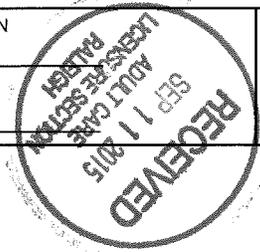


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| D 000 | <p>Initial Comments</p> <p>The Adult Care Licensure Section conducted an annual survey and complaint investigation on August 4-7; 10-12, 2015 with an exit conference via telephone on August 12, 2015. The complaint investigation was initiated by Wake County Human Services on July 15, 2015.</p> | D 000 | <p>D206-From 7am-9pm we have a designated laundry aide in place. Housekeeping is in place to address routine cleanings and housekeeping tasks.</p> | 8/7/15 |
| 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: Based on observation, interview, and record review, the facility failed to ensure housekeeping duties performed by aides on first and second shift were limited to non-routine tasks.</p> <p>The findings are:</p> | D 206 | | |

Confidential staff interviews revealed:
-"We're staffed with one personal care aide and one medication aide for these 30 residents."
-"It's impossible to give quality care, much less showers to these residents."
-"We are required to wash and dry the resident's

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Confidential staff interviews revealed:
- "We're staffed with one personal care aide and one medication aide for these 30 residents."
- "It's impossible to give quality care, much less showers to these residents."
- "We are required to wash and dry the resident's

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| D 206 | <p>Continued From page 1</p> <p>personal laundry and bed sheets, listen for call lights, in addition to provide am care, pass medications on time, bring residents to the dining room that are unable to propel themselves in their wheelchairs, do activities and provide showers.</p> <p>-There was no staffed laundry personnel for 100 or 200 hall.</p> <p>-Staff were expected to wash, dry, and put away at least two residents personal laundry, bedsheets during their shift, and wash the dining room table linens after each meal.</p> <p>-Having to do housekeeping duties took staff away from direct personal care of residents.</p> <p>-One personal care aide or nursing assistant and one medication aide were assigned to an average of 28 residents.</p> <p>-Four to five of those residents required total assistance.</p> <p>A confidential staff interview revealed: -"Many residents required two person-assist to shower. -Most residents were supposed to get three showers a week. I can assure you they are not getting done. We only have one nursing assistant and one medication aide scheduled, period. These residents get bed baths. At the very best we have done in the past was to provide one shower a week to them. "</p> <p>A fourth confidential staff interview revealed: -There were not enough staff to give showers as many residents required 2-person assist. -These residents were supposed to get 3 showers a week but rarely did they get one a week.</p> <p>An eighth confidential staff interview revealed: - Showers were not being done all over the facility due to staffing.</p> | D 206 | | |

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| D 206 | <p>Continued From page 2</p> <p>- "We don't have the staff to do 2-person assist."</p> <p>Confidential resident interviews revealed:</p> <p>- "I have to wait until after breakfast sometimes to use the bathroom because there's nobody to take me."</p> <p>- The resident had not taken a shower since admission a month ago.</p> <p>- She took "bird baths from her sink" in her bathroom because there was not enough help to go around, and she required the assistance of 2 staff if she got a shower.</p> <p>- She required 2 staffs' assistance if she was to have a shower; toileting and dressing took time to do; if she needed to go to the bathroom and staff were not available she might wet herself.</p> <p>- Staff were required to do laundry during all shifts. - "They don't have enough help around here. - Residents felt rushed because of all the tasks staff had to do.</p> <p>- "Staff is so busy; I'm amazed that nothing has happened."</p> <p>- "The staff that are here are good and doing the best they can."</p> <p>- It's by God's grace that we haven't had a tragedy yet."</p> <p>- Showers were not being given due to the combination of the current staffing situation and the extra housekeeping and dietary duties required.</p> <p>Interview with a Personal Care Aide (PCA) on 8/5/15 at 12:15 pm revealed that the PCA's assigned duties include personal care , dietary aide, laundry and housekeeping.</p> <p>Interview with a resident's family member on 8/12/15 at 1:50 pm revealed:</p> <p>- Resident has lived at facility for almost nine years.</p> <p>- Personal care aides have to take care of</p> | D 206 | | |
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D 206 Continued From page 3
residents, setting up dining room and clean the dining room for each meal.

D 206

D 209 10A NCAC 13F .0604 (2-e) Personal Care And

D 209

8/7/15

Other Staffing

D209-We have a dietary aide assigned to routine food service duties in all dining rooms during meal time. Care staff are no longer responsible for setting or clearing of tables. Designated care staff are assigned to care duties only during meal times. It is expected that there are sufficient aide staff to provide for the needs of the residents, including those who are in the dining room at meal time and those who do not go to the dining room at meal time.

10A NCAC 13F .0604 Personal Care Other Staffing

The following describes the nature of the aide's duties, including allowances and limitations

(E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Base on observation, interview and record

review, the facility failed to ensure that food service duties assigned to personal care aides were limited to providing assistance to individuals residents and carrying plates, trays or beverages to residents and resulted in residents needs not being met.

The findings are:

Observation on 8/5/15 at 9:15am revealed:

- One personal care aide and one medication aide on the floor for 30 residents on the 200 hall.
- The medication aide was treating a bleeding skin tear on the arm of a resident in the medication room.
- Staff were still trying to get residents from their

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| D 209 | <p>Continued From page 4</p> <p>rooms to the dining room from 100 and 200 hall for the breakfast meal service. While other staff were trying to get resident who had finished there breakfast back to their rooms.</p> <p>-The medication pass was interrupted by the lack of staff and residents still needing toileting and am care including dressing the residents during breakfast meal service time.</p> <p>Interview with a Resident on 8/5/15 at 9:15am revealed he had been waiting for 15 minutes to be seen and treated for a bleeding skin tear.</p> <p>-"They don't have enough help around here. They have to work like they're in a restaurant."</p> <p>-"How in the hell are 2 people supposed to get everybody in and out of the dining room and take care of us too? It's too much."</p> <p>A confidential staff interview revealed:</p> <p>-"We're staffed with one personal care aide and one medication aide for these 30 residents." -</p> <p>"We are required to set the dining room tables, serve plates to the residents, pour water and drinks during the meals, clear the table after the residents have eaten, wash and dry the table linens, in addition to, listen for call lights, provide heavy care and am care, bring certain residents to the dining room that are unable to propel themselves in their wheelchairs, provide showers, and assist with activities."</p> <p>-There was no dietary aide in the dining room during meals.</p> <p>-"It's impossible to give quality care, much less showers to these residents."</p> <p>-Staff were expected to provide up to 7 showers, wash, dry and put away at least 2 resident's laundry during their shift, be available to answer call lights, provide personal care, bus the dining room tables after meals, and wash the dining room table linens.</p> | D 209 | | |
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| D 209 | <p>Continued From page 5</p> <p>-Personal care aides or nursing assistants and medication aides floated to different areas of the facility.</p> <p>-"You might get tied up in a resident's room for 30 minutes and another call light would go off and you would have to leave that resident to make sure it wasn't an emergency going on in another resident's room."</p> <p>-It was not unusual for the call light to alarm for 30 minutes.</p> <p>-"A resident fell while I was trying to set up the dining room. I don't know how long the resident was down before someone found out."</p> <p>A third confidential staff interview revealed:</p> <p>-Staff were required to float to the special care unit, assisted living and the secured assisted living.</p> <p>-"We are so short staffed now and we are put into situations where we are trying to get people up and do am care, give showers, it's all that we can do to answer call lights."</p> <p>-"There is no way to be in two places at the same time. I've been in dangerous situations where I had 1 resident in the shower room and two call lights were going off at the same time. I had to leave the resident in the shower room and went to the resident I couldn't get to in time before she threw up all over herself and her bed, then go answer the 3rd call light and do care, and come back and apologize to the resident left in the shower room."</p> <p>-Whoever was scheduled helped each other as best that they could.</p> <p>A fourth confidential staff interview revealed: - "People are hired and quit the first day when they find out what is required of them during a shift." - Residents were getting to breakfast late because there was not enough staff to meet the needs of</p> | D 209 | | |
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| D 209 | <p>Continued From page 6</p> <p>the residents. -Management was aware but had not made changes in the staffing schedules.</p> <p>A fifth confidential staff interview revealed: - One personal care aide or nursing assistant and one medication aide were assigned to an average of 28 residents. -Four to five of those residents required total assistance. -There was no consistency because staff were floated every day. -Many residents got breakfast late and sometimes staff ended up taking their meals to their rooms. -Residents were complaining about being late to meals and having to wait so long before their call lights were answered.</p> <p>A sixth confidential staff interview revealed: -Staff had to go all the way into the medication room to view the call light alarm system board just to see who is ringing for help. -If you were not a medication aide you would not have keys to the medication room and have to find the medication aide to get the key to unlock the door just to view who was ringing their call light. "We know the residents feel like we are rushing them and they don't get quality care. How do you think that makes us feel?"</p> <p>Observation on 8/5/15 at 4pm revealed a resident was sitting in front of the medication room for 15 minutes.</p> <p>Interview with this resident revealed: - He was requesting a PRN medication but the staff were too busy with other duties to help him. -"I feel sorry for them."</p> | D 209 | | |
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| D 209 | <p>Continued From page 7</p> <p>Confidential resident interviews revealed: -"I had to wait 20 minutes after I rang for help." -Breakfast was served at 8am and supper at 5pm. -It was normal not to get to breakfast as late as 9:30am. -It was usually 6-7pm before the resident got supper.</p> <p>Another confidential resident interview revealed: -"For the residents like myself who are independent it was very difficult to watch other residents who were in pain or just wanted to go back to their rooms after meals just sitting there." -"Staff is so busy; I'm amazed that nothing has happened." -"The staff that are here are good and doing the best they can." -It ' s by God's grace that we haven't had a tragedy yet." -"We've had 30 people on this floor and it happens every day that someone calls out for help and has to wait a long time." -" It is scary for residents who cannot do for themselves. There is no way humanly possible to get everything done with the staffing number we have here."</p> <p>A third confidential resident interview revealed: - -"There is not enough help especially for us in wheelchairs. We even need more assistance getting closer to the tables in the dining room." -"We need help getting to and from meals; there is not enough staff to help at meals." -"I have to wait till after breakfast sometimes to use the bathroom because there's nobody to take me." -"Staff are rushed because there are so many people to take to meals and staff have to serve</p> | D 209 | | |
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| D 209 | <p>Continued From page 8</p> <p>the food and bus the tables in the dining room." - Staff were required to do laundry and work in the dining room.</p> <p>-The resident had not taken a shower since admission.</p> <p>-She took " bird baths from her sink" in her bathroom because there was not enough help to go around, and she required the assistance of 2 staff if she got a shower.</p> <p>-She was incontinent and required 20-30 minutes of care every am.</p> <p>-She pulled the chain in her bathroom to ring for help. A 15 minute response time was not uncommon.</p> <p>-She liked the staff that helped her but always felt rushed.</p> <p>Confidential interviews with 4 residents revealed:</p> <ul style="list-style-type: none"> - The resident did not get showered, she got bed baths. - Staff cannot get her in a tub to shower her safely. - She had not been showered in a week, although she should be showered 3 days per week. - The resident is terrified of falling, so she did not get showered. <p>Observation of the lunch meal in the 2nd floor dining room on 8/5/15 between 12:05pm and 12:45pm revealed:</p> <ul style="list-style-type: none"> - Thirty five residents from the 100 hallway and 200 hallway of the assisted living building, were seated in the dining room for lunch. - The kitchen staff brought food over to the kitchenette from the main kitchen in the other building in food carts. - There was one kitchen staff that plated the food in the kitchenette and passed the plated food to the two personal care aides (PCA), one medication aide (MA), the business office | D 209 | | |
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| D 209 | <p>Continued From page 9</p> <p>coordinator (BOC) and Regional Director of Marketing.</p> <ul style="list-style-type: none"> - The two PCAs, one MA and BOC and Regional Director of Marketing served the residents. - The PCAs and MA remained in the dining room throughout the meal and passed out the soup, salad, entrees, poured beverages, fed residents, and bussed the tables after the meal. - There was no dietary aide present during meal service. - During the meal service one of the aides served rice to a resident and she was informed by the resident that she was allergic to rice and requested to be served something different. <p>Interview with Resident #11 on 8/5/15 at 3:35pm revealed:</p> <ul style="list-style-type: none"> - She is allergic to rice and rice products, with an anaphylaxis reaction. - Different staff have offered rice to her quite often. - A few of the staff are aware of her rice allergy, but the dining staff change so frequently. <p>A second Interview with the PCA on 8/5/15 at 12:35 revealed</p> <ul style="list-style-type: none"> - She was not familiar with the residents in the assisted living building. - She did not know Resident #11 was allergic to rice. - Resident #11 informed her she was allergic to rice and she immediately took the plate away and served her noodles instead. <p>Interview with the Executive Director on 8/5/15 at 3:50pm revealed:</p> <ul style="list-style-type: none"> - The dietary aides do not serve residents in the dining room. - The PCAs are responsible for serving | D 209 | | |
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| D 209 | <p>Continued From page 10</p> <p>residents in the dining room.</p> <ul style="list-style-type: none"> - There was a diet list posted in the dining room for PCAs to use to refer to the diet types and allergies of each resident. <p>Observation of the dining room and kitchen on 8/5/15 at 4:00pm revealed:</p> <ul style="list-style-type: none"> - There was not a diet list posted on the dining room wall. - There was a diet list with a sign describing Resident #11 as being allergic to rice and associated products including, in the main kitchen and in the kitchenette in assisted living building. - The sign on the kitchenette was visible to the dietary staff in the kitchen. - There was a wall separating the information on the wall from the direct care staff serving the meal to the residents. <p>Interview with the Dietary Director on 8/6/15 at 9:55am revealed:</p> <ul style="list-style-type: none"> - The kitchen staff were not responsible for serving the residents in the dining room. - The kitchen assistants were responsible for meal preparation and the cook was responsible for plating the food and passing the plates to the PCAs to serve. - Dining room meal service was the responsibility of the PCAs. - The PCAs were responsible for setting the tables for each meal and breaking down the tables, serving the residents, and breaking down the tables following each meal service. <p>Another Confidential staff interview revealed: - "We have to bus tables in the dining room and are still trying to get people up out of bed and dressed." -"Residents are late getting to breakfast and complaining to us about it. Sometimes we are so</p> | D 209 | | |
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| D 209 | <p>Continued From page 11</p> <p>far behind we just have to bring them a meal to their room."</p> <p>Observation of the 2nd floor Assisted Living on 8/4/15 between 11:25 and 11:50am revealed:</p> <ul style="list-style-type: none"> - At 11:15am the personal care aide (PCA) assigned to the floor was in a room with a resident. - At 11:20am Resident #1 was in the bathroom alone. - At 11:25 am the medication aide (MA) was in the dining room setting the table. - No other direct care staff was observed on the 2nd floor. - At 11:47 am Resident #1 was on the floor in her room calling for help. - The MA or PCA did not hear the resident calling out. - The business office coordinator and the Executive Director heard the resident calling out and entered the room. - Resident #1 was found on the floor caught on her wheelchair between the bed, wheelchair and bedside table. - Resident #1 said she slid off of the bed. - The Executive Director went to the dining room to get the MA. - The MA arrived to assess Resident #1 for pain or injury. <p>Observation of the lunch meal in the 2nd floor dining room on 8/5/15 between 12:05pm and 12:45pm revealed:</p> <ul style="list-style-type: none"> - A resident was self- propelling down the hallway trying to get to lunch, when she got to the dining room, the salads and soups had already been handed out so the resident received a beverage, entrée, and desert. <p>Interview with a PCA on 8/5/15 at 10:30am</p> | D 209 | | |

