Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	FCL032105		C 06/14/2016

NAME OF PROVIDER OR SUPPLIER
NUCARE FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
713 EVA STREET
DURHAM, NC 27701

(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
C 000	Initial Comments The Adult Care Licensure Section and Durham County Department of Social Services conducted a complaint investigation on 5/27/16 - 6/14/16 with an exit conference via telephone on 6/14/16. The complaint investigation was initiated by Durham County Department of Social Services on 5/20/16.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure walls and the ceiling in the bathroom, and a resident room wall and floor coverings were kept clean and in good repair in the living room, hallway and storage area entrance. The findings are: Observation during tour of the facility living room on 5/27/16 at 10:30 am revealed: - The living room gray carpet had multiple dark, gray black stains. - There were shallow and deep burn marks from 2 inches long at the entrance to the living room and in front of the couch and inch to 3-4 inches in length. - There was a narrow 12 inch slit in the carpet in front of the television where a string of carpeting had come lose. - There was a narrow 6 inch slit in front of the	C 074		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C 074	Continued From page 1 sofa where a string of carpet had pull up and was curled around and was still attached the the carpet. - The pathway to the hall and in front of the television had carpet with a had wrinkled areas with stains at the threshold area to the kitchen. - The light brown carpeting in the hallway had multiple brown stains all along the hall. Observation on 5/27/16 at 10:35 am of the threshold between the kitchen and a storage room revealed: - The threshold had carpet threads missing and some sticking up - The carpet weave had become undone for three fourths of an inch wide all across the threshold. On 5/27/16 at 10:51 pm, observations of Resident #2's room revealed: - Carpet was stained with black marks and streaks. - Small bits of debris could be seen on the floor. - The wall had a gouged out hole with a scraped area without paint. - The gouged hole was deep with the inner wall board exposed. Interview on 5/27/16 at 10:40 am with the Supervisor-In-Charge (SIC) revealed: - There were previous residents who smoked in the house months ago and they caused the burn marks in the carpet. - Residents were not to smoke in the facility, but were to use the smoking area outside. - The Administrator knew about it and the carpet was due to be replaced. - The SIC cleaned the facility daily and as necessary.	C 074		

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C 074	Continued From page 2 Observation on 5/27/16 at 11:45 am revealed: - The residents' bathroom had walls along the top above the tub with areas of peeled and missing paint. - Down the side wall of the shower/tub next to the commode that had areas where the wall had no paint. - The area where the tub and the back wall met had missing caulking from the side of the tub around the back wall and to the soap ledge. - In the space space between the tub wall and the tub there was a build up of a black substance. - The wall next to the towel rack and the tub and hand grip had areas of paint missing. - The wall behind the tub on the side had black stains near the floor and a small pipe sticking disconnected out from the wall. - Where the corner of this wall and the wall behind the commode next to the tub came together had brown/black stains near the floor and paint peeling from the wall. - The wall near the bathroom door had areas of missing paint about three feet in length. - The bottom of the door frame molding had a black substance build up in the grooves of the molding. - The plastic bathroom floor vent was broken in half. - The broken piece of the grate had broken sharp edges and was tilted partially into the vent pipe. - The ceiling air exhaust fan and light fixture was yellowed and covered with a thick layer of dust in the vent grate on either side of the light cover. When questioned about the condition and plan for the carpeting, interview on 5/27/16 at 7:16 pm with the Administrator revealed: - He knew residents had burned holes in the carpeting. - The SIC had informed him of residents having	C 074		

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C 074	Continued From page 3 smoked in the facility in the past. - He knew the carpeting in the facility had stains. - No information related to a plan for the carpeting was provided when questioned.	C 074		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was clean, orderly, uncluttered and free of all obstructions and hazards in the living room, hallway, and in two resident rooms. The findings are: Observation during tour of the facility living room on 5/27/16 at 10:30 am revealed: - The large television set in the living room had a build-up of dust on the front speaker cloth, on the button controls, and drink smears and drip marks on the screen. - Under a desk shelf area with the printer was a dusty table with some of the the stain on the top missing and marks on the wood. - The handle to the drawer of the table had one side of the handle disconnected and hanging down. - A dirty rolling desk chair had stains on the chair seat.	C 078		

