

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/30/2015
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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULEVARD KANNAPOLIS, NC 28083
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{D 000}	<p>Initial Comments</p> <p>The Adult Care Licensure Section conducted a Follow-up survey on October 29-30, 2015.</p>	{D 000}		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to ensure every resident was free from mental and physical abuse, related to the mistreatment of residents by 1 staff member (Staff A).</p> <p>The findings are:</p> <p>Interviews with 5 residents during the initial tour on 10/29/15 related to questions regarding any concerns with their medications revealed: -Two residents said there was one MA that seemed to "enjoy" making "us" wait for our as needed (prn) medications. This MA would say, she would decide when the resident could get prn medications. She would intentionally withhold prn medications or conveniently leave them out of the medication cup. The residents knew what the MA's name was, but was afraid to say for fear the MA would not let the resident have any of the resident's medications. One resident had not told anyone about this because the resident was afraid of retaliation by other staff including this MA.</p>	D 338		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 338	<p>Continued From page 1</p> <ul style="list-style-type: none"> -One resident said a resident had asked for a prn medication after waking up in pain. A resident asked the MA (Staff A) on duty for pain medication and the MA did not get the pain medication for a resident until 45 minutes later and the MA (Staff A) called the resident a [curse word] for no reason. One resident said no response was given back to the MA and was fearful of not getting medication if the resident said something to Staff A. -One resident said Staff A would give a pain medication at the medication pass 2 hours later. The Administrator and the Resident Care Coordinator (RCC) were aware of Staff A withholding medications within the last 3 weeks. One resident said nothing was done because the resident had not heard back from the Administrator or the RCC. -Three residents reported that they regularly run out of medication. -All five residents said if residents were not in their rooms when medications were passed they did not get their medications when Staff A was passing medications. -All five residents said, other MAs would come back to give medications to them if they were not in their rooms during medication pass, but Staff A would not. When Staff A was on duty and residents were not in their rooms when she passed medication, "you just don't get your medications". -All five residents said if residents go to the MA (Staff A) and request medications missed during medication pass, the MA would tell them they would have to wait until the next medication pass. -All five residents said, when "We request" prn pain medications, she purposely made us wait for at least 30 minutes or more to give pain medications. -Two of five residents were unable to recall 	D 338		

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D 338	<p>Continued From page 2</p> <p>specific dates and times when medications given were late.</p> <p>-Three residents said this happened mostly at the morning medication pass when Staff A was on duty. The morning medication pass was usually around 6:00 am to 8:00 am.</p> <p>-One resident said medications were late approximately 3 times a week. The resident was not sure how long medications had been administered late. The resident was not able to identify which staff member administered medications late. The resident had not notified management regarding late medication administration.</p> <p>Continued interviews with 5 residents during the initial tour on 10/29/15 related to concerns of residents' treatment by Staff A revealed:</p> <p>-Two residents said there was one Medication Aide (MA) (Staff A) that was "really mean". This one MA (Staff A) talked disrespectfully to all the residents. Both residents said they had witnessed this MA (Staff A) saying or talking about residents in a negative way to other MAs "right in front" of residents. Both residents had told the Administrator about the MA's (Staff A) behavior and treatment of residents several times in the past month and as early as last week, but nothing was done. Both residents said, nothing had been done because the residents had not heard anything else about it from the Administrator or the RCC.</p> <p>-All five residents said if "We need help or assistance when Staff A was on duty you might as well not ask because she won't help you".</p> <p>-All five residents said when Staff A was on duty "We keep away from her" because she would "call us names and curse at us".</p> <p>-All five residents said the residents were "taking a big risk" talking about this because of retaliation</p>	D 338		

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D 338	<p>Continued From page 3</p> <p>from this MA (Staff A) as well as other staff at the facility.</p> <p>-One resident said that Staff A would make inappropriate sexual comments about the resident's male family member.</p> <p>-Four residents said the Administrator and the RCC was made aware of Staff A's treatment towards them within the last three weeks, and this had not been the first time the residents had made the Administrator and RCC aware of the MA's (Staff A) behavior.</p> <p>Interview with a sixth resident revealed:</p> <p>-The resident heard another resident screaming for help for over an hour (on evening shift on 10/28/15) and was afraid to help the other resident.</p> <p>-If the resident made the MAs mad they would retaliate by withholding medications.</p> <p>Interview with a seventh resident revealed:</p> <p>-Staff A was very rude and very rough when providing personal care.</p> <p>-She would rush this resident and refused to assist the resident with personal care.</p> <p>-Staff A cursed at the resident and told the resident that the resident had to clean themselves up since the resident made the mess.</p> <p>-This resident was made to feel "Sub-human" and the resident dreaded having to rely on Staff A to care for the resident.</p> <p>Review of residents' Medication Administration Records from June 2015 to October 2015 revealed no missed medication administration documentation for the 6:00 am to 8:00 am medication pass.</p> <p>Review of medications on hand on 10/30/15 for 5 sampled residents revealed medications were</p>	D 338		

