

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/29/2016
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NAME OF PROVIDER OR SUPPLIER CEDARBROOK RESIDENTIAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1267 PINNACLE CHURCH ROAD NEBO, NC 28761
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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 7/25/16 - 7/29/16.	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, interviews the facility failed to assure the floors, common bathroom floors, resident bathroom floors and residents' bedroom walls were cleaned daily as evidence by stains on the 400 hallway floor, residents' rooms had brown stain on walls and un-emptied trash in residents' bathroom.</p> <p>The findings are:</p> <p>During the initial tour of the 400 hall on 7/25/16 between 11:40 am-12:05 pm revealed:</p> <ul style="list-style-type: none"> - The hallway floor had multiple brown stains near the entrance to room 410. -In room 410 the wall near the room entrance had brown stains above the trash can going upward on the wall. -The 400 hall even bathroom had a wet substance on the floor next to the shower stall with dirty towels. -The shared bathroom for rooms 403/405 smelled of urine, there were dirty wash cloths on the floor. -Room 403 walls had brown stains the wall near 	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>the trash can at the entrance to the room.</p> <p>-The shared bathroom for rooms 404/406 floor had a dark black substance on the floor and an un-emptied trash can that was full of brown paper towels.</p> <p>-The 400 hall odd bathroom shower stall drain cover was missing.</p> <p>Observation of the 400 hall resident rooms, bathroom and common bathrooms on 7/26/16 at 10:51 am revealed:</p> <p>- The hallway floor had multiple brown stains near room 410.</p> <p>-In room 410 the wall near the room entrance had brown stains above the trash can going upward on the wall.</p> <p>-The 400 hall even bathroom had a wet substance on the floor next to the shower stall with dirty towels.</p> <p>-The shared bathroom for rooms 403/405 smelled of urine, there were dirty wash cloths on the floor.</p> <p>-Room 403 walls had brown stains the wall near the trash can at the entrance to the room.</p> <p>-The shared bathroom for rooms 404/406 floor had a dark black substance on the floor and an un-emptied trash can that was full of brown paper towels.</p> <p>-The 400 hall odd bathroom shower stall drain cover was missing.</p> <p>Interview with the Lead Housekeeper on 7/26/16 at 10:51 am revealed:</p> <p>-There were no housekeeping staff on duty today (7/26/16).</p> <p>-There were usually two housekeeping staff on duty daily.</p> <p>- One staff had to go to an appointment and we are trying to hire for the other position.</p>	D 074		

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D 074	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The lead housekeeper had to work the floor as a personal care aide this week (the housekeeper was trained as a personal care aide). -Housekeeping staff were supposed to clean the common bathrooms daily. -Housekeeping staff were supposed to deep clean resident residents weekly. -Empty residents' trash cans daily. -Sweep, mop and dust in residents room -Wipe down walls in residents rooms. -Personal care aides were responsible for keeping common areas cleaned after hours if necessary. -His main job is to maintain the floors (mop, wax, buff). -He can not do the floors when working as a personal care aide. <p>Interview with the Assistant Operations Manager on 7/26/16 at 4:15 pm revealed:</p> <ul style="list-style-type: none"> -He was responsible for assuring the building was cleaned. -Staff were responsible for completing the assigned task(sweeping, mopping, emptying trash, replenishing soap, tissue, paper towels, cleaning resident's rooms, and bathrooms). -The facility is in the process of hiring housekeeping staff. -The lead housekeeper was primary responsible for the floors. -The lead housekeeper had to work as a personal care aide this week and there was no else to do the floors. -Staff were responsible for cleaning the residents' bathrooms, floors, walls, empty trashcans clean and dust off dressers daily. -Staff were supposed to deep clean once a week which consist of moving furniture to get behind the furniture, clean light fixtures and hard to reach areas. 	D 074		

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D 074	Continued From page 3 -Assistant Operations Manager tries to check each room once a week during my walk around. -Assistant Operations Manager randomly spot checks rooms during the week. -Common bathrooms were supposed to be cleaned at the beginning and the end of each shift. -If staff were not able to spot mop the floors or rooms then they were to report to me. If they were unable to remove any stains then he will report to the maintenance staff to evaluate for painting.	D 074		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to follow proper procedures for performing bed baths, perineum care and incontinence care for Resident #2, who required extensive assistance with bathing, grooming, transfers and dressing, and documented the provision of personal care services for showering and shave that were not provided. The findings are:	D 269		

