

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 000	Initial Comments The Adult Care Licensure Section issued a Notice of Summary Suspension on 07/30/2015. This report is the documentation of noncompliance identified which necessitated the Notice of Summary Suspension and the facility's noncompliance with the Suspension of Admissions licensure action that was in effect.	D 000		
D 022	10A NCAC 13G .0214 Suspension Of Admission 10A NCAC 13G .0214 Suspension Of Admission (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered	D 022		

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

TITLE

(X6) DATE

Division of Health Service Regulation

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D 022	<p>Continued From page 1</p> <p>without the license being affected.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to comply with the Suspension of Admission licensure action in effect by admitting one resident (Resident #1), who had been moved from the facility during the summary suspension licensure action, to the facility after the summary suspension licensure action was lifted.</p> <p>The findings are:</p> <p>Review of the facility's licensure file revealed: -The facility received a Suspension of Admissions via fax on 02/13/2015 and via certified mail on 02/18/15. -The Suspension of Admissions included the following statement: "Therefore, you are hereby ordered to suspend all admissions to the home effective immediately. The Suspension of Admissions is to continue until conditions or circumstances merit removing the suspension."</p> <p>Review of the settlement agreeemnt signed by the facility and in effect on 07/22/2015, the Suspension of Admissions issued on 02/13/2015 remains in effect until lifted by ACLS.</p> <p>On 07/29/15 at 10:35 am, the Notice of Summary Suspension served to the person identified as in charge of the facility revealed: -Residents were to be relocated due to the impact of the health and safety of residents due to no power service. -The facility's license was suspended. -Facility was to not admit any new residents nor re-admit any former residents who were discharged during the summary suspension period.</p>	D 022		

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D 022	<p>Continued From page 2</p> <p>-Admission or re-admission of any resident constituted a breach of the Suspension of Admissions issued in February 2015 and a Settlement Agreement dated July 22, 2015.</p> <p>Observation on 07/30/15 at 10:45 am revealed:</p> <ul style="list-style-type: none"> -There were 6 residents remaining in the facility. -The 6 residents, including Resident #1, were present at the meeting to inform residents of the need to move and that the facility was to close because the power was being shut off that day. -Resident #1 expressed not wanting to leave and that if he was to move then someone would have to pack his stuff up and he had a bed and lots of things and he was going to his brother's place. -One of the local county Social Services staff told Resident #1 the county would take care of moving the resident's belongings, including his bed. -Resident #1 nodded his head in agreement. <p>Observation at 11am on 07/30/15 revealed:</p> <ul style="list-style-type: none"> -Resident #1's bed being loaded into a pickup truck by staff with mental health agency and department of social services. -Resident #1's personal belongings being packed up by staff with mental health agency and county Social Services. -Resident #2's belongings were being packed up by the staff with the facility, the resident was moving to. <p>Observation of Resident #1 at 11:05 am on 7/30/15 revealed Resident #1 in the entrance area talking to staff and other individuals.</p> <p>Observation of Resident #2 at approximately 11:20 am, the resident was leaving the facility with the staff from the admitting facility. The resident's belongings had already been packed</p>	D 022		

Division of Health Service Regulation

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D 022	<p>Continued From page 3</p> <p>and loaded for moving.</p> <p>Observation on 07/30/15 at 11:30 am revealed Resident #1 leaving the premises of the facility.</p> <p>Interview on 07/30/15 at 11:35 am with staff with the Adult Care Licensure Section revealed: -Information from the electrical utility company had been received and the facility had made a sufficient payment to the electric utility company and there was no longer a threat of service disconnection. Therefore, the service would not be disconnected. -The Summary Suspension would be lifted but readmission of residents was not allowed as stated in the Summary Suspension notification served.</p> <p>On 07/30/15 at 11:55 am, the person identified as person in charge was informed of the decision regarding the Summary Suspension lifted and was informed that residents were not be readmitted and no contact with the residents who had moved or the facilities receiving the residents regarding the residents could return to the facility. The person in charge acknowledged understanding the information shared.</p> <p>Observation and interview on 07/30/15 at 12:10 pm with the Franklin County DSS revealed there were 3 residents currently at the facility.</p> <p>On 07/30/15 at 4:36 pm, Franklin County DSS contacted the Adult Care Licensure Section to inform the Section that Resident #1's family member had brought the resident back to the facility. The resident's family member told Franklin County DSS staff that the person in charge at the facility had called him and told him that the resident could come back to the facility.</p>	D 022		

