

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/20/2016
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NAME OF PROVIDER OR SUPPLIER AUTUMN WIND ASSISTED LIVING OF LOUISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 361 LEONARD ROAD LOUISBURG, NC 27549
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D 000	Initial Comments The Adult Care Licensure Section and Franklin County Department of Social Services conducted an annual and a follow-up survey and complaint investigation on May 10, 2016 - May 12, 2016 and May 17, 2016 - May 20, 2016. The complaint investigation was initiated by Franklin County Department of Social Services on March 14, 2016, March 24, 2016, April 1, 2016 and April 28, 2016.	D 000		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>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;</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls with holes and loose hand rails, unrepaired baseboards, broken floor tiles and ceilings with stains were in good repair on the 100, 200 and 300 halls. The findings are:</p> <p>Observation of the 300 Hall on 5/10/16 at 12:15 p.m. - 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> - The the vinyl baseboards had multiple areas of small - large (1/2 - 3 inches) scuffed and damaged spots revealing an underlying dark brown color. - The damaged vinyl baseboards were all along the 300 Hall and the connecting hall leading to the 100 Hall. - The doorway threshold between the connecting hall from the 300 Hall to the 100 Hall was discolored and dirty with a piece of the tile broken 	D 074		

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

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D 074	<p>Continued From page 1</p> <p>off.</p> <ul style="list-style-type: none"> - Along the 300 Hall, multiple metal frames had paint scraped away up to 8-10 inches from the floor. - An attached hand rail on the wall at room #325 had the end of the wooden handrail broken off. - Observation of resident room #328 revealed the wall behind the sink was plastered with paint missing about 1 1/2 foot by 2 1/2 foot size area. - Observation of the wall behind A bed in resident room #332 had a large dark reddish dried liquid splatter stain. - Observation of resident room #324 revealed there was a small round rust like stains on the floor near the sink. - The room had a large stain on the floor near the window, about 1 foot by 1 1/2 foot circle. - Observation of resident room #323 revealed the wall behind the sink had black scuff marks and a 2 inch size piece of a hardened thick brown substance. - Observation of resident room #322 revealed gouged out areas of floor tile down to the concrete subflooring. <p>Interview with a personal care staff member on 5/10/16 at 12:55 p.m. revealed most of the residents on the 300 Hall were not interviewable due to diagnoses.</p> <p>Observation on 5/10/16 at 12:55 p.m. of the 100 hall ceiling near the two dining rooms revealed several beige circle stains.</p> <p>Interview with a staff member on 5/10/16 at 12:55 p.m. revealed the area had been there for months and they did not know how it got that way.</p> <p>Observation with the Executive Director (ED) on 5/19/16 at 11:20 a.m. of the 100 Hall near the</p>	D 074		

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D 074	<p>Continued From page 2</p> <p>bathroom revealed:</p> <ul style="list-style-type: none"> - The green hallway wall had white unpainted marks where handrails had been attached with brackets. - In the area near the nurse office at the 100 Hall there was a short handrail hanging by only one bracket in a diagonal position. - The other end of the handrail was not attached to the wall. <p>Interview with a resident living on the 100 Hall on 5/18/16 at 10:15 a.m. revealed:</p> <ul style="list-style-type: none"> - The resident thought the housekeeping and repairs were kept up well. - He did not know how the green lower walls on the 100 Hall got the paint removed where the hand rails were missing. - Most residents did not need handrails. - He thought the rails were removed because they were not being used. - He thought the ceiling stains on the 100 Hall had been there for months. - He would tell the ED or maintenance person if something needed repair. <p>Interview with the Executive Director on 5/19/16 at 11:20 a.m. revealed</p> <ul style="list-style-type: none"> - She had not been aware of the loose rails in this area and she noticed the other bracket marks from another set of rails that were missing until the observation with the surveyor. - She would ensure the handrails were reattached by maintenance to ensure safety. - She was not aware when or how the stains on the 100 Hall at the dining area ceiling had occurred. - Since ythe ED had started working in the facility we had noticed some areas of concern for maintenance. - She had not addressed the continued condition 	D 074		

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D 074	<p>Continued From page 3</p> <p>of the floors, walls and baseboards.</p> <ul style="list-style-type: none"> - Maintenance was to inspect and ensure areas were well maintained on a routine daily basis. - Staff members were to report to the maintenance person when areas needed to be fixed, painted or repaired. - There had not been a system in place to specifically inspect the facility for needed repairs. - All staff and the maintenance person reported concerns to her as needed. <p>Interview on 5/19/16 at 11:50 a.m. with the maintenance person revealed:</p> <ul style="list-style-type: none"> - He would secure the unattached handrail - The 200 Hall had a set of handrails that had come off as well. - He knew about the handrails missing by the bathroom on the 100 Hall and had removes them as they were not secure. - He had replaced them as yet. - He would ensure this one near the nurse office would be reattached and secure. - He did not routinely check the handrails to see if they were safe. - He would check the other hand rails to ensure safety. - The ceilings had already begun to be worked on starting with the 300 Hall. - He made daily checks for repairs as he went through each day's work in the facility. - The ED was aware of this. <p>Interview on 5/19/16 at 9:20 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - She was to report any repair or other problems to the maintenance person. - All staff were to report to her about any housekeeping concerns and she would take care of them. - She was not sure how the stains on the ceiling 	D 074		

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D 074	Continued From page 4 across from the dining room on the 100 Hall got that way. - She would report it to the maintenance person. Observation on 5/20/16 at 9:15 a.m. of the small handrail near the nurse office revealed it had been firmly reattached.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure furniture was clean and in good repair in six of six bedrooms on the 300 Hall and in the Activity Room. The findings are: Observation of resident room #330 at 12:21 p.m. revealed the cloth mattress and box spring had multiple brown liquid stains on the surface all across the length of the bed. Observation of resident room #328 at 12:25 p.m. revealed: - Bed B had a round brown liquid splash mark 9 inches in diameter on the box spring near the head of the bed. - Bed A side table had two drawer knobs missing. - The bottom shelf had a thick stain, covered with gray dust and the stain surface of the shelf was worn off along the edge.	D 076		

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D 076	<p>Continued From page 5</p> <p>Observation of resident room #332 at 12:42 p.m. revealed:</p> <ul style="list-style-type: none"> - Bed B had a tear in the mattress at the seam from the head of the bed to the foot of the bed with the springs exposed inside. - Bed B side table had a whitish stained top surface with the furniture stain worn off along the top edge. - The bottom shelf and kick board furniture stain had worn off. - Bed A had a tear in the green plastic covered mattress near the foot of the bed. - Bed A side table had two knobs missing on the drawer. <p>Observation of resident room #324 on 5/10/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> - Both side tables in the room did not have any furniture wood stain left on the tops. - The foot boards on both beds in the room had scuffed off wood stain and gouges. <p>Observation in resident room #322 on 5/10/16 at 12:58 p.m. revealed:</p> <ul style="list-style-type: none"> - The corner of the wooden bedside table had a broken off corner. - Bed B side table had dirty black gray dust and stains on the top. - Wood stain had worn away on the table shelf. <p>Observation of resident room #323 on 5/10/16 at 12:59 p.m. revealed:</p> <ul style="list-style-type: none"> - Bed A had a green plastic covered mattress with brownish beige stains and liquid splatter. - Bed A side table was missing two knobs. - The side table had dirty black stains and dust on the bottom shelf. - Bed A had bluish stains across the top edge of the head board 	D 076		

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D 076	<p>Continued From page 6</p> <ul style="list-style-type: none"> - Old dried beige colored chewing gum was stuck to the top edge the head board and up onto the back of the head board. <p>Observation of resident room #318 on 5/18/16 at 9:00 a.m. revealed:</p> <ul style="list-style-type: none"> - The single bed in the room had a green mattress with liquid drip stains on the side. - The mattress had a large a many pointed star pattern of cracks and tears in the middle of the mattress exposing the stuffing. <p>Interview with a resident who lived in room #318 on 5/18/16 at 9:00 a.m. revealed:</p> <ul style="list-style-type: none"> - The furniture in the bedrooms was not cared for well. - The mattress had been like that since she arrived but she could not recall how long that had been. - It was very bad and uncomfortable to sleep on the mattress. - The resident wanted a new mattress. - She had told someone about it recently, but nothing had been done. <p>Interview on 5/18/16 at 3:45 p.m. with a resident living on the 300 Hall revealed:</p> <ul style="list-style-type: none"> - The resident's mattress was in good condition at this time. - Before, the resident's mattress was torn and dirty. - Staff make up the bed each day but never said anything about the mattress condition. - The resident had to inform the staff of the condition of the mattress and it was eventually removed and taken out to the trash. <p>Based on attempted interviews on 5/10/16 at 3:55 p.m. with two residents on the 300 Hall revealed they were not interviewable.</p>	D 076		

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D 076	<p>Continued From page 7</p> <p>Observation of the resident television and Activity Room on 5/18/16 at 8:50 a.m. revealed:</p> <ul style="list-style-type: none"> - An over stuffed beige arm chair had brown stains on the back head rest and both of the arm rests. - The blue sofa in the room was missing two seat cushions. - A blue and white checked chair had brown stains on the back and left arm rest. - Two faded red vinyl covered arm chairs had long splits in the seats with the inner stuffing visible. - One of the faded red arm chairs had a rip in the vinyl on the front left corner exposing a sharp wood piece of the chair frame and stuffing. - One of the faded red arm chairs had the underneath covering under the chair torn and falling down. - Both chairs had wood stain scuffed off of the wood support and legs. <p>Interview on 5/18/16 at 8:50 a.m. with the activity coordinator revealed:</p> <ul style="list-style-type: none"> - Many residents used this room to watch television and to do activities. - The furniture in the activity television room had been in this same condition since she started working almost a year ago. - She said hopefully the plan was to replace the furniture in the room. - "The furniture was very dirty." - Some needed repair. - The blue sofa cushions had been taken to a resident room to be used for something which she was not aware of. <p>Interview on 5/10/16 at 12:40 p.m. with the Executive Director revealed:</p> <ul style="list-style-type: none"> - She had been working in this facility a few 	D 076		

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D 076	<p>Continued From page 8</p> <p>months.</p> <ul style="list-style-type: none"> - She did not realize the mattresses were torn and the furniture was dirty and torn. - There had not been a walk through check of the furniture in the facility since she started. - No one had mentioned the condition of the furniture to her. - The facility had other mattresses in the storage building and each mattress would be examined and replaced as needed. - The bedside table and head boards would be polished and cleaned. - Other furniture would be looked at and cleaned or changed out. <p>Observation on tour of the 300 Hall on 5/20/16 at 11:02 a.m. revealed the furniture in the residents rooms and Activity Room remained in the same condition as observed during the facility tour on 5/10/16 and 5/18/16.</p>	D 076		
D 077	<p>10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record</p>	D 077		

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D 077	<p>Continued From page 9</p> <p>reviews, the facility failed to maintain an approved sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times. The findings are:</p> <p>Review of the facility's Environmental health Sanitation Grade for the facility dated 6/09/15 revealed a facility score of 82.5.</p> <p>Review of some areas cited included:</p> <ul style="list-style-type: none"> - Walls, ceilings, cleanable, clean good repair - 2 demerits. - Furniture clean and in good repair; mattresses clean need repair, cleaned and or replaced. - Kitchen, raw meat stored with ready to eat turkey. <p>Interview on 5/10/16 at 12:40 p.m. with the Executive Director (ED) revealed:</p> <ul style="list-style-type: none"> - She was not aware of the score being low. - The sanitarians had not been called back for reinspection of the facility. - She was not aware their kitchen, floors, ceiling and furniture had been cited previous to her starting with the facility in August of 2015. - She did not know the mattresses and other furniture were a problem. - Some concerns in the kitchen had been addressed. - She would ensure mattress replacements and furniture and other repairs were initiated. <p>Refer to 10A NCAC 13F.0306 (a)(1), 10A NCAC 13F.0306 (a)(3), and 10A NCAC 13F .0904 (a) (1).</p>	D 077		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	<p>Continued From page 10</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 of 3 employees (Staff D) Health Care Personnel Registry (HCPR) check had been performed prior to employment as a cook.</p> <p>The findings are:</p> <p>Review of Staff D's personnel file revealed: -Staff D was hired as a cook on 1/22/16.</p> <p>Interview with the Executive Director on 5/19/16 at 11:05 am revealed: -Staff D was hired as a cook in January 2016. -Staff D's HCPR check should be in the personnel file. -She had completed the HCPR check on Staff D on the day he was hired. -On 5/10/16, the Executive Director and Resident Care Coordinator were auditing personnel files and could not locate the HCPR check on Staff D. -The Executive Director performed a Registry check on 5/10/16, since it was not located in the file on that day, there were findings. -HCPR checks are always done by the Executive Director when the employee reports for a second interview prior to reporting work. -The Executive Director was not sure why the HCPR check was not in the employee's personnel file.</p>	D 137		

