

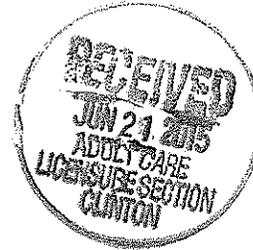
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2015
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NAME OF PROVIDER OR SUPPLIER
CASTLE CREEK MEMORY CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
**4724 CASTLE HAYNES ROAD
CASTLE HAYNE, NC 28429**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted an annual, follow-up, and complaint investigation survey on April 12 - 15, 2015. The complaint investigation was initiated by the New Hanover County Department of Social Services on March 30, 2015.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure follow-up to meet the health care needs of 1 of 5 sampled residents (Resident #5) who had a positive tuberculin skin test. The findings are: Review of Resident #5's FL-2 dated 10/16/14 revealed diagnoses which included Alzheimer's Dementia, diabetes mellitus II, gastro-esophageal reflux disease, hiatal hernia, esophagitis, and hypertension. Review of Resident #5's "Resident Register" revealed resident was admitted to the Special Care Unit on 11/3/14, from a skilled facility.	D 273	Responses to the cited Deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law. Castle Creek Memory Care Administrator, Care Manager, and Care Staff will continue to assure referral and follow-up to meet the routine and acute healthcare needs of residents.	6/29/15



Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Robin Eichon

Regional Director of Operations

6/21/15

Division of Health Service Regulation

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D 273	<p>Continued From page 1</p> <p>Review of admitting tuberculin skin test from skilled facility revealed: -Tuberculin skin test was administered 9/25/14 and read on 9/27/14 with results of 3.5 centimeters by 3.8centimeters. (According to guidelines from the Centers for Disease Control, persons with a positive TB skin test shall be evaluated by an interview to screen for symptoms and a chest x-ray if they do not have a documented chest x-ray that was performed on the date of the positive test or later). -Tuberculin skin test was read by a registered nurse</p> <p>Review of Resident #5's TB skin test administered on 11/10/14 revealed: -On 11/13/14, the test results were documented as positive (8mm). -The TB skin test was administered by the facility's registered nurse.</p> <p>Review of Resident #5's progress notes revealed: -Resident #5 was seen at nursing home by nurse practitioner on 11/3/14. -No documentation of tuberculosis skin test on 11/3/14 by nurse practitioner.</p> <p>Interview with Executive Director on 5/13/15 at 5:30pm revealed: -She had no knowledge of positive tuberculosis skin test reading for Resident #5. -There has to be a chest x-ray for TB somewhere for Resident #5 after 11/3/14 admission as follow up to positive reading</p> <p>Interview with Executive Director on 5/14/15 at</p>	D 273		

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D 273	<p>Continued From page 2</p> <p>11:10am revealed:</p> <ul style="list-style-type: none"> -Executive Director was away from the facility on 11/3/15 (admission date for Resident #5). -Memory Care Coordinator (MCC) and Business Office Manager (BOM) admitted Resident #5 to facility. -MCC would be responsible for clinical information/follow up and BOM would be responsible for financial. -MCC and Marketing Manager are responsible for going out doing assessments on potential residents and gathering paperwork to be reviewed for admission. -MCC did not bring positive TB reading to Executive Director's attention upon return to facility. -Facility should have confirmed a negative TB skin test before the resident was admitted. -Contracted nurse by facility would have seen documentation of tuberculosis skin test read on 9/27/14 when Step 2 tuberculosis skin test was administered by nurse on 11/10/14. -Once a resident gets a positive tuberculin skin test a Step 2 is not given. -Resident #5's physician only had knowledge of positive tuberculosis skin test read on 11/13/14. <p>Interview with facility's Memory Care Coordinator (MCC) on 5/14/15 at 11:55am revealed:</p> <ul style="list-style-type: none"> -MCC did remember Resident #5 being admitted to facility but did not work directly with Resident #5's chart. -At the time of Resident #5's admission, there were two MCC's (one for North Hall and one for South Hall). -MCC for South Hall would have worked with Resident #5's chart. -MCC did not go out and assess Resident #5 prior to admission to facility and has never been 	D 273		