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C 078	Continued From page 4 - There were several open plastic bags with toiletries and with other miscellaneous items on the floor next to a large resident chair. Observation on 5/27/16 at 10:45 am of Resident #1's bedroom revealed: - Resident #1's bedroom had no closet door attached to the closet. - The door was leaning against the wall next to the closet. - Baseboards were covered with dust. On 5/27/16 at 10:51 am, observations in the room of Resident #2 revealed: - Closet door was off the track, doors were stacked against the wall. - The nightstand for Resident #2, had black marks, grime and dirt over nearly half of the nightstand. Observation on 5/25/16 at 11:50 am of the facility's hallway to bedrooms and the bathroom revealed: - Cleaning materials such as a mop and broom were leaning up against the wall near the bed frame. - A small shelf was sitting in the hallway against the wall and it had canned food on a shelf. - The hallway was cluttered with a mattress/boxspring leaning against the wall with the fabric side to the wall and wooden frame toward the hallway easily able to injure residents because of the close proximity. - The mattress boxspring was tilted at an angle and was sticking out at least a foot into the hallway. - Upon entering the hallway, the SIC was observed to hurry over to shut the door to her quarters. - The door frame had a piece of lit and smoking	C 078		

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C 078	Continued From page 5 incense with the wood end sticking in a hole in the door frame about 4 feet above the floor carpeting. No burn holes were observed on the carpet. - A hot ash had begun to form. - There was no container to catch the hot ash from the incense. - Incense smoke was drifting up towards the ceiling where a smoke detector had not reacted to the smoke. Interview on 5/27/16 at 11:48 am with the SIC revealed: - Some of the things in the hallway, like the bed was there because a resident left a short while ago and it was removed from the room. - No information was provided when questioned about how long it was there in the hallway nor when it would be removed. - The bedroom of Resident #1 was being cleaned since the bed had been removed. Interview on 5/27/16 at 11:52 am with the SIC revealed: - She had lit the incense for her personal religious reasons. - She did not agree when asked to extinguish the incense because of the possible hazard of causing a fire in the building. - When asked about the smoke detector in the hallway with the incense smoke rising up to it that was not alarming she said the one in the living room worked. - She said the smoke detector in the living room worked. - No information was provided related to why the hallway smoke alarm was not working. Observation on 5/27/16 at 11:52 am revealed: - The SIC quickly went into the living room and	C 078		

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C 078	Continued From page 6 made the smoke alarm sound. - The burning incense was not removed from the door frame. Interview on 5/27/16 at 6:20 pm with the Administrator revealed: - He knew residents had burned holes in the rug. - The SIC had informed him of residents having smoked in the facility in the past. - He was not aware incense was being burned in the facility. Telephone interview on 6/7/16 at 12:58 pm with the state construction section revealed: - The burning incense with the ashes ready to drop on to the carpet at the SICs quarters was a definite concern. - The incense was lit with an open flame (a match of lighter) was burning had a hot ash. - The incense was not being used in the manner of typical use and did not have an approved and safe holder to catch the ash. - Hot ash could have fallen on the carpet and ignited a fire and/or a smoldering melting of the carpet which may have eventually started to burn.	C 078		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator	C 185		

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C 185	Continued From page 7 for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to notify the department of allegations of abuse, assure residents were free of mental and physical abuse and residents were not left alone at anytime without a staff member in accordance to rules and regulations. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure residents had the right to be free of mental and physical abuse including hitting, abusive and demeaning language, punishments including confinement and threatening language leaving residents with fear of retaliation for 1 of 2 residents. (Resident #1).[Refer to Tag C 311. 10A NCAC 13G .0909 (Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to protect residents by not investigating allegations of abuse or reporting within 24 hours after becoming aware of allegations of abuse to the Health Care Personnel Registry (HCPR) for the Supervisor-In-Charge (SIC) and by not completing and forwarding an investigation report within 5 days of the initial notification to HCPR.[Refer to Tag C 428 10A	C 185		

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C 185	Continued From page 8 NCAC 13G .1205 (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure each resident was free of mental and physical abuse related to hitting, staff use of abusive and demeaning language, punishments including confinement, threatening behaviors and causing fear of retaliation; and neglect by not reporting to the Health Care Personnel Registry and failing to suspend staff who was accused of abusing the residents.[Refer to Tag C 914 G.S. 131D-21(4)] 4. Based on observations, interviews and record reviews, the facility failed to assure two facility residents (#1 and #2) were not left alone at any time with out a staff member.[Refer to Tag D242, 10A NCAC 13G .601(b1)]	C 185		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in	C 186		