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D 137	Continued From page 11 -The Executive Director was responsible for assuring the HCPR are completed and filed in the employee's personnel file.	D 137		
D 269	<p>10A NCAC 13F .0901(a) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.</p> <p>This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to provide personal care to include catheter care for 1 of 5 sampled residents (#7) who required assistance with transfers, toileting and bathing.</p> <p>The findings are:</p> <p>Review of Resident #7's current FL2 dated 1/14/16 revealed: - Diagnoses included Hypothyroidism, Chronic Conjunctivitis, GERD, Chronic Renal Insufficiency, Overactive Bladder, Hyperlipidemia, Hyperglycemia, Pain, Nausea and Muscle Spasms. - Patient information included patient is constantly disoriented, semi ambulatory with wheel chair, bladder and bowel incontinent.</p> <p>Review of the Resident #7's care plan dated 1/10/16 revealed the resident needed suprapubic</p>	D 269		

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D 269	<p>Continued From page 12</p> <p>catheter care in addition to limited assistance with eating, toileting, bathing, dressing, grooming/personal hygiene and transferring.</p> <p>1. Review of Resident #7's record revealed:</p> <ul style="list-style-type: none"> - Home health nurses had to replace the resident's catheter 8 times in the past 3 months. - Home health notes describe recurrent episodes of redness, edema and excoriation in the penile and groin, buttock and perineal area. - Home health notes on 2/24/16 describe finding resident "in bed saturated with urine with partially dried bowel movement in the incontinent brief. Catheter was in place with bag filled with 600 ml of urine and backing up". - Home health notes on 3/31/16 describe finding resident in "bed and incontinent brief and trousers completely saturated with urine. On this date resident also had swelling, redness and bloody excoriation around meatus tip of penis. - Home health notes on 4/10/16 describe finding resident with "catheter with bulb deflated lying on the floor, leg bag very soiled (soiled with urine and feces) still on leg. Resident had on 2 incontinent briefs, both saturated with urine". - Home health notes on 4/29/16 reveal resident found with catheter out with the bulb deflated laying in the closet floor. - Home health notes on 5/4/16 reveal resident found with the catheter out and with penile excoriation and bloody drainage. <p>Observation of Resident #7 on 5/11/16 at 3:30 pm revealed Resident #7 was soaked with urine through the clothing and catheter bag was full.</p> <p>Interview on 5/11/16 at 3:30 pm with the resident revealed:</p> <ul style="list-style-type: none"> - He had contacted his home health nurse regarding his catheter. 	D 269		

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D 269	<p>Continued From page 13</p> <ul style="list-style-type: none"> - Resident #7 also reports that he had put on his incontinent brief the night before. <p>Observation and interview of Resident #7 on 5/12/16 at 9:38 am revealed:</p> <ul style="list-style-type: none"> - Resident was still in bed and had not been changed this date. - Resident's catheter bag was full. - Interview with Resident #7 revealed he had not asked for help. - Resident #7 reports that he empties his own catheter bag and sometimes puts on his own incontinent brief. - The staff does not help enough and he often gets weak calling out for help. - There was no call bell system in the room. - The staff will check his catheter when he is showered or when they change which was on no regular schedule but when he told them he needed help - He does not see 3rd shift as he is always sleeping, they do not check his incontinent brief or his catheter on 3rd shift. <p>Observation of Resident #7 on 5/17/16 at 1:35 pm revealed:</p> <ul style="list-style-type: none"> - Resident's catheter bag was laying on the undercarriage of the wheelchair. - The urine in the bag appeared clear, but the urine in the tubing appeared cloudy. - Resident was observed on 5/18/16 at 10:45 am with his catheter bag full and the resident had a foul smell. <p>Interview of Resident #7 on 5/17/16 at 1:35 pm revealed:</p> <ul style="list-style-type: none"> - His bath days were Tues Thurs and Sat., but he had not had a bath. - He was bathed last on Friday 5/13/16. - His catheter was checked and cleaned 2 or 3 	D 269		

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D 269	<p>Continued From page 14</p> <p>times per week.</p> <ul style="list-style-type: none"> - He soaked his brief and clothes several times per week, he tells staff and then they help him. <p>Observation of Resident #7 on 5/20/16 at 10:15 am revealed:</p> <ul style="list-style-type: none"> - Resident was still in his bed in his same clothes from 5/18/16. - He had not been changed or checked. - Resident ' s catheter bag was full and leaking onto the floor underneath the bed. - The catheter bag revealed 800 cc's of urine was in the bag with urine spilling out under the bed. - Resident was not wet, but observation with RCC revealed his catheter area had not been cleaned and had dried clumping ointment on the incontinent brief area. <p>Interview of Resident #7 on 5/20/16 at 10:15 am revealed the ointment was last used when he was showered.</p> <p>Review of Resident #7's personal care log revealed only initials of staff, no indication or codes for what care had been provided to resident.</p> <p>Interview with Medication Aide #1 on 5/17/16 at 2:25 pm revealed:</p> <ul style="list-style-type: none"> - Resident's suprapubic catheter in his abdomen had come out several months ago. - He had pulled it out and staff did not know so the skin grew over and it could not be put back in. - He now has a Foley catheter. - Resident seems to do well with the new Foley catheter, he had only pulled it out once that she knows of and when that happens staff called home health and they came and put it back in. - They clean the tubing and area twice per shift and she has never seen him soaked through his 	D 269		

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D 269	<p>Continued From page 15</p> <p>clothes.</p> <ul style="list-style-type: none"> - He will not tell you when his catheter is out and that is why they have to check him. <p>Interview with home health nurse on 5/17/16 at 11:15 am revealed:</p> <ul style="list-style-type: none"> - The resident needs daily assistance with all Activities of Daily Living. - She or another nurse see him several times per week. - Resident #7 will pull catheter out often, primarily due to attempting to transfer himself. - On more than 3 occasions, she had found him in 2 incontinent briefs at 1 time and soaked through both briefs and his clothes. - There have been multiple times that home health was not called for several days when catheter had come out. - His not having the catheter would result in infections in which he had been hospitalized for in the past. - The nurse did not observe that he was being checked for incontinent care or catheter care by the staff unless he asked. - The nurse had experienced that he does not ask for help much, but needs the help. <p>Interview with Medication Aide #2 on 5/18/16 at 11:30 am revealed:</p> <ul style="list-style-type: none"> - Resident's catheter area should be cleaned each time he is changed and then documented on the personal care log. - Medication Aide could not tell what care had been given to resident in looking at the personal care log. - There were only staff initials on the log and not the event or care given. - She reported it is policy to report these issues to the Resident Care Coordinator and Executive Director which she has done previously. 	D 269		

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D 269	<p>Continued From page 16</p> <ul style="list-style-type: none"> - When the resident is showered on Tuesday, Thursday and Saturday, all care should be done, including, hair care, dental care, nail care and shaving. - Medication Aide reported that on 5/16/16, home health had been contacted due to the resident's catheter being out. - She also found him bowel incontinent and he refused care today. - She and home health nurse were able to assist him with changing and catheter care. - Medication Aide reported the resident was dressed and under covers when 1st shift arrived, she assumes 3rd shift dressed him. - The facility is frequently out of soap, body wash and bath linens for the residents. <p>Interview with a home health nurse #2 on 5/18/16 1:00 pm revealed:</p> <ul style="list-style-type: none"> - She had worked with resident for many years. - Staff contacted home health when the catheter ws out or when the resident had an issue. - Assisted Living Staff will call and report catheter is out and still not change resident. - Staff would put resident in two incontinent briefs at one time to keep him dry. - This has caused excoriation in the groin area on multiple times. - It was not recommended to put on 2 incontinent briefs on at one time as the resident will become too wet. - The nurse recalled a recent event on 4/10/16 when the resident was so soiled and wet despite two incontinent briefs and that the leg strap of the catheter was dark brown from excrement and had to be replaced. - The nurse reported she had asked staff about two incontinent briefs and they reported to her it will keep him dry when the catheter was out. - On another occasion, the nurse had found the 	D 269		

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D 269	<p>Continued From page 17</p> <p>resident with an incontinent brief that was dated 3 days prior and he was again soaked and soiled through his clothes and bedding.</p> <ul style="list-style-type: none"> - The nurse reported, it was her belief that staff did not check the resident and with the resident's current mental status, he would not tell staff, and finding him soaked and soiled continued to happen. <p>Interview with a Personal Care Assistant (PCA) on 5/18/16 at 3:50 pm revealed:</p> <ul style="list-style-type: none"> - The PCA caref for the Resident several times per week. - His catheter is cleaned twice a day and recorded on his care log. - The resident will not tell staff when he has soiled his incontinent brief, so she is used to his schedule and knows he will need a change at the same time each night. - It was a concern that he will not tell when he needs things. - She reported she had noted he would often fall when transferring from wheel chair to the toilet, and call staff for help. - She did not know how many times this happens per week. <p>Interview with another PCA on 5/18/16 at 9:30 am revealed:</p> <ul style="list-style-type: none"> - The resident needed total care. PCA described total care as changing, feeding, turning every 2 hours, and changed if bowel incontinent. - The resident's catheter was checked every 2 hours, sometimes he is found wet, but not very often. - PCA reported the resident emptied his own catheter bag, but the PCA was to empty it after every shift. - The resident was to be showered every other day. PCA reported he showered the resident on 	D 269		

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D 269	<p>Continued From page 18</p> <p>Friday, 5/12/16. PCA did not know if the resident had been showered since that time, but he should have.</p> <ul style="list-style-type: none"> - The resident often needs assistance with transfers to bed or toilet and he will call for help. <p>Interview with Resident Care Coordinator (RCC) on 5/19/16 at 2:00 pm revealed:</p> <ul style="list-style-type: none"> - Resident #7 should be checked every 2 hours by Medication Aide and PCA for incontinent care and record on the Personal Care log when changed. - She is currently unaware of care, due to codes not being used on the personal care log. - The Medication aide on duty monitors the personal care log daily. - Catheter care and cleaning should be done at each change of incontinent briefs. - She was not aware of any episodes of PCAs not changing or providing care for Resident #7. - RCC reported that "limited assistance" on the care plan described that he can wash himself a little, but needs help, such as checking behind him and assisting. <p>2. Observation and interview of Resident #7 on 5/17/16 at 1:35 pm revealed:</p> <ul style="list-style-type: none"> - The resident's fingernails were brown tinged with residue under the nails. - The nails were approximately 1cm in length. - Resident also had significant facial hair and appeared unshaven. <p>Interview of Resident #7 on 5/17/16 at 1:35 pm revealed:</p> <ul style="list-style-type: none"> - He was shaved when he showers. - Staff sometimes cut his nails. <p>Observation of Resident #7 on 5/18/16 at 4:15 pm revealed the resident had been shaved,</p>	D 269		

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D 269	Continued From page 19 showered and changed. Interview with Resident Care Coordinator (RCC) on 5/19/16 at 2:00 pm revealed: - RCC reported that "limited assistance" on the care plan described that he can wash himself a little, but needs help, such as checking behind him and assisting. - She is currently unaware of care, due to codes not being used on the personal care log. - The Medication aide on duty monitors the personal care log daily. - She was not aware of any episodes of PCAs not changing or providing care for Resident #7.	D 269		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for one of six sampled residents (#6) related to behaviors leading to hospitalization. The findings are: Review of Resident # 6's current FL-2 dated 1/04/16 revealed: - Diagnoses of Schizophrenia, Diabetes Mellitus	D 270		

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D 270	<p>Continued From page 20</p> <p>Type II, Hyperlipidemia, Cataracts, Hypothyroidism, Vitamin D Deficiency.</p> <ul style="list-style-type: none"> - The resident was not a danger to himself or others. - There was no indication of any behavior concerns listed. - No admission date to the facility was listed. - Active and discharge hospital problems included on the FL-2 documentation included Schizophrenia, Hyperparathyroidism, Acute Hyperkalemia, Hypercalcemia, Pharyngeal Dysphagia, Hypertension, Diabetes Mellitus and Tremor. <p>Review of Resident #6's Resident Register revealed:</p> <ul style="list-style-type: none"> - An admission date of 10/27/15. - Under the Personal Information Section, Memory was listed as "Significant loss-Must be redirected." - The Resident Register listed the resident as using a walker and a wheel chair. - He was a smoker. <p>Review of a hospital admission dated 12/27/15 with discharge on 1/14/16 revealed:</p> <ul style="list-style-type: none"> - Resident #6 was admitted to the psychiatric unit on an involuntary basis from this facility. - The resident presented with threatening and aggressive behavior and paranoid thinking. - Hospital course included medication management with subsequent change in behaviors and thinking. - He was discharged with a pleasant attitude, non-aggressive and denied paranoid thoughts. - At discharge, the resident was found not to be an imminent danger to himself or others. <p>Review of Resident #6's current Assessment and Care Plan dated 10/29/15 revealed:</p>	D 270		