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D 338	<p>Continued From page 4</p> <p>available for administration.</p> <p>Interview with 2 staff members revealed: -Both staff members were not aware of any issues or concerns with interactions between staff and residents or residents and residents. -Both staff members said the policy was if staff saw or were aware of any mistreatment of residents or other staff, they were supposed to tell the MA on duty, and the MA would let the Administrator or the RCC know. -No residents had expressed any concerns to them related to any mistreatment by staff.</p> <p>Interview with a third staff member revealed: -The staff member was not aware of any issues or concerns by residents with staff. -If a resident came to the staff member and told about any problems, the staff member would let the Administrator or the RCC know. -There were "some things" going on with a staff member "named MA" (Staff A) that the staff member had concerns about. -The staff member would not and had not made the Administrator or the RCC aware because the staff member did not want to "lose this job". -The staff member was "very afraid" of losing this job if it was reported what the staff member had seen and heard. -There was one MA "named MA" (Staff A) that "did not treat the residents right". The staff member did not want to say anymore.</p> <p>Interview with a fourth staff member revealed: -Staff A had been heard repeatedly swearing loudly at residents. -The staff member had reported to the administration three times in the way of written notes within the past 3-4 weeks, but nothing had been done.</p>	D 338		

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D 338	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The staff member had witnessed Staff A giving one of the residents a "marshmallow". A marshmallow was then described as bending the pinky finger down on itself to cause pain in efforts to curb a resident's [named specific resident] bad behavior. -The staff member said Staff A had told the staff member this was the technique Staff A used on residents who needed personal care assistance to keep the residents from resisting personal care. -The [named specific] resident was bed-bound and did not talk. -The staff member witnessed Staff A refusing to care for a resident on evening shift on 10/28/15 who required assistance after having slid off the commode. The resident required assistance getting up and getting cleaned up and Staff A said, "Get the [curse word] up! If you can [curse word] all over yourself then you can clean it the [curse word] up." -Staff A had a male visitor who came to the facility on 10/28/15 and stayed for most of the evening shift with Staff A. -The staff member witnessed Staff A pull medications and then not administer the medications to the residents. The staff member did not know where the medications would end up. -The staff member had not observed Staff A pass medications to the residents. -The staff member had reported these incidents to administration, but had never heard anything back about it. -The staff member would probably "lose this job", but did not care because what was going on "was not right" and the staff member "could not take it anymore". <p>Interview with Staff A on 10/29/15 at 5:43 pm</p>	D 338		

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D 338	<p>Continued From page 6</p> <p>revealed:</p> <ul style="list-style-type: none"> -She had been employed at the facility since December 2014. -Upon hire, she worked in the kitchen and then transferred to the floor providing resident care and medication administration. -She worked 1st, 2nd, and 3rd shifts during varying hours. -Her responsibilities included assisting residents with personal care, activities of daily living and medication administration. -The residents did not have any patience and they all want their medications at the same time. -"Residents do not like to be told to wait if she is busy with medication administration." -"Some residents do not understand the timeframes for PRN (as needed) medications." -She tried to focus on one resident at a time and the residents would get verbally nasty when they did not get their medications. -If she was having problems with a resident she was to go get another MA to witness the interaction between herself and the resident. -There was no pre-pulling medication as this was against policy. -The MAs were not allowed to "pre-pull" medications prior to the scheduled administration medication time frames. -"We would get fired on the spot for pre-pulling medications." -She did not know of any resident complaints in regards to being mistreated by staff. -She had never had to report other staff members for mistreating residents. -She had never withheld medication from a resident, but did wait to administer medication so it would be administered within the specified parameters (1 hour before or 1 hour after scheduled administration times). 	D 338		