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D 273	<p>Continued From page 3</p> <p>out to access potential residents.</p> <ul style="list-style-type: none"> -Executive Director and BOM get admission paperwork and then information is shared with MCC to review and put together chart. -She did not recall Resident #5 having a positive tuberculosis skin test and was not aware Resident #5 was admitted with a positive tuberculosis skin reading -The MCC was responsible for reviewing documentation of TB skin tests during admission process. - If results were positive Executive Director would be informed of results. -If resident was admitted with a negative PPD skin test, residents' name would be placed on board for nurse to administer Step 2 TB skin test. <p>Interview with a medication aide (MA) on 5/14/15 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -At the time of Resident #5's admission, the MA was working as MCC for South Hall and would have been responsible for admission paperwork for Resident #5. -The MA had no knowledge Resident #5 had a positive PPD at admission. If she had seen a positive TB skin test, it would have been questioned. -After paperwork is reviewed by the business office manager, paperwork is given to MCC after resident has been accepted for admission <p>Review of a "Tuberculosis Screening" (provided by the facility's medical provider) for Resident #5 dated 11/20/14 revealed:</p> <ul style="list-style-type: none"> -The resident has no symptoms of active TB. - The document was faxed to the facility on 5/13/15. -A copy of this "Tuberculosis Screening" sent to the facility on 5/13/15 was not available at the 	D 273		

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D 273	Continued From page 4 facility Review of radiology report dated 5/13/15 for Resident #5 revealed no radiographic evidence of active tuberculosis.	D 273	Castle Creek Memory Care completed audits of all TB records of current residents for compliance.	5/13/15
	-----Review of the facility's plan of protection dated 5/13/15 revealed: -Facility will immediately audit all TB records of current residents. -Facility will notify PCP of any positive test results and obtain chest x-ray to rule out active TB disease. -Executive Director and care managers with support team will complete this task -If (1 positive) is not confirmed will send resident out for x-ray to rule out TB. -Prior to admission TB results will be obtained and reviewed by Executive Director and care managers to ensure no active TB for all admissions.		Executive Director and Care Manager will continue to obtain and review TB test results prior to admission to ensure no active TB for all admissions.	6/29/15
	CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED JUNE 29, 2015.		Executive Director in-serviced LHPS nurse and Care Manager on NC TB Control Program Policy Manual regarding positive TB skin test reactions to include letter "C" number "2" letter "e." (see attached)	5/13/15
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338	Castle Creek Memory Care Administrator, Care Manager, and Care Staff shall continue to 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.	6/14/15

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D 338	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews and record review, the facility failed to protect residents from abuse/physical assault for 3 of 10 sampled resident as related to Resident #6 being physically assaulted by Resident #7, and Residents #'s 9 and 10 being physically assaulted by Resident #3.</p> <p>The findings are:</p> <p>1. Review of Resident #7's Resident Register revealed the resident was admitted to the facility on 9/23/13.</p> <p>Review of Resident #7's current FL-2 dated 9/23/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses which included Alzheimer's disease, syncope, pain in joint (shoulder region), difficulty walking, dysphagia, weakness and chronic airway obstruction. - The resident was intermittently disoriented. <p>Review of facility "Care Notes" for Resident #7 revealed:</p> <ul style="list-style-type: none"> - On 4/15/15, "Resident [#7] is becoming aggressive toward other residents". - "Faxed his doctor to make her aware". - On 5/1/15, "2pm to 10pm, resident [#7] struck another resident [#6] with a closed fist". - PCA [personal care aide] intervened and redirected both residents. - Resident [#7] placed on 15 minutes checks for increased supervision. <p>Review of a facility "Accident/Incident Report" for Resident #7 dated 5/1/15 revealed the</p>	D 338		