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D 270	<p>Continued From page 21</p> <ul style="list-style-type: none"> - The resident was currently receiving medications and mental health services for mental illness/behaviors. - A history of developmental disabilities and mental illness. - He had intermittent disorientation and was forgetful-needed redirecting. - The Assessment and Care Plan did not indicate any specific behaviors or mental health issues. - There was no documentation on the Care Plan of a supervision instructions for Resident #6 when aggressive, agitated and violent behaviors occurred. <p>Review of Interdisciplinary Progress Notes dated 3/26/15 at 7 am. by the facility revealed:</p> <ul style="list-style-type: none"> - Resident #6 was very combative against other residents and talking loudly and being very disruptive. - The physician was called. - The physician gave verbal orders for the resident to be involuntarily committed to the hospital. - The Executive Director and the family were notified. - The facility called the sheriff and the emergency medical service. - Upon arrival, the sheriff was able to calm the resident down. - The emergency service got vital signs of Blood pressure-116/68, blood sugar 134, Temperature 97.6 degrees Fahrenheit (F), pulse 83, respirations 18. - There was no documentation of the physician being notified of the resident not being involuntarily committed as ordered. <p>Review of Interdisciplinary Progress Notes on 3/26/15 at 9:30 pm by the facility revealed:</p> <ul style="list-style-type: none"> - Resident had been very abusive that day and 	D 270		

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D 270	<p>Continued From page 22</p> <p>was communicating threats all day.</p> <ul style="list-style-type: none"> - Resident refused to take all of his medications. - He was naked during this episode. - The resident became physically abusive and began to swing a chair at other residents. - Staff tried to stop the resident and he began to swing at the staff's heads - The medication aide decided to send him to the hospital as he was being a threat to himself and others. - The sheriff arrived and talked to the resident and calmed the resident down for a while. - After a short while the resident allowed staff to put on his pants but would not let staff put on his shirt. - The resident was transferred to the hospital. - The family was notified but there was no documentation of contact with the physician related to this incident and hospitalization. <p>Record review revealed the resident returned from the hospital on 3/27/16.</p> <p>Review of Interdisciplinary Progress Notes of the facility dated 3/27/15 at 7 am by the facility revealed:</p> <ul style="list-style-type: none"> - The resident was still acting in a combative manner. - He would not come into the building. - He sat on the ground and began hollering yelling. - Staff tried to get the resident to stand up but the resident stated swinging and kicking staff. - Emergency medical service was called and the resident was transported to the hospital. - The Executive Director and family were notified. - There was no documentation of contact with the physician being notified of the hospitalization. <p>Telephone interview on 5/19/16 at 10:05 am with</p>	D 270		

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D 270	<p>Continued From page 23</p> <p>the local emergency management service Compliance Director (CD) revealed:</p> <ul style="list-style-type: none"> - The report related to this resident's services dated 3/26/16 and 3/27/16 led the CD to notify social services because of the three calls in 2 days at this facility. - The CD read the report of the incident on 3/26/16. - The incident on 3/26/16 at 9:26 pm emergency services were called and arrived to find the deputies on site. - The resident was being violent, agitated towards staff. - The resident was nice to emergency staff and the deputies. - The resident was inside sitting on a chair. - He was transferred to the hospital. - The CD read the services' report dated 3/27/16 of the call out to the facility. - At 8:50 a.m. a call was placed to the service referencing a fall at the facility. - The emergency services arrived at the facility at 8:58 am. - The resident was found lying on the ground with a sheet over him. - A staff member was with the resident on the ground. - Staff had not gotten the resident up to take him inside. - Resident vital signs taken by emergency services were Oxygen Saturation 98%, Blood Sugar 104, Blood Pressure 104/72, Pulse 66 and regular, respirations 18 and regular, and the resident's Temperature was 93.7 degrees Fahrenheit. - Emergency services staff had to use hot packs to warm the resident up before they could transport the resident to the hospital. - The CD was concerned about the length of time the resident had been exposed to the cold 	D 270		
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D 270	<p>Continued From page 24</p> <p>outside.</p> <p>Interview on 5/12/16 at 2:20 pm with a nursing assistant (NA) revealed:</p> <ul style="list-style-type: none"> - The resident had behaviors and could get out of control. - There had not been any injuries of other residents when he got out of control. - The resident was not supervised one to one by an assigned staff member, but it was concerning when he was left near residents when staff were not around especially if he was acting out. - If we knew he was acting out then we could watch him to protect him and other residents. - All staff were to check on Resident #6 every 30 minutes and every 2 hours for toileting like all residents. - The NA was told to stand off away from him like inside but looking out of a window when he was outside smoking. - If he saw you watching him, he would act out and could be get agitated and aggressive. <p>Interview on 5/17/16 at 11:00 am with the Executive Director (ED) revealed:</p> <ul style="list-style-type: none"> - Resident #6 has had aggressive behaviors with agitation and had been hospitalized previously. - The resident did not return to the facility after this last admission on 3/27/16. - His physician was aware of the resident's behaviors. - The resident was aggressive with residents, but mostly with staff members. - If the resident became loud, and was cussing and hollering, staff would try to calm him down. - When the resident was loud and aggressive staff would watch the resident to ensure others were safe. - The resident was more aggressive and agitated when he was out of cigarettes. 	D 270		

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NAME OF PROVIDER OR SUPPLIER AUTUMN WIND ASSISTED LIVING OF LOUISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 361 LEONARD ROAD LOUISBURG, NC 27549
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D 270	<p>Continued From page 25</p> <ul style="list-style-type: none"> - Staff knew to employ a one to one staff to resident supervision when residents were agitated but there was not any supervision between these episodes other than routine supervision as for all residents-checks every 2 hours for toileting and every 30 minute resident checks. - She was not aware staff were concerned about the resident having behaviors when not in the view of the staff, especially when residents were near him. - The ED did not know that not every staff knew to supervise the resident with by watching him one on one with any behaviors nor when he went out to smoke. - There was no area in the record where nursing assistants would write about resident behaviors. - There was only the area in the facility notes where the medication aides wrote about incidents with residents. - Personal care staff did not document supervision of the residents. - The ED was not aware the resident had been out of the facility on 3/27/16 in the early morning and developed a low body temperature reading with no staff observing him. <p>Interview 5/17/16 at 11:15 am with the Resident Care Coordinator (RCC)revealed:</p> <ul style="list-style-type: none"> - Resident #6 had agitation behaviors. - He was previously hospitalized in December 2015 as well as the hospitalization in March 2016. - The incident on 3/26/16 documented in the facility notes at 7 am was related to Resident #6 stealing another resident's cigarettes. - Because he was agitated and stole the cigarettes, the sheriff had been called as well as the physician. - The resident was not transferred to the hospital per physician orders because the magistrate 	D 270		

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D 270	<p>Continued From page 26</p> <p>would not commit a resident who was not displaying aggressive behaviors and putting himself or other in harms way.</p> <ul style="list-style-type: none"> - There was no special supervision for Resident #6 between his agitation episodes only when they happened. - The staff were required to "watch him" and "Keep an eye on him". - No further details were given by the RCC for the type of supervision of Resident #6 with the aggressive agitated episodes. - No information related to a policy for aggressive and combative residents was indicated. <p>Interview on 5/17/16 at 4:45 pm with a medication aide (MA) revealed:</p> <ul style="list-style-type: none"> - She usually worked the 3 pm - 11 pm shift but sometimes worked nights. - She knew about Resident #6's aggressive behaviors. - His behaviors would include both verbal and physical aggression. - He would walk up and down the halls at night with agitation and almost always had on a coat. - The resident also would frequently take off his clothes. - If he would "act up", staff would try to calm him down, but it was best to just watch him and not say anything to him because it would make his behavior get worse. - He would sometimes yell, curse and become combative with his hands with staff and residents. - He did not respond as well to the women staff as he did with the men staff. - Staff were to watch the resident to prevent him from getting to other residents if he was agitated especially if staff could not see him, someone would go watch him in the smoking area. - Sometimes residents were redirected away from the incident. 	D 270		
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NAME OF PROVIDER OR SUPPLIER AUTUMN WIND ASSISTED LIVING OF LOUISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 361 LEONARD ROAD LOUISBURG, NC 27549
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D 270	<p>Continued From page 27</p> <ul style="list-style-type: none"> - Otherwise supervision was watching the resident per the regular resident check routines. - There was no one on one supervision of Resident #6 unless he acted up. - All residents were checked and assisted as needed with toileting every 2 hours. - All residents were checked on every 30 minutes as was Resident #6. - He frequently sat in the television living room at the front entrance where staff could see him. - Other residents sat in the television area as well and staff could see them easily. - Staff were to call the physician when he had behaviors. - The resident would smoke about every hour and staff were supposed to watch him while outside of the building. - Staff would stand nearby but would not let the resident see them because he would get agitated. - The report from the day shift on 3/26/16 at shift change indicated the resident was having behaviors related to the incident that morning. - That evening on 3/26/16 he was inside of the building sitting down on a chair in the living room when she saw him and he had his shirt half off. - Sometimes he would get completely naked. - She saw him agitated and aggressively yelling and threatening staff and residents. - He was swinging a chair around at some of the ladies in the living room and then at staff members. - He had not actually hit any residents or staff members. - She could see the residents were very concerned by looks on their faces and they were holding their hands up in a defensive way. - Residents were moved away from Resident #6. - The emergency services, the police, the RCC and a family member were notified and he was transferred to the hospital. 	D 270		
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D 270	<p>Continued From page 28</p> <p>Interview on 5/20/16 at 3:02 pm with a MA revealed:</p> <ul style="list-style-type: none"> - The MA said staff were to observe the resident unobtrusively when he was smoking outside. - On 3/27/16 the MA arrived just before 7 am and Resident #6 was not on the front porch smoking area. - The MA began to pass medication at 7 am and the resident was not on the porch as she glanced out of the front window. - Medications were passed down the hall away from the area of the front porch window. - It usually took somewhere between 8 am and 9 am to get back to the front of the facility where she would be able to see the resident on the front porch. - When she got back around to the front of the building she could see him outside on the bench in the front of the facility smoking without a staff person watching him. - Staff were to watch him when he went out to smoke especially if other residents were out there. - She was not certain of the time she got back to the front of the building that day. - It was a cold morning, but she did not know the temperature that morning. - The MA went out to try to get the resident back in the facility. - The resident became verbally abusive and was making combative motions with his hands when she tried to get him to put his shirt back on. - The MA went back in to get help from one of the male nursing assistant (NA). - When they got back he was still on the porch and the male NA tried to help him put the shirt back on but he got aggressive again. - Before she went back to the med cart, she asked the male NA to get the resident something 	D 270		

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D 270	<p>Continued From page 29</p> <p>to cover him up.</p> <ul style="list-style-type: none"> - When the male NA got back, the resident was on the ground and emergency services were called. <p>Interview on 5/20/16 at 3:15 pm with a NA revealed:</p> <ul style="list-style-type: none"> - When he came to work on 3/27/16 at maybe a little before 7 am, Resident #6 was not on the porch. - Whe he and the MA got to the porch he had his pants on and was on the ground. - He did not know what time they got to the porch or when the resident went out to smoke on the porch. - The resident was being combative and flailing his hands around. - The MA asked him to get a blanket to cover the resident as they had not been able to get him to put on his clothes. - He did not know how long the resident had been outside with his shirt and off. - He thought it was around 45 minutes since he had arrived at work when the MA came to get him after she had assessed the resident. - He had another aide to stand by the resident when he went to get a blanket. - He and the aide tried to get him to come in but he would not get up off of the ground. - The NA said he the supervision for Resident #6 was an every 2 hour check for toileting and every 1 hour or so for routine checks on residents including Resident #6. - He said there was no other special supervision for Resident #6 between his frequent behavior episodes. - The second NA that helped watch him when the NA went to get the blanket was no longer available for interview. 	D 270		

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D 270	<p>Continued From page 30</p> <p>Interview with another NA on 5/20/16 at 3:22 pm revealed:</p> <ul style="list-style-type: none"> - Resident #6 was difficult and would get agitated, combative and uncooperative such as when he was swinging the chair around on 3/26/16. - Residents were frightened of Resident #6, "You could see it in their faces." - Resident #6 could go outside to smoke around other residents on his own. - He was not disoriented, no one supervised him out there in the smoking area. - It was not possible to watch him every minute and it was not certain when his behaviors would start up. - The resident was very volatile and could start behaviors up when he was around other residents but not around staff. - The resident would sit in the living room a lot so staff watched him when he was there. - He did not know of any injuries to other residents by Resident #6. - There had been no special supervision of Resident #6 not even when he acted up. - The resident would be agitated if he did not get a cigarette. - There was no special 1:1 supervision for the resident even if he acted up because if any staff were near him his behaviors would get worse. - Supervision was routine for every resident, every 30 minutes to 2 hours checks. <p>Interview on 5/19/16 at 1:50 pm with Resident #6's physician revealed:</p> <ul style="list-style-type: none"> - The physician knew about the volatile behaviors of Resident #6. - The resident might benefit from hospitalization on a more permanent basis. - He might require increased supervision. - His behaviors could escalate at anytime and it 	D 270		
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D 270	<p>Continued From page 31</p> <p>could be dangerous for staff and resident's if he became harmful to them or himself.</p> <ul style="list-style-type: none"> - The physician did not know about the resident not being involuntary committed on the morning of 3/26/16 after staff from the facility had called her. - She did not know about the third incident within the 2 days on 3/27/16 in the early morning. - She was not aware the resident had been hypothermic with a temperature of 93.7 when the emergency services checked him outside that morning. - The ED looked up on an internet site and said it was between 35 and 40 degrees F. temperature the morning on 3/27/16. - The physician said it would be difficult to assess how long it would have taken the resident to drop his temperature to that level. <p>_____</p> <p>Review of the facility's Plan of Protection dated 5/20/16 revealed:</p> <ul style="list-style-type: none"> - Immediately, a staff person will be placed with residents with aggressive behaviors as soon as assessed to supervise and to keep them calm until police are able to transport them to the hospital. - Staff will complete more than every 30 minute checks on residents identified to have behavior problems. - Physicians will be notified immediately. - Prior to prospective resident admissions, full documentation and information such as history and physical from referring agency will be available before taking them into our care. - Ensure all staff are alert and watching residents. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 19, 2016.</p>	D 270		