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D 269	<p>Continued From page 4</p> <p>Review of Resident #2's current FL-2 dated 6/23/16 revealed: -Diagnoses included schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, cellulitis with abscess, and degenerative joint disease.</p> <p>Review of Resident #2's care plan dated 7/12/16 revealed: -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfers. -The resident required a wheelchair for ambulation. -The resident was incontinent of bowel and bladder at times and used incontinence briefs.</p> <p>Observation of Resident #2 on 7/26/16 at 1:06 pm revealed: -The resident was sitting in a wheelchair on the front porch near the basketball goals. -Resident #2's face was unshaven and had light brown substance in the inside and outside corners of both eyes. -The resident's hair was uncombed with two small plaits at the end of the hair on the resident's left side head. -The resident had white socks on without shoes.</p> <p>Interview with Resident #2 on 7/26/16 at 1:10 pm revealed: -"My hands don't allow me to shave, I will cut myself." -"I have too much pain in my hands." -"I can't push the wheelchair by myself." -"I don't like the tube in my nose at night." (The resident had physician orders for oxygen 2 liters at bedtime) -The resident indicated he was in pain in his</p>	D 269		

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D 269	<p>Continued From page 5</p> <p>genitalia area and the incontinence brief was causing the pain. He could not reposition himself in the wheel chair to alleviate the pain.</p> <p>Observation on 7/26/16 at 1:15 pm revealed: -The Personal Care Aide (PCA) asked Resident #2 to go with her inside the facility so he could be checked. -Resident # 2 stated he wanted to stay outside. -The PCA walked away.</p> <p>Interview with the PCA on 7/26/16 at 1:20 pm revealed: -Resident #2 refused to come inside to be checked and he will become combative. -The PCA reported to the MA supervisor that Resident #2 was complaining of his genital area hurting and refused to be checked.</p> <p>Observation on 7/26/16 at 1:30 pm revealed: -The Medication Aide/Supervisor (MA) and the personal care aide went to the front porch. -The MA explained to the resident that he needed to go to the bathroom so staff could see what was going on. -When asked, the resident gave the surveyor permission to observe staff providing incontinence care. The MA supervisor and the PCA assisted Resident #2 in the wheelchair to the 200 hall community bathroom. -The MA and the PCA attempted to help the resident transfer to the toilet. The resident began "don't let me fall, don't put me on that nasty toilet". The lead housekeeper came into the bathroom to help. -The toilet lid was up and had a yellow colored liquid in the bowl. -There were paper towels on the floor next to the toilet, with a wet substance on the floor.</p>	D 269		

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D 269	<p>Continued From page 6</p> <ul style="list-style-type: none"> -The staff stood the resident up and removed the resident's sweatpants and incontinent wear. The resident began yelling indicating that his genital area was in pain, "put the cream on me", "y'all are not putting the right cream on me". -The incontinence brief removed was placed in the trash can. -The incontinence brief had a smeared brown substance in the center of the brief with a light red substance on the outer edge of the left side of the brief. -The MA nor the PCA had any incontinence care supplies to clean the resident. The MA indicated that she was not prepared to provide incontinence care to Resident #2 when the first PCA reported Resident #2's pain . -The MA and PCA sat Resident #2 down on his bare bottom in the wheelchair. -The MA left the bath room. -The MA returned to the bathroom with a small white tube and two washcloths. - The MA and the PCA stood the resident up in front of the wheelchair and the MA took one wash cloth and held it under running water in the sink. The resident began yelling don't put that on me, it's nasty". The MA explained to the resident that she was trying to clean the area. - The MA wiped the resident's anus area with the wet wash cloth twice. -The cloth had a brown substance after wiping the anal area. -The MA took the second washcloth and placed it under the running water and wiped the anal area again. -The MA did not wipe/clean the resident's front genital area. -There were redden areas (one dime size with multiple small area) on the buttocks and left hip area. The resident complained of pain in the genital area. 	D 269		

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D 269	<p>Continued From page 7</p> <ul style="list-style-type: none"> -The MA took the white tube and squeezed a clear substance in the palm of their gloved hand (triple antibiotic ointment). -The MA applied the substance to the resident's buttocks. -The MA, PCA and a second PCA sat the resident down on his bare bottom in the wheelchair. -The MA took a clean incontinence brief and began putting it on the resident along with the resident's sweatpants. -The two PCAs stood the Resident #2 up. The MA pulled the incontinence brief and sweat pants up on the resident. The resident began to pull the incontinence brief off as it got to his thigh area. The resident yelled "don't put that on me it hurts me". -The MA pulled the sweatpants up on the resident without any incontinence brief or under garments and sat the resident in the wheelchair. -The MA and PCA left the bathroom. -Resident #2 and the second PCA remained in the bathroom. -The MA and the first PCA did not return to the bathroom. -The second PCA pushed the resident in his wheelchair down the hallway towards the common area. -The resident's wheelchair was placed in front of a large circular fan located in the hall way next to the second entry way to the dining room. <p>Review of the July 2016 Medication Administration record revealed there were no initials documented that the standing order for Triple Antibiotic Ointment had been administered to the resident.</p> <p>Observation on 7/27/16 at 9:37 am revealed:</p> <ul style="list-style-type: none"> -The MA and a third PCA were performing incontinent care in the Resident #2's room. 	D 269		

