

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL045008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 01/07/2016
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NAME OF PROVIDER OR SUPPLIER  BLUE RIDGE RETIREMENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1009 NINTH AVENUE WEST HENDERSONVILLE, NC 28739
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section and the Henderson County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation on January 6 - 7, 2016. The complaint investigation was initiated by the Henderson County Department of Social Services on November 18, 2015 and conducted December 8, 11, and 21, 2015.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;  This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to maintain walls, ceilings and floors or fixtures attached to them for 4 of 22 resident rooms (Rooms #103, #110, #112 and #117), the activity room, a common bathroom, a common tub room and hallways.  The findings are:  Observations from 1/6/16 at 9:45AM through 1/6/16 at 10:55AM of the facility revealed: -Brown-stained ceiling (approximately 4 square feet) adjacent to a patched area of ceiling (approximately 4 square feet) and located in the hallway outside of the medication room, with an approximately 6 inch crack in the vicinity of this area. -In the common bathroom across from the medication room an approximately 6 inch long by	D 074	Submission of this response and Plan of Corrections is not a legal admission that the deficiency was correctly cited. It is not to be construed as an admission of interest against the facility, the Administrator, Director of Nursing or any employee, agent or other individuals who draft or may be discussed in the Plan of Correction.  In addition, preparations and submission of this Plan of Correction does not constitute any admission or agreement by the facility of the truth of any facts alleged or correction of any conclusions set forth in this allegation by the survey agency. For the deficiencies cited during this survey, this facility has developed a Plan of Correction with the regulations. We would like you to accept this POC as our credible Allegation of compliance.  The brown stained ceiling has been primed and painted.	1-16-16

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Chris Drake*

TITLE

*Exp Director*

(X6) DATE

*2 Feb. 2016*

STATE FORM

6899

41BJ11

If continuation sheet 1 of 18

*Reviewed and Accepted.  
of (RSC) 2/8/16*

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D 074	<p>Continued From page 1</p> <p>1 inch wide hole in the drywall along the vinyl baseboard which was pulling away from the wall, and a wall with chipped paint over the toilet paper holder measuring approximately 1 foot in diameter.</p> <p>- Resident Room 112 with a dust-covered heating vent in the ceiling and a missing electric outlet faceplate behind the bed headboard alongside the window.</p> <p>-In the common tub room across from Resident Room 103 was brown staining in the tub above the drain, a dirty sidewall of the tub, black-stained grout in the corner between the top of the tub and the tub enclosure, a white vinyl shower curtain liner covered in orange/grey stains with black spotted matter along the folds from the bottom hem up half of the curtain, a black mark approximately 2 feet long under the window and loose vinyl floor tile at the base of the tub over an approximate 3 square foot section of floor.</p> <p>-Resident Room 103 with a dust-covered heating vent in the ceiling.</p> <p>-In the hallway ceiling between Resident Rooms 104 and 104 and adjacent to the emergency exit an air return vent covered in dust and the air filter inside the vent with a gray appearance.</p> <p>-The exit door from the Activity Room to the outside smoking area with chipped paint, an adjacent piece of vinyl baseboard peeling away from the wall and the door was not closing fully when released, sticking inside of the door jamb.</p> <p>-In the Activity Room in a corner adjacent to the Mechanical Room door, painted drywall paper was peeling away from the wall, which was easily pushed in with pressure applied on the vinyl baseboard.</p> <p>-Resident Room 117 with an electric outlet located in wall under the window with a missing faceplate and the south wall and west wall had numerous scrapes and black scratch marks that</p>	D 074	<p>The 6 inch crack in the same vicinity of this area has also been patched and painted.</p> <p>Common bathroom has also been patched and painted.</p> <p>1 inch wide hole in the drywall patched and painted.</p> <p>Resident Room 112 – registers and return dusted and faceplate replaced.</p> <p>Common tub room – Shower curtain has been replaced, reglued the tile and painted 2 foot mark under window.</p> <p>Resident Room 103 – heated vent was cleaned and dusted. 1-13-16</p> <p>Hallway between 104 and 105 – air filter was replaced and dusted.</p> <p>Activity Room Exit Door – tightened hinges, re-attached door closer, primed and painted chipped paint.</p> <p>Activity Room Corner adjacent to Mechanical room door – remove and replace drywall, prime and paint.</p>	<p>1-16-16</p> <p>1-16-16</p> <p>1-16-16</p> <p>1-16-16</p> <p>1-16-16</p> <p>2-1-16</p> <p>2-2-16</p> <p>2-1-16</p> <p>2-1-16</p>