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C 186	Continued From page 9 the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home; This Rule is not met as evidenced by: Based on observations, interviews the facility failed to assure residents were not left alone. The findings are: Based on observations, interviews and record reviews, the facility failed to assure two facility residents (#1 and #2) were not left alone at any time without a staff member [Refer to Tag C 242, 10A NCAC 13G 901(b)]	C 186		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure two facility residents (#1 and #2) were not left alone at anytime without a staff member. The findings are:	C 242		

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C 242	Continued From page 10 Observation on 5/20/16 at 5:00 pm, revealed: - Resident #2 was on the back porch. - A young male answered the door of the facility. - The young male reported the Supervisor-In-Charge (SIC) was "down the street." - The young male reported the SIC would be back in minute. - Within 5-6 minutes, the SIC returned. - Resident #2 was observed in the kitchen sweeping the floor. Interview on 5/20/16 at 5:06 pm with the SIC revealed: - The SIC reported she had been assisting a neighbor with their cable television. - The SIC reported the young male was her nephew. - She reported that her nephew was watching the residents while she was away. - She indicated that her nephew does not work for the facility. - There was no personnel file for her nephew. Review of Resident #1's current FL2 dated 9/14/15 revealed: - Diagnoses of Schizophrenia, Mental Retardation - Acute Encephalopathy, Gastro-Esophageal Reflux Disease and Constipation. - Resident #2 was ambulatory. - The resident was verbally abusive. - The orientation level was left blank. Review of the facility resident notes and staff shift notes for Resident #1 revealed: - There were no notes or reports of behavioral problems or incidents since admission. - There were no notes of altercations between	C 242		

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C 242	Continued From page 11 the resident and staff or other residents since admission. Review of Resident #2's current FL2 dated 3/24/16 revealed: - Diagnoses of Schizoaffective Disorder. - The disoriented level was left blank. - Resident #2 was ambulatory. Review of Resident #2's record revealed: - Resident #2 had been adjudicated incompetent. - There were no notes or entries of behavioral problems or altercations between the resident and staff or other residents in facility resident notes and staff shift notes. - There were no notes or entries in facility resident notes or staff shift notes about the the resident having been found smoking in the facility. On 5/27/16 at 10:11 am, interview with the SIC, revealed Resident #2 had been caught repeatedly smoking in the resident's room. Interview on 5/23/16 at 5:37 pm, with the Administrator revealed: - He had reviewed the closed circuit video of the facility's security cameras on 5/20/16 and had seen the SIC leaving. (No time was given.) - The SIC left prior to the arrival of the surveyors. - The SIC was only gone from the facility for 3 minutes. - He indicated the SIC was assisting an elderly couple who were experiencing trouble with the cable connection. - He thought the rules allowed for staff to be away up to 3 minutes. - The SIC was less than 500 feet away from the home. - The SIC should not have left the residents	C 242		

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C 242	Continued From page 12 alone.	C 242		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure residents had the right to be free of mental and physical abuse including hitting, abusive and demeaning language, punishments including confinement and threatening language leaving residents with fear of retaliation for 1 of 2 residents. (Resident #1). The findings are: Review of the current FL-2 dated 9/14/15 for Resident #1 revealed: - Diagnoses included schizophrenia, mild mental retardation, acute encephalopathy, and gastro-esophageal reflux disorder. - Admission date was 6/10/14. - Resident was verbally abusive. - Orientation level was left blank. Review of Resident #1's facility notes and staff shift notes revealed: - There were no entries of behavioral problems. - There were no entries of altercations between the resident and staff or other residents.	C 311		

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C 311	Continued From page 13 Interview on 5/27/16 at 9:45 am with the Supervisor-In-Charge (SIC) revealed: - She was the SIC and was the only staff person to care for residents. - There were no relief staff as she lived-in and was the sole staff person. - The SIC's duties were to pass resident medications, cook, clean, laundry, transport residents to appointments, activities and ensuring residents were dressed and groomed. - Current residents got along pretty well. - There was a previous resident who acted out and was violent and that resident went to the hospital. Interview on 5/27/16 at 12:45 pm with a staff member at a local resident day program revealed: - Resident #1 had been coming to the program for some time. - The resident was a loving, caring person with very good adjustment at the program. - She had made friends and close relationships without any aggression to anyone in the program. - The resident enjoyed the program and loved to see her friends here. - On several days, the two residents from the facility had to walk to the program in the cold because there was no transportation. - There had been times when the resident expressed to her and other staff in the program that the supervisor at the home had mistreated her. - The SIC spoke "nasty" was "short and cussed at the residents" (#1 and #2). - The SIC was generally disrespectful to staff and residents when she would drop them off and pick them up. - On one occasion, the SIC came to pick the residents up and she spoke "nasty" to them to get in the car.	C 311		