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D 338	<p>Continued From page 6</p> <p>following documentation:</p> <ul style="list-style-type: none"> - At 9:35pm another resident [Resident #6] wandered into the room. - Resident [Resident #7] struck other resident because he entered the room, staff present. <p>Review of a facility "Accident/Incident Report" for Resident #6 dated 5/1/15 revealed the following documentation:</p> <ul style="list-style-type: none"> - At 9:35pm, Resident [#6] was observed with right eye swollen and blood coming from scratch above eye. Resident also has scratch on nose. - First aide was administered; pressure put on right eye to stop bleeding. - The resident was transported to the local emergency room via ambulance. <p>Review of facility "Care Notes" for Resident #6 revealed the following:</p> <ul style="list-style-type: none"> - On 5/1/15 at "9:45pm PCA [personal care aide] observed resident [Resident #6] going into another resident's room". - "Upon entering room to redirect resident, PCA observed the other resident [Resident #7] strike [Resident #6]". - Resident [#6] has swelling to R [right] eyelid and a small cut on R [right] eyelid and scratch to middle of nose. <p>Review of the emergency room report dated 5/1/15 for services provided to Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses were assault, laceration and head injury. - A CAT scan (computed tomography scan) of head was performed. - The resident was discharged back to the facility with instructions for suture/wound care 	D 338		

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D 338	<p>Continued From page 7</p> <p>Review of a medical provider visit note dated 5/13/15 for Resident #6 revealed:</p> <ul style="list-style-type: none"> - "Today [Resident #6] is being examined as assault victim". - "[Resident #6] has been assaulted by a resident in the facility the past week". - "Today on evaluation [Resident #6] has large right facial ecchymosis involving forehead and extending to lower jaw. Multiple ecchymotic areas visible on both forearms". <p>Interview with a medication aide (MA) on 5/13/15 at 11:35am revealed:</p> <ul style="list-style-type: none"> - There was a resident who lived on the men's hall (Resident #7) who "picked" at Resident #6 (laughed at the resident and threatened to hit him). - Resident #7 has never hurt Resident #6. <p>Interview with another MA on 5/13/15 at 12:45pm revealed:</p> <ul style="list-style-type: none"> - Resident #6 "likes" to wander in other residents rooms. - He had an "incident" with Resident #7 in another resident's room on 5/1/15. - A second shift PCA was walking down the men's hall and saw Resident #6 enter into another resident's room. - When the PCA arrived at the resident's room, she observed Resident #7 hit Resident #6 across his face with his closed hand. - The PCA assisted Resident #6 to the nurse's station, and first aide was applied to the wound (cut) on his face; pressure was applied to stop the bleeding and emergency medical service was called to transport the resident to the local ER for treatment. - The MA observed Resident #7 with a fingernail clipper in his hand after the incident. - Resident #7 stated he hit Resident #6 	D 338		

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D 338	<p>Continued From page 8</p> <p>because he tried to pull him out of his wheel chair.</p> <ul style="list-style-type: none"> - On Monday or Tuesday following the incident, Resident #6 was moved to the women's hall. <p>Interview with a 2nd shift PCA on 5/13/15 at 3:30pm revealed:</p> <ul style="list-style-type: none"> - She was walking down the men's hallway and glanced in a resident's room. - She observed Resident #7 throw a punch and hit Resident #6. - There was nothing she could do to prevent the resident from punching Resident #6. - She assisted Resident #7 out of the other resident's room and applied first aide (pressure) to Resident #6's bleeding wound. - EMS was called and Resident #6 was transported to the local ER for treatment <p>Interview with Resident #7 on 5/13/15 at 4:15pm revealed:</p> <ul style="list-style-type: none"> - On 5/1/15, Resident #7 was in another resident's room and Resident #6 wandered in and out of the room 3 times. - Resident #7 confronted the resident, who became hostile. - Resident #7 took the resident's arm and attempted to take the resident out of the room. - Resident #6 then grabbed Resident #7's left arm which caused pain. - Resident #7 raised his right arm and hit Resident #6, causing the resident's eye to turn black. - Resident #7 stated he "wasn't trying to hit him, just defend myself". - Resident #7 stated he has not had "anymore problems" with Resident #6 and do not blame him. - Resident #7 stated I "blame myself". 	D 338		