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D 074	<p>Continued From page 2</p> <p>covered most of the wall surfaces.</p> <p>-In the shared bathroom between Resident Rooms 116 and 117 there was an approximately 4 foot square area of a blackish/brown discoloration on the tile around the base of the commode; circling a floor drain approximately 2 feet in front of the commode were numerous, hairline cracks in the tile over surrounding concrete that had uplifted, resulting in an uneven floor surface.</p> <p>-Resident Room 110 with loose vinyl threshold at the door between the floor tile in the room and the carpet in the hallway.</p> <p>-In the hallway across from the Property Manager's office, on a corner of the wall adjacent to the water cooler, there was damage to the drywall in an area approximately 6-inches long just above the vinyl baseboard.</p> <p>Review of the most recent environment health inspection report dated 5/12/15 revealed: -An overall score of 95.50. -"Replace [Resident Room] #117 restroom floor" and "replace damaged baseboards in restrooms and rooms" with total points deducted of 1.0.</p> <p>Review of the most recent fire department inspection report dated 8/31/15 revealed: -An overall inspection result of "passed." -"Repair or maintain exit doors and hardware to operate properly." -"Seal unapproved openings with approved material." -"Each outlet shall have a cover faceplate or fixture canopy."</p> <p>Confidential interview with a resident revealed: -The "roof leaks" and it had last leaked into her room in October, but nothing was damaged. -When it rained, water came in through the exit</p>	D 074	<p>Resident Room 117 – faceplate was replaced, primed and painted black scratch marks.</p> <p>Room 116 -117 bathroom – replaced the discolored tile, fixed the drain.</p> <p>Resident room 110 – re-glued loose vinyl threshold between floor tile and carpet.</p> <p>Property Manager's Office – patched and painted and added corner trim.</p> <p>Health Inspection Report – We have diverted water and changed the threshold on door to prevent water coming in again. Confidential Interview with Maintenance Employee – A maintenance repair request form will implemented in daily activities in future. Maintenance Supervisor will walk building weekly and notate repairs.</p>	<p>1-12-16</p> <p>1-12-16</p> <p>2-2-16</p> <p>2-2-16</p> <p>1-29-16</p>

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D 074	<p>Continued From page 3</p> <p>door in the activity room and the carpet would get "soaked."</p> <p>Confidential interview with a second resident revealed when it rained water would come in through the "back door" in the activity room.</p> <p>Interview on 1/7/16 at 2:45PM with the Maintenance staff member revealed: -Her duties included maintenance repairs, provide resident transportation and help in resident activities and with housekeeping. -If something was observed by staff as needing repair, they would leave a note on her door or call her for things that required more immediate attention. -She addressed issues but would call a Maintenance staff member at a sister facility for assistance as needed. -She walked through all the rooms on at least a monthly basis, checking for blown light bulbs and if call bells worked. -She tried to go from room by room to paint and replace window blinds. -Staff were good to report maintenance issues. -Painting was an on-going project when time was available. -Some rooms were deep cleaned 2 to 3 times a month and housekeeping staff also deep cleaned. -Anything "dangerous," like electric outlets with broken or missing faceplates, light switches or broken beds required immediate attention.</p> <p>Interview on 1/7/16 at 5:00PM with the Property Manager and the Executive Director (ED) revealed: -The ED had seen the list compiled by the Maintenance Supervisor from the facility tour with the state surveyors and supplies would be made</p>	D 074		

