medications to the resident because without hard copies of scripts they were not allowed.</li> <li>-Resident #17 self-administered the medications that he brought with him when admitted on 12/04/14, so there was no need to set-up MARs for the resident.</li> <li>-There was an FL2 in the resident's record dated 12/04/14 with medication orders, however she did</li> </ul> | D 358         |   |                    |

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| D 358              | <p>Continued From page 123</p> <p>as she was told by management.</p> <p>Observation on 05/12/15 at 5:40 pm of Resident #17's medications on hand at the facility revealed: Omeprazole 20mg; Combivir 150-300; Valtrex 1gm; Kaletra 200/50mg; Zoloft 25mg; and Naproxen 500mg were available for administration.</p> <p>Interview on 05/14/15 at 3:44 pm with Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #17 was previously a resident at the facility, then went to another setting for a few months.</li> <li>-When the resident returned to the facility, he had medications in a bag that were given to him by personnel at the other setting.</li> <li>-Resident #17's Medicaid was not approved because it stopped when he was not a resident of this facility.</li> <li>-The Administrator told her and the rest of the staff they could not administer Resident #17's medications because they did not have hand written scripts for the medications.</li> <li>-The Administrator stated that Resident #17 would have to self-administer his own medications until they got scripts for the medications.</li> <li>-She did not obtain an order for the resident to self-administer his medications.</li> <li>-She was unsure of Resident #17's ability to self-administer his own medications, and did not assess the resident to find out his cognitive ability to self-administer.</li> <li>-She was unaware of the quantity of medications Resident #17 brought with him from the other facility.</li> <li>-She was aware Resident #17 was out of medications for a period of time, but was unaware how long.</li> </ul> | D 358         |   |                    |

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| D 358              | <p>Continued From page 124</p> <p>Interview on 05/15/15 at 4:08 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-When Resident #17 returned to the facility in December 2014 from another facility there was a problem with the resident's Medicaid being approved.</li> <li>-The resident had medications that he brought with him from the other setting.</li> <li>-The Administrator was unaware of the supply of medications the resident had.</li> <li>-The Administrator instructed the staff not to administer Resident #17's medications.</li> <li>-He said that Resident #17 would have to self-administer his own medications.</li> <li>-The Administrator stated he was aware there was an FL2 dated 12/04/14 in Resident #17's record.</li> <li>-He was also aware that FL2's were orders for medications.</li> <li>-He still insisted that he needed actual "scripts" in order for facility staff to administer Resident #17's medications.</li> <li>-He did confirm facility staff did not start administering Resident #17's medications until February 2015, and prior to that the resident was without medications.</li> <li>-He was unable to recall how long Resident #17 was without medications.</li> <li>-The Administrator responded "that will never happen again," "I should have never accepted [Resident #17's name] back into the facility."</li> </ul> <p>Interview on 05/14/15 at 5:21 pm with Resident #17 revealed:</p> <ul style="list-style-type: none"> <li>-He came back to live at the facility in December 2014.</li> <li>-He had medications that were given to him by personnel at the other setting.</li> <li>-The Administrator told him that he would have to</li> </ul> | D 358         |   |                    |

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| D 358              | <p>Continued From page 125</p> <p>self-administer his own medications.</p> <p>-Resident #17 said that he self-administered his own medications for three days.</p> <p>-After the three days he was without medications for almost two months.</p> <p>-He was aware that he took medications twice daily and he kept the medications in his room.</p> <p>-Resident #17 was aware that he was ordered medications for a CI but was unaware what those medications were called.</p> <p>Interview on 05/18/15 at 10:43 am with the pharmacy regarding Resident #17's medications revealed:</p> <p>-The facility did not send the pharmacy the FL2 dated 12/04/14.</p> <p>-The first orders received by the pharmacy to fill Resident #17's medications (Combivir, Valtrex, Kaletra, Zolof, Naproxen, and Omeprazole) were dated 02/19/15.</p> <p>-Prior to 02/19/15 they did not fill any medications for the resident.</p> <p>Review of the facility's medication administration policy revealed:</p> <p>-Only medications prescribed by a physician will be administered to residents of this facility.</p> <p>-No medication (prescription or non-prescription) will be stored in the resident's room unless prior written authorization has been obtained from resident's physician and resident is deemed capable of following guidelines established in Pharmaceutical Policy and Procedures Manual for self-administration.</p> <p>B. Review of Resident #10's current FL-2 dated 04/17/15 revealed diagnoses included Urinary Retention, Severe Protein Calorie Malnutrition, Cardiomyopathy and left leg below the knee</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 126</p> <p>amputee.</p> <p>1. Review of Resident #10's record revealed:<br/>-Resident #10 had a hospital admission from 04/05/15 to 04/13/15 with a chief complaint of non-productive cough for 3 days.<br/>-The admitting diagnosis was Pneumonia.<br/>-The hospital discharge summary included a diagnosis of Failure To Thrive.<br/>-A physician's order dated 04/13/15 for Megace 400 mg/10 mls and directions to take 10 mls twice a day at 8:00am and 8:00pm. (Megace is used to increase appetite.)</p> <p>Review of Resident #10's Medication Administration Record (MAR) for April 2015 revealed the order for Megace suspension was not transcribed on the MAR and no documentation regarding the administration of Megace.</p> <p>Review of Resident #10's MAR for May 2015 revealed Megace suspension was transcribed onto the MAR, scheduled at 8 am and 8 pm, and documentation that the Megace had been administered as scheduled.</p> <p>Observation of the medication on hand for Resident #10 on 05/14/15 revealed there was no Megace suspension on the cart available for administration.</p> <p>Interview with Medication Aide (MA) on 05/14/2014 at 9:15 am revealed:<br/>-The facility "ran out of the medication yesterday".<br/>-She documented incorrectly that morning, documenting the Megace as administered at 8:00 am.<br/>-She was unsure if the MA Supervisor had notified the pharmacy for a refill.</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 127</p> <p>Telephone interview on 05/14/15 at 9:30 am with the contract pharmacy representative revealed:</p> <ul style="list-style-type: none"> <li>-The facility was responsible to fax new orders to the pharmacy.</li> <li>-The facility was responsible to transcribe new orders which occur in the middle of the month onto the MAR.</li> <li>-The pharmacy received the new order from the facility for Megace on 04/13/2015.</li> <li>-The pharmacy has not been able to fill it yet due to the need for prior authorization.</li> <li>-The pharmacy had not sent the Megace to the facility for administration to the resident.</li> <li>-"We have not filled the order at all." was the response.</li> </ul> <p>Interview with MA Supervisor on 05/15/15 at 2:10 pm revealed:</p> <ul style="list-style-type: none"> <li>-The Megace bottle of Megace was finished on 05/14/15.</li> <li>-They do not use a back up pharmacy to fill medications.</li> <li>-She was not aware of the prior authorization needed for the Megace for Resident #10.</li> <li>-The MA on duty was responsible for adding any new orders on the MAR and faxing the order to pharmacy.</li> </ul> <p>Review of Resident #10's record revealed:</p> <ul style="list-style-type: none"> <li>-January 2015 weight was recorded by the facility as 124 pounds.</li> <li>-February 2015 weight was recorded by the facility as 127 pounds.</li> <li>-March 2015 weight was recorded by the facility as 123 pounds.</li> <li>-April 2015 weight was recorded by the local hospital as 114 pounds.</li> </ul> <p>Resident #10 refused to have a weight obtained</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 128 on 05/15/15.</p> <p>Interview with Resident #10 on 05/14/15 at 11:00 am revealed:<br/>- He knew nothing about his medications.<br/>-"I just take what they give me."</p> <p>2. Review of Resident #10's record revealed:<br/>-Resident #10 had a hospital admission from 04/15/15-04/17/15 with a chief complaint of urinary retention.<br/>-The hospital treatment regimen included intravenous antibiotics and a foley catheter was placed.<br/>-The hospital admission diagnosis was Urinary Tract Infection.<br/>-A physician's order from the local hospital dated 04/17/15 for Cipro (used to treat infection) 500 mg take one tablet by mouth every twelve hours to treat infection for 10 days.</p> <p>Review of Resident #10's Medication Administration Record (MAR) for April 2015 revealed Cipro was not transcribed on the MAR and no documentation for administration of Cipro to the resident was recorded on the MAR.</p> <p>Observation on 05/15/15 at 9:15 am revealed there was no Cipro available for administration.</p> <p>Telephone interview on 05/14/15 at 9:30 am with the contract pharmacy representative revealed:<br/>-The facility was responsible for faxing new orders to the pharmacy.<br/>-The facility was responsible to transcribe new orders that occur in the middle of the month onto the MAR.<br/>-The pharmacy received the new order from the facility for Cipro on 04/17/2015.<br/>-The pharmacy filled the order on 04/17/15 and</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 129</p> <p>that twenty Cipro capsules was delivered to the facility on 04/17/15.<br/>-The pharmacy had not received the Cipro back from the facility for any reason.</p> <p>Interview with Supervisor MA on 05/15/15 at 2:10 pm revealed:<br/>-Cipro was delivered to the facility on 04/17/15 and completed on 04/27/15 according to her memory.<br/>-The MA on duty was responsible for adding any new orders on the MAR when a resident returned from a outside facility.<br/>-"I do not know where the documentation is. I can not find it" for the medication administration of Cipro to Resident #10.</p> <p>Interview with Resident #10 on 05/14/15 at 11:00 am revealed:<br/>- He knew nothing about his medications.<br/>-"I just take what they give me."</p> <p>3. Review of Resident #10's record revealed:<br/>-Resident #10 had a hospital admission from 04/15/15-04/17/15 with a chief complaint of urinary retention.<br/>-The hospital treatment regimen included intravenous antibiotics and a foley catheter was placed.<br/>-The hospital admission diagnosis was Urinary Tract Infection.<br/>-A physician's order dated 04/17/15 for Diflucan (used to treat fungal infections) 100 mg take one tablet daily to treat infection.</p> <p>Review of Resident #10's Medication Administration Record (MAR) for April 2015 revealed Diflucan was not transcribed on the MAR and no documentation of administration of Diflucan.</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 130</p> <p>Observation on 05/15/15 at 9:15 am revealed there was no Diflucan on hand available for administration.</p> <p>Telephone interview on 05/14/15 at 9:30 am with the contract pharmacy representative revealed:<br/>-The facility was responsible for faxing new orders to the pharmacy.<br/>-The facility was responsible to transcribing new orders that occur in the middle of the month onto the MAR.<br/>-The pharmacy received the new order from the facility for Diflucan on 04/17/2015.<br/>-The pharmacy filled the order on 04/17/15 and that seven capsules of Diflucan was delivered to the facility on 04/17/15.<br/>-The pharmacy had not received the Diflucan back from the facility for any reason.</p> <p>Interview with Supervisor MA on 05/15/15 at 2:10 pm revealed:<br/>-The Diflucan was delivered to the facility on 04/17/15 and completed on 04/24/15, according to her memory.<br/>-The MA on duty was responsible for adding any new orders on the MAR when a resident returned from a outside facility.<br/>-"I do not know where the documentation is. I can not find it." for the medication administration of Diflucan to Resident #10.</p> <p>Interview with Resident #10 on 05/14/15 at 11:00 am revealed:<br/>- He knew nothing about his medications.<br/>-"I just take what they give me."</p> <p>Telephone interview with Resident #10's guardian on 05/15/15 at 10:45 am revealed:<br/>-She visits Resident #10 once every 2-3 months.</p> | D 358         |   |                    |