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| D 209 | Continued From page 12 revealed: - She was working as a floater on 8/5/15 it was her first day as a floater. - She had been scheduled to work regularly as a laundry aide and on the special care unit as a PCA. Observation of the lunch meal on 8/5/15 revealed: - There was one MA and two PCAs served the lunch meal. - There was no direct care staff on the floor. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26,2015 | D 209 | | |
| D 210 | 10A NCAC 13F .0604 (3) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (3) In addition to the staffing required for management and aide duties, there shall be sufficient personnel employed to perform housekeeping and food service duties. (f) Information on required staffing shall be posted in the facility according to G.S. 131D-4.3(a)(5). This Rule is not met as evidenced by: Based on observations and interviews; the facility failed to ensure sufficient personnel to perform housekeeping duties and food service duties. | D 210 | D210-We have a dietary aide assigned to routine food service duties in all dining rooms during meal time. Care staff are no longer responsible for setting or clearing of tables. Designated care staff are assigned to care duties only during meal times. It is expected that there are sufficient aide staff to provide for the needs of the residents, including those who are in the dining room at meal time and those who do not go to the dining room at meal time. | 8/7/15 |

The findings are:

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| D 210 | <p>Continued From page 13</p> <p>Confidential resident interviews revealed: -"They don't have enough help around here. They have to work like they're in a restaurant." -"How in the hell are 2 people supposed to get everybody in and out of the dining room and take care of us too? It's too much." -"There is no way humanly possible to get everything done with the staffing number they use here." -"I haven't had a bath or shower since I've been here. I need two people to help me. They are supposed to know that. There aren't enough staff to do that here. I clean myself the best I can. I would like to be able to take a bath. I haven't told anybody I haven't had a bath because I don't think they have time to."</p> <p>Confidential staff interview revealed: -This was an everyday occurrence to only have one personal care aide and one medication aide for 30 residents. -"We are required to set the dining room tables, serve plates to the residents, pour water and drinks during the meals, clear the table after the residents have eaten, wash and dry the table linens, wash and dry the resident's personal laundry and bed sheets, listen for call lights, provide heavy care and am care, bring certain residents to the dining room that are unable to propel themselves in their wheelchairs, pass medications on time, provide showers, and assist with activities." "We have to bus tables in the dining room and are still trying to get people up out of bed and dressed." -"Residents are late getting to breakfast and complaining to us about it. Sometimes we are so far behind we just have to bring them a meal to their room." -There was no laundry personnel for 100 or 200</p> | D 210 | | |

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| D 210 | <p>Continued From page 14</p> <p>hall.</p> <ul style="list-style-type: none"> -There was no dietary aide in the dining room during meals. -It was common to only have one housekeeper for the entire facility(2 buildings). -Staff could not remember having a dietary aide in the dining room. <p>Confidential family interview revealed:</p> <ul style="list-style-type: none"> -Family member only saw one housekeeper for the entire facility (2 buildings). -Family could not comprehend how one or two housekeepers could clean all the floors, resident rooms, bathrooms, and take care of any emergencies that might come up. -Resident's roommate had diarrhea and could not make it to the bathroom so some feces ended up on the carpeted floor. -Family alerted staff to request the housekeeper to come clean the floor but it took that person a "long time" to come because of being so short-staffed. -The housekeeper did eventually clean up the soiled areas of the carpet. -"Feces on the floor should have been a priority." <p>Another confidential family interview revealed: - Staffing was an issue in both buildings. -There was no staff trained to work in the dining room.</p> <ul style="list-style-type: none"> -There was no laundry personnel. -The family had cleaned their resident's bathroom before because it was "filthy." -The facility did not have enough staff to properly take care of residents. -"I can assure you that people that can't do for themselves are not getting showers." <p>Confidential interview on 8/5/15 at 11:40 am revealed:</p> <ul style="list-style-type: none"> - Duties are to plate food, wash dishes, do | D 210 | | |
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| D 210 | <p>Continued From page 15</p> <p>snacks, prepare salads and assist cook.</p> <ul style="list-style-type: none"> - Dietary staff do not go out on the dining room floor to serve residents their plates. - The floor staff such as the personal care aides serve plates to residents. - They stated "we need more help". <p>Interview with a Personal Care Aide (PCA) on 8/5/15 at 12:15 P.M. revealed:</p> <ul style="list-style-type: none"> - Dietary Aids do not serve food to residents. - PCAs' assigned duties include personal care, dietary, laundry and housekeeping. <p>Interview with Dining Services Director on 8/5/15 at 12:50 pm revealed:</p> <ul style="list-style-type: none"> - Was hired in April 2015. - There is usually one cook and two dietary aides per shift. - The dietary aides prep deserts, wash dishes and do basic sanitation such as keeping kitchen area clean. - Dietary aides do not do any of the serving of plates to the residents. - That's the responsibility of the personal care assistants. <p>Confidential interview on 8/5/15 at 12:57 pm revealed:</p> <ul style="list-style-type: none"> - There is extra staff in today. - Lunch time is usually longer because there is less staff. - The facility staff does not have enough staff to take care of residents and complete all the other duties that are assigned. - Residents have to wait as long as 20 minutes to get assistance. <p>Confidential resident interview on 8/6/15 at 10:05 am revealed:</p> <ul style="list-style-type: none"> - She states that they need to hire more help. | D 210 | | |