Division of Health Service Regulation

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D 022	<p>Continued From page 4</p> <p>Review of an email dated 07/31/15 at 10:22 am from the facility manager revealed: -He witnessed via camera 2 residents (Resident #1 and Resident #2) leave the building after the suspension was lifted. -Both residents left with families. -He did not understand how residents are forcibly discharged after the suspension was lifted. -These two residents did not have anywhere to go.</p> <p>Interview on 07/31/15 at 11:05am with staff at the facility that Resident #2 was discharged to revealed the resident was currently at the facility and adjusting well.</p> <p>Interview with a family member on 07/31/15 at 11:15am revealed: -He was contacted by Resident #1 and told the resident had to leave cause the facility power was to be shut off. -He was told by the person in charge at the facility when he picked Resident #1 up that the power bill was paid and the resident could return. -"Resident #1 was only visiting for a while." -Resident #1 only had a one day supply of medication with him/ -Somebody brought the bed to his house and did not even ask about him or Resident #1. -Resident #1 was back at the facility and doing OK.</p> <p>Interview with a staff person with the local management care organization at 11:30 am on 07/31/15 revealed -The staff person is a peer support specialist and works with Resident #1. -He was told the facility was closing and they found a location willing to accept Resident #1 but</p>	D 022		

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D 022	<p>Continued From page 5</p> <p>Resident #1 wanted to go with his brother. -He helped packed up all of Resident #1's belongings, including the resident's bed, and moved Resident #1 to Resident #1's family member's house. -All of Resident #1's medications were provided when resident left and taken to the family member's house. Medications were in a plastic bag. -The Quality Professional that he works with talked to Resident #1's family member about resident having to move. -Resident #1's family member was at facility when meeting held with residents about having to move. -He had discussed with Resident #1 about he was trying to get the resident food stamps and also changing the address for his social security income.</p> <p>Review of email dated 07/31/15 from the Adult Care Licensure Section's attorney to the facility provider's attorney revealed Resident #1 would not be required to leave the facility since the resident was already there however, this was a violation of the Suspension of Admissions.</p>	D 022		
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: TYPE B VIOLATION</p>	D 105		

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D 105	<p>Continued From page 6</p> <p>Based on interview and record review, the facility failed to ensure all fire safety, electrical, mechanical equipment was maintained in a safe and operating condition as evidenced by notice of the electric utility company of service disconnection and failure to resolve the service disconnection until residents were being relocated. The findings are:</p> <p>Interview with a supervisor of a local electric utility company the afternoon of 07/23/15 revealed:</p> <ul style="list-style-type: none"> -The facility was a customer of the company and the electric utility company was contacting the Adult Care Licensure Section (ACLS) regarding service for the facility. -The electric utility company was ready to disconnect service and was requesting all residents be removed from the facility so they would not be in danger. -The facility owed an outstanding amount and the electric utility company had been unable to either contact the facility representative, facility manager, or the facility had failed to follow through with payments as agreed upon. -When asked if the facility had been recently notified of the company ' s intent to disconnect service, the supervisor wanted "to assure" the Section that multiple attempts have been made to resolve the matter. The company had spoken with the facility manager on several occasions over the past 2 months. -The company is limited with the information that may be shared but by the time accounts were sent to her office, the company had made multiple attempts to settle the matter. These issues have been reviewed by legal and other management in the company. -Disconnecting service is a last resort for the company and the company wanted to ensure the residents are moved before disconnecting 	D 105		

