

Amended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025026	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/23/2015
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NAME OF PROVIDER OR SUPPLIER RIVERSTONE	STREET ADDRESS, CITY, STATE, ZIP CODE 104 EFIRD BOULEVARD NEW BERN, NC 28562
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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
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{D 000} Initial Comments

The Adult Care Licensure Section conducted a follow-up survey on October 21-23, 2015.

{D 000}

D 066 10A NCAC 13F .0305(h)(3) Physical Environment

10A NCAC 13F .0305 Physical Environment
(h) The requirements for outside entrances and exits are:
(3) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys, and

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to assure the front exit door push bar was in proper working order and able to be utilized by all residents:

The findings are:

- Observation of the front entry/exit door to facility on 10/22/15 between 9:45am and 10:00am revealed:
- A resident exited the facility on the fourth attempt after 3 failed attempts at pressing the push bar to unlock the latch.
- I was unable to push the handle to exit the facility using only my hands.
- I had to bang the exit bar with force to exit the facility.
- Another resident used his hips to depress the door's exit bar after a failed push attempt by hand.
- An ambulatory resident asked for assistance to open the door from staff to exit the building.

Interview with the Administrator on 10/22/15 at 4:05pm revealed:

- The door bar mechanism was replaced a few

D 066

12/30/15

The facility has contacted the Maintenance Director to repair the door. The maintenance Director has purchased the necessary tools to make repairs to the door to ensure that it is easily operable by a single hand motion from the inside at all times. The management will check the door weekly ensure that it remains in proper working order as well as maintenance will do weekly door checks.

11/9/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Myla J. Burdick Administrator
TITLE
DATE
12/30/15
STATE FORM 7YFH12 If continuation sheet 1 of 9

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D 066 Continued From page 1
weeks ago.
-She felt it just needed more usage to loosen up.
-She was able to open it.

Observation of the front door during the Administrator interview by the front door on 10/22/15 at 4:07pm revealed:
-Transportation aide exited the front door on the 6th attempt after 5 failed attempts at pressing the exit bar while the Administrator watched.
-The Administrator said she would call maintenance to have it repaired.

D 066

D 270 10A NCAC 13F .0901(b) Personal Care and Supervision

10A NCAC 13F .0901 Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

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

Based on interview and record review, the facility failed to provide supervision for 1 (Resident #2) of 1 sampled resident who was observed with a cord around her neck on 10/10/15 and 10/18/15 and who attempted to choke (#3) on 10/18/15 and was non-compliant with medications.

The findings are:

Review of Resident #2's current FL-2 dated 9/22/15 revealed diagnoses included schizoaffective disorder, cerebral palsy,

D 270

It was and will remain to be the procedure of the facility that when a resident is refusing their medications that after 3 consecutive refusals the primary care physician and psychiatrist will be notified. If the resident is exhibiting behaviors that are threatening to themselves or other residents or staff, the facility will begin the necessary steps to have

12/30/15

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gastroesophageal reflux disease (GERD) and hypercholesterolemia.

Review of Resident #2's Resident Register revealed an admission date of 3/10/10.

Review of Resident #2's mental health and social history section in the Care Plan dated 5/4/15 revealed:

- Resident #2 was verbally and physically abusive.
- Resident #2 exhibited disruptive behavior and was socially inappropriate.
- Resident #2 was injurious to self and others.
- Resident #2 is currently receiving mental health service

Review of a note documented on Resident #2's physician order sheet dated 9/3/15 revealed:

- "Patient has been refusing meds and threatening harm to [self] and others. [Patient] stated she is having nightmares often (Satan is after me). (God will heal me, so I won't have nightmares.) Patient needs to be evaluated for ongoing problem of refusing medications and nightmares. Patient is trying to harm herself.
- The note was signed on 9/3/15 by the mental health assessor.

Review of Resident #3's Incident/Accident Report dated 10/18/15 at 1:48 p.m. revealed:

- [Resident #2] jumped on [Resident #3].
- [Resident #2] told [Resident #3] she would cut her throat.
- Resident #3 was asked to call for help instead of fighting with Resident #2 to prevent occurrences.

Attempted to interview Resident #3 revealed she did not want to be interviewed.

Review of the Resident Log for Resident #2

D 270

If the resident involuntarily committed for stabilization. While waiting for the resident to be involuntarily committed the resident will be assigned one on one supervision to ensure that they and everyone else remain safe and cared for. In addition, when appropriate additional services may be requested to provide additional support. (ie, mental health provider, local law enforcement, additional staff) Once the resident is safely IVC'd and stabilized the Administrator will go and do an assessment to ensure that the residents needs can ~~be~~ continue to be met at the facility. If they can be met the resident will be re-admitted to the facility, but will be placed on a 15 minute check for the next 30 days in an effort to continue to monitor their behavior for aggression.