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D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure contact with the physician of one of six sampled residents (#6) related to behaviors and hospitalization. The findings are:</p> <p>Review of Resident #6's current FL-2 dated 1/04/16 related psychiatric unit hospital visit revealed:</p> <ul style="list-style-type: none"> - Diagnoses of Schizophrenia, Diabetes Mellitus Type II, Hyperlipidemia, Cataracts, Hypothyroidism, Vitamin D Deficiency. - There was no indication of behavior concerns listed. - No admission date to the facility was listed. - Active and discharge hospital problems included schizophrenia, constipated, hyper-parathyroidism, acute hyperkalemia, Hypercalcemia, pharyngeal dysphagia, hypertension, diabetes mellitus and tremor. <p>Review of Resident #6's Resident Register revealed:</p> <ul style="list-style-type: none"> - An admission date of 10/27/15. - Under the Personal Information section, Memory was listed as "Significant loss-Must be redirected." was checked. - The Resident Register listed the resident as using a walker and a wheel chair. - He was a smoker. 	D 273		

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D 273	<p>Continued From page 33</p> <p>Review of Resident #6's current Assessment and Care Plan dated 10/29/15 revealed:</p> <ul style="list-style-type: none"> - The resident was currently receiving medications and mental health services for mental illness/behaviors. - A history of developmental disabilities and mental illness was listed. - The Assessment and Care Plan did not indicate any specific behaviors or mental health issues. <p>Review of Interdisciplinary Progress Notes on 3/26/15 at 7 a.m. by the facility revealed:</p> <ul style="list-style-type: none"> - Resident #6 was very combative against other residents and talking loudly and being very disruptive. - The physician was called. - The physician gave verbal orders for the resident to be involuntarily committed to the hospital. - The facility called the Sheriff and the emergency medical service. - Upon arrival the sheriff was able to calm the resident down and was not transferred to the hospital. - The Executive Director and the family was notified. <p>Record review revealed there was no documentation of the physician being notified of the resident not having been involuntarily committed as ordered.</p> <p>Review of Interdisciplinary Progress Notes on 3/26/15 at 9:30 p.m. by the facility revealed:</p> <ul style="list-style-type: none"> - Resident had been very abusive that day and was communicating threats all day. - Resident refused to take all of his medications. - He was naked during this episode. - The resident became physically abusive and 	D 273		

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D 273	<p>Continued From page 34</p> <p>began to swing a chair at other residents.</p> <ul style="list-style-type: none"> - Staff tried to stop the resident and he began to swing at the staff's heads. - The medication aide decided to send him to the hospital as he was being a threat to himself and others. - The sheriff arrived and talked to the resident and calmed the resident down for a while. - The resident was transferred to the hospital. - The family was notified but there was no documentation of contact with the physician related to this incident and hospitalization. <p>Record review revealed the resident was readmitted in the night to the facility from the hospital on 3/27/16.</p> <p>Interview on 5/17/16 at 4:45 p.m. with a medication aide (MA) revealed:</p> <ul style="list-style-type: none"> - She usually worked the 3 p.m. - 11 p.m. shift but sometimes worked nights. - She knew about Resident #6's aggressive behaviors. - His behaviors would include both verbal and physical aggression. - He would walk up and down the halls at night with agitation and almost always had on a coat. - The resident also would frequently take off his clothes. - If he would "act up", staff would try to calm him down, but it was best to just watch him and not say anything to him because it would make his behavior get worse. - He would sometimes yell, curse and become combative with his hands with staff and residents. - She saw him agitated and aggressively yelling and threatening staff and residents on 3/26/16 in the evening. - He was swinging a chair around at some of the ladies in the living room and then at staff 	D 273		

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D 273	<p>Continued From page 35</p> <p>members.</p> <ul style="list-style-type: none"> - The emergency services, the police, the RCC and a family member were notified and he was transferred to the hospital. - She did not notify the physician of the behaviors and the hospitalization. <p>Review of Resident #6's record revealed there was no documentation by facility staff of contact with the physician being notified of behaviors and the hospitalization on the evening of 3/26/16.</p> <p>Review of Interdisciplinary Progress Notes of 3/27/15 at 7 a.m. by the facility revealed:</p> <ul style="list-style-type: none"> - The resident was still acting in a combative manner. - He would not come into the building. - He sat on the ground and began hollering and yelling. - Staff tried to get the resident to stand up but the resident stated swinging and kicking staff. - Emergency medical service was called and the resident was transported to the hospital. - The Executive Director and family were notified. <p>Interview on 5/20/16 at 3:02 p.m. with a MA revealed:</p> <ul style="list-style-type: none"> - The MA arrived just before 7 a.m and Resident #6 was not on the front porch area. - The MA began to pass medication at 7 a.m. and the resident was not on the porch as she glanced out of the front window. - Medications were passed down the hall away from the area of the front porch. - It usually took somewhere between 8 a.m and 9 a.m. to get back to the front of the facility where she could see the resident on the front porch. - When she got back around to the front she could see him outside on the bench in the front of the facility. 	D 273		

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D 273	<p>Continued From page 36</p> <ul style="list-style-type: none"> - She was not certain of the time she got back to the front of the building that day. - The MA went out to try to get the resident back in the facility. - It was a cold morning but she did not know the temperature that morning. - The resident became verbally abusive and was making combative motions with his hands when she tried to get him to put his shirt back on. - The MA went back in to get help from one of the male nursing assistant (NA). - When they got back he was still on the porch the male NA tried to help him put the shirt back on but he got aggressive again. - Before she went back to the med cart, she asked the male NA to get the resident something to cover him up. - When the male NA got back, the resident was on the ground and emergency services were called. <p>Telephone interview on 5/19/16 at 10:05 a.m. with the local emergency management service Compliance Director (CD) revealed:</p> <ul style="list-style-type: none"> - The report related to this resident's services dated 3/26/16 and 3/27/16 led the CD to notify social services because of the three calls in 2 days at this facility. - The CD read the report of the incident on 3/26/16. - The incident on 3/26/16 at 9:26 p.m. emergency services were called and arrived to find the deputies on site. - The resident was being violent, agitated towards staff. - The resident was nice to emergency staff and the deputies. - The resident was inside sitting on a chair. - He was transferred to the hospital. - The CD read the services' report dated 3/27/16 	D 273		
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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 273	<p>Continued From page 37</p> <p>of the call out to the facility.</p> <ul style="list-style-type: none"> - At 8:50 a.m. a call was placed to the service referencing a fall at the facility. - The emergency services arrived at the facility at 8:58 a.m. - The resident was found lying on the ground with a sheet over him. - A staff member was with the resident on the ground. - Staff had not gotten the resident up to take him inside. - Resident vital signs taken by emergency services were Oxygen Saturation 98%, Blood Sugar 104, Blood Pressure 104/72, Pulse 66 and regular, respirations 18 and regular, and the resident's Temperature was 93.7 degrees Fahrenheit. - Emergency services staff had to use hot packs to warm the resident up before they could transport the resident to the hospital. - The CD was concerned about the length of time the resident had been exposed to the cold outside. <p>Interview on 5/17/16 at 2:45 p.m. with the Executive Director revealed:</p> <ul style="list-style-type: none"> - The usual policy for hospital transfer in these cases is if the sherriff can calm residents down they are not transfered to the hospital because the magistrate would not sanction the commission for admittance to the hospital if not displaying serious physical harm to self or others. - The MA or RCC were to notify the physician for any hospitalizations and escaltation of behaviors. - The physician was notified by her about the episode with Resident #6 on 3/27/16 at 7 a.m. - She called the physician at 12:30 p.m. when notified by the medication aide about transfer to the hospital, but did not document it in the record. 	D 273		
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D 273	<p>Continued From page 38</p> <ul style="list-style-type: none"> - She did not know the physician had not been contacted by staff for the other two episodes of behaviors and hospitalization with Resident #6 on 3/26/16. <p>Interview on 5/19/16 at 1:50 p.m. with Resident #6's physician revealed:</p> <ul style="list-style-type: none"> - The physician did not know about the resident not being involuntary committed on the morning of 3/26/16 after staff from the facility had called her. - She did not know about the third incident in the early morning within the 2 days on 3/27/16. - She was not aware the resident had been hypothermic with a temperature of 93.7 when the emergency services checked him outside that morning. - The ED looked up on an internet site and said it was between 35 and 40 degrees F. temperature the morning on 3/27/16. - The physician said it would be difficult to assess how long it would have taken the resident to drop his temperature to that level. 	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by:</p>	D 276		

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D 276	<p>Continued From page 39</p> <p>Based on observations, record review and interviews, the facility failed to implement daily weights as ordered by the physician for 1 of 5 sampled residents (#3). The findings are:</p> <p>Review of Resident #3's current FL2 dated 2/18/16 revealed: -Diagnoses included Cellulitis of Leg, Hypertension, Benign Prostatic Hypertrophy, Atrial fibrillation, Restless Leg Syndrome, Gout, Hyperlipidemia, Esophageal Ulcers, Hypomagnesemia -The resident is semi ambulatory with wheel chair, bladder and bowel incontinent, has leg wraps by home health. -Orders for No Added Salt Diet and daily weights. -Admission date was 5/02/15.</p> <p>Review of Resident #3's record revealed: -Daily weight logs for November 2015 and December 2015 with no entries made. -No other weights or weight logs were documented for the resident.</p> <p>Interview with a Medication Aide on 5/18/16 at 11:30 am revealed: -She provided care for Resident #3 on multiple occasions, she did not recall him having an order for daily weights. -She did remember that he was losing weight, as he had a cancer diagnosis before he was discharged. -She did not know his discharge date. -She had a resident with monthly weights and she logs weight into the medical record, but she did not remember having daily weights for Resident #3</p> <p>Interview with the Resident Care Coordinator</p>	D 276		

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D 276	<p>Continued From page 40</p> <p>(RCC) on 5/18/16 at 9:35 am revealed :</p> <ul style="list-style-type: none"> -RCC did not recall an order for Resident #3 to have daily weights. -Staff were monitoring Resident #3's weights due to his weight loss, but she did not know that it was not recorded on the logs. -It is the expectations for all weights, blood pressures and blood sugars to be put in the logs in the record. <p>Review of resident's personal care log revealed only intermittent initials of staff, no indication or codes for what care had been provided to resident.</p> <p>Interview with another Medication Aide on 5/18/16 at 2:00 p.m. revealed:</p> <ul style="list-style-type: none"> -All care provided by staff should be in the residents medical record and on the personal care log. - MAs monitor personal care logs daily. 	D 276		
D 282	<p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:</p> <p>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen equipment was clean, orderly and protected from contamination. The findings are:</p> <p>Observation of the facility kitchen on 5/10/16 at</p>	D 282		

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D 282	<p>Continued From page 41</p> <p>3:45 p.m. - 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The ice maker had dried white liquid drips down the lower front panel of the ice maker and down the back of the unit. - The ice maker had an area of thick cream colored dried food on the left lower corner of the front panel. - The three compartment sink behind the stove had dried white drip marks, dried on food particles and smears all along the front panel. - Inside of the middle sink was a black build up area near the top back left corner. - Under the sink was a plastic protective glove and food particles and pieces. - The stove had a well at the back of the stove covered with dried burned on food. - A stove well across the front of the stove had dried burned on food in it. - The area under the stove burners was covered with burned food pieces and this greasy substance. - Streaks of food and liquid spills were down the right side of the stove. - The inside of the stove/oven door glass had become opaque with burned on food and liquids. - The floor of the oven was covered with burned food pieces and particles. - The double door steamer had thick dark brown greasy substance build-up and food particles accumulated around the steamer dial. - The steamer glass doors were smeared and foggy from food/steam. - The steamer had a brown build-up substance and burned on food around the body and top of the steamer where the double doors touch the body. - The outside metal sides top and doors were dulled from food smears. - The double door refrigerator had food smears on the outside of the doors. 	D 282		