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D 105	<p>Continued From page 7</p> <p>service.</p> <p>-The purpose of contact with ACLS at this time was to inform the Section of the company's plans, request immediate removal of the residents and to find out how much time would be needed for the residents to be relocated.</p> <p>-When asked what was the final date the bill could be paid, it was explained that the final dates for payment had past and the decision to disconnect the facility's service and remove the meter was made and would occur as soon as the residents were out of the facility.</p> <p>Review of email dated 07/23/2015 from the representative of the electric utility company revealed:</p> <p>-The company was in the process of disconnecting the electric service of the facility.</p> <p>-Required notice by the company had been provided to the facility.</p> <p>-The company was requesting the Section to transfer all residents form the facility before the electrical service was disconnected.</p> <p>Review of emails dated 07/23/15 between the attorneys representing Adult Care Licensure Section and the attorneys representing the facility revealed:</p> <p>-Attorney for ACLS (AA) contacted the facility's attorney (AF) on 07/23/15</p> <p>-AA explained the ACLS had been contacted to move residents due to service disconnection.</p> <p>-AF documented that the facility manager had been in contact with the electric utility company and made arrangements to pay the bill on Monday, July 27th and that payment was acceptable to the electric utility company. AF had requested written confirmation from the electric utility company from her client and would provide when received.</p>	D 105		

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D 105	<p>Continued From page 8</p> <p>-AA shared with AF the name of the electric utility company representative who contacted Adult Care and provided the contact number and email address.</p> <p>-AF provided the online account information obtained via the electric company's email and documented the service would be disconnected if not paid by 07/28/15. AF wrote the facility manager would contact the representative at the electric company on 07/24/15.</p> <p>Review of the emails between AA and AF dated 07/24/15 revealed:</p> <p>-AA shared the facility manager needed to contact the representative at the electric company about payments.</p> <p>-AF communicated the facility manager had been in contact with one of the representative's employees and payment arrangements were made. The facility manager did not have any documentation but said one of the employees would confirm.</p> <p>Telephone conversation with the electric utility company supervisor on 07/23/15 revealed:</p> <p>-The facility manager had made contact with a company representative, however, not the appropriate department that the facility manager was directed to contact to resolve the issue.</p> <p>-ACLS would be contacted, if sufficient payment was not made, about the service being disconnected.</p> <p>Telephone conversation with the electric utility company supervisor at 12:10 PM on 07/28/15 revealed:</p> <p>-There had been no changes to the account, payment arrangements had not been met and wanted to find out how long it would take to move residents.</p>	D 105		

Division of Health Service Regulation

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D 105	<p>Continued From page 9</p> <p>-A technician would be onsite at the facility at the time scheduled and confirm that all residents had been moved before the service was disconnected.</p> <p>Review of email dated 07/29/15 to ACLS from the supervisor of the electric utility company revealed: -The email was communication notifying ACLS that the company had disconnection of the electric service for the facility scheduled on Thursday, July 30, 2015. -The technician would confirm with ACLS staff onsite that all residents had been removed from the facility and proceed with the disconnection.</p> <p>Interview with Franklin County Department of Social Services on 07/29/15 at approximately 10:20 am revealed: -Franklin County DSS representatives were onsite and residents were being informed about the service disconnection. -Residents were told that upon request of the electric utility company and to ensure residents were not left without power, the residents needed to be relocated. -Ten residents volunteered to be relocated.</p> <p>On 07/29/15 at 9:12 am, telephone call with the electric utility company supervisor revealed: -No payment had been made on the account. -A service technician would be on-site to remove the meter.</p> <p>On 07/29/15 at 10:35 am, Notice of Summary Suspension was served to the facility.</p> <p>On 07/29/15 at 10:43 am, telephone call with the electric utility company supervisor revealed: -No payment had been made on the account. -A service technician would be on-site at noon to</p>	D 105		