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D 074	Continued From page 4  available to provide repairs to identified items. -The facility had access to vendors to address repairs that were beyond the scope of the Maintenance Supervisor.	D 074		
D 321	<p>10A NCAC 13F .0906(a) Other Resident Care And Services</p> <p>10A NCAC 13F .0906 Other Resident Care And Services</p> <p>(a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members, as well as facility vehicles.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide transportation for health services for 5 of 11 residents (Resident #3, #4, #6, #7 and #8) reviewed for missed dental appointment and specialist appointments.</p> <p>The findings are:</p> <p>A. Review of Resident #3's FL-2 dated 5/26/2015 revealed diagnoses which included mixed urine incontinence.</p> <p>Record review of facility notes for Resident #3 dated 10/13/15 revealed "pt's [patient's] appt</p>	D 321	D 321  Facility has implemented policy of 3 employees are available with two company owned vehicles in addition to the local county transportation services to ensure that no appointments will not be missed.	1-7-16

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D 321	<p>Continued From page 5</p> <p>[appointment] for [local hospital] urology has been rescheduled for 10/27/15 @ 2pm due to company van still being in shop."</p> <p>B. Review of Resident #4's FL-2 dated 5/4/15 revealed diagnoses which included shoulder pain and osteoporosis.</p> <p>Record review of facility notes for Resident #4 revealed missed and rescheduled appointments on the following days:</p> <p>-"Pt has appt w [with]/[physician's name] at [local sports medicine clinic] on July 2nd @ 8:15...had to leave a message for a return call due to the facility not having any transportation that day...rescheduled until July 23rd @ 9:30am."</p> <p>-"Pt appt for [local dental clinic] has been rescheduled till 7/21/15 @9am."</p> <p>-"Pt dental appt has been rescheduled for 8/13/15 @2pm at [local dental clinic]."</p> <p>-"[local dental clinic] was scheduled her appt for dental work on 9/1/15 @ 11 am on a Thursday."</p> <p>-"Pt dental appt has been rescheduled for 9/17/15 @ 11am."</p> <p>-"Due to facility transporter being at the hospital w[with]/2 other residents at time of pts podiatry appt today, pt missed her appt to see [/ [physician's name]... new appt to see [physician's name] will be Tuesday 9-22-15 @ 9am..."</p> <p>-"Pt's appt @ [local dental clinic] for tomorrow Oct 13th has been cancelled due to our facility van still being in the shop. Will reschedule when van is back."</p> <p>C. Resident #6's FL-2 dated 12/15/15 revealed diagnoses which included diabetes.</p> <p>Record review of facility notes for Resident #6 revealed on 10/8/15 "Pt had appt at [local endocrinology clinic] today. Pts appt had to be</p>	D 321		

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D 321	<p>Continued From page 6</p> <p>cancelled due to facility van being in the shop. I will call to reschedule appt when the van is back."</p> <p>Review of a computer-generated appointment history for Resident #6 from the local endocrinology clinic revealed a cancelled appointment on 10/8/15 and the next scheduled appointment on 2/4/16 at 9:50am.</p> <p>D. Resident #7's FL-2 dated 9/1/15 revealed diagnoses which included Alzheimer's and Parkinson's.</p> <p>Record review of facility notes for Resident #7 revealed the following missed/rescheduled appointments:                      -"Due to company van being in shop pt's dental app has been rescheduled for 10/22/15 @1pm."                      -"Pt appt to pick up dentures has been rescheduled for 11/11/15 @1pm."</p> <p>Resident #8's FL-2 dated 12/1/14 revealed diagnoses which included Alzheimer's.</p> <p>E. Record Review of facility notes for Resident #7 revealed the following missed/rescheduled appointments:                      -"Pt came to me stating her upper denture was not fitting correctly called [dentist] pt has an appt 10/2/15 @10am" and "Pt's dental appt has been rescheduled till 10/6/15 @1:15pm, due to company van being in shop."                      -On 10/6/15 "Due to company van still being in shop + a backup transport from [sister facility] is booked up, pts appt has been cancelled. Will reschedule when van returns."                      A confidential interview with a resident revealed:                      -"My [family member] carried me to the doctor after the facility told me the bus didn't have any</p>	D 321		