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| D 210 | Continued From page 16 - She states that it is too much for "the girls to have to do". Interview with Resident's family member on 8/10/15 at 1:30 pm revealed: - On Sunday nights sometimes the personal care aides leave the dining room and residents that need assistance with feeding are not fed. Confidential interview on 8/10/15 at 2:15 pm revealed: - When I started there was a laundry person. - There is one laundry for both buildings. - If there is a person designated as a laundry person, they do not stay in that position for long before they are pulled to do personal care aide duties. | D 210 | | |
| D 255 | 10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment | D 255 | D255-Resident re-assessed for condition change. Care plan updated. Will continue monitoring for additional changes in condition. We will initiate another assessment within 10 days of the change in condition. Current care plan meeting residents needs, coordinating with Hospice services provided. Any change in weight of 5lbs. or greater the physician will be notified and notification and recommendations will be documented in the residents chart. | 9/9/15 |

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| D 255 | <p>Continued From page 17</p> <p>for an identified problem;</p> <p>(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;</p> <p>(G) threat to life such as stroke, heart condition, or metastatic cancer;</p> <p>(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;</p> <p>(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;</p> <p>(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;</p> <p>(K) new onset of impaired decision-making;</p> <p>(L) continence to incontinence or indwelling catheter; or</p> <p>(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure an assessment was completed within 10 days following a significant change in 1 of 1 sampled resident's condition. (#16) The findings are:</p> <p>Review of Resident #16's current FL-2 dated 5/15/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of CVA, Dementia, Hypertension - Required limited assistance to eat. | D 255 | | |
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| D 255 | <p>Continued From page 18</p> <p>Interview with Resident # 16 on 8/11/15 at 11:00 A.M. revealed that she cannot feed herself and is fed every day.</p> <p>Observation of Resident #16 on 8/11/15 revealed:</p> <ul style="list-style-type: none"> - She had a brace on her left arm. - Her right hand grip is very weak. <p>Interview with Staff Development Director (SDD) on 8/11/15 at 11:03 A.M. revealed:</p> <ul style="list-style-type: none"> - Resident has been a two person assist for a while. - A Registered Nurse is supposed to do a reassessment on resident. - Resident is to be feed. - A Personal Care Aide on every shift should be feeding her. - Resident has been at this level of care since SDD started working at facility in April 2015. <p>Interview with Medication Aide (MA) on 8/11/15 at 11:30 A.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 is a total care who was admitted to hospice on 8/5/15 after returning from the hospital. - Resident was sent out to the hospital because she was non-responsive, spiking a temperature and drooling from the mouth. - Before having to be sent to the hospital, resident was more alert than she is now. - Resident will have a hospice Home Health Aide every Monday, Wednesday and Fridays. - At first resident was feeding herself, but she would waste most of the food in her lap, so we started feeding her off and on maybe two weeks before she went non-responsive. - Level of care assessments are performed every six months, unless there is a change in resident ' s condition. - Once there has been a change in the level of | D 255 | | |

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| D 255 | <p>Continued From page 19</p> <p>care that becomes the new care plan.</p> <ul style="list-style-type: none"> - MA did not know why a new level of care assessment was not done on Resident #16. - The nurse does the level of care assessment. - MA was not aware of any time that resident was not fed. - Resident #16 needs a lot of care to be done. <p>Interview with Resident Services Director on 8/11/15 at 12:15 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 is going to be re-evaluated for her level of care. - A recommendation was made to Executive Director for a re-evaluation to see if resident needed a higher level of care or possible skilled care. - If nothing is going on with resident a level of care assessment is done two times per year. - If staff tells us that a resident is getting worse or at the request of the family, a level of care assessment is performed. - If there are changes in a resident's level of care, these changes are communicated to staff by daily communication. - Also the Care Tracker computers on the halls needs to reflect the care plan. <p>Confidential interview on 8/11/15 at 5:05 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 had not been fed at least more than once in the last two months. - Resident #16 been fed late was "pretty routine". - Have not noticed any weight loss. <ul style="list-style-type: none"> - Resident is more confused than when she came to facility. <p>Review of Resident #16's monthly weight and vital signs log revealed:</p> <ul style="list-style-type: none"> - In January 2014, she weighed 151.4 | D 255 | | |

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| D 255 | <p>Continued From page 20</p> <p>pounds.</p> <ul style="list-style-type: none"> - In January 2015, she weighed 140.6 with a loss of 10.8 pounds. - In April 2015, she showed a weight loss of 11.6 pounds. - In July 2015, she showed a weight loss of 5.2 pounds. <p>Review of facility's Resident Weight and Vital Sign Monitoring policy revealed:</p> <ul style="list-style-type: none"> - The Resident Services Director or designee shall notify the resident's physician for weight loss or gain of five pounds, and continued weight loss or gain. - Notify the dietician regarding weight loss or gain to seek further evaluation and/ or recommendation. - Document the notification(s) to the physician and dietary consultant on the resident care notes in the resident's medical record. <p>Interview with Staff Development Director (SDD) on 8/11/15 at 12:35 P.M. revealed:</p> <ul style="list-style-type: none"> - If there is a weight loss or gain of five pounds or greater, staff is to get in touch with the resident's physician. - This change in weight and notification of physician should be documented under the notes. <p>Interview with Resident Services Director on 8/11/15 at 4:50 P.M. revealed:</p> <ul style="list-style-type: none"> - Any change in weight of five pounds or greater, physician needs to notified. - All residents are weighed monthly, unless otherwise ordered. - If there has been a change in weight for Resident #16, there should have been a note or fax notifying physician. <p>Interview with Executive Director on 8/11/15 at</p> | D 255 | | |

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| D 255 | Continued From page 21 5:30 P.M. revealed: - Was not aware that Resident #16 was having weight loss. - Our nurse would be involved to monitor nutrition and weight loss. - Not aware of Resident #16 having to wait an extremely long time to eat or not getting fed. - Typically it's a five pound difference in weight for physician to be notified. | D 255 | | |
| 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 A1 VIOLATION Based on record review and interview, the facility failed to implement a physician's order to treat all residents and staff for possible scabies infection resulting in 2 of 9 sampled residents having confirmed diagnoses for scabies (Residents #8, #9). The findings are: Review of physician's order dated April 21, 2015 revealed an order to treat all residents and staff for scabies. Review of facility's pharmacy dispensing records revealed the facility did not start treatment for all residents for scabies until July 10, 2015. "Scabies is an itchy skin condition caused by a tiny burrowing mite leading to intense itching in the area of its burrows. Scabies is contagious and can spread quickly through | D 273 | D273-Past corrected. Community is symptom free. Plan of Protection for rash with multiple cases- suspected scabies The plan is outlined per CDC guidelines in "multiple cases" Surveillance: Skin assessments have been performed for early detection of cases in residents and staff. Suspected cases have been evaluated and skin scrapings have been obtained. Diagnostic Services: We have consulted with Doctors Making House Calls for assistance in differentiating skin rashes and confirming the diagnosis of scabies. Control & Treatment: All original staff exhibiting rash were sent to Concentra Urgent Care for treatment. Staff with that had symptoms have all received consultation and treatment... (continued on next page) | 7/31/15 |

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| D 273 | <p>Continued From page 22</p> <p>close physical contact. Because of the contagious nature of scabies, doctors often recommend treatment for entire families or contact groups." (Mayo Clinic)</p> <p>1. Resident #8's Current FL-2 dated 1/28/15 revealed diagnoses that included Dementia, Hypertension, Insomnia, and Hyperlipidemia.</p> <ul style="list-style-type: none"> - Potassium Chloride 20mg extended release by mouth daily.(Replenishes potassium and helps with heart function) - Trazodone 50mg by mouth daily (Used for anxiety and depression) - Myrbertriq 25mg by mouth daily. (Used to treat overactive bladder) - Ativan 0.5mg by mouth daily as needed for anxiety. - Lisinopril 10mg by mouth daily. (Used to treat hypertension and congestive heart failure) - Donepezil 10mg by mouth daily. (Used for alzheimers) - Amlodipine 5mg by mouth daily. (Used for hypertension) <p>Review of Resident #8's health care provider's order written 4/21/15 revealed instructions to "treat everyone in the assisted living facility [for scabies]."</p> <p>Review of Resident #8's prescription faxed to facility's local pharmacy dated 4/21/15 revealed:</p> <ul style="list-style-type: none"> - Permethrin 5% topical cream; take 1 application topically once, repeat in 7 days, and again in 2 weeks. - The pharmacy's transmission verification report was timed 11:31pm 4/21/2015. <p>Review of fax physician order sheet from the facility to Resident #8's primary health care provider dated 4/22/15 revealed:</p> <ul style="list-style-type: none"> - "Resident was seen in your facility on 4/21/15. | D 273 | <p>D273-(Cont.) All staff and residents received proactive treatment. All care staff to avoid direct skin-to-skin contact with any resident who is suspected or confirmed to have scabies. Gloves were used when giving hands-on care to any resident who was suspected or confirmed to have scabies; staff informed to wash hands thoroughly after providing care to any resident. We have offered treatment to household members (e.g. spouses, children, etc.) of staff who received scabies treatment. Medication for treatment for residents that had an active rash and for all other residents residing in Assisted Living, Main St. and Heartland Village was prescribed, ordered and administered. All staff and residents received proactive treatment. (continued on next page)</p> | |