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DURHAM, NC 27701

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C 311	Continued From page 14 - The residents were observed to not be settled in their seats and had not put on seat belts when the SIC took off with the car. - Staff at the program were very concerned about comments made by Resident #1 and previous residents from the facility in regards to terrible treatment of residents by the SIC. - Resident #1 and previous residents at the facility told staff at the day program they were afraid of the SIC. On 5/27/16 at 12:47 pm, interview with Resident #2 at the day program revealed: - Everyone treats us good. - The SIC treats us good - The resident had never seen the SIC yell, curse, or hit anyone. - The resident had never seen the SIC have a problem, altercation or fight with Resident #1 or a previous resident. On 5/27/16 at 1:07 pm, observations at the local day program revealed: - Resident #1 was walking in the hall with staff from the day program and upon seeing the surveyors, Resident #1 became very upset, to the point of tears. - Resident #1 was heard saying, "I was told not to talk to the (county monitor) or the (state monitor)." - Resident #1 was heard saying, "My caretaker told me if I talk to him (the county monitor) or anyone that I would be thrown out!". - Staff from the day program took Resident #1 to another room in an effort to calm the resident. - At 1:27 pm, Resident #1 wanted to speak to the surveyors. On 5/27/16 at 1:12 pm, interview with a staff person at the local day program, revealed:	C 311		

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C 311	Continued From page 15 - The SIC is "awful" and had a "nasty attitude and called a staff person at the day program a b****." - The residents are "terrified" of her, fearful of being yelled at and/or punished. - Resident #1 and previous residents have reported being afraid of her. - Residents #1 and a previous resident had reported being left in a car alone for more than an hour while the SIC conducted personal errands. - The day program staff reported a few times last year the SIC was called to pick up the residents because the day program would be closing, and the SIC told the staff the residents would be fine to walk home. - Resident #1 reported to the day program staff that the SIC had kept the residents away from the day program as a form of punishment (no dates indicated). Interview on 5/27/16 at 1:27 p.m. with Resident #1 revealed: - Resident #1 "did not feel safe" at the facility. - The SIC was "mean, yells at me, gets in my face, tells me to shut up, and calls me dumb". - The SIC "will get me now that I have told" what she did to me. - The SIC "threw a cup" at Resident #1 in anger. - The SIC hit Resident #1 "in the back" with a closed fist in January-2016. - Resident #1 saw the SIC hit a previous resident in the arm with a closed fist. - On separate occasions in October-2015, November-2015 and January-2016, the SIC confined Resident #1 to the resident's room to punish the resident. - The resident was not allowed to leave the resident's room except to use the bathroom and for meals. - Resident #2 and a previous resident had been	C 311		

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C 311	Continued From page 16 similarly punished in this manner. - The SIC confined the resident to the resident's room for 2-3 days at a time. - The SIC often took residents with her while she ran personal errands, leaving the residents in the car alone for as long as an hour on several occasions with the last time being about 2 weeks ago. A second interview on 5/27/16 at 2:25 pm with Resident #1 revealed: - The SIC would not let residents go out to the front yard because they would be seen by the neighbors and they would know it was a "group home." - The resident could not go out in the yard when she wanted, such as around 8 a.m., so she could enjoy the morning. Residents could go out only when they asked the SIC if they could go outside. - Sometimes the resident would be confined in her room by the SIC for a couple days if she walked out of the neighborhood. - The SIC had done this several times to her in the last three months. - The SIC had locked her in her room because she did not tell the truth about going outside or using too much milk without asking. - Last year, around 12/12/15 - 12/14/15, she was kept in her room. - Sometimes the SIC "locked" her in her room and other times she just made her stay in her room. - Most of the time, she was made to stay or locked in her room for two to three days. - She could only come out to go to the bathroom or eat something. - "It made me feel like a kid. I am 52 years old!" - The resident did not like it and was very unhappy when the SIC made her stay in her room for days as a punishment	C 311		