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D 321	Continued From page 7  tags." -"My [family member] doesn't get paid to bring me to the doctor and she shouldn't be the one taking me."  A confidential interview with a second resident revealed: -An appointment was almost cancelled the month prior, but a family member was coming to visit anyhow and took the resident to the appointment. -The resident reported the family member as stating "why don't they do what they are supposed to do?"  Interview with the Property Manager and the Executive Director on 1/7/16 at 5:00PM revealed: -When appointments were made they were cleared through the Maintenance staff member (who provided transport services) so they did not get double-booked. -Appointments were set up for Tuesdays and Thursdays but some specialists scheduled on other days. -The Maintenance staff member, the Maintenance Supervisor (at a sister facility) and the transporter at the sister facility all had a schedule for transport services. -\$1800 to \$2000 was spent on repairs for the facility van and the van at the sister facility was always available, so there was no reason why appointments had to be cancelled for lack of transportation.	D 321		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds  10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use	D 421		

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D 421	<p>Continued From page 8</p> <p>of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.</p> <p>This Rule is not met as evidenced by: Based on interview the facility failed to assure a record of resident transactions involving the use of the resident's personal funds shall be maintained in the home.</p> <p>The findings are:</p> <p>On 12/8/15 a log of resident transactions was not available for review during a monitoring/complaint investigation.</p> <p>An interview on 12/8/2015 at 12:50PM with the new Property Manager revealed: - Corporate was working on rebuilding the residents' accounts. - There was money in the bank but the facility did not know who it was for. - The new Property Manager started on 12/1/2015 after the previous Property Manager stopped coming to work at the end of November.</p> <p>A confidential interview with a resident revealed "people get their money."</p> <p>A confidential interview with a second resident revealed: -"I got money from [the previous Property Manager] recently, \$30-\$40. -"I hardly ask for money," "I didn't sign anything" and "I got it in a red and white envelope with my</p>	D 421	<p>D 421</p> <p>Beginning December 1, 2015 records have been maintained and stored in the building under lock and key.</p> <p>Facility Property Manager working with Corporate Accounting Department to update resident register information.</p> <p>Records will be maintained in building in the future under lock and key to prevent reoccurrence.</p>	1-7-16

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D 421	Continued From page 9 name on it.  An interview with Staff #1 and the Executive Director on 1/6/2016 at 12:10PM revealed: with the executive director revealed Corporate was "rebuilding [recreating] the accounts" and was "still working on this."	D 421		
D 433	10A NCAC 13F .1201(a) Resident Records  10A NCAC 13F .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;	D 433	D433  Resident Records – Care Plans were replaced on 12/12/15. Original copy will be in chart and copy in Property Manager's office.	1-7-16

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D 433	<p>Continued From page 10</p> <p>(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and</p> <p>(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain on-site 8 of 33 resident assessments and care plans.</p> <p>The findings are:</p> <p>Interview on 12/8/15 at 12:40PM with the Licensed Health Professional Support (LHPS) nurse revealed there were no care plans on property.</p> <p>Interview on 12/8/15 at 1:10PM with the new Property Manager revealed:</p> <ul style="list-style-type: none"> <li>-Care Plans for 2014 were in the building but there were none for 2015.</li> <li>-The previous Property Manager left at the end of November and the new Property Manager started 12/1/15.</li> <li>-The previous Property Manager has not attended any meetings arranged with the Executive Director or the new Property Manager to review where the documents were.</li> <li>-The facility kept a separate 3-ring binder that had only resident Care Plans, which were not kept in resident files.</li> </ul>	D 433		

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NAME OF PROVIDER OR SUPPLIER  <b>BLUE RIDGE RETIREMENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1009 NINTH AVENUE WEST HENDERSONVILLE, NC 28739</b>		
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D 433	Continued From page 11  Record review on 1/7/2016 revealed 8 out of 33 Care Plans were missing from the Care Plan binder and resident files.  Interview on 1/7/15 at 1:17pm with the Property Manager revealed: -"Care Plans were missing when I got here on December 1st." -"I told [Resident Care Coordinator, or RCC] to get them done on December 1st." -"Some were still missing last night and I told the RCC I need them today, but she left to go get her kids."	D 433	D912  Physician orders have been written to replace wheelchairs, and wheelchairs that are not replaced will have new armrests pads.	2-29-16
D912	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.  This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to repair or replace armrests on 6 of 6 wheelchairs used by residents (Residents #3, #9, #10, #11, #12 and #13) and 2 of 2 wheelchairs found unoccupied in common areas, and to lock a storage room door containing archived resident records too numerous to count.  The findings are:  A. 1. Review of Resident #3's FL-2 dated 5/26/15 revealed:	D912	Wheelchairs will not be stored in common areas.  Resident Records were moved to a secured area.	1-12-16  1-7-16