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| D 273 | <p>Continued From page 23</p> <p>Returned with new orders. Please fax a copy orders so medication can start."</p> <p>- Response to fax request dated 4/22/15 read, Apply Permethrin 5% (Common topical treatment for scabies) to entire body. Reapply 7 days later and then reapply 2 weeks after that."</p> <p>Review of Resident #8's primary healthcare provider letter to facility dated 4/22/15 revealed:</p> <p>- "Resident #8 was seen on 4/21/15 and diagnosed with scabies. 2 healthcare providers evaluated Resident #8. Unable to conduct a definitive test in our office at this time. Please treat her with Permethrin as soon as possible and repeat application in 7 days. Also, please consider treating all staff as well as any resident who has slept in the same room for the past month. If Resident #8's symptoms do not resolve in one week, please consider treating the entire facility."</p> <p>Review of Resident #8's medication administration record for April 2015 revealed:</p> <p>- Permethrin 5% cream apply once x 1 dose was documented as applied on 4/29/15.</p> <p>- Triamcinolone 0.1% (relieves redness, itching, swelling, or other discomfort caused by skin conditions) cream apply to chest and back every evening x 14 days was documented as applied 4/24/15----4/30/15.</p> <p>Review of Resident #8's May 2015 medication administration record revealed:</p> <p>- Permethrin 5% cream apply topically once x 1 dose was documented as applied 5/13/15.</p> <p>- No other documentation provided for the last topical treatment for scabies.</p> <p>- Triamcinolone 0.1% cream apply to chest and back every evening x 14 days was documented as given 5/1/15---5/7/15.</p> | D 273 | <p>D273-(Cont.)</p> <p>Environmental Disinfection: All residents bed linens washed with hot water/ dried on hot and all clothes worn in the last 3 days washed with hot water and dried on hot at the same time as the treatment was given. Per CDC guidelines environmental disinfestation is neither necessary nor warranted. Routine cleaning and vacuuming of the rooms were completed. Implemented alcohol disinfectant of all surfaces 7/22. Carpet cleaning and all common spaces and infected resident rooms, 7/21. Vendor completed deep clean common area flooring and upholstery as well as infected resident rooms 9/3. Main Street also completed on 8/4/15. (continued on next page)</p> | |
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| D 273 | <p>Continued From page 24</p> <p>Review of Resident #8's fax order sheet dated 7/13/15 revealed: - Ivermectin 8mg (Oral form of medicine commonly used to treat scabies) give 1 by mouth on day 1 and same dose for day 10. - Benadryl 50mg 1 tablet by mouth every 4 hours for severe itching. -The order was signed and dated by Resident #8's primary healthcare provider on 7/13/15.</p> <p>Review of Resident #8's July 2015 medication administration record revealed: - Ivermectin 3mg tablet take 3 and a half tablets by mouth on day 1 of therapy documented as given 7/18/15. - Ivermectin 3mg tablet take 3 and a half tablets by mouth on day 10 of therapy documented as given 7/27/15.</p> <p>Review of Resident #8's care notes dated 4/21/15 revealed: -"Resident given a shower and ointment to affected area." -"Resident's laundry including bed sheets and laundry in closets was done, carpet was vacuumed."</p> <p>Review of Resident #8's care notes dated 4/22/15 revealed: "Resident to remain in room until further notice." Review of Resident #8's care notes dated 4/23/15 revealed: "Dr. appt. Please see new orders for Triamcinolone 0.1%."</p> <p>Review of shift to shift report in the secured assisted living revealed 15 residents had been treated for scabies on July 11, 13, 17, 18, 23, and 28, 2015.</p> <p>Family interview revealed family took Resident #8</p> | D 273 | <p>D273- (Cont.) Communication: Consulted local area scabies expert Debbie Hart on 7/22. Provided information about scabies to all staff and provided preventative treatment for employees and, when appropriate, their household members. Communicated in one to one format and at community all staff meeting, 7/23. Provided CDC FAQ handout. Conducted ongoing staff teaching. Maintained an open and cooperative attitude between management and staff Communicated to all employees, vendors and families for Assisted Living, Heartland Village and Main Street communities concerning a rash that may be contagious. Continued to educate on PPE or other preventative measures. Documented communication efforts and actions. Posted sign on Main Street door to inform families to see front office or an SIC before visiting. Posted sign on the Assisted Living front door to inform families to see front or an SIC office before visiting. County confirmed that we do not need to notify the health department. Plan of protection to be monitored by Resident Services Director daily.</p> | |
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| D 273 | <p>Continued From page 25</p> <p>to their own primary health care provider on 4/21/15 because Resident #8 had a rash all over her stomach.</p> <ul style="list-style-type: none"> - Resident #8 was diagnosed with scabies on 4/21/15, a prescription for treatment of scabies was provided to the family and an order to treat the entire facility was provided to the family to take back to the facility. - Both orders were given to the facility on 4/21/15. - The facility managers and health care provider told the family that it was not scabies. - As far as the family knew, Resident #8 was treated with medicine for scabies. - The family member was informed during conversation with the facility's PCP's physician's assistant, that administration was supposed to have ensured the entire facility was treated for scabies including professionally treating furniture, washing and drying linens, personal laundry, and cleaning carpets and floors. <p>A confidential staff interview revealed:</p> <ul style="list-style-type: none"> - Resident #8's family took resident to their own primary health care provider and brought back orders for medicine to treat scabies and an order to treat the entire facility for scabies on 4/21/15 - On 4/21/15 the former Resident Services Director (RSD) managing nursing was shown the order to treat everyone in the facility but after doing a skin Assessment on Resident #8, made the determination that Resident #8 did not have scabies. -The RSD told staff that anytime a resident came back from their personal health care provider with a diagnosis of scabies "it was because they resided in a facility." -The order for Permethrin 5% topical cream to apply 1 dose and repeat in 1 week was faxed to the pharmacy and the topical treatment was applied that evening. -The RSD gave staff instructions to put all of | D 273 | | |
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| D 273 | <p>Continued From page 26</p> <p>Resident #8's clothes in a bag for 72 hours, to clean her room, wash and dry her linens, and vacuum the carpet.</p> <ul style="list-style-type: none"> - Resident #8's roommate had scabies. - On 3rd shift there was only 1 staff; a nursing assistant/medication aide scheduled and that staff had to carry out a set of instructions for the roommate of Resident #8 that included gathering up laundry, sheets, and clothing to be washed, and vacuum the floors. -The RSD instructed staff to pass along the same cleaning instructions to housekeeping staff. -"A note was left for housekeeping, but there was no way housekeeping could do all the rooms because some days there was only one housekeeper for both buildings." -"The RSD stated he had Resident #8 seen by the facility's health care provider and "this doctor did a skin test and told staff that Resident #8 didn't have scabies. That's when all the treatment stopped." (no documentation for a skin test for scabies for Resident #8 was available). -"We (Staff) were worried the residents would start to suffer from scabies. None of the other rooms were treated in the building. Everywhere that Resident #8 sat we knew could affect other residents." -"Almost all of the staff got scabies and we were still required to work unless we had a doctors excuse from our own personal health care provider." -"We had protective gear only for the residents' that actively showed signs and symptoms of scabies. We went room to room doing personal care for the other residents." <p>A 2nd confidential family interview revealed: -"I was notified by phone in early July 2015 (did not remember the name) that there was a "skin condition" going around the facility only specific</p> | D 273 | | |
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| D 273 | <p>Continued From page 27</p> <p>to the secured assisted living." -"There was a resident there that was "eaten up" with scabies and I saw the marks when the resident leaned over the dining room table." -The family member believed it was the facility's former doctor and administrator that "let it get like this." -"I don't think they have enough help around here."</p> <p>A 3rd confidential family interview revealed: -"I don't feel like the care is adequate at the facility." -The resident had a rash going back to April 2015 and it was getting worse. -Steroid creams were being used to treat the resident. -The doctor treating the resident at that time never mentioned the word scabies. -The facility had notified the family member of a rash going around the facility in July 2015 but was not given any different instructions for visiting the facility. -"I was allowed to come and go freely." -Resident was transferred to current building with a rash on both arms and torso. -The family member just visited last week and described what looked like bites and little pin-head dots in a line which covered the resident's arms. -The resident was not treated for scabies until late July 2015.</p> <p>A 4th confidential family interview revealed: - "We just got through a scabies outbreak." -This skin condition had been going around the facility for the past 3 months but the administration never referred to the condition as scabies to the family. -The family had never been told that the</p> | D 273 | | |
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| D 273 | <p>Continued From page 28</p> <p>resident's previous roommate had scabies. -The family was told as recent as 3 weeks ago to buy another bed for the resident. -The resident was still scratching and had scabs all over her body. -The family believed the resident was treated for scabies in late July. -The resident was on Benadryl as needed and no antibiotics that the family was are of.</p> <p>Another confidential staff interview revealed: - Resident #8's order for steroid cream (Triamcinolone) was written by the former facility doctor. -The former doctor did not acknowledge the outbreak as contagious; she was telling staff that resident did not have scabies and called it "old people rash." -The RSD explained to staff "He did not want everyone to know about it."(Scabies) -The RSD believed he would have to "report it to the county."</p> <p>A third confidential staff interview revealed: -"Protective gowns were not available until late June into early July 2015. No one person was ever put on contact isolation; the residents all sat together and ate together." -The person doing laundry in the secure assisted living was still required to work even when she got scabies. She was finally allowed to get treatment after telling the new administrator."(staff did not reveal when treatment was received).</p> <p>A fourth confidential staff interview revealed: - staff reported to supervisors and nursing management that 3 residents had signs and symptoms of scabies and nothing had been done about it.</p> | D 273 | | |
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| D 273 | <p>Continued From page 29</p> <ul style="list-style-type: none"> -The facility's doctor called it an "Old person's rash." - In May 2015 scabies was again reported to the former RSD and staff were instructed not to say the word scabies and to quit talking about it. - No new orders or medications were received at that time. - Staff had witnessed residents waking up scratching until they bled at times. - Staff had no knowledge of professional cleaning of furniture. - No precautions were given to staff pertaining to laundry or cleaning of rooms and carpets. - In late July the majority of residents and staff were treated for scabies. <p>A fifth confidential staff interview revealed:</p> <ul style="list-style-type: none"> - Almost all of the personal care aides, nursing assistants and medication aides got scabies. - These staff informed management and were told that they did not have scabies and not to talk about it. -The RSD told staff not to wear a gown and gloves at work because he did not want to cause a panic and management did not want visitors to be afraid to come to the facility. - Some staff were afraid for their jobs but wore protective gowns anyway. -This staff received treatment for scabies in April and May 2015, and had not been itching since then. <p>A sixth confidential staff interview revealed:</p> <ul style="list-style-type: none"> - A resident was transferred from assisted living in early July 2015 to the secure assisted living building with a rash on his back, torso, forearms and noticeable discolorations with different stages of scabs and healing. -"This resident had scratches all over." -The resident had been treated for scabies but | D 273 | | |

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| D 273 | <p>Continued From page 30</p> <p>not until late July 2015.</p> <ul style="list-style-type: none"> -This resident had been and continued to suffer. -The facility's last doctor did not believe residents had scabies and did not want to talk about scabies. - Staff were provided with protective gowns in late July. -The current facility doctor had assessed the resident and was continuing to treat the resident. <p>A seventh confidential staff interview revealed:</p> <ul style="list-style-type: none"> -They transferred a resident from the assisted living building to the other building July 1, 2015 with a known rash. -This resident's treatment for scabies did not start until July 17, 2015. <p>Two confidential staff interviews revealed:</p> <ul style="list-style-type: none"> - The whole facility was not treated back in April 2015. -They floated back and forth between buildings and passed medication frequently. <p>An eighth confidential staff interview revealed: -</p> <ul style="list-style-type: none"> - They did not treat the facility back in April 2015. - Staff had scabies in May 2015 and received treatment with Permethrin cream applied neck to foot, showered the next day and repeated in 1 week. - Staff were taking care of residents with active scabies. - At no time did this staff see the linens being washed at the same time or see anyone treating the furniture. <p>A ninth confidential staff interview revealed: -"We were given no instruction on what to do with the dirty gowns.</p> <ul style="list-style-type: none"> -We put them in a single bag and threw them in the dumpster outside." | D 273 | | |