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D 338	<p>Continued From page 9</p> <p>Interview with Resident #6's family member on 5/15/15 at 11:30am revealed:</p> <ul style="list-style-type: none"> - Resident #6 was attacked and assaulted by another resident at the facility. - Resident #6 does wander in the facility at night. - Resident #6 had wandered into another resident's room and Resident #7 did not like him being in the other resident's room. - Resident #7 "punched" the resident in his eye several times. - Resident #8 required 2 sutures above his eye. - A staff member told the family member that Resident #7 had Alzheimer's disease and was aggressive - Resident #6 has never hit anyone at the facility. - The family member's biggest concern was Resident #6 was assaulted. <p>Interview with the facility's Executive Director on 5/15/15 at 12:00 noon revealed:</p> <ul style="list-style-type: none"> - She was aware of Resident #7 hitting Resident #6 on 5/1/15 and causing injury to the resident. - Resident #7 was placed on 15 minute checks for 24 hours. - Resident #6 was moved to the women's hall. - A mini-mental evaluation was completed on Resident #7 after the incident. - Since Resident #7 was not at risk for wandering, placement in a memory care facility may not be appropriate. - The resident has a new FL-2 and the facility was looking for placement in an adult care facility. <p>Resident #6 was confused and was not interviewable.</p>	D 338		

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D 338	<p>Continued From page 10</p> <p>2. Review of Resident's current FL-2 dated 04/24/15 revealed the following:</p> <ul style="list-style-type: none"> - Diagnoses of Vascular Dementia, Hypertension (controlled), and Atrial Fibrillation. - The Resident was constantly disoriented. - The Resident has inappropriate behaviors related to wandering. - The Resident was ambulatory. <p>Review of Resident #3 's Resident Registry revealed an admission date of 03/13/15.</p> <p>Review of Resident #3's current MAR revealed that current medications include Depakote Sprinkles, Aivan, Seroquel, Zoloff, Desyrel, and Geodon.</p> <p>Review with Personal Care Aide (PCA) on 05/13/15 at 12:30 PM revealed:</p> <ul style="list-style-type: none"> - Resident #3 will not cooperate with personal care until he has been medicated. - Resident #3 will fight those who are attempting to provide care until the medication becomes effective - Resident #3 is " like a cornered dog-he will come out after you if he feels threatened " - Resident #3 went into another Resident's room and the Resident demanded that Resident #3 leave. Resident #3 pulled the other Resident into the hall and went back into the now empty room. - PCA thinks that other Residents are afraid of Resident #3. - PCA thinks Resident #3 would harm someone. - At meals, Resident #3 is given a plastic fork 	D 338		