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| D 358              | <p>Continued From page 131</p> <p>-"I think he (Resident #10) has done well at the facility".</p> <p>-This is the only home that Resident #10 has known and that he has been living at.</p> <p>C. Review of Resident #4's current FL2 dated 10/30/14 revealed:<br/>-Diagnoses included lower extremity Cellulitis, pancytopenia,and chronic pain.</p> <p>Review of Resident #4's record revealed:<br/>-Resident #4 had a hospital admission from 4/21/15 to 4/24/15 for right lower extremity swelling, warmth, erythema, and low grade fever.<br/>-Deep vein thrombosis was ruled out and the resident was treated for cellulitis, first with intravenous antibiotics and then switched to oral antibiotics.<br/>-A physician's order from the local hospital dated 4/24/15 for nystatin powder apply twice a day to affected area.(Nystatin powder is used topically to treat fungal infections.)</p> <p>Review of Resident #4's MAR for April 2015 revealed Nystatin powder was not transcribed on the MAR and there was no documentation of administration of nystatin powder.</p> <p>Review of Resident #4's record revealed a subsequent physician's order dated 5/07/15 from the facility Nurse Practitioner for nystatin powder, apply twice a day to affected area.</p> <p>Review of Resident #4's MAR for May 2015 revealed Nystatin powder was not transcribed on the MAR and there was no documentation of administration of nystatin powder.</p> <p>Observation on 5/14/15 at 11:00 am of Resident</p> | D 358         |   |                    |

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| D 358 | <p>Continued From page 132</p> <p>#4, while staff were performing personal care, revealed no visible irritation or redness of the hip area, buttocks, perianal area, or upper legs.</p> <p>Telephone interview on 5/14/15 at 12:45 pm with the contract pharmacy representative revealed:<br/>-The facility was responsible to fax new orders to the pharmacy.<br/>-The facility was responsible to transcribe new orders to the resident's Medication Administration Record (MAR).<br/>-Medication orders received late in the month may not be added to the next month preprinted MAR if the order came in after the MAR had been printed and sent to the facility for review. (The pharmacy routinely sent the upcoming month's MAR to the facility about one week before the end of the month.)<br/>-The pharmacy received the order for nystatin powder from the facility on 4/24/15.<br/>-Nystatin powder (15 gram bottle) was dispensed on 4/24/15 and 5/07/15 for Resident #4.</p> <p>Observation of the medication on hand for administration for Resident #4 on 5/14/15 revealed a 15 gm bottle of nystatin powder dispensed 5/07/15 with the seal removed and approximately 12 grams remaining in the bottle.</p> <p>Interview on 5/14/15 at 12:30 pm with the day shift Medication Aide (MA) revealed<br/>-She administered residents' medications according to listing and directions on the residents' MARs.<br/>-Medications ordered for administration 2 times a day would routinely be scheduled in the morning and evening.<br/>-She was not aware Resident #4 was ordered nystatin powder because it was not listed on the MAR.</p> | D 358 |  |  |
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| D 358              | <p>Continued From page 133</p> <ul style="list-style-type: none"> <li>-Nystatin powder and other topical medications were stored in a separate tray away from oral medications, therefore she would not have seen the nystatin or known to look for it when she administered the resident's oral medications.</li> <li>-She had not administered nystatin powder to Resident #4 when she worked.</li> </ul> <p>Interview on 5/14/15 at 12:40 pm with the Supervisor revealed:</p> <ul style="list-style-type: none"> <li>-The MA on duty when medication orders were received (any order from doctor visits, hospital visits, labs, or telephone orders) was responsible to make a copy of the order for the resident's record, a copy for the front of the MAR book, fax a copy to the pharmacy, and send the original to the pharmacy with next delivery.</li> <li>-The MA was responsible to transcribe the order to the resident's MAR and place a copy a box for the Supervisor to review.</li> <li>-The Supervisor was responsible to review the MARs order entry for correctness.</li> <li>-She overlooked Resident #4's nystatin powder not being listed on the April 2015 and May 2015 MARs.</li> <li>-She thought some of the MAs must have been administering nystatin powder since the 15 gram bottle dispensed on 4/25/15 was no longer on the medication cart.</li> <li>-She was not aware of a system currently in place for routine audits of the residents' MARs compared to physician's orders.</li> </ul> <p>Interview on 5/14/15 at 3:10 pm with an evening shift MA revealed:</p> <ul style="list-style-type: none"> <li>-The MA stated she did not have any information regarding Resident #4's nystatin for April 2015.</li> <li>-She transcribed a medication (an oral antibiotic ordered 5/07/15) to Resident #4's MAR on 5/08/15 because she found the medication in the</li> </ul> | D 358         |   |                    |