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| D 273 | <p>Continued From page 31</p> <p>A tenth confidential staff interview revealed: -Staff saw the order to treat the entire facility back in April. -The facility's former doctor told us it was nothing to worry about in June 2015. - Most staff got scabies from doing personal care of residents that had not been treated. - Staff and residents were treated in July only after it "hit the fan." -"The only reason why they got treated then was because staff complained so much. " -"I feel like residents were suffering because the doctor and management wouldn't listen to us." -"I was not given a gown to wear until I insisted, and then they ran out of gowns." -"We were told we had to use the facility's doctor." - Some of the staff got cream and others got the pill form of treatment for scabies. -The residents were treated on different dates and only after showing signs and symptoms of scabies.</p> <p>An eleventh confidential staff interview revealed: -The facility's former doctor said she was conducting scrape tests after staff or residents received their first dose of treatment and the results were negative. - Staff believed the results were a false negative after 1 treatment. - By April 2015 at least 3 residents and several staff were showing signs and symptoms of scabies. -"By June 2015 it was non-stop with signs and symptoms of scabies for residents and staff." - It was reported to the RSD that one particular assisted living resident was "eaten up with scabies"(body was covered by marks from scratching the skin) and the RSD said; "Don't say</p> | D 273 | | |
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| D 273 | <p>Continued From page 32</p> <p>that. They are getting cream." - Staff thought residents were suffering.</p> <p>Interview with the facility's current LPN (Supervisor of special care units and secured assisted living) on 8/7/15 at 4:45pm revealed: -The current LPN was not the Resident Care Director back in April 2015. -The current LPN was not responsible for the Special Care units and Secured Assisted Living in April 2015. -The former RCD instructed the current LPN to take Resident #8 to get a scrape test in April 2015. -The former RCD told the current LPN that the test was negative but did not show her the order to treat the entire facility. - Resident #8 was taken by family to their family health care provider and was diagnosed with scabies. - A prescription for Permethrin 5% topical cream to be applied once, then again x 7 days, and again in 2 weeks was sent with the family to take back to the facility on April 21, 2015. - She was not aware of an order to treat the entire facility for scabies. -The current LPN reviewed Resident's #8's nurse's notes and medication administration record from April 2015 and believed that Resident #8 did receive treatment for scabies at that time. - She did not take precautions for herself at that time. - She took the prophylactic treatment on July 8th 2015. - Two staff complained of signs and symptoms of scabies around that time and they were sent out for treatment. - All staff and residents were treated on the secure assisted living and special care units starting July 9th, 2015.</p> | D 273 | | |
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| D 273 | <p>Continued From page 33</p> <ul style="list-style-type: none"> -The facility's local pharmacy did not have Ivermectin (Oral form to treat scabies) on July 8th which was a Friday. -The medicine came to the facility on Saturday July 9, 2015 and the facility referred to the Centers for Disease Control, guidelines to treat a facility for scabies at that time. -The assisted living building was treated for scabies 7/24/15 through 7/27/15. - Her expectation would have been to treat the entire facility in April 2015 if she had seen the order. <p>An Interview with Resident #8's Primary Health Care Provider (PA-C) on 8/7/15 at 12:55pm revealed:</p> <ul style="list-style-type: none"> - Resident #8 was assessed at the provider's office on April 21,2015 and the rash on her body was diffuse (all over) with burrowing of scabies. - The health care provider wrote an order 4/21/15 that read, "Treat everyone in assisted living facility for scabies." -The expectation was that every resident in both buildings would be treated at that time to avoid re-infestation. -The health care provider expected the furniture to be professionally treated, all resident linens and personal clothes to be washed and dried, the carpets to be vacuumed, and any item that could not be washed were to be put in a bag for 72 hours. - All furniture would need to be treated because residents sometimes visited the other building for walks and certain activities. The furniture throughout the facility was located in communal settings and shared by residents, families, and visitors. - Scabies was contagious and if these steps were not taken the entire facility could become perpetually re-infested. | D 273 | | |
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| D 273 | <p>Continued From page 34</p> <p>Interview on 8/11/15 at 5:00 pm with the ED revealed:</p> <ul style="list-style-type: none"> - On 4/21/15 Resident #8 had a rash and went to (a local family medicine clinic) and was tested for scabies. The test was negative. - The facility did not proceed with the physician order to treat all facility residents and staff for scabies because Resident #8 did not test positive for scabies. <p>2. Review of Resident #9's current FL-2 dated 9/10/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Alzheimer's dementia, macular degeneration, and cataracts. - The resident was constantly disoriented, needed personal care assistance for bathing and dressing and was ambulatory. <p>Observation on 8/06/15 at 3:30 pm of Resident #9 revealed:</p> <ul style="list-style-type: none"> - The resident was standing in the lounge area of the secured assisted living where other residents were seated. - The resident looked around, not speaking; staff approached her and guided the resident to a seat. - The resident was well groomed and dressed and had no visible signs of rash. - Resident #9 did not talk. <p>Interview on 8/6/15 at 2:55 pm with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Staff first noticed Resident #9 having a rash on her back and around the shoulders in mid-October, 2014. - The resident was taking a bath and was | D 273 | | |

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| D 273 | <p>Continued From page 35</p> <p>scratching her skin.</p> <ul style="list-style-type: none"> - The resident's family was called on a Saturday in November, 2014 and took the resident to an urgent care for evaluation; a cream was prescribed for the rash. - The facility physician saw the resident on the following Wednesday and continued the prescribed cream. - The facility physician did not think the rash was scabies. - The second occurrence of rash was around the first of the year, January or February, and a different cream was ordered for the resident. - The rash was around her neck, shoulders, and back. - The rash would decrease and come back. - The resident continued battling with the rash and the same cream was continued. - Ivermectin was prescribed for Resident #9 last month (July, 2015) and the rash went away. <p>Review of chart "Resident Notes" for Resident #9 revealed:</p> <ul style="list-style-type: none"> - On 10/31/14 the resident was seen by the physician's assistant for "rash to right lower back and left thigh; rash consistent with scabies." - Follow scabies protocol and isolate patient; permethrin 5% cream to be applied to patient's entire body following a bath tonight using freshly laundered towels, clothes. - Follow-up 11/05/14 with (primary care physician). - On 11/02/14 the resident was taken to an urgent care and was diagnosed and prescribed Valtrex, a medication for shingles. - On 11/07/14 the resident's back and leg had decreased redness and had no complaints of itching. - On 5/19/15 the "resident has red bumps in entire back and upper chest. Also on (right) arm. | D 273 | | |
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| D 273 | <p>Continued From page 36</p> <p>MD notified. Resident continued to scratch until they start to bleed."</p> <ul style="list-style-type: none"> - On 5/25/15 "red bumps on body, back, and chest don't appear to be clearing up. Triamcinolone 0.1% cream already used 5 days." Fax to (Resident #9's PCP). - On 6/08/15 Rash on back, rash noted on arms. - On 6/13/15 Resident #9 given shower with "Hibiclens (skin cleanser and antiseptic) applied as directed, rash on body appears red, with small bumps, Triamcinolone cream applied for itching." - On 6/23/15 "She has rash and scratch on body, she had Triamcinolone cream for itching." - On 6/28/15 " Resident refused to be washed and dressed up, Triamcinolone cream applied to her affected areas, chest, back." - On 7/03/15 "Triamcinolone applied as needed also continue Hibiclens wash daily." - On 7/10/15 "Called about 12:30 to (family member), left message to call facility at her earliest convenience." - On 7/11/15 "Resident #9 to start Ivermectin (used to treat scabies) 3 mg x 4 tablets; first dose started; no reaction to medication." - On 7/15/15 "Resident's rash looks better, decrease in redness and bumps, some scratching. Benadryl 25 mg given at 8 pm". - On 7/21/15 "Rash appears to be clearing up, (Resident #9) decrease scratching; 2nd treatment of Ivermectin 3 mg given." - On 7/23/15 "Rash looks much better, noticed very little scratching." - On 7/25/15 "Rash healing, decreased redness and scratching." <p>Review of the facility's former healthcare primary care physician (PCP) for Resident #9 office chart notes for physician/patient visits from 11/5/14 to 7/28/15 related to skin conditions revealed:</p> | D 273 | | |
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| D 273 | <p>Continued From page 37</p> <ul style="list-style-type: none"> - On 11/5/14 "the resident was seen for rash, fever, runny nose, lethargy; prescribed Valtrex (used to treat infections caused by herpes virus) for shingles; scabies?" - On 12/24/14 the resident was evaluated for skin lesions on left scalp area; no complaints of itching rash. - On 2/25/15 the resident had no mention of skin rashes or concerns. - On 5/20/15 the resident was evaluated for rash on back; patient had minimal awareness of rash with no complaints of pain. Prescribed Triamcinolone (used to treat itching, redness, and discomfort of various skin conditions) cream for rash. - On 5/27/15 one week follow-up; rash not clearing up; no significant rash observed today, continue cream. - On 6/10/15 follow-up for rash; (Resident #9) has intermittent rash on abdomen, no other symptoms, not sure why she is getting this rash, a few of the other residents are having the same symptoms on the same floor, facility has already checked for bed bugs, rash is not consistent with scabies. Order for Triamcinolone cream for 2 weeks, staff to monitor closely for changes, consult dermatologist. - On 6/24/15 the resident had been suffering from a rash on her body, used Triamcinolone cream, test for scabies is negative, facility did not send resident for dermatology referral, request again for referral, started a higher strength steroid cream, Clobestol .05% cream for 2 weeks. - On 7/9/15 the facility requested the PCP to come out and test for scabies for several residents. Physician assistant's evaluation of the rash on Resident #9's chest, ongoing itching, suspicions for scabies. <p>Review of the facility's physician's scabies testing</p> | D 273 | | |
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results documentation for 5 facility residents including Resident #9 revealed: "Sample(s) for Scabies testing was taken however no results were obtained and could not accurately conclude because container may have not had enough of specimen to give accurate results."

Interview on 8/11/15 at 10:00 am with Resident #9's current primary care physician (PCP) revealed:

- The PCP was asked by his practice group to replace the former PCP for Resident #9.
- On 7/21/15, he had heard in his practice office there was an outbreak of scabies at (facility).
- Testing was done, but there was no confirmatory information; not aware of any further testing being done.
- Treatment for scabies had started 2 weeks prior to his coming.
- Ivermectin (treatment for scabies) was the primary treatment and some residents were administered Benadryl for itching.
- 7/28/15 was his first day at the facility.
- At his last visit on 8/4/15, he did not see any signs of scabies.

Review of PCP's physician assistant (PA) order for Resident #9 dated 7/9/15 revealed:

- Ivermectin 3 mg tab - give 1 tab by mouth on day 1 and repeat second tab on day 10.
- Benadryl 50 mg - 1 tablet by mouth every 4 hours as needed for severe itching.