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D 269	<p>Continued From page 8</p> <ul style="list-style-type: none"> -The resident was lying on the bare mattress. -The MA stated the supervisor stated that the surveyor must obtain consent from the resident to see personal care provided. When asked, the resident indicated it was ok to observe. -The resident had on a white sweat shirt with no clothing on below the waist except white socks. -The third PCA was wiping the resident buttocks with a dry towel. -The resident had a white powdered substance on his genitals and pubic area. The MA stated the resident was not supposed to have powder on his genitals and did not know how it got there. -The MA and third PCA pulled the resident's bed away from the wall and gathered two plastic basins, that were on the floor underneath the resident's bed next to the wall. -The third PCA left the room with the basins. -The third PCA returned to the room with one basin with clear water and the other with soapy water. -There was an open area on the resident left buttocks (cheek fold near the resident's left leg). -There was a dime size circular reddened area on the resident right buttocks. -The resident yelled indicating the scrotum was red and tender to touch, when the third PCA attempted to clean the area. -The resident yelled: "I am [explicit word] down there", "stop", "y'all are not giving me the right medicine", "give me the right medicine". <p>Interview with the third PCA on 7/29/16 at 10:50 am revealed:</p> <ul style="list-style-type: none"> -Resident #2 needs to be shave. -The resident said he did not want a shave. -PCA stated the resident will do what you ask of him, all you have to do is ask. -Resident #2 does not have any personal care that belongs to the resident. Staff use the facility 	D 269		

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D 269	<p>Continued From page 9</p> <p>supplies for his personal care.</p> <p>Interview with Resident #2 on 7/29/16 at 10:52 am revealed: -"I like my face shaved". -"I like my face shaved in a goatee style".</p> <p>Observation of Resident #2 on 7/29/16 at 10:52 am revealed both sides of the resident's face had approximately 1 inch of hair.</p> <p>Review of the personal care record for Resident #2 revealed on 7/27/16, first shift, had been initial by a fourth personal care aide that the resident had received a shower, skin care, hair care, mouth care and shave.</p> <p>Interview with a fourth PCA on 7/27/16 at 10:08 am revealed: -The fourth PCA reported that the personal care provided on 7/27/16 was not done by her. -" [Another PCA name] reported that care was provided" and "I documented that the care was provided". I do not check to see if the care reported had been completed. -"Only trained staff to document on the personal care record are allowed to complete the personal care records". -Other staff provide care to residents and report to the aides what had been done. - "We were trained to complete the personal care records to initial exactly what is highlighted in yellow". -"I documented (S-shower) on the record today because that is what we are instructed to do by the Business Office Manger, Resident Care Coordinator and medication aide supervisor". -"It was reported that the resident received a sponge bath today" (7/27/16). -"We are supposed to report to the MA supervisor</p>	D 269		

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D 269	<p>Continued From page 10</p> <p>,when the PCAs report to the person signing the book that something different was done for the resident".</p> <p>-The deviation report is supposed to be completed at the end of the shift and given to the MA supervisor daily.</p> <p>-The personal care record only reflects the codes that are highlighted in yellow that we are supposed to document.</p> <p>-If something is going on with the resident and the personal care could not be done, such as refusal of care or the resident in the hospital or appointments, a deviation report is supposed to be completed.</p> <p>-"We all do the same thing when completing the personal care record, the resident care coordinator can tell you why we have to do it this way."</p> <p>- "It's all of us that code the book as it is highlighted because that is what we were tell to do".</p> <p>-"I documented the code for Monday that the resident had a shave, but he was not shaved on Monday".</p> <p>- The [third PCA name] and [the fifth PCA name] reported that they gave Resident #2 a bath and the fourth PCA documented it on the personal care record.</p> <p>-The normal code is (S) for shower and we put the code in exactly as it is high lighted.</p> <p>-The care we document is not the care given.</p> <p>-If there are any deviations we are to report them to the supervisor in charge. If there are changes, like a sponge bath, we document shower and verbally report to the supervisor and they fill out a form.</p> <p>-There's a deviation form we date and put our initials down.</p> <p>- Staff are supposed write any care given and any care refused.</p>	D 269		

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D 269	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Any type of refusals are to be written down on the deviation report sheet. -The personal care record are coded at the beginning of the month by a MA supervisor. -The supervisor or the MA were responsible for making any changes on the personal care record during the month. - If changes were documented the personal care record was supposed to be updated to reflect the change. <p>Interview with the Medication Aide Supervisor on 7/27/16 at 10:10 am revealed:</p> <ul style="list-style-type: none"> -We work as a team when providing care to residents. -"I do not check to see if the personal care had been provided to the resident's. -The personal care aide reports to the personal care aide that had been trained by the supervisors to document on the personal care record. - The personal care aide documented the care that was suppose to be completed on the personal care record. - The personal care task assessed for the resident is then signed off on the record. -Staff were supposed to complete a deviation report if the personal care is not completed. -A deviation report had not been completed for 7/27/16 for Resident #2. -If a deviation report is done the personal care aides will fill out the report and turn it in to me. -Any completed deviation reports are given to the billing staff on Wednesdays. <p>Interview with the Business Office Manager (BOM) on 7/27/16 at 11:59 am revealed:</p> <ul style="list-style-type: none"> -The RN for Medicaid comes out and does a hands-on assessment and creates a care plan. -The personal care sheets have to reflect exactly 	D 269		