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revealed:

- On 9/1/15 at 9:00 a.m., Resident #2 spat medications back into the cup.
- On 9/2/15 at 9:00 a.m., Resident refused all a.m. medications. She was yelling out at [intervals]. Resident #2 was seen by her physician.
- On 10/8/15 (no time), Resident #2 refused all medications. Resident #2's physician was notified.
- On 10/9/15 at 6:45 p.m., Resident #2 was sent out for an evaluation.
- On 10/9/15 at 9:55 p.m., Resident #2 returned back to the facility. Staff documented, "The nurse stated the doctor on call said Resident is not a danger to herself or staff."
- On 10/10/15 at 7:15 a.m., Resident #2 was refusing medications, swinging at staff and other residents. Resident #2's physician was notified. Resident fell, and she was sent out to the emergency room.
- On 10/10/15 at 1:00 p.m., Resident #2 returned back to the facility. Resident #2 was still hitting, yelling and pinching staff.
- On 10/10/15 at 11:41 p.m., Resident #2 had a [call bell cord] around her neck. "Emergency Medication Technicians (EMTs) saw this behavior. She was sent out for an evaluation. Primary Care Physician (PCP) was notified.
- On 10/15/15 at 1:00 p.m., Resident returned to the facility. She was still refusing medications, yelling and throwing objects.
- On 10/16/15 at 8:00 a.m. Resident refused all a.m. medications.
- On 10/16/15 at 5:00 p.m., Resident threw her medications on the floor in her room.
- On 10/17/15 at 10:30 a.m., Resident refused her morning medications.
- On 10/18/15 at 2:25 p.m., Resident #2 jumped on [Resident #3]. She began choking Resident #3 and telling her she would cut her throat.

D 270

The resident will also be placed on a high risk chart for supervision that will be maintained by the Administrator and Rec. Every attempt will be made to provide person centered care to include all necessary interventions. All occurrences will be evaluated and treated based on severity and need, through depending on the specific circumstances of an incident, further interventions may be put in place up to including discharge. If the resident is not successfully IVC'd on the 1st attempt the resident will remain on 1 on 1 supervision until the physician, psychiatrist, family member, Administrator, Regional Administrator and or the owner conference to decide on where the resident can be safely discharged to immediately. It is the policy of the facility to always provide supervision

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D 270	Continued From page 4 Resident #2 also put a wire cord around [self] neck. -On 10/19/15 at 8:00 a.m. Resident refused all a.m. medications. Resident was throwing objects in the room, and she tried to turn table over the dining room. -On 10/19/15 at 11:00 a.m., Primary Care Physician (PCP) was notified. Telephone interview with the mental health assessor on 10/22/15 at 11:00 a.m. revealed: -Resident #2 had been sent to the mental health provider for an evaluation on 9/3/15. -On 9/3/15, Resident #2 was admitted to the in-patient mental health facility regarding threatening to harm self and others and for being non-compliant with medications. -On 9/23/15, Resident #2 was discharged for the mental health facility. -On 9/23/15, Resident #2 returned back to the facility. Resident #2's Primary Care Provider (PCP) was unavailable by phone. Resident #2's mental health provider was unavailable by phone. Resident #2 Responsible Party was unavailable by phone. Confidential interview with the 1st staff revealed: -On 10/10/15, Resident #2 wrapped the call bell cord around her neck, and she started to turn blue. -911 was called and the Emergency Medical Technicians (EMT's) were able to remove the cord. -On 10/18/15, Resident #2 grabbed Resident #3's shirt at the neck and started pulling her by the	D 270	of residents in accordance with each residents assessed needs, care plan and current symptoms. This plan will be communicated to all staff in our Weekly Quality Assurance meeting. All current employees will be re-trained on these procedures on 1/22/16. New employees will receive initial training upon hire and on-going as needed.	1/19/16	

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D 270	<p>Continued From page 5</p> <p>collar.</p> <ul style="list-style-type: none"> -The staff intervened. -The only intervention put in place for Resident #2 was for staff to check the whereabouts of resident, if they passed by Resident #2's door. <p>Confidential interview with the 2nd staff revealed:</p> <ul style="list-style-type: none"> -When Resident #2 was non-compliant with her medications, "she would hit staff and residents, pee on the floor, tear down curtains and turn over the dining room table". - " We can do nothing to calm her down. " -We cannot meet Resident #2's needs. -Resident #2's physician was notified, if resident threatened to or attempted to harm self and others, or she was non-compliant with her medications after three doses of "refused medications". <p>As of 9/23/15, the staff had been instructed to do 15 minutes checks on Resident #2.</p> <ul style="list-style-type: none"> -On 10/10/15, Resident #2 had wrapped a call bell cord around [self] neck. -She was sent out for an evaluation on 10/10/15. <p>The only intervention put in place for Resident #2 after she attempted to choke self on 10/10/15 was every 15 minutes checks.</p> <p>Confidential interview with the 3rd staff revealed:</p> <ul style="list-style-type: none"> -On 10/18/15, Resident #2 wrapped the call bell cord around her neck and threatened to kill herself. -On 10/18/15, Resident #2 threatened to choked Resident # 3 with a wire cord. -Resident #3 was able to defend herself. -Resident #2 was checked on every 15 minutes, prior to 10/18/15. -Three interventions were put in place for Resident #2 after she attempted to choke self and Resident #3 on 10/18/15. -1st intervention was Resident #2 had 1:1 supervision on 10/18/15. 	D 270		