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D 282	<p>Continued From page 42</p> <ul style="list-style-type: none"> - Inside on the bottom of the refrigerator was a large package of wrapped hamburger meat touching a package of luncheon meats in an enclose package. <p>Second observation of the kitchen on 5/20/16 at 10:45 a.m. revealed:</p> <ul style="list-style-type: none"> - The ice machine continued to have food and liquid drips on the outside. - The sink continued to have the smears and liquid drips and food particles. - The refrigerator had food smears on the front of the doors. - The stove continued to have the dark brown greasy burned on food all over the stove and inside of oven. - The double door steamer continued to have the burned on food areas and foggy glass. - The control dial of the double door steamer had been cleaned partially with some greasy build up and food particles. - The front of the doors were dulled with food smears. - On the floor and behind the dish sink was a whole tomato. <p>Observation of the range grease/air filter hood on 5/20/16 at 10:45 a.m. revealed:</p> <ul style="list-style-type: none"> - The back wall of the hood was covered with a greasy build-up and dust. - The six range hood filters were all covered with a grease build-up and dust and dirt accumulation. - It was not possible to see the thick foam like inner filter because of the thick build-up of grease and food particles. <p>Interview on 5/20/16 at 10:55 a.m. with the kitchen manager revealed:</p> <ul style="list-style-type: none"> - Kitchen staff had been trained on where to store food within the refrigerator. 	D 282		

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D 282	<p>Continued From page 43</p> <ul style="list-style-type: none"> - Kitchen staff had a diagram on the front of the refrigerator to follow and the ready to eat lunch meat should not have been stored with the raw meat packages. - There was no system to check on the cleanliness and food storage. - She was not aware of the tomato on the kitchen floor. - She said the kitchen staff have to clean the kitchen after meals which gives them a minimal amount of time before the next meal. - Staff does routine cleaning after meals such as mopping and sweeping the floor, wiping down equipment, dish cleaning areas, including removing trash and garbage. - There was no deep cleaning schedule for the kitchen. - The equipment had not been steamed clean but was wiped down as needed. - The vent hood and filter were not professionally cleaned for some time. - She could not remember how long it had been since the hood filters were cleaned by the hood company. - The maintenance and housekeeper most of the time took the six filters down from the greasy hood one time per month and clean them. <p>Interview with the Executive Director on 5/20/16 at 11:02 a.m. revealed:</p> <ul style="list-style-type: none"> - She thought the kitchen staff cleaned up the kitchen on a daily basis. - There was not a deep cleaning schedule for the kitchen and equipments. - She was not aware of documentation of cleaning the kitchen. - The equipment was old and not expected to look new. - She was not aware of the condition of the kitchen or the range hood grease filters. 	D 282		

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D 282	<p>Continued From page 44</p> <ul style="list-style-type: none"> - The range hood grease filters were cleaned periodically by maintenance. - She was not aware of a company coming to the facility to professionally clean the range hood filters. <p>Interview with the maintenance person on 5/20/16 at 11:15 a.m. revealed:</p> <ul style="list-style-type: none"> - The range hood filters used to be cleaned one time per month by the range hood company. - He had not seen the company for about a year at the facility to clean the filters. - He had been cleaning them on a monthly basis for some time. - He would remove the filters and take them out and use a degreaser on them and rinse them off and put them back. - He could not remember when he had cleaned them last. 	D 282		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes:</p> <p>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the table service included a knife, fork and spoon at the each meal delivery. The</p>	D 287		

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D 287	<p>Continued From page 45</p> <p>findings are:</p> <p>Observation of the preparation of noon lunch meal service in both dining rooms on 5/11/16 at 11:15 a.m. revealed every resident had a place setting of a either a fork or a spoon and a napkin with no knives used in the place setting in both resident dining rooms.</p> <p>Interview with a kitchen aide on 5/11/16 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - Knives were never given to residents to use at the meals. - Residents take silverware from the dining room and keep them in their rooms. - The kitchen aide thought residents could hurt someone with a knife. <p>Interview on 5/11/16 at 11:40 a.m. with the cook revealed knives were not used because they were too dangerous with their type of residents.</p> <p>Interview with a resident sitting in a dining room on 5/11/16 at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> - The resident had been in the facility since November 2013 and had been served food with either a fork or a spoon with which to eat. - No knives were placed on the tables. - If food needed to be cut up and it could not be accomplished with a fork or spoon, staff in the dining room would cut it up with a knife for residents. - The resident would like to have had all the silverware pieces when admitted. - The resident said it was alright now that there was only a fork or a spoon and the resident had gotten used to it over time. <p>Observation in the dining room on 5/11/16 at 11:55 a.m. revealed:</p>	D 287		

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D 287	<p>Continued From page 46</p> <ul style="list-style-type: none"> - No residents had knives, only a fork or a spoon to eat with. - The meal consisted of soft ground meat patty, soft vegetables, soft potatoes and roll. - Residents were observed cutting the pattie with their fork or spoon. <p>Interview on 5/11/16 at 12:45 p.m. with the Executive Director revealed:</p> <ul style="list-style-type: none"> - She was not aware of the food service requirement for a knife, fork and a spoon were to be at the place stetting for each resident. - Staff were present in the dining room to assist residents with their meals as needed to cut up food as necessary for any resident. - She thought it was not allowed for a knife to be at the place setting because it would be dangerous to residents if someone were to use a knife as a weapon. - Residents were known to take silverware from the dining room to their rooms. - It had always been the policy of the facility to not allow knives in the dining room. - Some residents with behaviors might be of concern in relation to possible harm to others if knives were available in the dining room. - She was not aware of any current residents of concern for dangerous use of knives. <p>Observation on 5/19/16 at during the dinner meal at 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> - A resident was sitting in the dining room lifting up his bowl to his mouth and was drinking his chicken noodle soup. - A fork was placed at the table for the resident to use for the meal. - No knife or spoon were available for use at the table. - All other place settings left on the table included a knife, fork and a spoon. 	D 287		

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D 287	<p>Continued From page 47</p> <p>Interview with the resident on 5/19/16 at 5:15 p.m. revealed:</p> <ul style="list-style-type: none"> - The resident was drinking his second bowl of chicken noodle soup. - He did not want the dinner to be served and asked for soup. - He said he did not asked for a spoon to eat the soup. - It did not matter to him, he liked to drink the soup from the bowl. <p>Interview with a staff member in the dining room on 5/19/15 at 5:17 p.m. revealed:</p> <ul style="list-style-type: none"> - She was not aware the resident had not received a spoon to eat the soup - She would have would have gotten one if he had asked for it. 	D 287		
D 296	<p>10A NCAC 13F .0904(c)(7) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure matching therapeutic diet menus for guidance of food service staff for 2 of 2 sampled residents with physician ordered therapeutic diets of Reduced Concentrated Sweets (RCS). (Resident #1 and #2) The findings are:</p> <p>1. Review of the current FL-2 dated 3/10/16 for Resident #1 revealed:</p>	D 296		

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D 296	<p>Continued From page 48</p> <ul style="list-style-type: none"> - Diagnoses of Diabetes Mellitus, Hypertension, Mood Disorder and Tardive dyskinesia. - Resident was ordered an oral diabetic agent. - Resident was admitted on 1/09/14. - Diet order was for a Reduced Concentrated Sweets diet. <p>A diet order sheet in the resident's record dated 3/10/16 had an order for Reduced Concentrated Sweets (RCS), mechanical soft chopped or ground meats and No Added Salt (NAS) with an explanation the NAS meant no added table salt.</p> <p>Review of the facility diet list provided by the Resident Care Coordinator (RCC) which was not dated indicated Resident # 1 was on a RCS/NAS.</p> <p>A regular menu, Fall Winter 2015 - 2016 - Week 2, was observed in the kitchen on 5/11/16 at 11a.m. being used by the kitchen staff.</p> <p>There were no therapeutic diet menus available in the kitchen for staff guidance.</p> <p>Review of the Fall Winter 2015- 2016 - Week 2 lunch menu revealed residents were to receive veal parmesan, parslied noodles, mixed vegetables, oranges and white or wheat roll, coffee/tea and water as allowed.</p> <p>Observation on 5/11/16 at the 11:30 a.m. - 12:00 p.m. lunch meal services revealed the residents received a meat pattie, mixed vegetables, noodles, white roll, baked sweet potato, mandarin oranges, water and tea with a sugar substitute.</p> <p>Observation on 5/11/16 at 12:00 p.m. of Resident #1 during the lunch meal revealed the resident ate all of the food served.</p>	D 296		

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D 296	<p>Continued From page 49</p> <p>Based on record review, the resident was not interviewable for the meal.</p> <p>Interview with Resident #1's responsible person on 5/19/16 at 10:26 a.m. revealed:</p> <ul style="list-style-type: none"> - He was not aware of the diet order for Resident #1. - He thought the resident was on a diabetic diet. - The resident sometimes ate in the her room. <p>Review of Resident #1's record reveald blood sugar checks were within normal limits.</p> <p>Refer to observation on on 5/11/16 at 12:45 p.m.</p> <p>Refer to interview with the Kitchen Manger on 5/11/16 at 12:45 p.m.</p> <p>Refer to interview with the Executive Director on 5/11/16 at 12:45 p.m.</p> <p>2. Review of the current FL-2 dated 10/29/15 for Resident #2 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of Diabetes Mellitus. - Diet order of Reduced Concentrated Sweets (RCS), and No Added Salt (NAS) with an explanation of the NAS as no added table salt. <p>Review of the facility diet list provided by the Resident Care Coordinator (RCC) which was not dated indicated Resident #2 was on a RCS diet.</p> <p>A regular menu, Fall Winter 2015 - 2016 - Week 2, was observed in the kitchen on 5/11/16 at 11a.m. being used by the kitchen staff.</p> <p>Review of the Fall Winter 2015- 2016 - Week 2 lunch menu revealed residents were to receive veal parmesan, parslied noodles, mixed vegetables, oranges and white or wheat roll,</p>	D 296		

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D 296	<p>Continued From page 50</p> <p>coffee/tea and water as desired.</p> <p>Review of the residents record revealed blood sugar levels were within normal limits.</p> <p>Observation on 5/11/16 at the 12 noon lunch meal service revealed the resident received a meat pattie, mixed vegetables, white roll, baked sweet potato, mandarin oranges, water and tea with a sugar substitute.</p> <p>Refer to interview with the Kitchen Manager on 5/11/16 at 12:45 p.m.</p> <p>Refer to observation on on 5/11/16 at 12:45 p.m.</p> <p>Refer to interview with the Executive Director on 5/11/16 at 12:45 p.m.</p> <hr/> <p>Interview with the Kitchen Manager on 5/11/16 at 12:45 p.m. revealed:</p> <ul style="list-style-type: none"> - All residents got the same food. - A regular menu, Fall Winter 2015 - 2016 - Week 2, was used for kitchen staff to prepare and serve residents' food. - She thought the residents with RCS orders were getting that meal. - She was not clear on what therapeutic menus were. - No therapeutic menus were used or served in the kitchen. - There were some other menus in the main office, but not in the kitchen. <p>Observation in the facility office on 5/11/16 at 12:45 p.m. revealed:</p> <ul style="list-style-type: none"> - The Kitchen Manager and the Executive Director (ED) were looking for therapeutic diet menus. 	D 296		

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D 296	<p>Continued From page 51</p> <ul style="list-style-type: none"> - They were found in a drawer. - The menus provided by the Kitchen Manager did not match the weekly Spread Sheet. - The therapeutic diet menus for diabetic diets only included No Concentrated Sweets, Low Concentrated Sweets and 1800 calorie diet. - There was not a therapeutic diet menu for RCS diet orders. <p>Interview with the Executive Director on 5/11/16 at 12:45 p.m. revealed;</p> <ul style="list-style-type: none"> - She was not aware the kitchen should be using the therapeutic menus for those with modified therapeutic diet orders. - She thought the No Concentrated Sweets diet would be the same as the RCS diet. - The residents with RCS orders had not had the diet order clarified with the physician. 	D 296		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure 1 of 1 resident with orders for honey thickened liquids, were served as ordered by the resident's physician. (Resident #4) The findings are:</p> <p>Review of the current FL-2 dated 4/14/16 for Resident #4 revealed:</p>	D 310		

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D 310	<p>Continued From page 52</p> <ul style="list-style-type: none"> - Diagnoses of dementia, edema, anemia, angina, bipolar manic, hypothyroidism, schizoaffective d/o, duodenum ulcer. - Diet orders for pureed food and honey thickened liquids. <p>Review of the Facility Therapeutic Diet List provided by the Resident Care Coordinator revealed Resident # 4 was to receive pureed honey thick liquids and as needed.</p> <p>Review of Resident #4's Care Plan dated 7/2/15 revealed the resident required total assistance with feeding.</p> <p>Review of the thickener package directions for use revealed:</p> <ul style="list-style-type: none"> - Honey Thick Tea, use 4 - 5 teaspoons for a 4 ounce glass - Honey Thick Tea, use 8 - 10 teaspoons for 8 ounces. - One large scoop measured 3 teaspoons. - One small scoop measured 1 teaspoon. <p>Observation on 5/10/16 at 4:35 p.m. of the nursing assistant (NA) revealed:</p> <ul style="list-style-type: none"> - An NA was feeding Resident #4 her dinner in the resident's room. - The meal was pureed and an 8 ounce glass of tea was on the tray with ice in the glass of tea with no straw. - Before eating, the liquid appeared of nectar consistency. - The NA left the room with the glass of tea and then returned. - There was no ice in the tea and the tea had a cloudy appearance. - During the meal eaten by Resident #4 there was no ice left in the tea and the consistency was honey thick. 	D 310		