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D 269	<p>Continued From page 12</p> <p>what the care plan states.</p> <ul style="list-style-type: none"> -The MA supervisor writes down the care needs from that care plan onto the PCS sheets in the beginning of each month. They are to document exactly what is on this PCS care plan. -When deviation reports were requested, the BOM revealed Resident #2 has not had any deviations in the last few months. <p>Interview with the Administrator on 7/27/16 at 11:36 am revealed:</p> <ul style="list-style-type: none"> -The MA supervisor or BOM help with the training on the care sheets. -The nurse assessor from the state says he needs a shower so we try do what they say. -The MA supervisor makes the PC Sheets based on what they tell us the resident needs. -The blue sheets (personal care sheets) are reflecting what the nurse thinks they should get and we put the care they get. <p>Interview with the Resident Care Coordinator (RCC) 7/27/16 at 11:40 am revealed:</p> <ul style="list-style-type: none"> -That PC sheet is basically just for billing. -They are the logs that show care was done and not necessarily who gave the care. -They document the code and any change has to be documented on the deviation form - things like refusals or sponge baths rather than showers - but what is documented on the PC sheets is what is coded. <p>Interview with the Medication Aide supervisor 7/27/16 at 11:39 - 11:45 am revealed:</p> <ul style="list-style-type: none"> -There are only a few care aides that can sign the personal care sheets. -As long as there is communication going on and it is documented what they get it does not matter. -If they gave a sponge bath instead of a shower or there was a refusal - this should be 	D 269		

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D 269	<p>Continued From page 13</p> <p>documented on the deviation sheets. Or if he refuses a shower on Wednesday and takes a shower the next day we document that on the deviation form. That's what they are for.</p> <p>-The blue sheets have a code S=shower and that is what the Medicaid nurse expects.</p> <p>Interview with the Administrator on 7/29/16 at 12:20 pm revealed:</p> <p>-"Staff are supposed to provide personal care to all residents including resident #2 as they were trained to do".</p> <p>-"Procedures should be the same even when staff are providing incontinent care. They should provide the personal care as they were taught to become a personal care aide".</p>	D 269		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision</p> <p>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE A1 VIOLATION</p> <p>Based on these findings, the previously unabated Type A1 Violation was abated. Non-compliance continues.</p> <p>THIS IS A TYPE B VIOLATION</p> <p>Based on interviews, record reviews, and</p>	D 270		

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D 270	<p>Continued From page 14</p> <p>observations, the facility failed to assure staff provided supervision in accordance with 1 of 6 sampled residents (Resident #8) assessed needs and current symptoms resulting in Resident #8 leaving the facility property multiple times and walking into traffic.</p> <p>The findings are:</p> <p>Review of Resident #8's current FL2 dated 5/4/16 revealed:</p> <ul style="list-style-type: none"> -The resident's diagnoses included schizophrenia and extrapyramidal symptoms. -The resident was documented as constantly disoriented, a wanderer, and ambulatory. <p>Review of Resident #8's current Care Plan dated 4/20/16 revealed:</p> <ul style="list-style-type: none"> -"Resident came to facility in May 2004, following a psychiatric hospitalization." -"Resident was recently hospitalized in March 2016 for psychiatric reasons, which was the first since 2004." -"Resident is difficult to understand at times, but on a good day resident likes to play basketball and or watch television." -"When resident is not doing well he is more isolated, sleeps more or displays unusual behaviors (ie: attempting to leave grounds without signing out)." -"When resident is upset/agitated or anxious offer prn medication." -"If prn is ineffective, contact mobile crisis." <p>Observation of Resident #8 on 7/29/16 at 3:10 pm revealed:</p> <ul style="list-style-type: none"> -Resident was walking alone with an unsteady gait up from the facility through the parking lot towards the road. -There were no staff in the parking lot. 	D 270		