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D 270	<p>Continued From page 6</p> <p>-2nd intevention was Resident 3 was moved to another room.</p> <p>-3rd intervention was Resident #2 was sent out to the mental health provider for an evalation on 10/19/15.</p> <p>Interview with the Administrator on 10/22/15 at 5:00 p.m. revealed:</p> <p>-She was aware Resident #2 was non-compliant with her medications.</p> <p>-Resident #2's physician was notified, if resident threatened to or attempted to harm self and others, or she was non-compliant with her medications after three doses of "refused medications".</p> <p>-She was aware Resident #2 attempted to harm herself on 10/10/15 and 10/18/15.</p> <p>-Resident #2 was sent out for evaluation on 9/3/15, 10/9/15, 10/10/15 and 10/15/15 for attempting to harm self and being non-compliant with medications.</p> <p>-After Resident #2 was evaluated on 9/3/15, 10/9/15, 10/10/15 and 10/15/15, Resident #2 required 1:1 supervision.</p> <p>No extra staff had been assigned to do 1:1 with Resident #2 from 9/23/15 to 10/19/15.</p> <p>-The department heads were assigned to do 1:1 with Resident #2, while staff was taking care of other residents.</p> <p>-On 3rd shift, there was no extra staff assigned to do 1:1 with Resident #2.</p> <p>-She was aware Resident #2 attempted to harm her roommate on 10/18/15.</p> <p>-Three additionally interventions were put in place after Resident #2 attempted to choke self and Resident # 3 on 10/18/15.</p> <p>-The 1st intervention was Resident #3 was moved to another room on 10/18/15.</p> <p>-The 2nd intervention was Resident #2 was sent out for evaluation on 10/19/15.</p>	D 270		
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D 270	Continued From page 7 -The 3rd intervention was Resident #2 was discharged from the facility on 10/22/15 -The facility's policy and procedure on when to discharge residents who are danger to self and others were based on the state guidelines for discharging residents. The decision was made on 9/22/15 to discharge Resident #2 from the facility. -We cannot handle Resident #2 unless she is treated." A plan of protection was requested by this office on 10/23/15. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 7, 2015.	D 270			
(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 interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are:	(D912)	It is the policy of the facility to always ensure that the rights of the residents are maintained and may be exercised without hindrance. This and will remain to be the procedure of the facility that when a resident is refusing their medications that after 3 consecutive refusals the primary care physician and psychiatrist will be notified. If the resident is exhibiting behaviors that are threatening to themselves or other residents or staff the facility will begin the necessary steps to have the resident IVCD for stabilization. While waiting	12/30/15	

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{D912}	Continued From page 8 Based on interview and record review, the facility failed to provide supervision for 1 (Resident #2) of 1 sampled resident who was observed with a call bell cord around her neck on 10/10/15 and 10/18/15 and who attempted to choke (#3) on 10/18/15 and was non-compliant with medications [Refer to Tag D 270 10A NCAC 13F .0901(b) (Type B Violation)]	{D912}	for the resident to be IVC'd. The resident will be assigned one on one supervision to ensure that they and everyone else remain safe and cared for. In addition when appropriate, additional services may be requested to provide additional support. (ie, mental health provider, local law enforcement, additional staff) Once the resident is safely IVC'd and stabilized, the Administrator will go and do an assessment to ensure that the residents needs can continue to be met at the facility. If they can be met the resident will be re-admitted to the facility but will be placed on a 15 minute check for the next 30 days in an effort to continue to monitor their behaviors for aggression. The resident will also be placed on a High Risk chart for supervision that will be maintained by the Administrator and REC. Every attempt will be made to provide person centered care to include all necessary interventions. All occurrences will be evaluated and treated based on severity and need, therefore depending on specific circumstances of an incident further interventions may be put in place up to and including the possibility of discharge.	
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If the resident is not successfully IVC'd on the 1st attempt the resident will remain on 1 on 1 supervision until the physician, psychiatrist, Administrator, family member, Regional Administrator and on the owner conference to decide on where the resident can be safely discharged to immediately. It is the policy of the facility to always provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. OVER →

This plan will be communicated
to all staff in our Weekly
Quality Assurance meetings.