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D 310	<p>Continued From page 53</p> <ul style="list-style-type: none"> - All of the tea was consumed by the resident. - The resident ate most of the meal and drank all of the tea without choking or coughing. <p>Interview with the NA feeding Resident #4 on 5/10/16 at 5:05 p.m. revealed:</p> <ul style="list-style-type: none"> - He put ice in the glass of warm tea before bringing it to the resident's room in order to cool it down. - He said there was already thickener in the glass of tea with ice fixed by the kitchen staff when he picked up the tray. - When the ice melted, he got thickener from the medication aide (MA) to thicken it back up before the resident drank it. - The large end of the scoop was used, full of thickener, and put into the cooled tea and stirred well. - He did not know the thickness ordered for liquids for Resident #4. - He did not know the size of the cup used for the tea. - He did not know how much thickener was put into the glass by the kitchen prior to bringing the tray to the room. <p>Interview on 5/10/16 at 5:30 p.m. with a MA revealed:</p> <ul style="list-style-type: none"> - The MA sometimes made the liquids with thickener for residents meds especially if the pitcher of thickened liquid made up by the kitchen in the morning had been sitting all day. - He would make a fresh glass when this occurred. - He said he puts "some" in the glass of liquid until it thickened up. - He did not know what size of glass was used. - The thickener was kept on the medication cart. - The MA did not know what consistency of liquids was ordered for Resident #4. 	D 310		

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D 310	<p>Continued From page 54</p> <p>Observation on 5/10/16 at 5:30 p.m. revealed the MA opened a small drawer on the medication cart but did not find the thickener.</p> <p>Interview on 5/10/16 at 5:40 p.m. revealed another MA did not make up the thickened liquids.</p> <p>Interview on 5/10/16 at 5:45 p.m. with the kitchen aide and the cook revealed:</p> <ul style="list-style-type: none"> - The kitchen aide said, no large containers of thickened liquids were made ahead of the time in the morning, rather it was made as needed. - The kitchen aide said she made up the thickened liquids that evening for the dinner for Resident #4. - She was told to use 1 large scoop in the glass, but did not know how much thickener the large scoop held nor how large the glass was that was served. - She said the directions on the label of the thickener carton were to be followed. - The cook said only one resident, #4 had thickener and the large scoop was to be used. - Neither the cook nor the kitchen aide knew what the size of cup was given to Resident #4 for the dinner. - They were not aware the size of the cup was needed to ensure the proper directions for use were followed. - Neither the cook nor the kitchen aide knew how much thickener was listed on the thickener container to be used for the 8 ounce cup. - As the kitchen aide pointed to the thickener container instructions for use she said she was told to use 1 large scoop of thickener for 8 ounce cup should be used for any size glass or type of liquid. - Both the kitchen aide and the Kitchen Manager 	D 310		

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D 310	<p>Continued From page 55</p> <p>were not aware the amount on the container instructions should be followed and the size of glass or cup needed to be know in order to prepare the correct amount.</p> <ul style="list-style-type: none"> - The kitchen aide said a nurse came and trained the kitchen staff on how to make the thickened liquids. <p>Observation with the kitchen aide on 5/10/16 at 5:45 p.m. revealed:</p> <ul style="list-style-type: none"> - A measuring cup was used to measure what how many ounces were in the cup used for dinner. - The cup used at the dinner was an 8 ounce glass. <p>Interview on 5/10/16 at 5:50 p.m. with the Executive Director revealed:</p> <ul style="list-style-type: none"> - The MA usually fixed the thickened liquids for the meals. - They should know how to fix the thickener. - She did not know the kitchen staff was making up the thickened liquids in the kitchen for meals. - She was not aware the thickener was being prepared incorrectly for Resident #4 by the kitchen staff. - She did not realize the medication aide thought the thicker container was on the med cart and that the kitchen staff made up thickened liquid for the whole day for all to use. - She would ensure staff would have training on how to prepare the thickener correctly. 	D 310		
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</p>	D 338		

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D 338	<p>Continued From page 56</p> <p>and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 sampled residents were free from resident to resident abuse, (Resident #7) who was assaulted by Resident #8 who had a history of aggressive behavior and Resident #9 who was sexual exploited by Staff D. The findings are:</p> <p>1. Review of Resident #9's current FL-2 dated 3/03/16 revealed diagnoses included morbid obesity, depression and osteoarthritis.</p> <p>Review of Resident #9's Resident Register revealed an admission date of 11/25/13.</p> <p>Review of the resident's care plan dated 02/27/16 revealed:</p> <ul style="list-style-type: none"> - The resident was receiving mental health services. - The resident had a history of mental illness and was receiving medication for mental illness/behavior. - The resident ambulated with the use of a wheelchair. - The resident had limited upper strength - The resident required limited assistance with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care and transferring. <p>Interview with a resident on 5/17/16 at 4:00pm revealed:</p> <ul style="list-style-type: none"> - Some of the residents and employees were talking about Resident #9 and Staff D were 	D 338		

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D 338	<p>Continued From page 57</p> <p>caught by the Activity Director having oral sex in the resident's room about a month ago.</p> <ul style="list-style-type: none"> - The incident was reported to the Executive Director (ED). - The resident asked Resident #9 about the incident but she became upset and denied it. - Staff D was a cook and continued to work at the facility. - Staff D was a good cook and friendly with the residents; he had a good relationship with the residents. <p>Interview with the facility's ED on 5/17/16 at 4:30pm revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, the Activity Director reported she observed Staff D in Resident #9's room near her bed with his pants unzipped and his underwear was visible when she walked in her room with her roommate (before lunch). - The ED talked to Resident #9, Staff D, the Activity Director and The Dietary Manager. - Staff D denied his pants were unzipped and stated he was in the resident room telling her to come to eat. - She obtained written statements from the resident, Staff D, the Activity Director and the Dietary Manager. - The Resident Care Manager (RCC) and she talked to the resident and she denied any sexual contact with Staff D. - Staff D was never suspended and the alleged incident was not reported to the NC Health Care Personnel Registry because Staff D and the resident denied the allegation. - There were no further investigation of the allegations. - The ED stated she will complete a 24 hour report and fax to HCPR today and Staff D will be suspended effective immediately. - Staff D was not scheduled to work today. 	D 338		

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D 338	<p>Continued From page 58</p> <p>Review of the Activity Director's written statement dated 4/11/16 revealed:</p> <ul style="list-style-type: none"> - On April 8, 2016, I was rolling a resident into her room, where she stay. When I rolled her in the room, I witnessed [Staff D] in the room and the other resident was in the bed. - I didn't see anything going on, his [Staff D] pants were unzipped and I saw his boxers, but everything seemed in place. - He said he was telling her it was time to eat and was giving her a cigarette. Then he left when I came out. He went back towards the kitchen. <p>Review of the Dietary Manager's written statement dated 4/11/2016 revealed:</p> <ul style="list-style-type: none"> - I, [Dietary Manager] was in the kitchen on April 8, 2016. - I didn't witness anything. <p>Review of Resident #9's written statement dated 4/12/16 revealed:</p> <ul style="list-style-type: none"> - I was sleeping when [Staff D] came into the room to wake me up for lunch. - When the door opened with [the Activity Director] pushing [roommate] into the room, he moved toward the door so [the Activity Director] could come around to the other side of the bed. - Before he left, I asked for a [cigarette] and then I told him that I probably wouldn't be coming to lunch. <p>Review of Staff D's written statement dated 4/22/16 revealed:</p> <ul style="list-style-type: none"> - To whom it may concern: Allegations were made against me in an unprofessional and sexual nature. All fabricated by coworker with too much time on their hands and no business of their own. - My superior [ED] questioned me on these matters in detail: 1) Am I having sexual 	D 338		

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D 338	<p>Continued From page 59</p> <p>relationship with one of the residents? 2) Am I supplying alcoholic beverages to a resident?</p> <ul style="list-style-type: none"> - I told her the truth which is no I am not. - For the record, this whole mess is foolishness. If people did their work, they wouldn't have time for gossip for sure. <p>Interview with another resident on 5/17/16 at 4:07pm revealed other residents and staff talked about Resident #9 gave Staff D a "bl** job" about a month ago.</p> <p>Interview with the facility's Activity Director on 5/18/16 at 9:50am revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, before lunch, she was assisting Resident #9's roommate back to her room (in her wheelchair). - The room door was closed completely, and when she opened the door to push the roommate into her room, she observed Staff D standing near the head of Resident #9's bed (facing the bed). - Resident #9 was lying in her bed awake. - When Staff D turned away from the bed, she observed his pants unzipped with his underwear showing. - Resident #9's roommate stated "boy [Staff D] what are you doing in my room, if you are not here leaving me a cigarette, get out". - Staff D left the room and did not explain why he was in the resident's room with the door closed but stated he was telling the resident to come to eat lunch and gave her a cigarette. - Two other staff members were on the hall when this incident occurred. - The Activity Director reported the incident to the ED immediately. - Staff D continued to work at the facility as a cook, he was not suspended. 	D 338		
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D 338	<p>Continued From page 60</p> <p>Interview with a facility housekeeper on 5/18/16 at 10:05am revealed:</p> <ul style="list-style-type: none"> - He heard last month Staff D was caught having oral sex with Resident #9. - The Activity Director walked in on them and Staff D's pants were unzipped and his underwear was showing. - Staff D went back to the kitchen and told the Dietary Manager the Activity Director messed up his pleasure. - Nothing like this happened before Staff D came to work 2-3 months ago. - Resident #9 had a "crush" on most of the male employees, we stay away from her. <p>Interview with the Dietary Manager on 5/18/16 at 10:20am revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, Staff D and she were in the kitchen preparing the lunch meal. - Staff D left out of the kitchen between 11:00am and 11:15am (They were preparing the meal and had not started serving lunch). Lunch was served at 12 noon each day. - Staff D did not inform her where he was going but returned to the kitchen in approximately 20 minutes. - When Staff D returned he was a little agitated and was grunting under his breath. - Staff D told her the Activity Director "messed up my nut", "I was with [Resident #9] and she busted in her room, she [Resident #9] was licking it". - The Dietary Manager stated she did not report this to the ED nor did she document this in her statement given to the Ed because she did not want to get anybody in trouble. - Resident #9 had been "after other male employees in the past". <p>Interview with a 1st shift personal care assistant (PCA) on 5/18/16 at 11:00am revealed:</p>	D 338		
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D 338	<p>Continued From page 61</p> <ul style="list-style-type: none"> - The PCA was near Resident #9's room and observed Staff D go in her room and close the door. - Staff D was in Resident #9's room about 5-10 minutes before the Activity Director opened the door and pushed the resident's roommate in the room. - Staff D did not know I was on the hall (I was in the room across from Resident #9's room, but the door was opened). - The PCA did not observe Staff D's pants zipper when he walked out of the room and did not know if his pants were unzipped. <p>Interview with a 3rd resident on 5/18/16 at 4:30pm revealed:</p> <ul style="list-style-type: none"> - Staff D smoked in the smoking area with the residents. - Staff D repeatedly told the women residents that he would give them this [penis] if they asked. - Staff D stated he and Resident #9 had "been together". - Resident #9 told everybody [residents] she "su**ed" Staff D [penis] a few weeks ago (last month). - Staff D will "go with anybody" ; he is a "sex maniac and you better be careful around him". - She did not report this to the ED or anyone else. <p>Interview with Resident #9 on 5/19/16 at 12:15pm revealed:</p> <ul style="list-style-type: none"> - A few weeks ago, Staff D came to her room and woke her up for lunch, but did not know what time it was. - Staff D was standing at the head of my bed when the Activity Director came into the room with roommate. - Staff D walked away from my bed and I asked him for a cigarette. - Resident #9 did not know if his pants zipper was 	D 338		

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D 338	<p>Continued From page 62</p> <p>unzipped.</p> <ul style="list-style-type: none"> - Staff D did not have any sexual relationships with any other residents and the resident did not know why he would tell anyone he had sex with her. - Staff D talked a "lot of sh** about people and if it made him feel better by saying he had oral sex with me, then oh well". - The ED asked me about the allegations and I wrote a statement and denied everything. <p>Staff D was not available for interview.</p> <p>2. Review of Resident #8's current FL2 dated 11/23/15 revealed:</p> <ul style="list-style-type: none"> -Diagnosis of seizure disorder with breakthrough seizure, mental retardation, metabolic acidosis, hyperammonemia, leukocytosis, unspecified psychotic disorder, developmental disorder. <p>According to the Resident Register, Resident #8 was admitted to the facility on 11/25/15.</p> <p>Record review of Resident #8's care plan dated 11/25/15 revealed no information was documented on the Mental Health and Social History section.</p> <p>Review of Resident #8's record revealed:</p> <ul style="list-style-type: none"> - Resident had been admitted to hospital on 11/09/15 due to agitation and a fight with another resident in a group home. Resident could not return to previous placement due to behaviors. - Resident #5 was admitted to facility on 11/25/15 following the hospitalization - On 12/03/15, resident was referred to psychotherapist for assessment by psychiatric providers. - No documentation in record about follow-up 	D 338		