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| D 358              | <p>Continued From page 134</p> <p>resident's slot on the medication cart during medication administration.</p> <p>-She did not add nystatin powder to Resident #4's May 2015 MAR.</p> <p>-Nystatin powder was not stored in the resident's oral medications section of the medication cart so she did not see the powder or know to look for it.</p> <p>-The MA stated she had not been administering nystatin powder to Resident #4 when she worked.</p> <p>Interview on 5/18/15 at 12:10 pm with the Resident Care Director revealed the nystatin powder ordered for Resident #4 was for the upper area between the legs due to the resident being incontinent.</p> <p>Interview on 5/18/15 at 1:50 pm with Resident #4 revealed:</p> <p>-Staff never put powder on her, not even baby powder.</p> <p>-Staff never applied nystatin powder since she had been at the facility.</p> <p>-She stated " I do itch down there."</p> <p>-She stated she had been itching for a couple of days now.</p> <p>-She stated she told a medication aide about the itching.</p> <hr/> <p>On 05/15/15 the Administrator provided the following Plan of Protection:</p> <p>-The Resident Care Director and shift supervisors will immediately review all resident medication orders, MARS and medications on the med-cart to ensure all match and are available.</p> <p>-Weekly the shift supervisors will monitor orders, MARs and medications on the med-cart.</p> <p><b>CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 18, 2015.</b></p> | D 358         |   |                    |

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| D 392              | <p>10A NCAC 13F .1008(a) Controlled Substances</p> <p>10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, interview and record review, the facility failed to assure an accurate reconciliation record for one controlled medication (Hydrocodone/Acetaminophen 10-325) prescribed for 1 of 5 sampled residents with orders for controlled medication (Resident #4).</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 dated 4/24/2015 and previous FL2 dated 10/14/14 revealed:</p> <ul style="list-style-type: none"> <li>- Diagnoses included chronic pain.</li> <li>- An order for Hydrocodone/Acetaminophen 10-325 (narcotic pain reliever for moderate to severe pain) one tablet 4 times a day.</li> </ul> <p>Telephone interview on 5/14/15 at 2:30 pm with a representative for the contract pharmacy revealed dispensing dates for Resident #4's Hydrocodone/Acetaminophen 10-325 as follows:</p> <ul style="list-style-type: none"> <li>- On 2/07/15 quantity of 120 dispensed with directions of one tablet 4 times a day.</li> <li>- On 3/05/15 quantity of 120 dispensed with directions of one tablet 4 times a day.</li> <li>- On 3/31/15 quantity of 120 dispensed with directions of one tablet 4 times a day.</li> <li>- On 4/28/15 quantity of 120 dispensed with</li> </ul> | D 392         |   |                    |

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| D 392              | <p>Continued From page 136</p> <p>directions of one tablet 4 times a day.</p> <p>Review of Resident #4's February 2015 and March 2015 Medication Administration Records (MAR) and Controlled Drug Log sheet revealed:</p> <ul style="list-style-type: none"> <li>- The 120 tablets of Hydrocodone/Acetaminophen 10-325 dispensed 2/07/15 was documented as administered from 2/08/15 to 3/19/15.</li> <li>- Resident #4 refused medication 36 times from 2/8/15 to 3/19/15.(Resident refused medications and physician was aware per telephone interview.)</li> <li>- No medication was unaccounted for.</li> </ul> <p>Review of Resident #4's March 2015, April 2015 and May 2015 MARs and Controlled Drug Log sheet revealed:</p> <ul style="list-style-type: none"> <li>- The 120 tablets of Hydrocodone/Acetaminophen 10-325 dispensed on 3/05/15 was documented as administered from 3/19/15 to 5/09/15.</li> <li>- Resident #4 refused medication 88 times from 3/19/15 to 5/09/15.( Resident refused medications and physician was aware per telephone interview.)</li> <li>- No medication was unaccounted for.</li> </ul> <p>Observation of medication on hand for administration for Resident #4 on 5/13/15 revealed:</p> <ul style="list-style-type: none"> <li>- The Hydrocodone/Acetaminophen 10-325 dispensed on 4/28/15 was currently in use since 5/09/15. (A bingo card of 60 tablets with 54 remaining was in the MA/Supervisor's office for administration.)</li> <li>- A bingo card of 60 Hydrocodone/Acetaminophen 10-325 dispensed on 4/28/15 was located in the Administrator's office.</li> <li>- The Hydrocodone/Acetaminophen 10-325</li> </ul> | D 392         |   |                    |

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| D 392              | <p>Continued From page 137</p> <p>dispensed on 3/31/15 was not in Resident #4's medication overstock (MA/Supervisor's office or Administrator's office) and could not be accounted for by the facility.</p> <ul style="list-style-type: none"> <li>- The facility had no documentation for the disposition, administration or return of the medication.</li> </ul> <p>Interview on 5/11/15 at 3:20 pm with day shift MA/S revealed the current system, since around December 2014, for ordering and storing controlled medication was as follows:</p> <ul style="list-style-type: none"> <li>- Narcotic pain medication (like medications containing oxycodone, hydrocodone, Fentanyl) were sent in 7 day supplies to help monitor the medications.</li> <li>- Medications, including narcotics, were delivered from the pharmacy provider daily Monday through Saturday around 12:00 midnight to 1:30 am.</li> <li>- The night shift MA/S were responsible to receive medications directly from the drug delivery driver.</li> <li>- Only the pharmacy and the facility had a key to the lock on the medication totes.</li> <li>- All medications, including controlled drugs, were checked against the packing list and signed as received from the driver.</li> <li>- The medications were received in totes that were locked by the pharmacy provider and the driver did not have a key.</li> <li>- Once medications were received, the narcotic controlled drugs were stored locked in the supervisor's office, inside a locked tote, that was placed in a desk drawer secured with a hasp lock.</li> <li>- Controlled Drug Inventory sheets were sent by the provider for each card of controlled medication and the sheets were stored in a note book separate from the medication while waiting to be administered.</li> <li>- The Supervisor kept a copy of the packing list and provided the Administrator with a copy.</li> </ul> | D 392         |   |                    |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORNERSTONE LIVING CENTER OF WINSTON</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2900 REYNOLDS PARK ROAD</b><br><b>WINSTON SALEM, NC 27107</b> |
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| D 392              | <p>Continued From page 138</p> <ul style="list-style-type: none"> <li>- The non-narcotic controlled drugs were placed on the medication cart.</li> <li>- Excess narcotic medications are taken to the Resident Care Director/Administrator's office by the Supervisor and slid under the door (routinely around 3:00 to 4:00 am.)</li> <li>- The Resident Care Director (RCD) and Administrator were responsible for the medication once it was slid under the door.</li> <li>- No narcotic pain medication was stored on the medication cart (Narcotic pain medications were stored in the MA/s office and administered by the MA/S.)</li> <li>- The MA/S had been instructed that only the Supervisors were to administer the hydrocodone because hydrocodone is a Schedule II medication and Schedule II medications were handled by the the Supervisors only.</li> <li>- MA/S staff did not prepare Resident #4's Hydrocodone/Acetaminophen 10-325 until the resident agreed she was going to take the medication due to her repeated refusal of the medication. (This prevented unnecessary wasting of the prepared medication.)</li> </ul> <p>Interview with the RCD on 5/11/15 at 4:05 pm revealed the medication storage system in place since December 21, 2014 was as follows:</p> <ul style="list-style-type: none"> <li>- The night shift MA/S signed in all medications delivered from the pharmacy delivery driver.</li> <li>- The night shift MA/S did not put narcotic pain medication on the medication carts (oxycodone and hydrocodone medications) but secured one active card of medication in the locked tote, in the locked desk drawer, located in the Supervisor's office.</li> <li>- The night shift MA/S had the only set of keys available to staff.</li> <li>- The night shift MA/S was responsible to lock the Supervisor's door when not in the office.</li> </ul> | D 392         |   |                    |

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| D 392              | <p>Continued From page 139</p> <ul style="list-style-type: none"> <li>- The night shift MA/S was responsible to bring overstock controlled medications, including all narcotic pain medications except for the active supply, to the RCD/Administrator's office door and slide the medications far under the door.</li> <li>- The RCD or Administrator, whichever arrives first in the morning, was responsible to secure the medication until the Administrator moved the medication to a locked tote in a locked storage closet in the Administrator's office.</li> <li>- The RCD/Administrator's offices were under camera monitoring in addition to number coded key pad lock on the door.</li> </ul> <p>Telephone interview on 5/14/15 at 2:32 pm with the contract pharmacy representative revealed:</p> <ul style="list-style-type: none"> <li>- The pharmacy did not have a record of the return of 120 Hydrocodone/Acetaminophen 10-325 dispensed on 3/31/15 for Resident #4.</li> <li>- The facility should keep a copy of the form used to return controlled medications until a credit or receipt for disposition was received from the pharmacy.</li> <li>- The facility had contacted the pharmacy on 5/14/15 stating they had returned Resident #4's Hydrocodone/Acetaminophen 10-325 dispensed on 3/31/15 but could not give a definite day or what driver signed for the medication.</li> <li>- The facility did not routinely send overstock controlled medication back to the pharmacy.</li> </ul> <p>Intevew on 5/14/15 at 4:00 pm with the Adminstrator revealed:</p> <ul style="list-style-type: none"> <li>- He kept residents' overstock of Schedule II controlled medications, including Hydrocodone/Acetaminophen 10-325 for Resident #4 in a locked tote inside a locked closet inside his office.</li> <li>- He had a bingo card of 60 tablets, along with the inventory log sheet for Resident #4 which was</li> </ul> | D 392         |   |                    |