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C 311	Continued From page 17 - This happened very frequently. - "Some days it just makes you cry." - One time last summer, the resident had used a red cup she bought for herself to get milk for cereal. - She was told she could not have "extra" milk without asking. - The SIC said the resident did not tell the truth when asked by the SIC if she got "extra" milk. - She should have told the truth. "I should have said I got extra milk without asking." "It was my fault." - The SIC said the red cup was not the resident's and then she took it and slammed it on the table and cracked it. - She threw the resident's red cup away. - The resident said it made her so upset and mad that she cried most of the day. - The SIC would yell, curse, tell her to shut up, threaten to send her to the hospital and would yell whatever she wanted to say. - The things she said were not good and were hurtful all over extra milk without asking. - Sometimes the SIC would make her feel bad when Resident #1 would say things about a guy in the store she was watching. - The SIC said, "Stop watching him, he would not want you anyway." Telephone interview with a staff person from the day program on 5/27/16 at 4:20 p.m. revealed: - Resident #1 would not go with the person sent to pick the residents up from the program. - Resident #1 was very upset and was lying on the floor crying about how she did not want to go with this transport person since the person was dating the SIC. - Resident refused to get in the car with the transport person to go back to the facility.	C 311		

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C 311	Continued From page 18 A third interview on 5/27/16 at 4:45 pm with Resident #1 revealed: - She was very happy and relieved another facility had been found for her to go to live. - She was still very concerned she would have to go back to the facility with the SIC. - Resident #1 was concerned and anxious that the SIC would throw her belongings away before someone could get them for her. - Before when a resident left, the SIC threw their stuff away before they could get it. - If the SIC had been nicer to residents, the residents would not have had to get so upset. - Other residents had lived in the facility and been very unhappy and concerned about the SIC's behavior and so they left. Telephone interview on 6/03/16 at 11:16 am with a previous resident at the home revealed: - The SIC did not get along with the women in the facility. - She did not argue or yell too much with the men in the home because she did not want to get into it physically with the men. - There were many arguments at the facility. The SIC was always fighting with residents. - There was physical as well as verbal fighting. - The SIC would curse and yell about not asking to go out to the smoking area. - No one was on restriction or on a schedule for smoking. Residents should have been able to go out as needed. - On one occasion, the previous resident saw the SIC push another previous resident backward, then the SIC went to her room. - "I saw the SIC get a big kitchen knife from under her mattress when she went to her room." - The SIC came out with the knife, and went into the room where this other previous resident was, and preceded to threatened the resident verbally	C 311		

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C 311	Continued From page 19 and with the knife. - The SIC called the police but they believed that the previous resident attacked the SIC. - The other previous resident was "rebellious", but the SIC did not use proper respectful words and discussion with residents. - Resident #1 was made to clean up the facility. - Resident #1 sometimes liked to help clean up but not every time. - The SIC would yell and scream and curse like an "Old Sailor!" at Resident # 1 and others. - Resident #1 was "punished" if she went out of the facility too early or to the front yard without asking and if she said anything about not wanting to mop and clean up that day. - The SIC would make her stay in her room for 2 - 3 days at a time. - Resident #1 would cry and get upset because she wanted to come out of her room. - The previous resident did not tell the Administrator because "nothing would be done", the Administrator was very close with the SIC. - The SIC would retaliate and get worse if the residents told the Administrator. Interview on 5/2/16 at 5:45 pm with the Administrator revealed: - The resident had her medications changed when admitted in 2014, and was, more stable after those changes. - The resident had a traumatic family history. - The resident would get a bit depressed at times. - She had minimal issues now. - The resident might need medication changes now with this episode today. - She would assume responsibilities in the home and had an excellent memory. - The resident was great, he had a great relationship with her and she was like an aunt to	C 311		

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C 311	Continued From page 20 him. - He was not aware of any resident rights concerns with the current two facility residents. - He was very surprised about the reaction of the SIC as well as concerns with the SIC with residents. - The SIC was removed from the building and the second resident in the facility was taken to another facility. The SIC was not available for further interview. On 5/27/16 at 5:57 pm, Resident #1 was taken to another family care home. _____ Review of the facility's Plan of Protection dated 5/27/16 revealed: - The SIC would not work in the facility and was removed immediately. - Both residents were relocated to other facilities. - A qualified SIC would be obtained. - The staff, residents and Administrator will continue to verbalize open discussion with residents, provide continued supervision and develop an active line of communication with the community board and the facility. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 14, 2016.	C 311		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and	C 428		