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D 270	<p>Continued From page 15</p> <ul style="list-style-type: none"> -One surveyor called the facility and another surveyor went in the facility to notify staff that a resident was walking down the road towards the church. -The resident began walking on the side of the road facing traffic. -After a vehicle had passed, the resident entered the road and began walking on the double yellow line in the center of the road. -The resident walked along the yellow lines until another surveyor began calling him to get out of the road. -The resident then walked to the side of the road walking in the direction of traffic. -As two vehicles approached the resident walking in the curve of the road the surveyor motioned for the drivers to slow down. -After the vehicles passed, the resident then walked towards the middle of the road crossing the road to the side facing the traffic in front of the church. -The resident continued to walk along the side of the road edge. -Staff ran up the road to the resident with a soda in their hand. -Once staff got to the resident in front of the church, the resident stopped and turned around and followed the directions of the staff member. <p>Interview with the Assistant Operations Manager on 7/29/16 at 3:13 pm revealed he had been unaware Resident #8 was in the road, but would immediately get staff to help with him.</p> <p>Observation of one Medication Aide on 7/29/16 at 3:13 pm revealed she walked quickly through the parking lot to the road and began talking to and then walking beside Resident #8 encouraging him to walk on the edge of the road and come with her back to the facility.</p>	D 270		

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D 270	<p>Continued From page 16</p> <p>Observation of a Personal Care Aide on 7/29/16 at 3:15 pm revealed she joined the first medication aide and began walking beside Resident #8 and encouraging him back to the facility.</p> <p>Interview with the Medication Aide walking back towards the facility with Resident #8 on 7/29/16 at 3:20 pm revealed "He did not get near the truck. We let the truck know to slow down."</p> <p>Interview with a Personal Care Aide (PCA) walking with Resident #8 on 7/29/16 at 3:20 pm revealed: -She was going to take the resident into the facility and let him cool down. -She was going to then give him a shower. -Resident #8 had told her he had just wanted to take a walk like a normal person. -She had told him people don't walk in the road, but on the side of the road.</p> <p>Interview with the Resident Care Coordinator on 7/29/16 at 3:30 pm revealed: -Resident #8's psychiatric provider had been there to see him that day. -"We have called mobile crisis to come see him." -"We had him on 15 minute checks."</p> <p>Interview with a second PCA on 7/29/16 at 3:35 pm revealed: -"I got to work at 3 pm." -She had just gotten report and that is when the Assistant Operations Manager came inside and said Resident #8's had walked off. -Another PCA had gone "out to help with him."</p> <p>Review of Resident #8's 15 minute check logs on 7/29/16 at 3:35 pm revealed:</p>	D 270		

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D 270	<p>Continued From page 17</p> <p>-Staff had documented 15 minute checks on Resident #8 since 7/28/16 at 7 am through 7/29/16 at 3:30 pm.</p> <p>-On 7/29/16 at 3:00 pm the entry documented "outside."</p> <p>-On 7/29/16 at 3:15 pm the entry documented "walkoff."</p> <p>-On 7/29/16 at 3:30 pm the entry documented "going to snack."</p> <p>Review of Resident #8's hospital discharge summary dated 5/4/16 revealed:</p> <p>-Resident #8 was admitted for safety concerns in the setting of agitation, disorganization and possible psychosis.</p> <p>-"With treatment, [patient's] acute risk factors for safety have stabilized."</p> <p>-"It is noted that there are ongoing chronic risk factors for safety (including history of a psychotic disorder)...."</p> <p>-"Patient is committed to outpatient care and wrap around services are in place..."</p> <p>-"At this point, benefits of discharge outweigh risks and patient appears appropriate for discharge."</p> <p>-A physician's order for Seroquel (used to treat schizophrenia) 600mg daily at bedtime.</p> <p>-A physician's order for Seroquel 200mg daily.</p> <p>-A physician's order for Risperdal (used to treat schizophrenia) 2mg daily at bedtime.</p> <p>Review of Resident #8's electronic charting note dated 5/4/16 at 4:41 pm revealed:</p> <p>-"Spoke with hospital regarding resident and concern for the need of enhanced services after discharge.</p> <p>-Hospital will be referring resident for enhanced services."</p> <p>-"Management spoke to social worker regarding discharge and resident's new FL2 listing him as</p>	D 270		

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D 270	<p>Continued From page 18</p> <p>disoriented and a wanderer." "-Management explained that at baseline resident is not disoriented or a wanderer and facility is questioning whether he is stable for discharge." "-Social worker spoke with physician who clarified that resident is no longer disoriented or considered a wanderer and felt that those behaviors were the cause of his IVC and he is now stable and ready for discharge. "</p> <p>Review of Resident #8's progress note dated 5/25/16 at 7:45 am revealed: -Resident "walked to top of the road and started throwing chairs in the road. Staff brought him back down from the road, he turned around and ran back to the road and throwed [sic] another chair." -"Staff brought him back down, we put him in the medroom, prn was given, crisis was called." -Crisis called back at 8:30am and stated "next time he does things to harm himself [sic] and others we need to go ahead and IVC him."</p> <p>Review of Resident #8's electronic charting note dated 5/31/16 revealed: -A prn was administered to the resident. -"He is still running up the road, went and got him watching him close he is still on 15 min checks."</p> <p>Review of Resident #8's progress note dated 6/2/16 at 12:20 pm revealed: -Resident walked off at 12:20 pm. -"Made it up to the church." -"Staff brought him back."</p> <p>Review of Resident #8's electronic charting note dated 6/6/16 revealed: -"Resident issued a 30 day discharge notice due to continuing to walk away from facility grounds without signing out."</p>	D 270		