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| D 392              | <p>Continued From page 140</p> <p>filled on 4/28/15.</p> <ul style="list-style-type: none"> <li>- He was unable to locate the 120 tablets of Hydrocodone/Acetaminophen 10-325 dispensed on 3/31/15 or the inventory log sheet.</li> <li>- The medication could have been returned to the pharmacy since the resident did not take the medication as scheduled and she would have had an overstock.</li> </ul> <p>Interview on 5/14/15 at 4:30 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>- The RCD stated she and the day shift Medication Aide/Supervisor had filled out a return sheet for Resident #4's 120 tablets of Hydrocodone/Acetaminophen 10-325 dispensed on 3/31/15 and packaged the medication for return to the pharmacy but she did not remember the exact date.</li> <li>- She did record the date and must have sent all copies back with the medication.</li> <li>- The facility had no documentation for the disposition, administration or return of the 120 tablets of Hydrocodone dispensed on 3/31/15.</li> </ul> | D 392         |   |                    |
| D 393              | <p>10A NCAC 13F .1008 (b) Controlled Substance</p> <p>10A NCAC 13F .1008 Controlled Substance</p> <p>(b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, record reviews and interviews, the facility failed to properly store</p>  | D 393         |   |                    |

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| D 393              | <p>Continued From page 141</p> <p>excess supply of Schedule II medications under double lock and proper supervision upon receipt of the controlled medications.</p> <p>The findings are:</p> <p>Observation on 5/11/15 and 5/12/15 of the facility's medication administration carts revealed:</p> <ul style="list-style-type: none"> <li>- The facility had 3 medication carts for the residents' medications.</li> <li>- The medication carts were lockable.</li> <li>- The medication carts contained a separate locked drawer for controlled medications.</li> <li>- Controlled drugs (Schedule III-V) were stored in the separate locked drawer on the individual carts.</li> <li>- None of the 3 medication carts contained Schedule II narcotic pain medications such as Oxycodone, hydrocodone, or Fentanyl.</li> </ul> <p>Observation at various times on 5/11/15 of the Medication Aide/Supervisor's office revealed:</p> <ul style="list-style-type: none"> <li>- The office was locked, unless the Supervisor was present in the office.</li> <li>- The desk had a large door on the lower right side with a hasp and padlock.</li> <li>- The large door, when unlocked, had a small hard plastic pharmacy tote inside.</li> <li>- The pharmacy tote had a bi-fold interlocking lid which could be locked with a padlock at each end and had a locked padlock on each end.</li> </ul> <p>Review of the reported losses of Schedule II medications from the facility revealed losses as follows:</p> <ul style="list-style-type: none"> <li>- On 10/16/14= 2 residents missing oxycodone 30 mg tablets; reported to police, pharmacy, and HCPR.</li> <li>- On 11/02/14= 2 residents missing oxycodone 30 mg tablets; reported to police, pharmacy, and</li> </ul> | D 393         |   |                    |

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| D 393              | <p>Continued From page 142</p> <p>HCPR.</p> <ul style="list-style-type: none"> <li>- On 12/02/14= 1 resident missing oxycodone 30 mg tablets; reported to police, pharmacy, and HCPR.</li> <li>- On 12/21/14= 8 residents missing oxycodone 30 mg tablets, reported to police, pharmacy, and HCPR.</li> <li>- On 3/06/15= robbery at knife point 5 residents missing oxycodone tablets various strengths, and personal belongings taken also; reported to police and pharmacy but not to HCPR.</li> </ul> <p>Interview on 5/13/15 at 4:30 pm with the Resident Care Director (RCD) revealed:</p> <ul style="list-style-type: none"> <li>- The facility had reported loss of medication to the police department and the pharmacy (pharmacy billing department representative was the contact for the pharmacy) at the time each instance occurred.</li> <li>- The police had investigated all the reported instances.</li> <li>- The Health Care Personnel Registry (HCPR) had been notified when warranted.</li> </ul> <p>Telephone interview on 5/14/15 at 10:10 am with the contract pharmacy representative revealed:</p> <ul style="list-style-type: none"> <li>- The facility had reported the loss of medications on 10/17/14, 12/02/14, 11/02/14, and 12/21/14.</li> <li>- The contract pharmacy's pharmacist had contacted the facility NP and arranged for the residents to receive a smaller quantity of medications (in the event of a loss).</li> <li>- The facility and the pharmacy made changes and the facility had not reported any medication loss after 12/21/14 until the armed robbery on 3/06/15.</li> </ul> <p>Interview on 5/11/15 at 3:20 pm with day shift MA/S revealed the current system, since around December 2014, for ordering and storing</p> | D 393         |   |                    |

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| D 393              | <p>Continued From page 143</p> <p>controlled medication was as follows:</p> <ul style="list-style-type: none"> <li>- Narcotic pain medication (like medications containing oxycodone, hydrocodone, Fentanyl) were sent in 7 days supplies to help monitor the medications.</li> <li>- Medications are delivered from the pharmacy provider daily Monday through Saturday around 12:00 midnight to 1:30 am.</li> <li>- The night shift MAS was responsible to receive medications directly from the drug delivery driver.</li> <li>- Only the pharmacy and the facility had a key to the lock on the medication totes.</li> <li>- All medications, including controlled drugs, were checked against the packing list and signed as received from the driver.</li> <li>- Once medications were received, the narcotic controlled drugs were stored locked in the supervisor's office, inside a locked tote, that was placed in a desk drawer secured with a hasp lock.</li> <li>- Controlled Drug Inventory sheets were sent by the provider for each card of controlled medication and the sheets are stored in a note book separate from the medication while waiting to be administered.</li> <li>- The Supervisor kept a copy of the packing list and provided the Administrator with a copy.</li> <li>- The non-narcotic controlled drugs were placed on the medication cart, unless the resident had at least a full card already on the cart.</li> <li>- Excess controlled drug medication, including narcotic medications, are taken to the Resident Care Director/Administrator's office by the Supervisor and slid under the door (routinely around 3:00 to 4:00 am.)</li> <li>- The Resident Care Director (RCD) and Administrator were responsible for the medication once it was slid under the door.</li> <li>- No narcotic pain medication was stored on the medication cart.</li> </ul> | D 393         |   |                    |

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| D 393              | <p>Continued From page 144</p> <p>Interview with the RCD on 5/11/15 at 4:05 pm revealed:</p> <ul style="list-style-type: none"> <li>- The controlled medications were getting gone out of the pharmacy delivery totes and the controlled drug sheets were still in the totes.</li> <li>- The facility changed to the current system of storing the Schedule II medications.</li> <li>- The facility Nurse Practitioner and the pharmacy worked out a system to send only a 3 to 7 days supply of the residents' narcotic pain medications in response to the losses.</li> </ul> <p>Continued interview with the RCD on 5/11/15 at 4:05 pm revealed the medication storage system in place since December 21, 2014 was as follows:</p> <ul style="list-style-type: none"> <li>- The night shift MA Supervisor (MA/S) signed in all medications from the pharmacy delivery driver.</li> <li>- The night shift MA/S was responsible to stock the medication carts with the medications from the pharmacy.</li> <li>- The night shift MA/S did not put narcotic pain medication on the medication carts (oxycodone and hydrocodone medications) but secured one active card of medication in the locked tote, in the locked desk drawer, located in the Supervisor's office.</li> <li>- The night shift MA/S had the only set of keys available to staff.</li> <li>- The night shift MA/S were responsible to lock the Supervisor's door when not in the office.</li> <li>- The night shift MA/S were responsible to bring overstock controlled medications, including all narcotic pain medications except for the active supply, to the RCD/Administrator's office door and slide the medications far under the door.</li> <li>- The RCD or Administrator, whichever arrived first in the morning, was responsible to secure the medication until the Administrator moved the medication to a locked tote in a locked storage</li> </ul> | D 393         |   |                    |