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D 338	<p>Continued From page 63</p> <p>appointments or referrals to psychotherapy.</p> <ul style="list-style-type: none"> - On 3/24/16 Physician Notes - resident was described as agitated. - Multiple notes in medical record documenting refusal of medications and subsequent seizures. - On 4/11/16 documentation that resident physically attacked another resident because he changed the TV channel. He hit resident #7 in the face several times and was verbally and physically aggressive to staff who tried to stop the altercation. - On 4/11/16 resident was arrested by police for assault in the facility. - No discharge information was in the medical record. <p>Interview with Resident Care Coordinator (RCC) on 5/18/16 at 12:45 pm revealed:</p> <ul style="list-style-type: none"> - She had no knowledge of aggressive behaviors until the incident with Resident #7 - She was not aware of any staff concerns about his behaviors. - The resident refused medications for seizures a lot. - The resident came to meals, looked at the food, said it was not enough and walked away without eating. - The resident was having seizures frequently due to not being compliant with medication. - Staff checked on Resident #8 every 30 minutes to assure his safety and whereabouts. - She is uncertain where he was previously placed or the reason for discharge. - The policy on resident to resident aggression is that the staff tries to deescalate, then contact the executive director and possible Involuntary Commitment. - She had not read the history information in Resident #8's medical record. 	D 338		
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D 338	<p>Continued From page 64</p> <p>Interview with Executive Director (ED) on 5/18/16 at 1:30 pm revealed:</p> <ul style="list-style-type: none"> - The ED received information on his last placement after resident #5 was admitted to the facility. - She told staff to make sure he did not hit or fight anyone and to watch him. - ED described watch him as making sure he is not aggressive. - She never knew that he would become agitated, staff had not told her. - The resident saw the psychiatrist, but did not know if he received psychotherapy or if a referral was made. <p>Interview with Medication Aide on 5/17/16 at 12:45 pm revealed:</p> <ul style="list-style-type: none"> - The resident was an angry man, easily agitated. - He would stay to himself a lot and the escalate quickly - Physician was notified. - He often refused medications and the would have seizures. - She knows of at least 3 incidents including the incident with Resident #7, where the resident became aggressive with other residents. - All staff including the RCC were aware of him being aggressive and escalating quickly. - He was not in the room on the day of the incident with Resident #7, only heard that Resident #8 attacked him. <p>Interview with Personal Care Aide (PCA) on 5/17/16 at 10:30 am revealed:</p> <ul style="list-style-type: none"> - Resident #8 was always angry cursing and arguing with staff and other residents. - On the day of the incident with resident #7 he was irritable and had refused medications. - Staff attempted to keep him calm and reported it to RCC and doctor when this occurred. 	D 338		

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D 338	<p>Continued From page 65</p> <ul style="list-style-type: none"> - It was documented on an Accident/Incident Report. <p>Interview with the Activity Director on 5/17/16 at 1:15 pm revealed:</p> <ul style="list-style-type: none"> - The resident was usually quiet and stayed to himself, did not participate in activities often. - Other residents did not bother him much because he would argue and fight so much - She could recall at least 3 aggressive incidents with Resident #8. - The Resident thought the TV in the activity room was his own and would become angry when others watched it. <p>Interview on 5/17/16 at 11:00 am with Resident #7 revealed:</p> <ul style="list-style-type: none"> - Resident #8 was always yelling at people - The day of the incident he wanted to watch a different show on TV and Resident #8 got up and started hollering and hit him 3 times in the face and arm while resident #7 was in his wheelchair. - Resident #8 then tried to pick up TV and turn it over and staff came in. <p>Interview with Medication Aide (MA) on 5/18/16 at 10:30 am revealed:</p> <ul style="list-style-type: none"> -The resident was agitated more in the mornings for some reason. - Staff would know it was a bad day when he paced a lot and refused medications. - On his agitated days he would usually have more seizures. - She never saw resident #8 physically aggressive, just verbal with other residents. -Any aggressive behaviors were reported to RCC and ED. - She was in the building when the incident occurred with Resident #7, but did not see him hit, staff ran to the room and separated the two 	D 338		

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D 338	<p>Continued From page 66</p> <p>residents and diverted resident #8 and then called police.</p> <p>Interview with physician on 5/19/16 at 2:00 pm revealed:</p> <ul style="list-style-type: none"> - The resident did have behavior problems and staff made her aware of his behaviors multiple times. - The resident was paranoid, impulsive and easily agitated with a bad attitude. - The resident was also very non-compliant with medications which led to seizures and behaviors. - She did not do his admission screening. - The Executive Director did the admission screening. - She would not have allowed admission due to aggressive behaviors, but she was not asked about the admission. <hr/> <p>Review of the facility's Plan of Protection dated 5/17/16 revealed:</p> <ul style="list-style-type: none"> -Employee [Staff D] will be suspended immediately as of today, 5/17/16. -He will not work until investigation is completed and a 24 hour report will be sent to the NC HCPR. -The Administrator will contact the ombudsman and schedule classes for employees and residents on resident rights (exploitation). -The dietary staff will immediately stop leaving the kitchen during meal preparation and mealtime to confirm whether residents will eat meals. The medication aides and PCAs will be responsible for getting residents to their meals. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 19,</p>	D 338		

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D 338	Continued From page 67 2016.	D 338		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to assure medications were administered as ordered based on a 8% medication error rate during observation of the medication pass, 3 errors out of 25 (Resident #10's Lantus insulin administered instead of Novolog, Resident #11's Novolog insulin administered before a meal instead of with meal and Resident # 11's Geodon administered before a meal instead of with food). The findings are:</p> <p>The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 4pm medication pass on 05/10/2016, and the 11 am medication pass on 05/11/2016.</p> <p>1. Review of Resident #10's current FL-2 dated 03/28/16 revealed diagnoses included hyperglycemia and pneumonia.</p>	D 358		

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D 358	<p>Continued From page 68</p> <p>Review of a physician's order dated 4/28/16 revealed an order for Novolog insulin, 4 units with breakfast at 7:00am, lunch at 12:00pm and dinner at 4:30 pm. Hold if blood sugars are 120 and below.</p> <p>Review of another physician's order dated 5/10/16 revealed an order for Lantus insulin, 16 units, once a day, at bedtime.</p> <p>Observation of the medication pass on 5/11/16 at 11:12 am revealed:</p> <ul style="list-style-type: none"> - Handwritten instructions on the medication bottle label were "Lantus 16 units subcutaneous". - While preparing to draw up the insulin, the MA stated the physician had changed the Lantus insulin orders from 16 units to 4 units. -The medication aide (MA) drew up 4 units of Lantus insulin in an insulin syringe and administered the insulin in the resident's left upper arm. <p>Review of Resident #10's Medication Administration Records (MARs) for May 2016 revealed:</p> <ul style="list-style-type: none"> - Handwritten on the MAR was Novolog, inject 4 units with breakfast, lunch and dinner (scheduled for 7:00am, 12:00pm and 4:30pm). - The MA initialed the MAR, at 12:00pm on 5/11/16 that Novolog insulin, 4 units, was administered in left arm. <p>Interview with the medication aide (MA) on 5/11/16 at 12:00 pm revealed:</p> <ul style="list-style-type: none"> - Resident #10's Novolog insulin order was changed about 2 weeks ago to 4 units at breakfast, lunch and supper. - When asked the MA to provide insulin administered today at lunch, the MA provided 	D 358		

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D 358	<p>Continued From page 69</p> <p>Lantus insulin.</p> <p>Interview with the Resident Care Coordinator and MA on 5/11/16 at 2:30pm revealed:</p> <ul style="list-style-type: none"> - The MA stated "I may have given you the Lantus insulin when you ask to see it (the 2nd time at 12:00pm) but I thought I had administered the Novolog insulin to Resident #10. I will call the resident's physician and report the medication error". - The RCC stated she will complete a medication error report today. <p>The resident's BS was checked by the MA and was 169 at 2:40 pm.</p> <p>Interview with the Executive Director (ED) on 5/11/16 at 2:45pm revealed:</p> <ul style="list-style-type: none"> - The MA should have confirmed the right medication by checking the instructions on the label with the MAR. - The MA was probably nervous because she was being observed during the medication pass. <p>Interview with Resident #10's primary physician on 05/19/16 at 3:00pm revealed:</p> <ul style="list-style-type: none"> - Lantus insulin was a slow acting, basal insulin and Resident #10 only received 4 units at mealtime. - The resident's BS could have risen and the resident would have has symptoms of hyperglycemia. - If the Novolog insulin was administered as an error at bedtime, the resident's BS could have dropped (hypoglycemia) while the resident was asleep. <p>2. Review of Resident #11 current FL-2 dated 7/16/15 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included diabetes mellitus and vascular dementia. 	D 358		

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D 358	<p>Continued From page 70</p> <ul style="list-style-type: none"> - An order for Ziprasidone (Geodon) 20mg, 1 tablet, by mouth 2 times a day with food (used to treat schizophrenia and mood swings). <p>Review of an order dated 10/26/15 revealed Novolog insulin Flexpen, inject 4 units, subcutaneous, with breakfast, lunch and dinner.</p> <p>Observation of medication pass on 5/10/16 revealed:</p> <ul style="list-style-type: none"> - At 3:55pm, the MA administered 4 units of Novolog insulin (Flexpen) in the resident's right upper arm. - At 4:03 pm, the MA administered Geodon, 20mg with a sip of water. <p>Interview with the 2nd shift MA on 5/10/16 at 4:35 pm revealed:</p> <ul style="list-style-type: none"> - Resident #11 ate supper at 4:30pm. - According to the orders, and instruction on the MAR, the resident should have received both medications with food. - The resident had not complained of stomach upset. <p>Interview with the RCC on 5/11/16 at 11:15 am revealed the MA's should always read the entire order/instruction on the residents' MARs and follow the directions.</p> <p>Interview with the resident's physician on 5/19/16 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - Geodon was ordered to be administered with food to prevent stomach upset and prevent other side effects. - Novolog insulin administered with food decreased chances of hypoglycemia. <p>Review of the facility's Plan of Protection dated</p>	D 358		

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D 358	Continued From page 71 6/02/16 revealed: - The Resident Care Coordinator (RCC) would conduct medication pass observations once weekly. - The RCC will check and monitor daily to ensure insulin was administered correctly . - Medication Aides will be trained by a pharmacist on proper way to read and administer insulin and medications to ensure proper administration. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 04, 2016.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication	D 367		

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D 367	<p>Continued From page 72</p> <p>administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure accurate documentation of omission of medications or treatments and the reason for the omission, including refusals of 1 of 5 sampled residents. (#5). The findings are:</p> <p>Review of Resident #5's current FL2 dated 1/19/16 revealed: -Diagnosis include hypercholesterolemia, neuropathic pain, Osteo Arthritis-neck and back, dementia behavioral disturbance, hyperlipidemia, Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, Schizoaffective disorder, Arthritis degenerative. -Prescription for Temazepam Cap 15mg to be given 1 tab at bedtime. -Prescription for Tramadol HCL TAB 50mg to be given 1 tab everyday.</p> <p>Review of a physician's order dated 4/13/16 revealed an order to discontinue Temazepam after current meds are completed.</p> <p>Review of Resident #5's Medication Administration Record (MAR) for May 2016 revealed: -Temazepam Cap 15mg to be given 1 tab at bedtime. -Prescription for Tramadol HCL TAB 50mg to be given 1 tab everyday. -Residents MAR was initialed indicating that both medications had been administered on 5/01/16, 5/02/16 and 5/03/16.</p> <p>Review of Resident #5's medications on hand on 5/3/16 at 2:30 pm revealed: -Neither of these medications were in the facility</p>	D 367		

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NAME OF PROVIDER OR SUPPLIER AUTUMN WIND ASSISTED LIVING OF LOUISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 361 LEONARD ROAD LOUISBURG, NC 27549
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D 367	<p>Continued From page 73</p> <p>at the time of the documented administrations during May 2016.</p> <p>Interview with Medication Aide (MA) on 5/3/16 at 2:35 pm revealed: -The MAR indicated that the medication had been administered the Tramadol at 8 am the Temazepam at the and 8 pm. -The MA could not locate any of the medication on the medication cart or the building.</p> <p>Interview with the Resident Care Coordinator (RCC) on 5/3/16 at 2:50 pm revealed: -The MAR indicated that the medications were administered at the 8 am and the 8 pm -The RCC could not locate any of the two medications on the medication cart or in the building. -If medication was not on the cart, it was the expectation of the RCC that the MA would document on the back of MAR and notify the RCC and the pharmacy. -The MAR did not have documentation of the medication not being received. -The RCC had not been notified of the medication issue. -The pharmacy had not been notified of the medication issue</p> <p>Interview with Resident #5 on 5/3/16 at 12:30 pm revealed: -She is uncertain if she received the morning medication for pain. -She was told by night MA that they were out of her sleeping pills. -She had not received her pm medication, Temazepam, because she had not been sleeping well.</p>	D 367		