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D 338	<p>Continued From page 11</p> <p>rather than a regular one to prevent possible injuries Observation made on 4/13/15 at 9:00am revealed:</p> <ul style="list-style-type: none"> - Resident #3 was ambulation in the activity room during a planned facility group activity. - The resident was talking incoherently and walked up to surveyor and attempted to grab hand. - Resident #3 walked up to a male resident, who was ambulating with a walker, and grabbed at resident ' s arm. - The male resident became upset and agitated and was assisted to a chair by a staff member. - The staff member attempted to assist Resident #3 to sit in a chair several times. - Resident #3 pulled off his sock and when the staff member bent down to pick up sock, the resident raised up his arm and came down with hand as if he was going to hit the staff, but stopped just before hitting the staff ' s buttocks, <p>Interview with a 1st shift PCA on 4/13/15 at 9:15am revealed:</p> <ul style="list-style-type: none"> - Resident #3 was actually calm this morning. - The resident frequently got agitated and combative during care such as bath. - The staff knew to just leave him alone until he calmed down. - Some of the residents were scared of him. - The PCA did not know if Resident #3 had abused any of the residents at the facility <p>Entry from Resident #3 Care Notes dated 05/06/15 at 7:32 PM revealed:</p> <ul style="list-style-type: none"> - Staff reports Resident was walking hallways in a pleasant mood No agitation noted. [At entry to South Hall] Female Resident (#10) told 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2015
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 12</p> <p>resident to " get off this hall ". Staff member was approaching for re-direction when Resident #3 struck Resident #10. Resident #10 scratched Resident #3's neck. Both Residents were re-directed to opposite halls and 911 was called. Entry from Resident # 10 Care Notes dated 05/06/15 at 7:32 PM revealed:</p> <ul style="list-style-type: none"> - Staff reports Resident (#10) was on South Hall when another Resident (#3) tried to enter the hall. Resident (#10) stated " Get off this hall ", and Resident (#3) struck Resident (#10). In response, Resident (#10) scratched Resident #3. Staff were present and separated [the] two residents. Sent to hospital for evaluation. Review of Resident #10's Incident Report revealed: <ul style="list-style-type: none"> - Resident #10 was sent to Emergency Room (ER). - No injuries were found on Resident #10. - Resident #10 returned from ER with no new orders. - PCP, Responsible Party and Department of Social Services (DSS) were notified. Review of Resident #3's Incident Report revealed: <ul style="list-style-type: none"> - Diagnoses addressed at visit was Dementia with behavioral disturbances. - Resident was discharged back to facility with instructions to follow -up with PCP within 2 days. <p>Entry from Resident #3 Care Notes dated 05/12/15 at 5:45 AM revealed:</p> <ul style="list-style-type: none"> - Resident urinated from the medication carts to the TV room. I was trying to mop it up when the Resident came up behind me and grabbed the mop, refused to give it back to me, he also turned over the bucket of water that the mop was in. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/15/2015
NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 13 According to the facility's Plan of Protection dated 5/15/15, Resident #7 will receive increased supervision for behavioral intervention until transfer to an assisted living facility as suggested by the resident's primary care provider (PCP). The facility will monitor residents for changes in status, notify the resident's PCP and/or Psychiatrist. The facility will increase supervision, and room changes as needed. The facility will consider discharge when appropriate.	D 338	Castle Creek Memory Care Administrator, Care Manager, and Care Staff will continue to monitor residents for changes in status, will continue to notify the resident's PCP and/or Psychiatrist, will continue to increase supervision and will continue to consider room changes as needed to ensure the rights of all residents. The facility will continue to consider discharge of residents when appropriate and will continue to communicate these discharge considerations with Adult Home Specialist and Ombudsman.	
	THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 14, 2015.			6/14/15
D912	G S. 131D-21(2) Declaration of Residents' Rights G S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews and review of documentation, the facility failed to provide adequate and appropriate care and services related to follow-up on an admission positive TB skin test. The findings are: 2. Based on interview and record review, the facility failed to assure follow-up to meet the health care needs of 1 of 5 sampled residents (Resident #5) who had a positive tuberculin skin test. [Refer to Tag 273 10A NCAC 13G .0902(b) Health Care (Type B Violation)]	D912	Castle Creek Memory Care Administrator, Care Manager, and Care Staff will continue to ensure that all residents shall receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. Executive Director and Care Manager will continue to obtain and review TB test results prior to admission to ensure no active TB for all residents.	6/29/15 6/29/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/15/2015
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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: 4 To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect related to physical abuse.</p> <p>Based on observation, interviews and record review, the facility failed to protect residents from abuse/physical assault for 3 of 10 sampled resident as related to Resident #6 being physically assaulted by Resident #7, and Residents #'s 9 and 10 being physically assaulted by Resident #3. [Refer to Tag 338, 10A NCAC 13F .0909 Residents Rights (Type A2 Violation)].</p>	D914	<p>Castle Creek Memory Care Administrator, Care Manager, and Care Staff will continue to assure that every resident shall be free of mental and physical abuse, neglect, and exploitation.</p> <p>Castle Creek Memory Care Administrator, Care Manager, and Care Staff will continue to monitor residents for changes in status, will continue to notify the resident's PCP and/or Psychiatrist, will continue to increase supervision and will continue to consider room changes as needed to ensure the rights of all residents. The Administrator and Care Manager will continue to consider discharge of residents when appropriate and will continue to communicate these discharge considerations with Adult Home Specialist and Ombudsman.</p> <p>Residents Rights In-service conducted by Patti Sachetti, Ombudsman for Castle Creek employees.</p>	<p>6/14/15</p> <p>6/14/15</p>



no clinical significance and is not considered a positive test.