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C 428	Continued From page 21 .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to protect residents by not investigating allegations of abuse or reporting within 24 hours after becoming aware of allegations of abuse to the Health Care Personnel Registry (HCPR) for the Supervisor-In-Charge (SIC) and by not completing and forwarding an investigation report within 5 days of the initial notification to HCPR. The findings are: Observation on 5/23/16 at at 10:05am, during facility visit revealed: - Two residents were seen near the vehicle of the Supervisor-In-Charge (SIC). - The SIC came out of the facility closing and locking the door. - The SIC indicated that she had to take the residents to their day program. On 5/23/16 a letter was sent to the Administrator by the Department of Social Services (DSS) including: - Notification of an investigation of an allegation of abuse initiated on 5/20/16 concerning the current SIC. - Enclosed in the letter was a copy of the 24 Hour Initial Report and the 5 Working Day Report form for him to complete. - The Administrator was requested to send the completed copies to DSS when they were sent to the Health Care Personnel Registry. - It was advised that the SIC be away from the facility until you have completed your investigation. - A Plan of Protection related to the residents	C 428		

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C 428	Continued From page 22 being left alone on 5/20/16 when the complaint investigation was initiated was requested to be completed and faxed to DSS. Telephone interview with the Administrator on 5/23/16 at 4:45 p.m. revealed: - The Administrator was informed that DSS was investigating allegations of resident's rights and abuse concerning the facility's current SIC. - The SIC should not be around the residents until his investigation was completed. - Blank copies of the 24-Hour Initial Report & the 5 Working Day Report for the HCPR related to these events were to be completed and faxed to DSS and the HCPR. - The Administrator was informed that a Plan of Protection form was being forwarded for residents being left alone on 5/20/16. - The Administrator was to fill out the Plan of Protection and the HCPR reports and fax back to DSS. Observation on 5/27/16 at 9:25 a.m., the SIC was providing services in the facility to the two facility residents. Telephone interview on 6/02/16 at 3:19 p.m. with the Administrator and the Office Manager revealed: - The Administrator did not know what the allegations for the complaint were. - Office Manager said the Administrator did an investigation, but the two residents said there were no problems with resident rights. - He had completed the reports. - The reports had been sent. On 6/10/16 the facility provided a HCPR 24 Hour Initial Report not dated and the 5 Working Day Report, signed and dated 5/24/16, by fax without	C 428		

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C 428	Continued From page 23 an indication of the date the reports were sent to the HCPR. Review of a report from the HCPR dated 6/22/16 revealed: - The 24 Hour Initial Report was received at the HCPR. - The allegation type was listed as unknown and resident was unknown. - No documentation of a 5 Working Day Report was provided by the facility. - Attempted contacts with the Administrator were made on 5/22/16 and 5/31/16, but there was no response. Telephone interview on 6/27/16 at 11:56 a.m. with the HCPR revealed: - The 24 Hour Initial Report was provided to the HCPR by the facility on 5/23/16. - The report was not complete including no resident was identified and no allegation type was listed. - The 24 Hour Initial Report was not signed. - The 5 Working Day Report had not been provided to the HCPR. _____ Review of the facility's Plan of Protection dated 6/27/16 revealed: - Residents were removed from the facility. - All allegations will be reported to the HCPR in accordance with the reporting requirements. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 14, 2016.	C 428		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights	C 914		

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C 914	Continued From page 24 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 observations, interviews and record reviews, the facility failed to assure each resident was free of mental and physical abuse related to hitting, staff use of abusive and demeaning language, punishments including confinement, threatening behaviors and causing fear of retaliation; and neglect by not reporting to the Health Care Personnel Registry and failing to suspend staff who was accused of abusing the residents. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure residents had the right to be free of mental and physical abuse including hitting, abusive and demeaning language, punishments including confinement and threatening language, and leaving residents with fear of retaliation for 1 of 2 residents. [Refer to Tag C 311, 10A NCAC 13G .0909 Resident Rights (Type A2 Violation)] 2. Based on interviews and record reviews, the facility failed to protect residents by not investigating allegations of abuse or reporting within 24 hours after becoming aware of allegations of abuse to the Health Care Personnel Registry (HCPR) for the Supervisor-In-Charge (SIC) and by not completing and forwarding an investigation report within 5 days of the initial notification to HCPR. [Refer to Tag C 428, 10A NCAC 13G.1206 Health Care Personnel Registry, (Type A2 Violation.)]	C 914		

Division of Health Service Regulation

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