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D 105	<p>Continued From page 10</p> <p>remove the meter.</p> <p>On 07/29/15 at 11:34 am, notification was received from the electric company that a payment was pending and service disconnection was canceled at this time.</p> <p>Although the power to the facility was not disconnected due to residents being in the facility and not due to the facility implementing appropriate action to ensure the service was maintained. No power conditions would affect the fire alarm, sprinkler systems, lighting, cooking, food storage and other services needed for the care and safety of residents.</p> <hr/> <p>The Plan of Protection was the disconnection of the service was cancelled by the electric utility company on 07/30/2015.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2015.</p>	D 105		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated with consideration as evidenced by notice of the electric utility company of service</p>	D 338		

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D 338	<p>Continued From page 11</p> <p>disconnection and failure to resolve the service disconnection until residents were being relocated. The findings are:</p> <p>Interview with a supervisor of a local electric utility company the afternoon of 07/23/15 revealed:</p> <ul style="list-style-type: none"> -The facility was a customer of the company and was contacting the Adult Care Licensure Section (ACLS) regarding service for the facility. -The power company was ready to disconnect service and was requesting all residents be removed from the facility so they would not be in danger. -The facility owed an outstanding amount and had been unable to either contact the facility representative, facility manager, or the facility had failed to follow through with payments as agreed upon. -When asked if the facility had been recently notified of the company's intent to disconnect service, the supervisor wanted "to assure" the Section that multiple attempts have been made to resolve the matter. The company had spoken with the facility manager on several occasions over the past 2 months. -The company is limited with the information that may be shared but by the time accounts were sent to her office, the company had made multiple attempts to settle the matter. These issues have been reviewed by legal and other management in the company. -Disconnecting service is a last resort for the company and the company wanted to ensure the residents are moved before disconnecting service. -The purpose of contact with ACLS at this time was to inform the Section of the company's plans, request immediate removal of the residents and to find out how much time would be needed for the residents to be relocated. 	D 338		