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| D 393              | <p>Continued From page 145</p> <p>closet in the Administrator's office. (Double locked as required.)</p> <ul style="list-style-type: none"> <li>- The RCD and Administrator's offices were under camera monitoring in addition to number coded key pad lock on the door.</li> <li>-Schedule II medications slid under the RCD's door were not maintained under double lock or supervised at all times between the time the MA/S slid the medications under the RCD's door (usually around 3:00 am to 4:00 am) and when the Administrator or RCD arrived (routinely around 8:00 am daily) to secure the medications under double lock.</li> </ul> <p>Observation on 5/15/15 of the opening under the Resident Care Director's door revealed a space that measured 1 and one-quarter inches high and 31 inches wide. (Wide enough to pull medication back out.)</p> <p>Inteviu on 5/14/15 at 4:00 pm with the Adminstrator revealed:</p> <ul style="list-style-type: none"> <li>- He was aware Schedule II medications should be stored under double lock unless supervised.</li> <li>- He was aware the Schedule II medications were not under double lock from the time the Medication Aide/Supervisor slid the medications under the RCD/Administrator's door until either the RCD came into the office to supervise the medication storage, or he can into the office to lock the medications in the tote and storage closet.</li> <li>- He stated the office had constant video monitoring but realized that was not considered locked up.</li> </ul> | D 393         |   |                    |
| D 438              | 10A NCAC 13F .1205 Health Care Personnel Registry  | D 438         |   |                    |

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| D 438              | <p>Continued From page 146</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry<br/>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:<br/>TYPE B VIOLATION</p> <p>Based on interviews, and record reviews the facility failed to report to the North Carolina Health Care Personnel Registry (HCPR) an allegation of abuse by one staff (Staff K) resulting in an injury of a resident (Resident #2).</p> <p>The findings are:</p> <p>Review of Staff K record revealed:<br/>-She was hired on 8/7/14 as a Medication Aide (MA) and Personal Care Aide (PCA).<br/>-HCPR checked on 8/6/2014.</p> <p>Review of Resident #2's current FL2 dated 11/14/14 revealed:<br/>-Resident #2 admission date was 11/23/14.<br/>-Diagnoses that included paraplegic, decubiti, colostomy, foley, and osteomyelitis.<br/>-Documented ambulatory status as non-ambulatory, wheelchair.</p> <p>Interview on 5/11/15 at 9:30 am with Resident #2 revealed:<br/>-He lived in the facility for 6 months.<br/>-He had gotten into a verbal altercation with Staff K and she put her hands on both his shoulders and he grabbed her by her arms.<br/>-He said Staff K started walking backward and pulled him out of his wheelchair onto the floor.<br/>-He "cussed her and called her a bitch."</p> | D 438         |   |                    |

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| D 438              | <p>Continued From page 147</p> <ul style="list-style-type: none"> <li>-The Administrator came after the incident occurred.</li> <li>-Resident #2 refused ER treatment at that time.</li> <li>-He reported the incident to management and the facility ombudsmen.</li> <li>-The county adult home specialist came and spoke to him but he did not feel like she had listen to him.</li> <li>-He felt like the staff were all together in this incident.</li> </ul> <p>Telephone interview on 5/11/15 at 3:50 pm with Resident #2's contact person revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had spoken to her about being pulled out of the wheelchair by Staff K.</li> <li>-The Home Health (HH) nurse told Resident #2 contact person another injury had occurred to his sacral wound after the altercation of being pulled out of wheelchair.</li> </ul> <p>Review on 5/11/15 of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-An order for HH services which began on 11/24/14.</li> <li>-HH documentation of a stage 4 wound (A full thickness of the skin and subcutaneous tissue is lost. Able to see muscle or bone) measurement 10 cm X 9 cm X 3 cm depth.</li> </ul> <p>Telephone interview on 5/12/15 at 9:00 am with the Home Health nurse revealed:</p> <ul style="list-style-type: none"> <li>-Currently she performed wound care for Resident #2 three times weekly.</li> <li>-She staged the wound to the sacral area as a stage 4.</li> </ul> <p>Review of Resident #2's HH notes dated 3/10/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2's sacral wound had enlarged, "had a small slit-type area, the area had significant depth</li> </ul> | D 438         |   |                    |

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| D 438 | <p>Continued From page 148</p> <p>of greater than half the length of a sterile q-tip."<br/>-Resident #2 knew what had happened and explained he was "pushed out of wheelchair by Staff K."<br/>-"He had gotten into a verbal altercation with Staff K and ended when Staff K grabbed him with two hands and lifted him out of his wheelchair and onto the floor."<br/>-Documentation on 3/10/15 the HH nurse reported the altercation to her HH supervisor, the facility administrator, as well as the facility physician office.</p> <p>Interview on 5/11/15 at 3:35 pm with Staff K revealed:<br/>-She had been employed at the facility for 1 year as a Personal Care Aide (PCA) and a Medication Aide (MA).<br/>-She recalled the altercation that occurred on 3/6/15 with Resident #2.<br/>-She walked down the hall and was talking to another staff member, Resident #2 told her to "Shut the [expletive deleted] up, no one wanted to hear that."<br/>-She told Resident #2, "No one is talking to you."<br/>-She and the other staff person walked down the 300 hall toward the medication room.<br/>-Resident #2 told her "He was going to slap the [expletive deleted] out of her."<br/>-Resident #2 raised his hand to slap her and she placed both of her hands on his shoulders to prevent him from hitting her.<br/>-He grabbed her shirt and she tried to walk away, Resident #2 fell out of his wheel chair onto the floor.<br/>-She said Resident #2 ripped her shirt and her breasts were exposed.<br/>-Staff got the administrator, but he arrived after the altercation and Resident #2 was already on the floor.</p> | D 438 |  |  |
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| D 438              | <p>Continued From page 149</p> <p>Interview on 5/12/15 at 8:10 am with a resident on the 300 hall revealed:<br/>-He saw the altercation with Resident #2 and Staff K on 3/6/15.<br/>-He said both Staff K and Resident #2 were arguing and cussing.<br/>-He said "Staff K grabbed Resident #2 by his shoulders and pulled him out of the wheel chair."<br/>-Resident #2 got himself up off the floor and into his wheelchair.</p> <p>Interview on 5/12/15 at 9:40 am with another resident on the 300 hall revealed:<br/>-She saw the altercation between Resident #2 and Staff K.<br/>-She Staff K and Resident #2 were arguing and cussing.<br/>-She said Staff K grabbed Resident #2's wheelchair and his shoulders.<br/>-She said the Staff K turned the wheelchair over and Resident #2 fell on the floor.<br/>-She said the Staff K did not have a torn shirt nor were her breasts exposed.<br/>-She said the Administrator came after the altercation and ask Resdient #2 if he need to go to the ER.</p> <p>Review on 5/11/15 of the facility incident reports revealed:<br/>-Incident report completed on 3/6/15 at 10:30 am by the Resident Care Director (RCD) and signed by the administrator.<br/>-Documented Resident #2 had an altercation with Staff K.<br/>-Documented Resident #2 grabbed Staff K by shirt.<br/>-Documented Resident #2 tugged at Staff K and fell out of his wheel chair.<br/>-Documentation Resident #2 said, "He was fine and</p> | D 438         |   |                    |

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| D 438              | <p>Continued From page 150</p> <p>EMS was not called."</p> <p>Review of Staff K's interview documented during the investigation by the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-Staff K documented the altercation had occurred with Resident #2 on 3/6/15.</li> <li>-Staff K documented she placed both hands on Resident #2's shoulders to prevent him from hitting her.</li> <li>-Staff K documented Resident #2 grabbed her shirt and was holding on while she had both her hands on his shoulders.</li> <li>-Staff K documented she pulled away from Resident #2, and Resident #2 fell in the floor.</li> <li>-Staff K documented Resident #2 torn her shirt and exposed her breasts.</li> </ul> <p>Further review on 5/13/15 of interview by residents during the investigation of the allegation between Resident #2 and staff revealed:</p> <ul style="list-style-type: none"> <li>-Interviews were documented in Administrator's handwriting.</li> <li>-One resident documented, " They both had each other by the shirt, they were tustling and Resident #2 lost his balance and fell out of wheel chair."</li> <li>-Another resident documented, "Resident #2 rolled his wheel chair next to the Staff K and tried to grab her, she stayed back from him. He may had leaned over too far."</li> </ul> <p>Review of the facility policy on Harassment and Hostile Environment revealed:</p> <ul style="list-style-type: none"> <li>-Will not tolerate a hostile environment of any kind.</li> <li>-Prohibited conduct not limited to the use of physical conduct.</li> <li>-Policy was signed and dated 8/7/14 by Staff K.</li> </ul> <p>Review of the facility new hire Policy and Procedure Agreement revealed:</p> | D 438         |   |                    |