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D 338	<p>Continued From page 7</p> <p>Interview on 10/29/15 at 6:10 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was not aware of any issues any of the residents had with any staff. -She had received a note from a staff member concerning another staff member today, but was not aware of any staff mistreatment of any residents. -She had not looked into the concerns mentioned in the note left by another staff member because she just received it today. -Staff and residents were supposed to make her aware of any concerns or issues. -The Administrator planned to do an investigation into the allegations and had not reported the allegations to the Health Care Personnel Registry because she was not aware of any problems or concerns related to Staff A. <p>Observation of a Medication Aide (MA) and residents during medication pass on 10/29/15 between 9:05am and 9:32am revealed:</p> <ul style="list-style-type: none"> -Three residents received medications during this time. -The MA called the residents by their first names prior to medication administration. -The MA remained with each resident until all medications were taken. -The MA and residents interacted positively. -No complaints during medication pass were noted. <p>Interview with the Facility Registered Nurse Consultant on 10/30/15 at 10:30am revealed:</p> <ul style="list-style-type: none"> -The facility had a policy regarding "Abuse and Neglect " -All staff were educated regarding the policy upon hire. - The Administrator was responsible for updating the staff annually related to the policy. 	D 338		

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D 338	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The facility provided a confidential telephone number that could be used by staff and residents when they were not comfortable addressing concerns with management. -All staff and residents were informed regarding the confidential telephone number. -She was not aware of any issues any of the residents had with any staff. <p>Observation on 10/30/15 at 11:30am revealed the confidential telephone number with instructions were posted in the front main entrance hallway.</p> <p>Interview on 10/30/15 at 2:45pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was aware of "Code Green" (resident fall) on 10/28/15 during night shift. -She talked to the night shift staff on 10/29/15 regarding the resident incident. -The "Code Green" on 10/28/15 was not an official fall. -The resident slid down the wall in the bathroom and needed assistance to get up and incontinent care. -An incident report was not completed for the "Code Green" on 10/28/15. -In the past, she would make random unannounced visits to the facility to monitor staff on 2nd and 3rd shifts. -She was not aware of any issues any of the residents had with any staff. -She had an open door policy for residents and staff to address concerns and issues. <p>Interview on 10/30/15 at 1:55pm with the Assistant Resident Care Coordinator (ARCC) revealed:</p> <ul style="list-style-type: none"> -She had been employed at the facility for 5 years. -She worked Monday through Friday from 8:00am 	D 338		

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D 338	<p>Continued From page 9</p> <p>to 5:00pm.</p> <ul style="list-style-type: none"> -Her responsibilities included: ordered resident supplies, communicated with the physician, audited narcotic sheets, ordered Durable Medical Equipment (DME) for residents, medication clarification, and LHPS assessment completion. - None of the residents had expressed any concerns to her related to any mistreatment by staff. -Residents mostly complained about not receiving their medications. -When she looked into the residents' complaints "there was not ever an issue." -It was usually not time for the medication to be given when the resident asked for it. -Medications were dispensed one hour prior and/or one hour after the scheduled time frame. -Residents were to be in their rooms during medication pass. -It was announced over the facility intercom when the medication pass was to begin. -When a resident was not in their room, the MA was to flag the Medication Administration Record (MAR) to remind the MA that medication was not given. -Most residents were receptive to the process of waiting in their rooms for medication administration. -The staff were aware all concerns were to be reported to management. -The staff were educated on the reporting process upon hire and reminded during their daily standup meetings prior to the shift. -She had made unannounced visits to the facility during 2nd and 3rd shifts, but was not aware of any issues. -She had not heard complaints from staff about any resident behaviors or mistreatment of residents by staff. 	D 338		

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D 338	<p>Continued From page 10</p> <p>Interview on 10/30/15 at 2:25pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -She had been employed at the facility for 14 years. -She worked Monday through Friday from 6:00am to 3:00pm. -Her responsibilities included: assisting with nursing care for the residents, staffing schedules, and was in charge when the Administrator was not available. -Residents had complained about medications given late and medications not being given within the last three weeks. -She had looked into it and did not find anything, "there was nothing to it". -None of the residents had expressed concerns to her related to any mistreatment by staff. -If a resident did have a complaint about staff, she would question the staff who the resident complained about and would "look into it". -She would question other staff and residents and "tried to take care of it". -She was not aware of the MAs pre-pulling medications during their assigned shift. -She randomly checked the medication carts to monitor for pre-pulling of medications and had not found any. -The doors of the facility were locked between the hours of 8:00pm and 9:00pm and unlocked between the hours of 5:00am and 6:00am. -The staff were not to have visitors during their shift in the facility after the facility doors were locked unless it had been approved by the Administrator. -She would occasionally make surprise visits to the facility during 2nd and 3rd shifts but never discovered any issues. <p>_____</p> <p>The facility provided a Plan of Protection on 10/29/15 as follows:</p>	D 338		