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D912	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-Admission date of 5/26/15.</li> <li>-Diagnoses which included gait disturbance.</li> <li>-The resident was noted as ambulatory.</li> </ul> <p>Observation on 1/6/16 at 12:25PM of Resident #3 revealed:</p> <ul style="list-style-type: none"> <li>-The resident seated in a W/C at the dining table, alert and conversant.</li> <li>-The left armrest of her W/C was missing.</li> </ul> <p>2. Review of Resident #9's FL-2 dated 6/29/15 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 6/3/09.</li> <li>-Diagnoses which included anoxic encephalopathy.</li> <li>-The resident was noted as ambulatory with "W/C" (wheelchair) written in.</li> </ul> <p>Observation on 1/6/16 at 8:40AM of Resident #9 revealed:</p> <ul style="list-style-type: none"> <li>-The resident seated in a W/C, alert and conversant.</li> <li>-The vinyl covering on the left armrest of the W/C was cracked.</li> <li>-The right armrest was observed cable-tied to the frame; a flat black piece of metal (attached to the underside of the armrest) was observed with a notch that was slipped over the right side panel of the W/C</li> </ul> <p>3. Review of Resident #10's FL-2 dated 10/6/15 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 12/28/05.</li> <li>-Diagnoses which included rheumatoid arthritis.</li> <li>-The resident was noted as ambulatory with "W/C" written in.</li> </ul> <p>4. Review of Resident #11's FL-2 dated 3/6/15 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 3/6/15.</li> </ul>	D912	<p>Ambulatory with W/C denotes that resident can exit the building on their own in case of an emergency per Fire Marshall.</p>	1-7-16

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D912	<p>Continued From page 13</p> <ul style="list-style-type: none"> <li>-Diagnoses which included generalized weakness.</li> <li>-Limited assistance with ambulation.</li> <li>-The resident was noted as ambulatory with "W/C" written in.</li> </ul> <p>Observation on 1/6/16 at 8:40AM of Resident #11 revealed:</p> <ul style="list-style-type: none"> <li>-The resident seated in a W/C, alert and conversant.</li> <li>-Foam padding was coming out of a tear in the right armrest of the W/C.</li> </ul> <p>5. Review of Resident #12's FL-2 dated 10/6/15 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 7/7/00.</li> <li>-Diagnoses which included gait instability.</li> <li>-The resident was noted as ambulatory with "W/C" written in.</li> </ul> <p>Observation on 1/6/16 at 9:50AM of Resident #12 revealed:</p> <ul style="list-style-type: none"> <li>-The resident seated in a W/C, alert and conversant.</li> <li>-The left armrest of the W/C was wrapped in grey duct tape and the vinyl covering of the right armrest was cracked.</li> </ul> <p>6. Review of Resident #13's FL-2 dated 6/8/15 revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 4/10/09.</li> <li>-Diagnoses which included a history of cerebrovascular accident with right hemiparesis.</li> <li>-The resident was noted as semi-ambulatory with "W/C" written in.</li> </ul> <p>Observation on 1/6/16 at 12:10PM of Resident #13 revealed:</p> <ul style="list-style-type: none"> <li>-The resident seated in a W/C, alert but difficult to understand.</li> </ul>	D912		