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D 438 D 438	<p>Continued From page 74</p> <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 record reviews and interviews, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and 0102 following reporting requirements for suspected resident exploitation related to suspected sexual abuse of resident by staff member to Health Care Personnel Registry (HCPR) in 24 hours. The findings are:</p> <p>Interview with the facility's Executive Director (ED) on 5/17/16 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, the Activity Director reported she observed Staff D in Resident #9's room near her bed with his pants unzipped and his underwear was visible when she walked in the room with her roommate. - The ED talked to Resident #9, Staff D, the Activity Director and The Dietary Manager. - Staff D denied his pants were unzipped and stated he was telling the resident to come to eat (she was unsure of the time). - She obtained written statements from the resident, Staff D, the Activity Director and the Dietary Manager. - She and the Resident Care Manager (RCC) 	D 438 D 438		

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D 438	<p>Continued From page 75</p> <p>talked to the resident and she denied any sexual contact with Staff D.</p> <ul style="list-style-type: none"> - Staff D was never suspended and the alleged incident was not reported to the NC Health Care Personnel Registry (HCPR) because Staff D and the resident denied the allegation. - There were no further investigation of the allegations. - The Administrator stated she will complete a 24 hour report and fax to HCPR today and Staff D will be suspended effective immediately. - Staff D was not scheduled to work today. <p>Review of the Activity Director's written statement dated 4/11/16 revealed:</p> <ul style="list-style-type: none"> - On April 8, 2016, I was rolling a resident into her room where she stay when I rolled her in the room, I witnessed [Staff D] in the room and the other resident was in the bed. - I didn't see anything going on, his [Staff D] pants were unzipped and I saw his boxers, but everything seem in place. - He said he was telling her it was time to eat and was giving her a cigarette. Then he left out when I came out and he went back towards the kitchen. <p>Review of the Dietary Manager's written statement dated 4/11/2016 revealed:</p> <ul style="list-style-type: none"> - I, [Dietary Manager] was in the kitchen on April 8, 2016. - I didn't witness anything. <p>Review of Resident #9's written statement dated 4/12/16 revealed:</p> <ul style="list-style-type: none"> - I was sleeping when [Staff D] came into the room to wake me up for lunch. - When the door opened with [the Activity Director] pushing [roommate] into the room, he moved toward the door so [the Activity Director] could come around to the other side of the bed. 	D 438		
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D 438	<p>Continued From page 76</p> <ul style="list-style-type: none"> - Before he left, I asked for a [cigarette] and then I told him that I probably wouldn't be coming to lunch. <p>Review of Staff D's written statement dated 4/22/16 revealed:</p> <ul style="list-style-type: none"> - To whom it may concern: Allegations were made against me in an unprofessional and sexual nature. - All fabricated by coworker with too much time on their hands and no business of their own. - My superior [Administrator] questioned me on these matters in detail: 1) Am I having sexual relationship with one of the residents? 2) Am I supplying alcoholic beverages to a resident? - I told her the truth which is no I am not. - For the record, this whole mess is foolishness. If people did their work, they wouldn't have time for gossip for sure. <p>Interview with a resident on 5/17/16 at 4:07 pm revealed other residents and staff talked about Resident #9 gave Staff D a bl** job about a month ago.</p> <p>Interview with the facility's Activity Director on 5/18/16 at 9:50 am revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, before lunch, she was assisting Resident #9's roommate back to her room (in her wheelchair). - The room door was closed completely, and when she opened the door to push the roommate into her room, observed Staff D standing near the head of Resident #9's bed (facing the bed). - Resident #9 was lying in her bed awake. - When Staff D turned away from the bed, she observed his pants unzipped with his underwear showing. - Resident #9's roommate stated "boy what are you doing in my room, if you are not here leaving 	D 438		

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D 438	<p>Continued From page 77</p> <p>me a cigarette, get out".</p> <ul style="list-style-type: none"> - Staff D left the room and did not explain why he was in the resident's room with the door closed but stated he was telling the resident to come to eat lunch and gave her a cigarette. - Two other staff members were on the hall when this incident occurred. - The Activity director reported the incident to the Administrator immediately. - Staff D continued to work at the facility as a cook, he was not suspended. <p>Interview with a facility housekeeper on 5/18/16 at 10:05 am revealed:</p> <ul style="list-style-type: none"> - He heard last month Staff D was caught having oral sex with Resident #9. - The Activity Director walked in on them and Staff D's pants were unzipped and his underwear was showing. - Staff D went back to the kitchen and told the Dietary Manager the Activity Director messed up his pleasure. - The Executive Director never asked him any questions about the allegations. <p>Interview with the Dietary Manager on 5/18/16 at 10:20 am revealed:</p> <ul style="list-style-type: none"> - On 4/08/16, Staff D and she were in the kitchen preparing the lunch meal. - Staff D left out of the kitchen between 11:00am and 11:15am (They were preparing the meal and had not started serving lunch). Lunch was served at 12 noon each day. - Staff D did not inform her where he was going but returned to the kitchen in approximately 20 minutes. - When Staff D returned he was a little agitated and was grunting under his breath. - Staff D told her the Activity Director "messed up 	D 438		
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D 438	<p>Continued From page 78</p> <p>my nut", I was with [Resident #9] and she busted in her room, she [Resident #9] was licking it".</p> <ul style="list-style-type: none"> - The Dietary Manager stated she did not report this to the Administrator nor did she document this in her statement given to the Administrator because she did not want to get anybody in trouble. - Staff D continued to work as a cook at the facility and was not suspended after the allegations. <p>Interview with another resident on 5/18/16 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> - Staff D smoked in the smoking area with the residents. - Staff D repeatedly told the women residents that he would give them this [penis] if they asked. - Staff D stated he and Resident #9 had "been together". - Resident #9 told everybody [residents] she "su**ed Staff D [penis] a few weeks ago (last month). - Staff D will "go with anybody"; he is a "sex maniac and you better be careful around him". - The Administrator never asked the resident any questions about the allegations. <hr/> <p>Review of the facility's Plan of Protection dated 5/25/16 revealed:</p> <ul style="list-style-type: none"> - The Executive Director (ED) will immediately suspend the employee. - The 24 hour report and investigation forms will be completed and faxed immediately. - A policy and procedure will be completed. - Any allegation of abuse neglect or exploitation will be reported to the Executive Director and Administrator immediately. 	D 438		

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D 438	Continued From page 79 - All employees will be trained on reporting any incidents like these. - The Resident Care Director will follow-up after the Administrator/ED to make sure all allegations are reported to the Health Care Personnel Registry as required. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 04, 2016.	D 438		
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 interview and record review, the facility failed to assure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision and medication administration. The findings are: 1. Based on interview and record review, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for one of six sampled residents (#6) related to behaviors leading to hospitalization. [Refer to Tag D0270 10A NCAC 13F.0901 (b) (Type A2 Violation).]	D912		

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AUTUMN WIND ASSISTED LIVING OF LOUISBURG **361 LEONARD ROAD**
LOUISBURG, NC 27549

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D912	Continued From page 80 2. Based on observations, interview and record review, the facility failed to assure medications were administered as ordered based on a 8% medication error rate during observation of the medication pass, 3 errors out of 25 (Resident #10's Lantus insulin administered instead of Novolog, Resident #11's Novolog insulin administered before a meal instead of with meal and Resident # 11's Geodon administered before a meal instead of with food. [Refer to Tag D0367 10A NCAC 13F.1004 (a) (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents were free of abuse and exploitation as related to physical abuse and sexual exploitation. The findings are: 1. Based on record review and interview, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 130 .0101 and .0102 following reporting requirements for suspected resident exploitation related to suspected sexual abuse of resident by staff member to Health Care Personnel Registry (HCPR) in 24 hours. [Refer to Tag D0438 10A NCAC 13F.1205 (Type B Violation)] 2. Based on observations, interviews and record	D914		

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D914	Continued From page 81 reviews, the facility failed to assure 2 of 5 sampled residents were free from resident to resident abuse Resident #7 from another resident (# 8) who had a history of aggressive behaviors and sexual exploitation by one staff (Staff D) of Resident #9. [Refer to Tag D338 10A NCAC 13F.0909 (Type A2 Violation)]	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes	D935		

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D935	<p>Continued From page 82</p> <p>training and instruction in all of the following:</p> <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 1 out of 3 sampled staff (Staff A) had medication clinical skills and licensed health professional skills validation prior to administration of medications.</p> <p>The findings are:</p> <p>Review of Staff A's personnel file revealed:</p> <ul style="list-style-type: none"> -A hire date of 3/8/16 as Medication Aide. -Successful completion of the written medication exam dated 3/4/10. -Medication Aide employment verification dated 3/2/16. -There was no documentation that the Medication Aide had been clinical skills validated. <p>Interview with Staff A on 5/19/16 at 10:50 am revealed:</p> <ul style="list-style-type: none"> -She began working at the facility in March of 2016. -She works 5 days a week as a Medication Aide -She was trained by another Medication Aide prior 	D935		
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D935	<p>Continued From page 83</p> <p>to working independently on the medication cart. -Her skills had not been validated.</p> <p>Interview with the Resident Care Coordinator (RCC) on 5/19/16 at 11:50 am revealed: -Medication Aides are supposed to be checked off by the pharmacy resident nurse. -Medication Aides are checked off in the first 30 days of hire but we try to get staff checked off prior to working independently on the medication cart. -A new hire works with another Medication Aide for one week to get to know the residents. -I thought Staff A had been competency validated.</p> <p>Interview with the Executive Director on 5/19/16 at 11:00 am revealed: -Staff A was a new hire in March and worked with another Medication Aide for about one week then worked independently. -Staff A had not been skills validated by the Registered Nurse. -When the Registered Nurse came the first time to validate Staff A, she was not working, so we had to wait for the RN to come back. -The Resident Care Coordinator (RCC) is responsible for making sure staff are validated prior to medication administration assignments. -The Medication Aide will be removed from duties until she is competency validated by the Registered Nurse. - " I should have checked behind the RCC to assure the validation was completed".</p>	D935		
D980	<p>G.S. § 131D-25 Implementation</p> <p>G.S. 131D-25 Implementation</p> <p>Responsibility for implementing the provisions of</p>	D980		

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D980	<p>Continued From page 84</p> <p>this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to personal care and supervision, medication administration, resident rights, Health Care Personnel Registry investigation and reporting. The findings are:</p> <p>Interview on 5/12/16 9:15am with the Executive Director (ED) revealed:</p> <ul style="list-style-type: none"> - She was not a Certified Administrator. - She was using the title of ED and managing the day to day workings of the facility. - The ED was working on taking the admin test - She had experience with the Administrator's other facility for some time and had been at this facility since August of 2015. - The Administrator was aware of what was happening during the survey thru telephone calls. - The Administrator was kept apprised of the running of the the facility on a routine basis. - The Administrator had visited the facility during the survey. <p>Facility noncompliance identified during the survey included:</p> <ol style="list-style-type: none"> 1. Based on interview and record review, the facility failed to assure supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms for one of six sampled residents (#6) related to behaviors leading to hospitalization. [Refer to Tag D0270 	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL035022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 05/20/2016
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NAME OF PROVIDER OR SUPPLIER AUTUMN WIND ASSISTED LIVING OF LOUISBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 361 LEONARD ROAD LOUISBURG, NC 27549
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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
D980	<p>Continued From page 85</p> <p>10A NCAC 13F.0901 (b) Personal Care & Supervision (Type A2 Violation).]</p> <p>2. Based on observations, interviews and record reviews, the facility failed to assure 2 of 5 sampled residents were free from resident to resident abuse Resident #7 from another resident (#8) who had a history of aggressive behaviors and sexual exploitation by one staff (Staff D) of Resident #9. [Refer to Tag D0338 10A NCAC 13F.0909 Resident Rights (Type A2 Violation).]</p> <p>3. Based on observations, interview and record review, the facility failed to assure medications were administered as ordered based on a 8% medication error rate during observation of the medication pass, 3 errors out of 25 (Resident #10's Lantus insulin administered instead of Novolog, Resident #11's Novolog insulin administered before a meal instead of with meal and Resident #11's Geodon administered before a meal instead of with food. [Refer to Tag D0358 10A NCAC 13F.1004 (a) (Medication Administration (Type B Violation).]</p> <p>4. Based on record review and interview, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 130 .0101 and 0102 following reporting requirements for suspected resident exploitation related to suspected sexual abuse of resident by staff member to Health Care Personnel Registry (HCPR) in 24 hours. [Refer to Tag D0438 10A NCAC 13F.1205 Health Care Registry Reporting (Type B Violation).]</p>	D980		