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| D 438              | <p>Continued From page 151</p> <ul style="list-style-type: none"> <li>-No abusive language to residents or staff is permitted.</li> <li>-Employees must know resident rights which are posted in the community.</li> <li>-Profanity-bad attitudes-bad behavior will not be tolerated-misconduct may be grounds for immediate dismissal.</li> <li>-Signed and dated 8/7/14 by Staff K.</li> </ul> <p>Interview on 5/12/15 at 10:30 am with the facility RCD revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of the altercation on 3/6/15 with Resident #2 and Staff K.</li> <li>-She refer all questions about the altercation to the Administrator.</li> </ul> <p>Interview on 5/12/15 at 10:35 am with facility Administrator revealed:</p> <ul style="list-style-type: none"> <li>-He was working on 3/6/15 when the altercation took place.</li> <li>-Staff came to his office and said "they are fighting."</li> <li>-He arrived at the 300 hall and found Resident #2 on the floor.</li> <li>-He said Staff K and the Resident were still engaged in arguing.</li> <li>-He asked Resident #2 if he needed to go the ER.</li> <li>-He offered to help Resident #2 off floor but Resident #2 got himself into his wheelchair.</li> <li>-He said the Staff K was "heated", he sent her home for that day.</li> <li>-He conducted a investigation and obtained interviews from the staff as well as from residents who had seen the altercation.</li> <li>-Resident #2 reported to him being pulled out of the wheelchair 2 days after the altercation.</li> <li>-The HH nurse reported to him the allegation Resident #2 was pulled out of his wheel chair by Staff K and requested Resident be sent to the ER for evaluation of enlarged area to the sacral</li> </ul> | D 438         |   |                    |

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| D 438              | <p>Continued From page 152</p> <p>wound per physican orders on 3/10/15.<br/>-The Administrator, as of 5/12/15, had not reported the allegation of abuse by staff resulting in injury of Resident #2 to the North Carolina Health Care Personal Registry (HCPR).<br/>-The Administrator did not consider the incident as an allegation, and was unaware of the need to report Staff K to the HCPR for suspected allegation of abuse.<br/>-He filed a report to the HCPR on 5/12/15 with the named Staff K and the allegation that occurred on 3/6/15.</p> <p>_____</p> <p>On 5/12/15, the Administrator submitted a Plan of Protection as follows:<br/>-A 24 hour report has been created and faxed to the North Carolina Health Care Personnel Registry.<br/>-Any and all allegations shall be immediately sent to the Health Care Personnel Registry via the appropriate reports.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, July 2, 2015.</p> | D 438         |   |                    |
| D 454              | <p>10A NCAC 13F .1212(e) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting Of Accidents And Incidents<br/>(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:<br/>(1) any injury to or illness of the resident requiring</p>  | D 454         |   |                    |

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| D 454              | <p>Continued From page 153</p> <p>medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and</p> <p>(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.</p> <p>This Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to notify the resident's guardian for 1 of 3 sampled residents (Resident #4) who required hospitalization.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 and discharge summary dated 4/24/2015 revealed:<br/>- The resident was treated in a local hospital from 4/21/15 to 4/24/15 for lower extremity Cellulitis.<br/>- The FL2 listed the Primary Contact as a family member (not the Guardian).</p> <p>Review of Resident #4's Resident Register revealed:<br/>- The resident's guardian was documented as a county Department of Social Services (DSS).</p> <p>Review of Resident #4's record revealed a document in front of the Resident Register with the following information printed in bold letters:</p> | D 454         |   |                    |

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| D 454              | <p>Continued From page 154</p> <ul style="list-style-type: none"> <li>- DSS Guardian.</li> <li>- Change in Medical Condition, Death, Emergency, Hospitalization (was again noted).</li> <li>- Call (Proper Name) Social Worker at (phone number).</li> <li>- After hours, holidays and week call (Phone number).</li> </ul> <p>Review the care plan dated 2/05/15 revealed Resident #4:</p> <ul style="list-style-type: none"> <li>-Needed total assistance with toileting and bathing.</li> <li>-Needed supervision with grooming and transfers.</li> <li>-Needed assistance with eating, ambulation, and dressing.</li> </ul> <p>Review of Resident #4's record revealed a Nurses Note dated 4/21/15 stating "Per Doctor, resident is to be sent out for possible cellulitis."</p> <p>Review of Resident #4 record revealed:</p> <ul style="list-style-type: none"> <li>- Resident #4 had a hospital admission from 4/21/15 to 4/24/15 for right lower extremity swelling, warmth, erythema, and low grade fever.</li> <li>- Deep vein thrombosis was ruled out and the resident was treated for cellulitis.</li> <li>- The resident was treated with intravenous antibiotics first, and then switched to oral antibiotics.</li> </ul> <p>Interview on 5/13/15 at 1:30 pm with Resident #4's Guardian revealed:</p> <ul style="list-style-type: none"> <li>- She visited the facility on 4/15/15.</li> <li>- She reviewed the resident's record and spoke with the Resident Care Director (RCD) about Resident #4's health care since coming to the facility 2/05/15.</li> <li>- She had spoken to the resident for information regarding the resident's care and any concerns the resident had expressed.</li> </ul> | D 454         |   |                    |

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| D 454              | <p>Continued From page 155</p> <ul style="list-style-type: none"> <li>- The facility was aware staff were responsible to notify the Guardian for all accident or incidents.</li> <li>- She had instructed the facility to contact the Guardian for any changes in health care, medications, or behaviors.</li> <li>- The facility had not contacted her since her last visit on 4/15/15.</li> <li>- She was not aware Resident #4 had been hospitalized from 4/21/15 to 4/25/15.</li> <li>- The Guardian "expected the facility to let her know when the resident had new medications". (She was not aware Resident #4 had nystatin powder (used to treat fungal infections) ordered on 4/24/15 and 5/07/15.)</li> <li>- She was not contacted by the hospital for information regarding the hospital visit.</li> </ul> <p>Interview on 5/14/15 at 9:30 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- Medication Aides should notify the resident's responsible party as listed in the resident's record when preparing the resident to be sent out to a hospital.</li> <li>- The Hospital then would normally contact the Responsible Person or Guardian.</li> </ul> <p>Interview on 5/14/15 at 11:00 am with a Medication Aide/Supervisor (MA/S) revealed:</p> <ul style="list-style-type: none"> <li>- The resident had a "face sheet" in the front of the resident's record that was used by staff to contact Responsible Person in the event of emergency or hospitalization.</li> <li>- The number on the face sheet was the same number as the number on the Resident Register.</li> <li>- The Resident Register contact number did not match the updated phone number on the DSS documentation for the Guardian contact number.</li> <li>- Staff had called the phone number on the "face sheet" (same number as contact number on the Resident Register) but got an "out of order"</li> </ul> | D 454         |   |                    |

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| D 454              | Continued From page 156<br><br>message and no message was left.<br>- The information on the facility "face sheet" would have been sent out with the resident.<br><br>Interview on 5/15/15 at 3:45 pm with an evening shift Medication Aide (MA) revealed:<br>- She was working when Resident #4 was sent out to the hospital.<br>- Staff used the facility "face sheet" to call the Guardian.<br>- She was not aware the Guardian phone number had changed and the "face Sheet" had not been updated.<br>- The Medication Aide Supervisors were responsible for updating resident contact information.   | D 454         |   |                    |
| D912               | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding to water temperatures, North Carolina Department of Health facility rating less than 85, housekeeping and furnishings, North Carolina Health Care Personnel Registry, Licensed Health Professional Services, Infection Control, Resident's Rights, and Other Care and Services. | D912          |   |                    |