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D 338	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Immediately, staff member (Staff A) will be sent out of the facility. Staff A was immediately drug tested and suspended pending an investigation. -Staff and residents will be interviewed -The Regional Vice President will be notified. -An in-service on Residents' Rights will be scheduled with the Ombudsman. -Staff will be in-serviced on reporting abuse, neglect. <ul style="list-style-type: none"> -On 10/29/15, the Administrator, and Resident Care Coordinator (RCC) initiated interviews of all interviewable residents regarding allegation of abuse including any physical or verbal abuse. -On 10/29/15, the Administrator, Facility Nurse, and RCC completed skin assessments on all non-interviewable residents for signs or symptoms of abuse. Any negative findings were immediately addressed. -On 10/29/15, the Administrator and RCC initiated staff questionnaires regarding the allegation of verbal and physical abuse for 100% of staff. Staff members will not be able to work until staff questionnaires regarding the allegation of verbal and physical abuse is completed. Any negative findings will be addressed immediately. -On 10/29/15, the Administrator, and RCC initiated an in-service on the resident abuse/neglect policy for 100% of facility staff which included immediate reporting of any suspicions of abuse/neglect to the supervisor. -Staff members will not be allowed to work until they have completed training on the Resident Abuse/Neglect policy. -On 10/30/15, the Administrator and the RCC met with the Resident Council to discuss how to report verbal and/or physical abuse. -On 10/30/15, the administrator contacted the Ombudsman to schedule Residents ' Rights training to include resident abuse and neglect for 	D 338		

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D 338	<p>Continued From page 12</p> <p>100% of staff. Any facility staff who do not attend the residents ' rights training will not be allowed to work until such training is completed by the Ombudsman and/or Administrator.</p> <p>-Beginning 10/30/15, the Administrator, RCC and/or Assistant RCC will utilize the Resident questionnaire to monitor for any allegations of resident abuse/neglect. The resident questionnaire monitoring tool will be completed for ten residents daily for 1 week, ten residents weekly for 7 weeks, and then ten residents monthly for 1 month. Any negative findings will be addressed immediately.</p> <p>-Beginning on 10/30/15, the Administrator, RCC and/or Assistant RCC will utilize a skin assessment tool to monitor all non-interviewable residents for any signs or symptoms of abuse. The skin assessment tool will be completed for all non-interviewable residents daily for 1 week, weekly for 7 weeks, and then monthly for 1 month. Any negative findings will be addressed immediately.</p> <p>-Beginning 10/30/15, the Administrator, RCC and/or Assistant RCC will utilize the Employee Questionnaire to monitor for any allegations of resident abuse/neglect. The Employee Questionnaire monitoring tool will be completed for ten staff daily for 1 week, ten staff weekly for 7 weeks, and then ten staff monthly for 1 month. Any negative findings will be addressed immediately.</p> <p>-The Administrator will present all findings to the monthly Quality Improvement meeting monthly for 3 months for any recommendations and/or suggestions for further monitoring.</p> <p>DATE OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED, December 14, 2015.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/30/2015
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NAME OF PROVIDER OR SUPPLIER KANNON CREEK ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1808 N CANNON BOULVARD KANNAPOLIS, NC 28083
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D 438	Continued From page 13	D 438		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to investigate and report allegations of abuse by one staff (Staff A) to the North Carolina Health Care Personnel Registry (HCPR).</p> <p>The findings are:</p> <p>Refer to Tag 0338 10A NCAC 13F .0909 (Residents' Rights).</p> <p>Interviews with 5 residents during the initial tour on 10/29/15 related to concerns of residents' treatment by staff revealed: -Two residents had told the Administrator about the Staff A's (Medication aide) behavior and treatment of residents several times in the past month and as early as last week, but nothing was done. Both residents said, nothing had been done because the residents had not heard anything else about it from the Administrator or the RCC. -Four residents said the Administrator and the RCC were made aware of Staff A's treatment towards them within the last three weeks, and this had not been the first time the residents had made the Administrator and RCC aware of the</p>	D 438		