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D 270	<p>Continued From page 19</p> <p>-"Management spoke with resident today and resident states he will not walk away anymore. Staff will continue to monitor closely."</p> <p>Review of Resident #8's progress note dated 6/8/16 at 8:20 am revealed: -Resident #8 walked off the facility property. -"Staff caught up with him at the church." -"PRN had already been given."</p> <p>Review of Resident #8's Accident/Injury Report dated 6/10/16 at 6:15 am revealed: -"During 6:15 [am] check resident was unable to be found." -"Staff searched for resident and was unable to locate him." -"Sheriff and management notified." -Resident was found by staff at 7:35 am and returned to the facility." -15 minutes checks were continued.</p> <p>Review of Resident #8's electronic charting note dated 6/16/16 revealed: -Resident #8 had been "very manic this afternoon attempting to walk off from the facility and staff redirecting back." -As needed medication was given and routine 15 min checks continued at this time.</p> <p>Review of Resident #8's Accident/Injury Report dated 6/17/16 at 5:30 am revealed: -"Resident walked off from facility." -He was found at the end of the road by staff and returned to the facility at 6:20 am. -Sheriff's department was contacted but he was found before they arrived.</p> <p>Review of Resident #8's physician's order dated 6/30/16 revealed: -An order for clonazepam 1mg every 8 hours as</p>	D 270		

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D 270	<p>Continued From page 20</p> <p>needed for anxiety and agitation.</p> <p>-An order for clonazepam 0.5mg twice daily, do not administer as needed clonazepam within 2 hours of scheduled dose.</p> <p>-An order for Zyprexa (used to treat schizophrenia) 20mg daily.</p> <p>Interview with the Operations Manager on 7/26/16 at 9:35 am revealed:</p> <p>-If a resident walks off without signing out is agitated or angry, our staff would follow the resident and talk to them.</p> <p>-If the resident refused to come back, staff would contact law enforcement for assistance in getting the resident to return.</p> <p>-Staff would then contact the mental health provider for assistance with the resident.</p> <p>-Sometimes they try different staff to talk to a resident who refuses to come back and the resident may be more cooperative with one staff than another.</p> <p>-When someone walks off, staff implement 15 minute checks on the resident for 72 hours.</p> <p>-After the 72 hours, the resident is reassessed and the Operations Manager will make the determination if the 15 minute checks will be continued and for what time period.</p> <p>-The 15 minute checks are continued if the resident is assessed to need additional supervision.</p> <p>A second interview with the Operations Manager on 7/26/16 at 4:30 pm revealed:</p> <p>-When she had called to question the hospital social worker about Resident #8's FL2 for his hospital discharge on 5/4/16, the doctor had cleared him.</p> <p>-"I would not have taken him back if they felt he was disoriented or a wanderer."</p> <p>-Resident #8 had not had any walk off</p>	D 270		

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D 270	<p>Continued From page 21</p> <p>occurrences "in the last month." -"I did give him a 30 day discharge." -"We were unable to find placement for him and I did not continue to look for placement for him because his behaviors stopped." -The resident had been started back on the behavioral intervention team recently which may have helped to prevent incidents in the past month. -The resident had not walked off since the last incident 6/17/16. -They had been working on regulating the residents medication regimen.</p> <p>Interview with the Administrator on 7/29/16 at 3:50 pm and 4:03 pm revealed: -Resident #8 had lived at the facility since 2004. -"Sometimes he starts walking off and we have to commit him." -One of his behavioral intervention team had been there that day on a routine visit and spent time visiting the resident playing basketball. -His psychiatrist had just been contacted to notify about the current walkoff and for recommendations. -Mobile crisis had been notified about the current walk off and were already on site and would be assessing him. -The resident had just gotten a new roommate the day before, where he had been living in a room by himself and that could be causing his agitation. -The resident had been on 15 minute checks. -One PCA was staying with Resident #8 one on one until he could be assessed by the psychiatric provider, who had already been notified.</p> <p>Interview with mobile crisis representative on 7/29/16 at 3:55 pm revealed: -"These recent behaviors started when he got a</p>	D 270		

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D 270	<p>Continued From page 22</p> <p>new roommate." -The resident was currently showing no signs of aggression, suicidal ideation, or homicidal ideation. -"He's stable right now. He's doing great right now." -"He told me he just wanted to walk around like a normal person."</p> <p>_____</p> <p>The failure of the facility to provide supervision needed created opportunities for Resident #8, who lacked the ability to make safe decisions independently, to continually leave the facility, and walk in the middle of highway, which is detrimental to the resident's health, safety and welfare.</p> <p>_____</p> <p>The facility did not provide an acceptable Plan of Protection for residents nor a date by which this violation shall be corrected.</p>	D 270		
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: FOLLOW-UP TO CONTINUING TYPE B VIOLATION</p> <p>Based on these findings, the previous Unabated Type B Violation has not been abated.</p> <p>Based on interview and record review, the facility failed to notify the physician for 3 of 5 sampled</p>	D 273		