10. There is no contraindication to repeating a TST that was previously positive; a TST should be administered if there is no documentation of a prior mm reading.
11. TST is both safe and reliable throughout the course of pregnancy.
12. TST is safe for infants of any age. A negative reading is considered valid for infants at least 6 months of age or older (adjust age for premature infants). A positive reading is valid at any age.
13. TST is not contraindicated for individuals who have been vaccinated with BCG.

B. Reading

1. Read TST in 48-72 hours, preferably at 72 hours:
 - a. instruct individuals to return to the health department if induration occurs after the TST is read
 - b. positive TST reactions occurring after 72 hours are considered valid
 - c. negative TST reactions should be repeated when individuals fail to return within 72 hours
2. Locate induration (not redness) by palpating in a crosswise motion
3. Measure transversely (crosswise or "east to west") to the long axis of the forearm and record this as a single measurement
4. Record reaction in mm (example: 0mm, 16mm) and document date of reading and signature of person reading the test
5. Cold packs or over the counter topical steroid preparations may be used for the relief of pruritus and local discomfort
6. Evidence of severe scarring at an old TST site denotes a prior positive reaction and a repeat TST may not be indicated

C. Interpretation

1. A reaction of ≥ 5 mm induration is considered positive for;



- a. close contacts to an individual with known or suspected infectious tuberculosis within the past 2 years
 - b. those suspected of having active TB disease based on clinical and/or chest x-ray evidence
 - c. individuals with HIV infection
 - d. individuals with fibrotic changes on chest x-ray consistent with prior TB
 - e. individuals with organ transplants and other immunosuppressed patients, including those receiving ≥ 15 mg per day of Prednisone for one month or longer or persons taking or considering taking tumor necrosis factor (TNF) inhibitors such as etanercept (Enbrel®), infliximab (Remicade®), adalimumab (Humira®) or anakinra (Kineret™)
2. A reaction of ≥ 10 mm induration is considered positive for:
- a. children younger than 4 years of age
 - b. foreign-born individuals from high-prevalence countries, e.g. Asia, Africa, Caribbean, Latin America, México, South America, Pacific Islands or Eastern Europe
 - Low-prevalence countries for TB disease are USA, Canada, Japan, Australia, Western Europe and New Zealand
 - c. HIV-negative individuals who inject illicit drugs or use crack cocaine
 - d. individuals with medical conditions that have been reported to increase the risk of tuberculosis disease once infected:
 - diabetes mellitus
 - chronic malabsorption syndrome
 - chronic renal failure
 - leukemia, lymphomas, Hodgkin's disease
 - cancer of the head or neck
 - weight loss of $\geq 10\%$ below ideal body weight
 - silicosis
 - gastrectomy, or jejunioileal bypass
 - e. residents and staff in long-term care facilities
 - f. health care workers with direct patient contact
 - g. inmates in the Department of Corrections
 - h. staff with direct inmate contact in the Department of Corrections and Jails
 - i. employees of HIV/AIDS adult daycare centers
 - j. homeless shelter residents, employees and volunteers
 - k. individuals who increase their mm reading by 10mm or more within 2 years (converter)
 - l. mycobacteriology lab personnel

Herring, Belverly G

From: Kirby, Linda H
Sent: Tuesday, June 30, 2015 8:44 AM
To: mwinstead@nhcgov.com
Cc: Rodgers, Marie; Herring, Belverly G
Subject: Castle Creek MC 2015-06-21 POC
Attachments: Castle Creek Memory Care 2015-06-21 POC H0QO11.pdf

See Attachment.

Thanks,

Linda H. Kirby, RN, Nurse Consultant
North Carolina Department of Health and Human Services
Division of Health Service Regulation - Adult Care Licensure Section
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