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| D912               | <p>Continued From page 157</p> <p>The finding are:</p> <p>A. Based on observations, interviews and record reviews the facility failed to assure the hot water temperature for 2 of 8 sink fixtures and 2 of 8 shower fixtures in the common bathrooms and resident bathrooms were maintained between 100 degrees Fahrenheit (F) and 116 degrees F with hot water temperatures ranging from 98 degrees F to 148 degrees F. [Refer to Tag 113, 10A NCAC 13F. 0311(d) (Type A2 Violation).]</p> <p>B. Based on observations, interviews, and record reviews the facility failed to obtain physician certification and ensure non-licensed staff met the requirements for training and competency validation prior to performing wound care for greater than stage 2 wound for 1 resident (Resident #2) with a stage 4 sacral wound. [Refer to Tag 0163, 10A NCAC 13 F .0504(c) (Type A2 Violation).]</p> <p>C. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for wound care for 1 Resident (Resident #2) with a stage 4 sacral wound. [Refer to Tag 0932, G.S. 131D-4.4 (A)(b) (Type A2 Violation).]</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. [Refer to Tag 0077, 10A NCAC 13F. 0306(a)(4) (Type B Violation).]</p> <p>E. Based on observations, interviews and record reviews, the facility failed to maintain a clean and</p> | D912          |   |                    |

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| D912               | <p>Continued From page 158</p> <p>orderly environment, free of hazards, as related to bedbugs in multiple rooms throughout the facility biting and irritating residents, the safe storage of oxygen cylinders and repair and maintenance of hand rails for resident safety and mobility. [Refer to Tag 0079, 10A NCAC 13F. 0306(a)(5) (Type B Violation).]</p> <p>F. Based on record review and interviews the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when a resident whereabouts were unknown (Resident #1). [Refer to Tag 0328, 10A NCAC 13F. 0906(f)(4) (Type B Violation).]</p> <p>G. Based on interviews, and record reviews the facility failed to report to the North Carolina Health Care Personnel Registry (HCPR) an allegation of abuse by one staff (Staff K) resulting in an injury of a resident (Resident #2). [Refer to Tag 438, 10A NCAC 13F. 1205 (Type B Violation).]</p> | D912          |   |                    |
| D914               | <p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:<br/>4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, interviews, and record reviews, the facility failed to ensure each resident be free of neglect related to management of facility, resident rights, personal care and supervision, health care and medication administration.</p> <p>The finding are:</p>   | D914          |   |                    |

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| D914               | <p>Continued From page 159</p> <p>A. Based on observations, interviews, and record reviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility to maintain compliance in the rule areas including housekeeping and furnishings, water temperatures, health care, medication administration, staff qualifications, staffing, personal care and supervision, infection prevention, reporting of accidents and incidents, health care personnel registry, and resident rights.[Refer to Tag 0176, 10A NCAC 13F. 0603(a) (Type A1 Violation)].</p> <p>B. Based on record review, observations and interviews, the facility failed to ensure residents were free from neglect by failing to recognize its role in caring for individuals with communicable infections and those with diminished mental capacity; addressing the special care needs and interventions for the monitoring and reporting of communicable infections; and by failing to make available and implement preventative measures to protect other residents from transmission of a communicable disease and failed to ensure residents were free of abuse as evidenced by abuse of 1 resident (Resident #2) by Staff K. [Refer to Tag 338, 10A NCAC 13F. .0909 (Type A1 Violation).]</p> <p>C. Based on interviews, record reviews, and observations, the facility failed to provide supervision or monitoring related to safety for 4 residents of 8 residents sampled, 4 residents who left the facility frequently and were known to have guardians or the inability to make safe decisions (Residents #1, #3, #5, and #16) and failed to provide additional supervision for 1 resident who attempted suicide (Resident #5). [Refer to Tag 0270, 10A NCAC 13F. 0901(b) (Type A2 Violation).]</p> | D914          |   |                    |

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| D914               | Continued From page 160<br><br>D. Based on observation, interview and record review, the facility failed to assure prescribed medications (Megace, Cipro, Diflucan, Combivir, Valtrex, Kaletra, Zoloft, Naproxen, Omeprazole and Nystatin) were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 8 residents (#4, #10 and #17). [Refer to Tag 0358, 10A NCAC 13F. 1004(a) (Type A2 Violation).]<br><br>E. Based on record reviews and interviews, the facility failed to assure notification of health department, health care providers or the resident's guardian regarding residents' behaviors for 3 of 3 sampled residents (Residents #6, #16 and #17) regarding behaviors. [Refer to Tag 0273, 10A NCAC 13F. 0902(b) (Type A2 Violation).] | D914          |   |                    |
| D932               | G.S. 131D-4.4A (b) ACH Infection Prevention Requirements<br><br>G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements<br><br>(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:<br>(1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:<br>a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple  | D932          |   |                    |

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| D932 | <p>Continued From page 161</p> <p>residents.</p> <p>b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.</p> <p>c. Accessibility of infection control devices and supplies.</p> <p>d. Blood and bodily fluid precautions.</p> <p>e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.</p> <p>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p><br/></p> <p>This Rule is not met as evidenced by:<br/>TYPE A2 VIOLATION</p> <p><br/></p> <p>Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for wound care for 1 Resident (Resident #2) with a stage 4 sacral wound.</p> <p><br/></p> <p>The findings are:</p> | D932 |  |  |
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| D932               | <p>Continued From page 162</p> <p>Review of Resident #2's current FL2 dated 11/14/14 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was admitted to the facility 11/23/14.</li> <li>-Diagnoses that included paraplegic, decubiti, colostomy, foley, osteomyelitis and methicillin-resistant staphylococcus aureus MRSA (an infection that is caused by a strain of staph bacteria that's becomes resistant to antibiotics).</li> <li>-Documented small decubiti on sacral area.</li> <li>-Documented ambulatory status as non-ambulatory.</li> </ul> <p>Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-An order dated 11/24/15 by the facility nurse practitioner for Home Health (HH) services.</li> <li>-HH visits three times weekly for wound care dressing changes.</li> <li>-A order dated 11/24/15 for wound care as follows: <ul style="list-style-type: none"> <li>Wound care aseptic technique</li> <li>Irrigate wound with normal saline</li> <li>Flagyl 250mg crushed and applied to wound bed</li> <li>Pack gauze into tunneling area and wound bed</li> <li>Cover with ABD pads and secure with tape.</li> <li>Change dressing 2 times daily and as needed.</li> </ul> </li> <li>-Documentation of stage 4 wound (A full thickness of the skin and subcutaneous tissue is lost. Able to see muscle or bone) measurement 10 cm X 9 cm X 3 cm depth.</li> <li>-Documentation on admission to HH services, Resident #2 could not perform own dressing changes.</li> </ul> <p>Additional Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> <li>-Discharge instructions dated 4/15/15 from wound clinic for sacral wound dressing as follows: <ul style="list-style-type: none"> <li>-Cleanse wound with mild soap and water prior</li> </ul> </li> </ul> | D932          |   |                    |

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| D932               | <p>Continued From page 163</p> <p>to applying clean dressing.</p> <ul style="list-style-type: none"> <li>-Do not scrub or use excessive force.</li> <li>-Dakin's solution 0.025% wet to dry once daily and as needed. If able to change dressing twice daily, please do so.</li> <li>-Instructions were electronic signed by registered nurse.</li> </ul> <p>Interview on 5/12/15 at 9:00 am with the HH nurse revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had used HH services for the last 6 months.</li> <li>-Skilled nurse visit were 3 times weekly.</li> <li>-She was aware of the order for wound care dressing changes to Resident #2 sacral area two times daily.</li> <li>-She instructed a Medication Aide (MA) to perform wound care dressing change in the afternoon and on the days she was not in the facility</li> <li>-The MA watched her perform wound care dressing change for Resident #2 several times then performed a return demonstration.</li> <li>-It was her belief the MA was trained to perform wound care due to the instructions and return demonstration the HH nurse had given for Resident #2's sacral stage 4 wound.</li> </ul> <p>Observation on 5/12/15 at 1:00 pm of the MA as she performed wound care dressing change on 5/12/15 for Resident #2's sacral stage 4 wound revealed:</p> <ul style="list-style-type: none"> <li>-She crushed Flagyl 250 mg in the medication room prior to performing wound care.</li> <li>-She placed one pair of disposable gloves in her front uniform pocket.</li> <li>-She washed her hands in the medication room prior to entering Resident #2's room.</li> <li>-She opened all supplies which include gauze, ABD pads, Qtips long in length and placed them</li> </ul> | D932          |   |                    |