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D 273	<p>Continued From page 23</p> <p>residents regarding scrotum redness, open area on the buttocks (Resident #2), a resident's high blood pressures with physician ordered parameters (Resident #3) and a facial injury incurred during a physical altercation within the facility (Resident #6).</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 6/23/16 revealed: -Diagnoses included schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disease, cellulitis with abscess, and degenerative joint disease.</p> <p>Review of Resident #2's care plan dated 7/12/16 revealed: -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transfers. -The resident required a wheelchair for ambulation. -The resident was incontinent of bowel and bladder at times and used incontinence briefs.</p> <p>Interview with Resident #2 on 7/26/16 at 1:10 pm revealed: - The resident indicated that his genital area was painful and could not reposition himself in the wheel chair. -The resident indicated the incontinence brief was hurting his genital, and buttocks.</p> <p>Record review of Resident #2's progress notes revealed: -On 7/17/16, that the resident refused to let staff change him or linens. The staff were able to</p>	D 273		

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D 273	<p>Continued From page 24</p> <p>removed soiled linens but unable put clean linens back on the bed or clean the resident. First shift staff were notified.</p> <p>-On 7/24/16, that the resident had not been in bed for the last 3 days (7/21/16).</p> <p>-The resident reported that he laid down on the couch in the day room for a little while.</p> <p>-Documentation that the medication aide reported to the Operations manager the above information.</p> <p>-Documentation that the Operations manager advised staff to encourage the resident to go lay down and rest.</p> <p>Observation on 7/27/16 at 9:37 am revealed:</p> <p>-Staff in Resident #2's room.</p> <p>-When asked, the resident gave the surveyor permission to observe.</p> <p>- There was an open area on the resident's left buttocks-cheek fold near the resident's left leg.</p> <p>-There was a circular dime size reddened area on the resident right buttocks.</p> <p>-The resident's scrotum was red.</p> <p>-The resident complained of pain when staff touched the scrotum area.</p> <p>-The resident yelled at staff: "I am [explicit word] down there" "stop" "y'all are not giving me the right medicine" "give me the right medicine".</p> <p>Interview with a second shift Personal Care Aide (PCA) on 7/27/16 at 4:35 pm revealed:</p> <p>-On 7/22/16, Resident #2 had soiled himself and the three staff members took him to the shower.</p> <p>-The resident had "breakdown" on his left buttocks.</p> <p>-It was an open area on his buttocks.</p> <p>-The medication aide put some triple antibiotic ointment on it.</p> <p>-The resident is supposed to get his showers on first shift.</p>	D 273		

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D 273	<p>Continued From page 25</p> <ul style="list-style-type: none"> -The resident was showered on 7/22/16 because he had soiled himself. -It was not documented that a shower had been given. -Staff were supposed to report any issues regarding residents to the Medication Aide in charge for that shift. <p>Interview with another Personal Care Aide (PCA) on 7/29/16 at 10:24 am revealed:</p> <ul style="list-style-type: none"> -The resident was provided personal care in bed on 7/25/16 (bed bath). -The PCA had not had "the privilege to provide a shower to the resident yet". -The PCA reported to the Operations Manager and the Administrator that the resident "had a sore on his bottom on Monday (7/25/16)". -The Medication Aide put "Neosporin" on the resident's left buttocks. <p>Review of the July 2016 Medication Administration record revealed no documentation Triple Antibiotic Ointment, a standing order, had been administered to the resident.</p> <p>Interview with a first shift Medication Aide/Supervisor on 7/29/16 at 8:46 am revealed:</p> <ul style="list-style-type: none"> -Staff are supposed to report any issues with residents to the supervisor. -The supervisors are responsible for documenting in the resident record and contacting the physician. <p>Interview with another first shift Medication Aide/Supervisor on 7/27/16 at 9:37 am revealed:</p> <ul style="list-style-type: none"> -Staff were supposed to report any issues regarding resident's skin to the primary care provider. -Resident #2's reddened and open areas should have been reported to the primary care provider. 	D 273		