Review of the PCP's PA order for Resident #9 dated 7/10/15 revealed:

- Discontinue orders for Benadryl.
- Discontinue orders for Ivermectin 3 mg 1 by mouth x1. Then repeat dose in 10 days.
- Start Benadryl 25 mg, 1 tab by mouth every 4 hours as needed for itching.

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| D 273 | <p>Continued From page 39</p> <ul style="list-style-type: none"> - Start Ivermectin 3 mg, 4 tabs by mouth x1 dose; repeat Ivermectin 3 mg 4 tabs by mouth on day 10. <p>Interview on 8/6/15 at 7:35 pm with Resident #9's Power of Attorney (POA) revealed:</p> <ul style="list-style-type: none"> - The facility called the first part of November, 2014 and said (the resident) had a rash. - I took her to an urgent care and she was diagnosed with and treated for shingles. - A couple of weeks ago, about July 23rd, the facility called and said "there was a rash going around, but had not confirmed that it was actually scabies." - (A physician) for the facility made an emergency visit in July (not sure of date) and said it was scabies. - (The resident) took the medication for the treatment of scabies. <p>Interview with a Medication Aide on 8/6/15 at 2:55 P.M. revealed:</p> <ul style="list-style-type: none"> -All residents were treated as a precaution for possible scabies the middle of July, 2015. -All employees were also treated at the same time. -An employee had a rash and went to her doctor and was diagnosed with scabies. -The first medication dosage for treatment was given and then ten days later a second dosage of medication was given. -The medication dosage was based on weight and no resident or staff complained of adverse reactions. <p>Interview with a Personal Care Aide (PCA) on 8/6/15 at 3:10 P.M. revealed:</p> <ul style="list-style-type: none"> - She was treated with a cream medication on July 9, 2015 and seven days later was treated | D 273 | | |
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| D 273 | <p>Continued From page 40</p> <p>with the cream medication again.</p> <ul style="list-style-type: none"> - On July 15, 2015 she was treated with pill form medication and a second dose of pill form medication on July 25, 2015. - She was still itching every day and has small red bumps on arms, chest and stomach. - The PCA's primary care physician took the staff out of work for four days but facility's doctor wanted me back to work the next morning after using the cream medication. - Her rash and itching started end of May 2015, the beginning of June 2015. - Resident was given a skin assessment on May 20, 2015 in the Secure Care Unit and had a rash, red bumps all over everywhere. - Staff was told that it was "old peoples' rash". - It was heard that the rash and itching started downstairs in the secured Assisted Living Unit in October 2014 with a resident that was transferred from the unlocked Assisted Living Unit. - Then three to four other residents started having the rash with itching. <p>Interview with a secured assisted living resident's family member on 8/10/15 at 1:30 pm. revealed:</p> <ul style="list-style-type: none"> - Family had a major concern about scabies because they were not informed about the possible outbreak in the facility. - Overheard that there was a concern about scabies in the facility while in the hallway. - Resident broke out in a rash the second week in July 2015. - The family had concerns about scabies because we take resident's clothes home to be washed. <p>Eight confidential staff interviews revealed they became infected with scabies.</p> <ul style="list-style-type: none"> - Staff were told not to say the word scabies and that they probably did not have it. | D 273 | | |
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| D 273 | <p>Continued From page 41</p> <ul style="list-style-type: none"> - Staff were instructed to use the facility's doctor who did not believe scabies was in the facility. - Staff were told they had to continue working unless they could provide a work excuse from their personal health care provider. - Some staff were told to take off their protective gowns for fear of "casing a panic" and scaring off visitors. - Some staff stood up to management and insisted they had the right to wear protective equipment. - Staff were aware of scabies in the facility as early as April 2015. - Some staff and most residents were not treated for scabies until July 2015. - Staff was worried about re-infestation because they did not believe all required steps were taken to treat the entire facility. <p>Interview on 8/6/15 at 4:53 pm with the Executive Director (ED) revealed:</p> <ul style="list-style-type: none"> - The ED started her position on July 22, 2015. - There was a skin condition over the whole community, but did not have a clinical opinion since she was not a licensed professional. - There was a rash on residents and staff that was being treated for scabies. - Staff went to (a local urgent care) for diagnosing, and staff went at different times. - The new PCP was brought in to check residents having rashes. - Skin scrapings were done and treatment for scabies was ordered for residents. - The facility pharmacy sent the medication (Ivermectin) to the facility and the medication aides (MA) administered the medication to the residents. - There were 2 medication administrations for residents, 10 days apart. - There were no current symptoms. | D 273 | | |
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| D 273 | <p>Continued From page 42</p> <ul style="list-style-type: none"> - The ED did not recall how long the concern (scabies) had been going on. - Everyone, residents and staff had finished their treatments. - No new symptoms had been reported for residents and staff. - All residents' families were notified of the rash, there was an "open door policy for families and staff to talk". - Notices were posted on doors to "please see the office or supervisor before visiting the community"; the notices were already posted on (secure unit) when the ED started the position and notices were posted on the assisted living front door on July 22, 2015. - Families wanted to understand what the rash was, how it spread, and the plan for treatment. - Staff came to talk with me; they were given the same information the families were given. - Also, information was given out at staff meetings and had some 1:1 talks with staff; they had an opportunity to be up to date and informed. - The ED submitted documentation for 6 staff who were treated for scabies at a local urgent care, 1 on 4/24/15, 1 on 7/08/15, 2 on 7/09/15, 1 on 7/10/15, and 1 on 7/14/15. <p>Interview on 8/7/15 at 1:33 pm and 2:30 pm with the facility's pharmacy revealed:</p> <ul style="list-style-type: none"> - There were no orders for residents (for scabies medications) until July 2015 except for Resident #8 and that order was dated 4/21/15. - (Resident #8) filled the order at another pharmacy. - The pharmacy provided a listing of facility residents who were dispensed Ivermectin for the treatment of scabies in July 2015. - There were 124 doses of Ivermectin dispensed from the pharmacy for facility residents from 7/10/15 to 7/30/15. | D 273 | | |
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| D 273 | <p>Continued From page 43</p> <p>Interview on 8/11/15 at 5:00 pm with the ED revealed:</p> <ul style="list-style-type: none"> - On 4/21/15 Resident #8 had a rash and went to (a local family medicine clinic) and was tested for scabies. The test was negative. - The facility did not proceed with the physician order to treat all facility residents and staff for scabies because Resident #8 did not test positive for scabies. - In July the facility had (the facility physician group) in to assess residents and scrape tests were done. - From 7/9-31/2015 all residents in the facility were treated. - Staff had presented with symptom of a rash and were sent to (a local health care clinic). - Staff tested positive (for scabies) and were treated. - Staff had a cream and most of the residents had pills 10 days apart. - The treatment was effective; all residents and staff are symptom free. - There had been no further outbreaks. - Staff were now making skin assessments with all residents 2-3 times per week. - The facility and (a local commercial cleaner) treated all facility common areas, infected resident rooms, and all hard surfaces, carpet and upholstery. Centers for Disease Control (CDC) guidelines were used. <p>Review of Resident #16's current FL-2 dated 5/15/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of CVA, Dementia, Hypertension - Required limited assistance to eat. <p>Interview with Resident # 16 on 8/11/15 at 11:00</p> | D 273 | | |
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| D 273 | <p>Continued From page 44</p> <p>A.M. revealed that she cannot feed herself and is fed every day.</p> <p>Observation of Resident #16 on 8/11/15 revealed:</p> <ul style="list-style-type: none"> - She had a brace on her left arm. - Her right hand grip is very weak. <p>Interview with Staff Development Director (SDD) on 8/11/15 at 11:03 A.M. revealed:</p> <ul style="list-style-type: none"> - Resident has been a two person assist for a while. - A Registered Nurse is supposed to do a reassessment on resident. - Resident is to be feed. - A Personal Care Aide on every shift should be feeding her. - Resident has been at this level of care since SDD started working at facility in April 2015. <p>Interview with Medication Aide (MA) on 8/11/15 at 11:30 A.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 is a total care who was admitted to hospice on 8/5/15 after returning from the hospital. - Resident was sent out to the hospital because she was non-responsive, spiking a temperature and drooling from the mouth. - Before having to be sent to the hospital, resident was more alert than she is now. - Resident will have a hospice Home Health Aide every Monday, Wednesday and Fridays. - At first resident was feeding herself, but she would waste most of the food in her lap, so we started feeding her off and on maybe two weeks before she went non-responsive. - Level of care assessments are performed every six months, unless there is a change in resident ' s condition. - Once there has been a change in the level of care that becomes the new care plan. | D 273 | | |
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| D 273 | <p>Continued From page 45</p> <ul style="list-style-type: none"> - MA did not know why a new level of care assessment was not done on Resident #16. - The nurse does the level of care assessment. - MA was not aware of any time that resident was not fed. - Resident #16 needs a lot of care to be done. <p>Interview with Resident Services Director on 8/11/15 at 12:15 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 is going to be re-evaluated for her level of care. - A recommendation was made to Executive Director for a re-evaluation to see if resident needed a higher level of care or possible skilled care. - If nothing is going on with resident a level of care assessment is done two times per year. - If staff tells us that a resident is getting worse or at the request of the family, a level of care assessment is performed. - If there are changes in a resident 's level of care, these changes are communicated to staff by daily communication. - Also the Care Tracker computers on the halls needs to reflect the care plan. <p>Confidential interview on 8/11/15 at 5:05 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 had not been fed at least more than once in the last two months. - Resident #16 been fed late was " pretty routine " . - Have not noticed any weight loss. <ul style="list-style-type: none"> - Resident is more confused than when she came to facility. <p>Review of Resident # 16's monthly weight and vital signs log revealed:</p> <ul style="list-style-type: none"> - In January 2014, she weighed 151.4 pounds. | D 273 | | |
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| D 273 | <p>Continued From page 46</p> <ul style="list-style-type: none"> - In January 2015, she weighed 140.6 with a loss of 10.8 pounds. - In April 2015, she showed a weight loss of 11.6 pounds. - In July 2015, she showed a weight loss of 5.2 pounds. <p>Review of facility's Resident Weight and Vital Sign Monitoring policy revealed:</p> <ul style="list-style-type: none"> - The Resident Services Director or designee shall notify the resident's physician for weight loss or gain of five pounds, and continued weight loss or gain. - Notify the dietician regarding weight loss or gain to seek further evaluation and/ or recommendation. - Document the notification(s) to the physician and dietary consultant on the resident care notes in the resident's medical record. <p>Interview with Staff Development Director (SDD) on 8/11/15 at 12:35 P.M. revealed:</p> <ul style="list-style-type: none"> - If there is a weight loss or gain of five pounds or greater, staff is to get in touch with the resident ' s physician. - This change in weight and notification of physician should be documented under the notes. <p>Interview with Resident Services Director on 8/11/15 at 4:50 P.M. revealed:</p> <ul style="list-style-type: none"> - Any change in weight of five pounds or greater, physician needs to notified. - All residents are weighed monthly, unless otherwise ordered. - If there has been a change in weight for Resident #16, there should have been a note or fax notifying physician. <p>Interview with Executive Director on 8/11/15 at</p> | D 273 | | |
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| D 273 | <p>Continued From page 47</p> <p>5:30 P.M. revealed:</p> <ul style="list-style-type: none"> - Was not aware that Resident #16 was having weight loss. - Our nurse would be involved to monitor nutrition and weight loss. - Not aware of Resident #16 having to wait an extremely long time to eat or not getting fed. - Typically it ' s a five pound difference in weight for physician to be notified. <p>Review of Resident #16's current FL-2 dated 5/15/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of CVA, Dementia, Hypertension - Required limited assistance to eat. <p>Interview with Resident # 16 on 8/11/15 at 11:00 A.M. revealed that she cannot feed herself and is fed every day.</p> <p>Observation of Resident #16 on 8/11/15 revealed:</p> <ul style="list-style-type: none"> - She had a brace on her left arm. - Her right hand grip is very weak. <p>Interview with Staff Development Director (SDD) on 8/11/15 at 11:03 A.M. revealed:</p> <ul style="list-style-type: none"> - Resident has been a two person assist for a while. - A Registered Nurse is supposed to do a reassessment on resident. - Resident is to be feed. - A Personal Care Aide on every shift should be feeding her. - Resident has been at this level of care since SDD started working at facility in April 2015. <p>Interview with Medication Aide (MA) on 8/11/15 at 11:30 A.M. revealed:</p> | D 273 | | |
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| D 273 | <p>Continued From page 48</p> <ul style="list-style-type: none"> - Resident #16 is a total care who was admitted to hospice on 8/5/15 after returning from the hospital. - Resident was sent out to the hospital because she was non-responsive, spiking a temperature and drooling from the mouth. - Before having to be sent to the hospital, resident was more alert than she is now. - Resident will have a hospice Home Health Aide every Monday, Wednesday and Fridays. - At first resident was feeding herself, but she would waste most of the food in her lap, so we started feeding her off and on maybe two weeks before she went non-responsive. - Level of care assessments are performed every six months, unless there is a change in resident ' s condition. - Once there has been a change in the level of care that becomes the new care plan. - MA did not know why a new level of care assessment was not done on Resident #16. - The nurse does the level of care assessment. - MA was not aware of any time that resident was not fed. - Resident #16 needs a lot of care to be done. <p>Interview with Resident Services Director on 8/11/15 at 12:15 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 is going to be re-evaluated for her level of care. - A recommendation was made to Executive Director for a re-evaluation to see if resident needed a higher level of care or possible skilled care. - If nothing is going on with resident a level of care assessment is done two times per year. - If staff tells us that a resident is getting worse or at the request of the family, a level of care assessment is performed. - If there are changes in a resident ' s level of | D 273 | | |