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| D932               | <p>Continued From page 164</p> <p>on a clean disposable pad near Resident #2's right hip on the right side of the bed.</p> <p>-She prepared multiple strips of tape and secured a corner of the tape on the dresser in Resident #2's room.</p> <p>-She moved a trash bag near Resident #2's bed.</p> <p>-She removed the gloves out of her pocket and placed them on.</p> <p>-She removed the old sacral wound dressing which was saturated with yellowish brown discharge.</p> <p>-She opened the trash bag and placed the soiled dressing in the bag.</p> <p>-She removed the packing from the upper tunnel area near the lower back right side region, gauze was saturated with brownish discharge.</p> <p>-She placed the soiled gauze in the trash bag.</p> <p>-She removed a small 1/4 inch packing strip gauze approximately 14 to 16 inches long from the lower left region of the wound, which was brownish in color.</p> <p>-She sprayed the wound with normal saline spray and used several 4 X 4 gauze and wiped around the wound.</p> <p>-The tissue appeared pink, red, whitish yellow, with irregular borders and bone exposed.</p> <p>-She sprinkled the crushed Flagyl to the entire wound bed.</p> <p>-She applied Dakin's (A strong antiseptic that kills most forms of bacteria and viruses) solution to several 4 x 4 gauze and packed the top tunnel wound using the right index finger and packed several inches of gauze into the tunnel area.</p> <p>-She took scissors and cut a strip of 1/4" gauze which appeared to be about 14 inches in length and applied Dakin's solution, and packed the lower tunneled area with long QTip (approximately 6 inches long) using the wooden end of the Qtip.</p> <p>-She applied Dakin's solution saturated 4 x 4</p> | D932          |   |                    |

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| D932               | <p>Continued From page 165</p> <p>gauze to the entire wound bed area.<br/>-She covered the wound with ABD pads and secured with tape.<br/>-She collected the trash bag and took the closed trash bag out of the room.<br/>-She never at any time changed gloves while she performed wound care on Resident #2.<br/>-Staff failed to use aseptic (a sterile process to protect against infection) technique when performing wound care dressing change for Resident #2.</p> <p>Interview on 5/12/15 at 9:00 am with HH nurse revealed:<br/>-The wound care order for Resident #2 changed after he was sent to the ER for evaluation of wound.<br/>-She ordered supplies as well as the Dakin's solution for Resident #2.<br/>-Resident #2's supplies were delivered to the facility.<br/>-She was unaware the MA failed to use aseptic technique nor was she aware the MA did not change gloves during Resident #2's wound care dressing change.<br/>-She instructed the MA to use aseptic technique, pack wound, and change gloves after removing the soiled dressing.</p> <p>Interview on 5/13/15 at 11:15 am with the facility nurse practitioner revealed:<br/>-She made a referral to HH for Resident #2's wound to sacral area.<br/>-She never saw or assessed the stage 4 wound on Resident #2's sacral area.<br/>-She was not aware the HH nurse instructed facility staff to perform dressing changes for Resident #2.<br/>-She relied on HH to follow through on wound care and dressing change.</p> | D932          |   |                    |

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| D932               | <p>Continued From page 166</p> <p>Interview on 5/13/15 at 10:10 am with the MA revealed:<br/>-She performed wound care on Resident #2 on 5/12/15.<br/>-She watched the HH nurse perform wound care dressing change to Resident #2 one time and then the HH nurse watched her do a return demonstration.<br/>-The HH nurse had shown her how to pack the tunnel areas to the wound.<br/>-Was not aware of the discharge instruction on wound care from the wound clinic.<br/>-She said the HH nurse never changed her gloves when wound care was performed on Resident #2.<br/>-She said she was nervous when she performed wound care on 5/12/13 because State surveyor was watching her.</p> <p>Review on 5/13/15 of Facility Infection Control Universal Precautions revealed:<br/>-Staff in Adult Care Homes has responsibility to understand and follow the facility's infection control policies and procedures.<br/>-Universal Precautions is the procedure followed to keep germs from being spread from one person to another.</p> <p>Interview on 5/13/15 at 11:00 am with Resident Care Director (RCD) revealed:<br/>-She was aware the MA had performed wound care to Resident #2 on the days HH was not in the facility.<br/>-She was aware Resident #2 had a stage 4 wound to his sacral area.<br/>-She was not aware the MA did not change gloves when she performed wound care on Resident #2 on 5/12/15.<br/>-She was not aware the MA did not use aseptic</p> | D932          |   |                    |

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| D932               | <p>Continued From page 167</p> <p>technique when she performed wound care on Resident #2 on 5/12/15.</p> <p>-She did not consider the discharge instructions dated 4/15/15 from the wound clinic an order because a physican had not signed the instructions.</p> <p>-Neither she nor her staff obtained an order clarification from the wound clinic.</p> <p>Interview on 5/13/15 at 11:30 am with the Administrator revealed:</p> <p>-He was aware HH had seen Resident #2 for dressing changes.</p> <p>-He was aware staff was doing the dressing changes on the days HH could not be in the facility.</p> <p>-He was not aware the MA had not changed gloves nor use aseptic technique when she preformed wound care for Resident #2 on 5/12/15.</p> <hr/> <p>On 5/12/15, the Administrator submitted a Plan of Protection as follows:</p> <p>-The facility shall not have unlicensed staff perform wound care without a doctor's order.</p> <p>-Home Health has been contacted concerning the resident's needs.</p> <p>-Resident shall be seen by licensed Health care provider, or shall be upgraded to receive appropriate care as needed.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 18, 2015.</p> | D932          |   |                    |
| D992               | <p>G.S.§ 131D-45 Examination and screening</p> <p>G.S. § 131D-45. Examination and screening for the presence of controlled substances required</p>   | D992          |   |                    |

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| D992               | <p>Continued From page 168</p> <p>for applicants for employment in adult care homes.</p> <p>(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed before the staff began work at the</p> | D992          |   |                    |

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| D992               | <p>Continued From page 169</p> <p>facility for 2 of 10 sampled staff (Staff A and Staff D).</p> <p>The findings are:</p> <p>A. Review of Staff D's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Staff D was hired on 08/15/14.</li> <li>- Staff D was hired as a housekeeper.</li> <li>- No documentation of a controlled substance screening.</li> </ul> <p>Interview on 05/15/15 at 3:15 pm with Staff D revealed:</p> <ul style="list-style-type: none"> <li>- She did not recall when she began working at the facility.</li> <li>- She worked at the facility 38 - 40 hours week.</li> <li>- Her duties included sweeping and mopping the floors, cleaning the bathrooms and cleaning the windows.</li> <li>- She recalled having the screening for controlled substances performed, but did not recall when or where the test was performed.</li> <li>- The facility should have a copy of the test.</li> </ul> <p>Refer to the 05/15/15 3:25 pm interview with the Business Office Manager (BOM).</p> <p>Refer to the 05/15/15 3:40 pm interview with the Administrator.</p> <p>B. Review of Staff A's personnel record revealed:</p> <ul style="list-style-type: none"> <li>- Staff A was hired as a housekeeper on 01/03/15.</li> <li>- Staff A began training as a Personal Care Assistant (PCA) in February 2015.</li> <li>- No documentation of a controlled substance screening.</li> </ul> <p>Interview on 05/11/15 at 10:45 am with Staff A revealed:</p> | D992          |   |                    |

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| D992               | <p>Continued From page 170</p> <ul style="list-style-type: none"> <li>- He had worked at the facility for 1 year and 4 months.</li> <li>- He had completed the 80 hours of training and had a PCA certificate.</li> <li>- He usually worked first shift and every other weekend providing care for residents.</li> </ul> <p>Refer to the 05/15/15 3:25 pm interview with the Business Office Manager (BOM).</p> <p>Refer to the 05/15/15 3:40 pm interview with the Administrator.</p> <p>Interview on 05/15/15 at 3:25 pm with the BOM revealed:</p> <ul style="list-style-type: none"> <li>- New hire packets were completed by the office assistant, who left the facility in February 2015.</li> <li>- Since the resignation of the office assistant, it was her responsibility to complete the new hire packets.</li> <li>- She was confident the controlled substance screening had been performed upon hire for the staff.</li> <li>- She was not aware the controlled substance screening for the staff were not in the employee personnel folders.</li> </ul> <p>Interview on 05/15/15 at 3:40 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- He had been the Administrator at the facility since July 2014.</li> <li>- The former office assistant had been responsible for completing the new employee information as required.</li> <li>- The task of completing the new employee information was now the responsibility of the BOM.</li> <li>- He thought the controlled substance exam/screen had been performed.</li> <li>- He was not aware the controlled substance</li> </ul> | D992          |   |                    |

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| D992               | Continued From page 171<br><br>exam/screen forms were not in the employee files for the staff.                         | D992          |   |                    |