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D912	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>- The left armrest of the W/C was missing with and exposed and extruding bolt from the W/C frame, the bolt head was flat with no sharp edges.</li> <li>-The right armrest of the W/C had torn vinyl covering exposing foam padding.</li> </ul> <p>Observation on 1/6/16 at 8:40AM of the hallway outside the Activity Room revealed:</p> <ul style="list-style-type: none"> <li>-A bariatric W/C with no identifying resident information.</li> <li>-The left armrest of the W/C was completely missing.</li> </ul> <p>Observation on 1/6/16 at 10:55AM of the Activity Room revealed:</p> <ul style="list-style-type: none"> <li>-A folded W/C sandwiched between a chair scale and the soda vending machine, with no resident identifying information.</li> <li>-The left armrest of the W/C was missing half of its padding and vinyl covering, exposing the plastic base of the armrest.</li> <li>-The right armrest was missing half of its vinyl covering, exposing foam padding.</li> </ul> <p>A confidential interview with a resident observed using a WC revealed:</p> <ul style="list-style-type: none"> <li>-He owned his W/C for years and had brought it here from another facility.</li> <li>-The armrests needed replacement and he would do it if he "had the parts."</li> <li>-He could not recall staff commenting on need for replacing the armrests.</li> <li>-He could not remember asking the staff to fix the armrests.</li> </ul> <p>A confidential interview with a second resident observed using a W/C revealed:</p> <ul style="list-style-type: none"> <li>-He could not recall how long the armrests on his W/C were in the current condition.</li> <li>-He could not recall if staff had been told or have</li> </ul>	D912		

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D912	<p>Continued From page 15</p> <p>commented on the W/C, but that the armrests should be replaced.</p> <p>A confidential interview with a third resident observed using a W/C revealed: -He had told staff about his W/C but could not remember when or who he spoke to. -No staff had commented on the condition of his W/C for a while. -He had owned his W/C for a while. -The armrests were uncomfortable and he wanted them replaced.</p> <p>A confidential interview with a direct care staff member revealed if staff noticed things needing repair, past leadership wanted it passed on a shift-to-shift report, but now a note was left in a 24 hour book which was "not effective communication."</p> <p>An interview on 1/7/16 at 2:45PM with the Maintenance staff person revealed: -W/Cs were cleaned by third shift staff and if staff or residents reported W/C maintenance repair needs, she could either make the repairs or call the medical supply company that provided the W/C. -She expected staff to report "bad" armrests and she could replace them herself if she had them in stock. -No one had told her of W/C armrest issues.</p> <p>An interview on 1/7/16 at 5:00PM with the Property Manager and the Executive Director revealed: -If something was wrong with a resident's W/C, staff were expected to notify the Property Manager so a durable medical equipment company could be notified. -Third shift staff were expected to clean and</p>	D912		

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D912	<p>Continued From page 16</p> <p>inspect W/Cs and report any repairs issues to Maintenance.</p> <p>B. Observation on 1/6/16 at 10:00AM revealed:</p> <ul style="list-style-type: none"> <li>-A sign labeled Storage Room, on the wall adjacent to a door located across from the Property Manager's office.</li> <li>-The Storage Room door opened directly onto a hallway.</li> <li>-The door was unlocked.</li> <li>-Inside the storage room were five wooden shelves in a U-shaped pattern around three sides of the closet (the fourth side was the door itself), the closet approximately 5 feet by feet.</li> <li>-On the floor of the closet and on the bottom four shelves were stacked archived records in boxes and manila envelopes, too numerous to count (one envelope was observed with a name, a date and "D/C" [discharged]).</li> <li>-Other items in the closet, on the floor and the shelves, included boxes of Christmas decorations and personal care items (emesis basins, water pitchers and boxes of gloves).</li> </ul> <p>Observation on 1/7/16 at 8:50AM revealed:</p> <ul style="list-style-type: none"> <li>-The door to the Storage Room across from the Property Manager's office was unlocked.</li> <li>-Opening the door revealed shelving and the floor full of archived records in boxes and manila envelopes, too numerous to count.</li> </ul> <p>Observation on 1/7/16 at 11:15AM of the Resident Care Coordinator (RCC) revealed the door to the Storage Room was unlocked and easily opened.</p> <p>Interview on 1/7/16 at 11:15AM with the RCC revealed:</p> <ul style="list-style-type: none"> <li>-Archived resident records and old staff records were always kept in this place.</li> </ul>	D912		

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D912	Continued From page 17  -Recently instructions were given by leadership to leave the door unlocked so staff could access personal care supplies which were also stored in the closet.  Interview on 1/7/16 at 11:25AM with the Property Manager and the Executive Director revealed: -All facility records were to be locked at all times, with active resident records in the medication room and discharged resident records in the storage closet. -Discharged records should have been thinned with older records stored in another location, with those remaining records kept locked.	D912	Storage room – As earlier stated confidential records have been moved to a secure storage area.	1-7-16	