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D 338	<p>Continued From page 12</p> <p>-When asked what was the final date the bill could be paid, it was explained that the final dates for payment had past and the decision to disconnect the facility's service and remove the meter was made and would occur as soon as the residents were out of the facility.</p> <p>Review of email dated 07/23/2015 from the representative of the electric utility company revealed:</p> <p>-The company was in the process of disconnecting the electric service of the facility. -Required notice by the company had been provided to the facility. -The company was requesting the section to transfer all residents form the facility before the electrical service was disconnected.</p> <p>Review of emails dated 07/23/15 between the attorneys representing Adult Care Licensure Section and the attorneys representing the facility revealed:</p> <p>-Attorney for ACLS (AA) contacted the facility's attorney (AF) on 07/23/15 -AA explained the ACLS had been contacted to move residents due to service disconnection. -AF documented that the facility manager had been in contact with the electric utility company and made arrangements to pay the bill on Monday, July 27th and that payment was acceptable to the electric utility company. AF had requested written confirmation from the electric utility company from her client and would provide when received. -AA shared with AF the name of the electric utility company representative who contacted Adult Care and provided the contact number and email address. -AF provided the online account information obtained via the electric company's email and</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2015
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NAME OF PROVIDER OR SUPPLIER ESSEX MANOR ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 844 HIGHWAY 39 S. LOUISBURG, NC 27549
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D 338	<p>Continued From page 13</p> <p>documented the service would be disconnected if not paid by 07/28/15. AF wrote the facility manager would contact the representative at the electric company on 07/24/15.</p> <p>Review of the emails between AA and AF dated 07/24/15 revealed: -AA shared the facility manager needed to contact the representative at the electric company about payments. -AF communicated the facility manager had been in contact with one of the representative's employees and payment arrangements were made. The facility manager did not have any documentation but said one of the employees would confirm.</p> <p>Telephone conversation with the electric utility company supervisor on 07/23/15 revealed: -The facility manager had made contact with a company representative, however, not the appropriate department that the facility manager was directed to contact to resolve the issue. -ACLS would be contacted, if sufficient payment was not made, about the service being disconnected.</p> <p>Telephone conversation with the electric utility company supervisor at 12:10 PM on 07/28/15 revealed: -There had been no changes to the account, payment arrangements had not been met and wanted to find out how long it would take to move residents. -A technician would be onsite at the facility at the time scheduled and confirm that all residents had been moved before the service was disconnected.</p> <p>Review of email dated 07/29/15 to ACLS from the</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 14</p> <p>supervisor of the electric utility company revealed: -The email was communication notifying ACLS that the company had disconnection of the electric service for the facility scheduled on Thursday, July 30, 2015. -The technician would confirm with ACLS staff onsite that all residents had been removed from the facility and proceed with the disconnection.</p> <p>Interview with Franklin County Department of Social Services on 07/30/15 at approximately 10:20 am revealed: -Franklin County DSS representatives were onsite and residents were being informed about the service disconnection. -Residents were told that upon request of the electric utility company and to ensure residents were not left without power, the residents needed to be relocated. -Ten residents volunteered to be relocated.</p> <p>On 07/30/15 at 9:12 am, telephone call with the electric utility company supervisor revealed: -No payment had been made on the account. -A service technician would be on-site to remove the meter.</p> <p>On 07/30/15 at 10:35 am, Notice of Summary Suspension was served to the facility.</p> <p>Observation on 07/30/15 during the meeting to inform residents of the Summary Suspension revealed: - 6 residents in the dining room. - 2 of the residents expressed not wanting to relocate and having to pack everything up so suddenly.</p> <p>On 07/30/15 at 10:43 am, telephone call with the electric utility company supervisor revealed:</p>	D 338		

Division of Health Service Regulation

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D 338	<p>Continued From page 15</p> <p>-No payment had been made on the account. -A service technician would be on-site at noon to remove the meter.</p> <p>On 07/30/15 at 11:34 am, notification was received from the electric company that a payment was pending and service disconnection was canceled at this time. Although the power to the facility was not disconnected due to residents being in the facility and not due to the facility implementing appropriate action to ensure the service was maintained. No power conditions would affect the fire alarm, sprinkler systems, lighting, cooking, food storage and other services needed for the care and safety of residents.</p> <p>Due to non-payment and threat of disconnection as a result of the facility's failure to pay the bill, residents had to be abruptly relocated and their daily lives disrupted. The facility failed to ensure the protection of residents and provision of goods and services.</p> <p>_____</p> <p>The Plan of Protection was the disconnection of the service was cancelled by the electric utility company on 07/30/2015.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2015.</p>	D 338		
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p>	D911		

Division of Health Service Regulation

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D911	Continued From page 16 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were treated with consideration as evidenced by failure to resolve the service disconnection by the electric utility company until residents were being relocated. The findings are: Based on observation, interview and record review, the facility failed to ensure residents were treated with consideration as evidenced by notice of the electric utility company of service disconnection and failure to resolve the service disconnection until residents were being relocated. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation)]	D911		
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 observation, interview and record review, the facility failed to ensure residents received appropriate care and services in accordance with relevant federal and state laws and rules and regulations related to maintenance and safe operating condition of electrical, fire safety and mechanical equipment.	D912		

Division of Health Service Regulation

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D912	<p>Continued From page 17</p> <p>The findings are:</p> <p>Based on interview and record review, the facility failed to ensure all fire safety, electrical, mechanical equipment was maintained in a safe and operating condition as evidenced by notice of the electric utility company of service disconnection and failure to resolve the service disconnection until residents were being relocated. {Refer to Tag 105, 10A NCAC 13F .0311 (a) Other Requirements (Type B Violation)}</p>	D912		