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| D 273 | <p>Continued From page 49</p> <p>care, these changes are communicated to staff by daily communication.</p> <ul style="list-style-type: none"> - Also the Care Tracker computers on the halls needs to reflect the care plan. <p>Confidential interview on 8/11/15 at 5:05 P.M. revealed:</p> <ul style="list-style-type: none"> - Resident #16 had not been fed at least more than once in the last two months. - Resident #16 been fed late was " pretty routine " . - Have not noticed any weight loss. - Resident is more confused than when she came to facility. <p>Review of Resident # 16's monthly weight and vital signs log revealed:</p> <ul style="list-style-type: none"> - In January 2014, she weighed 151.4 pounds. - In January 2015, she weighed 140.6 with a loss of 10.8 pounds. - In April 2015, she showed a weight loss of 11.6 pounds. - In July 2015, she showed a weight loss of 5.2 pounds. <p>Review of facility's Resident Weight and Vital Sign Monitoring policy revealed:</p> <ul style="list-style-type: none"> - The Resident Services Director or designee shall notify the resident's physician for weight loss or gain of five pounds, and continued weight loss or gain. - Notify the dietician regarding weight loss or gain to seek further evaluation and/ or recommendation. - Document the notification(s) to the physician and dietary consultant on the resident care notes in the resident's medical record. | D 273 | | |

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| D 273 | <p>Continued From page 50</p> <p>Interview with Staff Development Director (SDD) on 8/11/15 at 12:35 P.M. revealed:</p> <ul style="list-style-type: none"> - If there is a weight loss or gain of five pounds or greater, staff is to get in touch with the resident ' s physician. - This change in weight and notification of physician should be documented under the notes. <p>Interview with Resident Services Director on 8/11/15 at 4:50 P.M. revealed:</p> <ul style="list-style-type: none"> - Any change in weight of five pounds or greater, physician needs to notified. - All residents are weighed monthly, unless otherwise ordered. - If there has been a change in weight for Resident #16, there should have been a note or fax notifying physician. <p>Interview with Executive Director on 8/11/15 at 5:30 P.M. revealed:</p> <ul style="list-style-type: none"> - Was not aware that Resident #16 was having weight loss. - Our nurse would be involved to monitor nutrition and weight loss. - Not aware of Resident #16 having to wait an extremely long time to eat or not getting fed. - Typically it ' s a five pound difference in weight for physician to be notified. <hr/> <p>The Executive Director provided a "Plan of Protection" for residents. Effective 8/07/15: Skin assessments will be conducted by medication aides by monitoring all residents. The Resident Service Director will monitor for completion weekly. Skin assessments will be ongoing. The facility will follow the Centers for Disease Control Plan of Protection for rash with multiple cases of suspected scabies.</p> | D 273 | | |
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| D 273 | Continued From page 51 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 11, 2015. | D 273 | | |
| D 298 | <p>10A NCAC 13F .0904(d)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to</p> <p>residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.</p> <p>This Rule is not met as evidenced by: Based on observation, and interview the facility failed to offer snacks or make snacks available to all residents three times a day. The findings are:</p> <p>Interview with the Dietary Director on 8/4/15 at 9:55 am revealed:</p> <ul style="list-style-type: none"> - The residents are offered a snack three times a day. - The snack times are 10:30am, 3:30pm and at bedtime. - Residents are offered bananas, muffins, crackers and cookies with water and or juice. <p>Observation on 8/5/15 at 11:00 am - 12:00pm revealed:</p> <ul style="list-style-type: none"> - On the second floor across from the day room, was a self-serve water cooler filled with water, and a tray full of bananas lying next to it. - On the first floor on a small table in front of the elevator was a tray full of bananas. <p>Confidential interviews with 16 residents and</p> | D 298 | <p>D298-Snacks served room to room and to each resident three times per day. Diet board posted for dietary aides. Diet roster on snack carts during snack pass.</p> | 8/7/15 |

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| D 298 | <p>Continued From page 52</p> <p>family members revealed residents were not offered snacks:</p> <ul style="list-style-type: none"> - "The snacks are out in the hallway, across from the day room." - "No one ever offer us a snack or a drink between meals" - "Snacks are not offered, but I'm pretty sure I could get one if I asked." - "I have not seen anybody offering snacks around." - "Nobody comes to our rooms to see if we want a snack between meals." - "Snacks are not offered." - "The staff give me anything I want, if I want a snack, all I have to do is ask for it and they would get me something." - "I have my own snacks in my room" - "It would be nice to get a snack sometimes". - She was surprised to see "the guy walking around with the bananas today". The snacks are usually around someplace for us to find, on a tray next to the elevator downstairs or on a large tray opposite the living room on the 2nd floor, or non-existent". - "I have seen snacks on a tray near the elevator, but they were not offered to anyone." - "They sit snacks out in the hallway at the water station once a day and when they run out, they don't refill the tray, sometimes its muffins or bananas, not much variety." - "The staff sit the snacks out in the hallway near the water in the morning and sometimes in the afternoon, it is possible they get one at night, but I have never seen any snacks at night." - "Residents get a snack once per day in the morning." - "My mom has her own snacks so they don't offer any to her, she could probably get some if she wanted." | D 298 | | |

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| D 298 | <p>Continued From page 53</p> <p>Five confidential staff interviews revealed snacks were not offered to residents:</p> <ul style="list-style-type: none"> - "The kitchen staff place snacks near the elevator on the first floor and at the water cooler on the second floor." - When she worked she would take snacks to the residents on the "first floor because there are some residents that take all of them". - "Snacks are set out in the hallway on both floors, the residents just come and grab them if they want them." - " The first floor get their snack delivered, not the second floor, there are a couple of residents that will take the whole tray. " - "Snacks are not offered" to residents "in the assisted living, they are set out in the hallway for residents to grab between 10:00am and 10:30am, some residents come get them, it depends if they see it or know it is there". <p>Observation of the lunch meal on 8/5/15 at 12:05 pm revealed:</p> <ul style="list-style-type: none"> - One resident had a banana sitting on the table in front of him in the dining room while beverages, soups and salads were being served to the residents. - A second resident at a different table asked him where he got the banana from. - He told him he got it off the tray near the elevator on his way to the dining room. - The resident stated "oh I'm going to have to go down there and get one after lunch". - The first resident gave him his banana and said he would get one for himself on his way back to his room. - A third resident overheard the first and second residents talking and she went up to the Regional Director of Marketing, that was helping serve in the dining room and requested "4 bananas for me and my friends". | D 298 | | |
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| D 298 | <p>Continued From page 54</p> <ul style="list-style-type: none"> - He told her he would go out to the water cooler and get them. - He returned with 2 bananas and handed them to her and told her he would go and find her 2 more. - The first resident told him there was a tray full near the elevator on the first floor, and he went and returned with 8 bananas. - Several residents raised their hands asking for them, at that point he ran out and had to make another trip to the first floor to get more bananas for all of the resident that had requested them. - Four of the residents immediately began eating the bananas at the lunch table while waiting on their lunch plate. <p>Observation of the snack areas on 8/5/15 at 3:30-3:45pm revealed:</p> <ul style="list-style-type: none"> - There were no snacks on the table near the elevator on the first floor. - There were no snacks on the table near the water cooler on the second floor. - There was no staff person in the assisted living building passing out snacks. <p>Interview with the Executive Director on 8/5/15 at 3:50 pm revealed she would find out what snacks were offered and if they were offered.</p> <p>Observation on 8/5/15 at 4:35pm revealed:</p> <ul style="list-style-type: none"> - The Dietary Director was in the hallway with a cart containing cheese, cookies, juice and water. - He was going room to room offering the snacks to residents. <p>Interview with the Executive Director on 8/5/15 at 4:45pm revealed:</p> <ul style="list-style-type: none"> - She spoke with the Dietary Director and he told her snacks were offered that afternoon at 3:30pm. | D 298 | | |