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D 438	<p>Continued From page 14</p> <p>MA's (Staff A) behavior.</p> <p>Interview with a staff member revealed:</p> <ul style="list-style-type: none"> -Staff A had been heard repeatedly swearing loudly at residents. -The staff member had reported to the administration three times in the way of written notes within the past 3-4 weeks, but nothing had been done. -The staff member witnessed Staff A refusing to care for a resident on evening shift on 10/28/15 who required assistance after having slid off the commode. The resident required assistance getting up and getting cleaned up and Staff A said, "Get the [curse word] up! If you can [curse word] all over yourself then you can clean it the [curse word] up." -The staff member witnessed Staff A pull medications and then not administer the medications to the residents. The staff member did not know where the medications would end up. -The staff member had not observed Staff A pass medications to the residents. -The staff member had reported these incidents to administration, but had never heard anything back about it. <p>Interview on 10/29/15 at 6:10 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She was not aware of any issues any of the residents had with any staff. -She had received a note from a staff member concerning another staff member today, but was not aware of any staff mistreatment of any residents. -She had not looked into the concerns mentioned in the note left by another staff member because she just received it today. -Staff and residents were supposed to make her 	D 438		

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D 438	<p>Continued From page 15</p> <p>aware of any concerns or issues. -The Administrator planned to do an investigation into the allegations and had not reported the allegations to the Health Care Personnel Registry because she was not aware of any problems or concerns related to Staff A.</p> <hr/> <p>The facility provided a Plan of Protection as follows:</p> <p>-On 10/29/15, an allegation was made by a few residents and staff that a Medication Aide (MA) was verbally and physically abusing residents. The MA was immediately drug tested and suspended pending investigation per facility policy.</p> <p>-On 10/29/15, the Administrator and Resident Care Coordinator (RCC) initiated interviews of all interviewable residents regarding the allegation of abuse including any physical or verbal abuse. The Administrator, facility Registered Nurse, and RCC completed 100% skin assessments for all non-interviewable residents to look for any signs of abuse on 10/29/15. Any negative findings were addressed immediately. The Administrator, and RCC initiated staff questionnaires regarding the allegation of verbal and physical abuse for 100% of staff. Staff members will not be allowed to work until staff questionnaires regarding the allegation of verbal and physical abuse is completed. any negative findings will be addressed immediately.</p> <p>-On 10/29/15, the Administrator and RCC initiated inservicing of 100% of facility staff on the Resident abuse/Neglect policy which included immediate reporting of any suspicions of abuse/neglect to the supervisor. Staff members will not be allowed to work until they have completed training on the resident Abuse/Neglect policy.</p>	D 438		

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D 438	<p>Continued From page 16</p> <p>-On 10/30/15, the Administrator and RCC met with the Resident Council to discuss how to report verbal and/or physical abuse.</p> <p>-On 10/30/15, he Administrator contacted the Ombudsman to schedule Residents' Rights training to include resident abuse and neglect to 100% of facility staff. any staff who do not attend the residents' rights training will not be allowed to work until the training is completed by the Ombudsman and /or Administrator.</p> <p>-Beginning 10/30/15, the administrator, RCC, and/or Assistant Resident Care Coordinator (ARCC) will utilize the Resident Questionnaire to monitor for any allegations of resident abuse/neglect. The Resident Questionnaire monitoring tool will be completed for ten residents daily x one week, ten residents weekly x 7 weeks, then ten residents monthly x 1 month. Any negative findings will be addressed immediately.</p> <p>-Beginning 10/30/15, the administrator, RCC, and/or ARCC will utilize a Skin Assessment tool to monitor all non-interviewable residents for signs or symptoms of abuse/neglect. The Skin Assessment tool will be completed for all non-interviewable residents daily x one week, weekly x 7 weeks, then monthly x 1 month. any negative findings will be addressed immediately.</p> <p>-Beginning 10/30/15, the Administrator, RCC and/or ARCC will utilize the Employee Questionnaire to monitor for any allegations of resident abuse/neglect. the Employee Questionnaire monitoring tool will be completed for ten staff daily x 1 week, ten staff weekly x 7 weeks, then ten staff montly x 1 month. any negative findings will be addressed immediately.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, December 14, 2015.</p>	D 438		

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D914	Continued From page 17	D914		
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 interview and record review, the facility failed to assure that every resident be free from abuse and neglect related and neglected to protect residents by not investigating or reporting allegations to Health Care Personnel Registry.</p> <p>The findings are:</p> <p>A. Based on interviews and record reviews, the facility failed to ensure every resident was free from mental and physical abuse, related to the mistreatment of residents by 1 staff member (Staff A).[Refer to Tag 0338 10A NCAC 13F .0909 (Type B Violation)].</p> <p>B. Based on interviews and record reviews, the facility failed to investigate and report allegations of abuse by one staff (Staff A) to the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag 0438 10A NCAC 13F .1205 (Type B Violation)].</p>	D914		