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| D 298 | <p>Continued From page 55</p> <ul style="list-style-type: none"> - The snack he offered was cookies, cheese, water, and juice. <p>Interview with the Dietary Director on 8/6/15 at 9:55am revealed:</p> <ul style="list-style-type: none"> - In the past the patient care aides (PCAs) were responsible for passing out snacks in assisted living. - The kitchen staff would set the snack out on the counter and the PCA would be responsible to pass the snack to the residents. - The snacks went out late on 8/5/15, he did not realize it was 4:30pm. - As of 8/5/15 the kitchen assistants would be passing snacks. <p>Three confidential interview with residents and family members on 8/10/15 revealed:</p> <ul style="list-style-type: none"> - "The nice gentleman knocked on my door and offered me something to eat after lunch, today." - "You know, they never usually bring us a snack, I wonder how long that will last." - "My mom said she's not sure what happened last week, but someone has been bringing a snack to her door lately". | D 298 | | |
| D 468 | <p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train</p> <p>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training</p> <p>The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to</p> | D 468 | <p>D468-Added trainings to web based system. Staffing Coordinator and Heartland Village Clinical leader to audit all associate trainings and ensure compliance. All new hires will receive trainings per state regulations.</p> | 9/30/15 |

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| D 468 | <p>Continued From page 56</p> <p>be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.</p> <p>(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.</p> <p>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 2 of 3 sampled staff (Staff C, and F) assigned to perform duties in the special care unit received 6 hours of orientation training within the first week of employment and 20 hours of training within six months of employment. The findings are:</p> <p>1. Review of staff C's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff C was hired on 11/17/09 as a personal care aide (PCA). - There was no documentation to indicate staff C completed six hours of orientation on the nature and needs of the resident in a special care | D 468 | | |
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| D 468 | <p>Continued From page 57</p> <p>unit training prior to working on the special care unit.</p> <ul style="list-style-type: none"> - There was no documentation to show Staff C had completed 20 orientation on the nature and needs of the resident in a special care unit within the first 6 months of working on the special care unit. <p>Interview with Staff C on 8/10/15 at 11:00am revealed:</p> <ul style="list-style-type: none"> - She mostly worked in the assisted living unit. - She had worked in the special care unit "quite a bit" over the last few months. <p>Interview with the Staff Development Coordinator on 8/10/15 at 2:00pm revealed she could not locate any documentation of Staff C having had the 6 hour training within the first week of hire, prior to working in the special care unit.</p> <p>Refer to Interview with the Executive Director on 8/10/15 at 2:00 pm</p> <p>Refer to interview with the Staff Development Coordinator on 8/10/15 at 2:15pm.</p> <p>2. Review of staff F's personnel record revealed:</p> <ul style="list-style-type: none"> - Staff F was hired on 10/13/13 as a personal care aide (PCA). - The documentation indicated staff F completed six hours of orientation on the nature and needs of the resident in a special care unit training by 11/1/13. - However, there was no documentation to show Staff F had completed 20 orientation on the nature and needs of the resident in a special care unit within the first 6 months of working on the special care unit. | D 468 | | |
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| D 468 | <p>Continued From page 58</p> <p>Staff F was not available for an interview.</p> <p>Review of the special care unit schedules from July 24, 2015 through August 7, 2015 revealed:</p> <ul style="list-style-type: none"> - Staff F was on the schedule to work 10 shifts. - He was scheduled to work as an aide on third shift in the special care unit. <p>Refer to Interview with the Executive Director on 8/10/15 at 2:00pm</p> <p>Refer to interview with the Staff Development Coordinator on 8/10/15 at 2:15pm.</p> <hr/> <p>Interview with the Executive Director on 8/10/15 at 2:00pm revealed:</p> <ul style="list-style-type: none"> - She had been employed at the facility for approximately 2 weeks. - The Staff Development Coordinator was responsible for staff qualifications, orientations, and training. <p>Interview with the Staff Development Coordinator on 8/10/15 at 2:15pm revealed:</p> <ul style="list-style-type: none"> - The individual staff were responsible for going to scheduled ongoing orientations or trainings. - They were "not reminded or kept up with" to ensure compliance. - There was no one responsible for checking back with staff or to monitor whether the trainings had been completed. - She could not find any documentation of Staff C and Staff F completing 20 hours of training within 6 months of hire or working in the special care unit. | D 468 | | |
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| D 476 | Continued From page 59 | D 476 | | |
| D 476 | <p>10A NCAC 13F .1408 Special Care Unit Staffing</p> <p>10a NCAC 13F .1408 Special Care Unit Staffing</p> <p>(a) Direct care and supervisory staff requirements in 10A NCAC 13F .0604 and .0605 shall apply and staff shall be present in the unit at all times in sufficient numbers to meet the needs of the residents.</p> <p>(b) There shall be a care coordinator on duty in the unit 8 hours per day, 7 days per week.</p> <p>(c) Staffing shall be consistent so that rotation of staff on and off the unit is avoided except for emergency situations or to alleviate staff burnout.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews, review of staff time sheets, and review of staff scheduling ; the facility failed to properly staff 2 of 6 shifts reviewed (3rd shifts) in the Special Care Unit to meet the needs of the residents.</p> <p>The findings are:</p> <p>Review of July 24, 2015 time records revealed there were 31.25 staffed hours for the unit on third shift.</p> <p>Review of July 25th, 2015 time records revealed there were 26.5 staffed hours for the unit for third shift.</p> <p>A phone interview on 8/13/15 with business office personnel confirmed there were 45 residents in the special care unit on Friday July 24th, 2015 and Saturday July 25th, 2015. Based on the requirement for staffing a special</p> | D 476 | <p>Staffing has been corrected. Staffing to state requirements. Staffing Development Coordinator continuing to ensure staffing to state regulations. Monitoring daily.</p> | 8/7/15 |

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| D 476 | <p>Continued From page 60</p> <p>care unit with 45 as a census; the minimum requirement should have been 36 hours of staffing for third shift.</p> <p>Four confidential staff interviews revealed most all staff floated back and forth between the special care unit and the assisted living building.</p> <ul style="list-style-type: none"> -The schedule for the special care unit would get changed over the weekend frequently and if you did not work the weekend you would not know your assignment until you came to work. -You could not go by what the staffing schedule showed on any given day. -Staff were always getting pulled and they were already short-staffed. -Staff felt like they were always rushed and running behind. - " Staff were quitting right and left. " -There were not enough staff scheduled to give residents showers, especially those residents with 2-person assist. - " It was impossible to bathe the residents, do laundry, help out in the dining room, and watch the halls. " <p>Confidential interview with a 1st shift special care unit staff (SCU) Staff revealed:</p> <ul style="list-style-type: none"> - There was not enough staff to attend to resident's needs since 1 staff was reassigned. - The right hall used to staff 3 personal care aides (PCA), 1 medication aide (MA), and the special care unit coordinator to provide for the needs of the residents. - There were a lot of wheelchair residents and those requiring 2-person assistance. - Now there were only 2 PCAs to provide the care as 1 was reassigned to do other duties. | D 476 | | |
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| D 476 | <p>Continued From page 61</p> <ul style="list-style-type: none"> - The reassigned staff would help with laundry and help in the dining room, setting up the dining room for meals, then go to the assisted living dining room and help serve the meal; the staff came back after the meal to do laundry. <p>Confidential interview with a 1st shift SCU Staff revealed:</p> <ul style="list-style-type: none"> - There was not enough staff to help residents since 1 of the 3 PCA staff's hours were changed and that staff floated back and forth working in the facility. - The MA positions were not changed. - Staff worked hard to keep resident care what it was supposed to be. - The MA and the SCU coordinator would help if needed. <p>Observation on 8/10/15 at 12:30 pm of the SCU hallways revealed:</p> <ul style="list-style-type: none"> - No staff were visible outside of the dining room on the 2 halls and central elevator area of the unit. - At 12:40 pm 2 Residents walked out of the dining room after lunch towards the right hallway unaccompanied by staff. - Between 12:40 pm and 12:58 pm 5 more residents walked out of the dining room unaccompanied by staff and down the hallway. -At 12:58 pm, a PCA was observed pushing a resident in a wheelchair down the hall to her room. <p>Interview on 8/10/15 at 1:00 pm with the SCU PCA pushing the wheelchair resident revealed: - One staff was supposed to be on the halls during the meals; the MA was supposed to be there.</p> <ul style="list-style-type: none"> - The PCA, looking around, stated not knowing where the MA was and the other PCA was | D 476 | | |
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| D 476 | <p>Continued From page 62</p> <p>assisting residents.</p> <p>Confidential interview with a Staff revealed:</p> <ul style="list-style-type: none"> - There were 4 people in the kitchen during meals and they all stayed in the kitchen. - The PCAs did all of the dining room work. <p>Confidential interview with a secured assisted living Staff revealed:</p> <ul style="list-style-type: none"> - There used to be a regular laundry staff, but she quit last year around September. - Another laundry staff was not hired, so the PCAs had to do all of their assigned residents' laundry. - Sometimes doing laundry would take away from resident time. - Sometimes changing a resident (pull-ups or diaper) would be delayed. - If a PCA was busy with a resident they might ask another PCA for help - PCAs tried to give good care, but really had to be flexible to get things done. - Staff wanted to take good care of residents. <p>Interview on 8/12/15 at 11:24 am with a SCU resident's family member revealed:</p> <ul style="list-style-type: none"> - The family member visited the resident 1-2 times a week. - There was a concern regarding the resident's ability to be stay hydrated. - The resident had been hospitalized in the past (over a year ago) for dehydration and the family wanted to be sure the resident had enough water. - The resident had a personal container in his room for water and had observed the container had been empty the last 3 times he was visited in the afternoon. - The resident had stated to the family member that the only time he got enough water was when family brought it. | D 476 | | |
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| 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: Based on record review and interview, the facility failed to assure referral and follow-up to meet the chronic and acute health care needs of residents from not following a physician's order to treat all residents and staff for possible scabies infection resulting in 2 of 9 sampled residents having confirmed diagnoses for scabies (Residents #8, #9) and other residents and staff facility-wide requiring treatment for scabies.[Refer to Tag D 0273, 10A NCAC 13F .0902(b). (Type A1 Violation)].</p> <p>Base on observation, interview and record review, the facility failed to ensure that food service duties assigned to personal care aides were limited to providing assistance to individuals residents and carrying plates, trays or beverages to residents and resulted in residents needs not</p> | D914 | <p>G.S. 131D-21(4)See Plan of Correction for D273.</p> | 7/31/15 |
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being met. [Refer to Tag D 0209, 10A NCAC 13 F .0604(2)(e). (Type B Violation)].