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D 273	<p>Continued From page 26</p> <p>"I will contact the primary care provider today" (7/27/16).</p> <p>Interview with the Administrator on 7/29/16 at 12:20 pm revealed:</p> <ul style="list-style-type: none"> - A PCA reported that Resident #2 had a sore on his buttocks on Monday (7/25/16). - "I didn't go look at it but I think [operations manager name] went and looked at it". We are both nurses. <p>Based on interview with the administrator the third medication aide/supervisor and the Operations Manager were not available for interview.</p> <p>Telephone interview with the primary care medical provider on 7/28/16 at 9:34 am revealed:</p> <ul style="list-style-type: none"> -The facility faxed a document on 7/26/16 about the resident's bottom. -The resident was seen by the co- primary care provider on 7/27/16. -The appointment was for a follow up visit, after a hospital visit on Monday 7/25/16 for his feet, the resident had chronic neuropathy issues. -The facility had not contacted us regarding any issues of refusals of personal care or that the resident had been up in a wheelchair for an extended period of time. -Resident #2 cannot walk and get up on his own, he has to be reposition and changed to prevent skin breakdown. -The facility staff should notify us if he is refusing care, the resident cannot do for himself. -If we would have known he refused to lie down, we could have made a referral to a psychiatry provider to evaluate the resident. <p>Review of physician order form for appointments dated 7/27/16 revealed:</p> <ul style="list-style-type: none"> -The resident was seen by the co- primary care 	D 273		

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D 273	<p>Continued From page 27</p> <p>provider at 3:00 pm on 7/27/16.</p> <p>-The resident had pain in the scrotum and the area was tender.</p> <p>-Medication orders for- Levaquin 500 mg every day for 10 days (used to treat infections) was prescribed for the scrotum area and Gabapentin 300 mg every night(used to treat neuropathy) was prescribed for the resident's feet.</p> <p>Interview with the co- primary care medical provider on 7/28/16 at 10:13 am revealed:</p> <p>-A facility staff member brought the resident in to be seen for follow-up for his feet, the resident has chronic neuropathy and was seen in the emergency room on 7/25/16..</p> <p>-The other primary care provider knew the resident was supposed to be seen today and gave me the fax sent by the facility on 7/26/16.</p> <p>-The facility did not send the chart or any notes.</p> <p>-The facility only sent a blank paper to document the visit and the medication administration record for the resident.</p> <p>-"We were not notified of any issues regarding the resident refusal of personal care".</p> <p>-"The resident had trouble standing and the staff and I had to help him stand".</p> <p>-"The resident's scrotum was red and tender to touch".</p> <p>-"We were not notified of any open areas on the resident's buttocks, staff should have notified us".</p> <p>-"The resident is incontinent and should be provided incontinence care as needed".</p> <p>-"I will call in a referral for home health to evaluate the resident".</p> <p>Interview with the home health Registered Nurse on 7/28/16 at 6:00pm revealed:</p> <p>-The home health agency received a referral for Resident #2 to be evaluated today (7/28/16).</p> <p>-The resident had a shearing wound on the</p>	D 273		

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D 273	<p>Continued From page 28</p> <p>buttocks. -Home health will treat the resident's wound.</p> <p>B. Review of Resident #6's current FL2 dated 07/12/16 revealed: -Diagnoses included alcohol intoxication; acute toxic encephalopathy; hyponatremia; schizophrenia, polysubstance abuse, and diabetes. -The resident was disoriented intermittently; ambulatory; and continent of bowel and bladder.</p> <p>Review of Resident #6's Care Plan signed by the physician on 06/08/16 revealed: -The resident was independent with toileting, ambulation, bathing, dressing, grooming and transferring. -The resident needed supervision with eating. -The resident had mental illness and currently received mental health services. -The resident had been hospitalized due to acute respiratory failure and acute alcohol intoxication.</p> <p>Observation on 07/26/16 at 5:20 pm revealed: -Resident #6 and #9 were in the residents' common living area outside the medication room arguing. -Resident #6 was observed with a 2-1/2 inch x 1/4" pale pink mark with three marks darker pink across the bottom of his left eye.</p> <p>Observation on 07/27/16 at 9:58 and 11:53 am of Resident #6 revealed the mark under his left eye was getting darker in color and the marks were more visible then yesterday.</p> <p>Observation on 07/28/16 at 10:48 am of Resident #6's face revealed the bruise under his left was still dark in color and visible for observation.</p>	D 273		

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D 273	<p>Continued From page 29</p> <p>Interview on 07/28/16 at 10:48 am with Resident #6 revealed: -On 7/26/16, Resident #9 "punched" him twice in the face. -His face only hurts when he touches it. -He usually did not touch his face. -When the incident happened he told staff that he did not want to go to the hospital. -He did ask for an ice pack because he felt his face was swelling. -He felt the bruise on his face was getting better and soon would be gone. -He had no fights for at least 2-3 years, but had arguments.</p> <p>Interview on 07/29/16 at 8:50 am with the second shift Medication Aide/Supervisor revealed: -Resident #6 was not sent out because the resident said he did not want to go to the hospital. -She had notified the physician about the incident on 07/26/16, regarding Resident #6 and #9 fighting, but did not tell the physician that Resident #6 had marks on his face resulting from the fight.</p> <p>Telephone interview on 07/27/16 at 10:50 am with Resident #6's guardian revealed: -He was unaware that Resident #6 had a fight on 07/26/16. -No one at the facility had notified him. -The facility said they would monitor the resident every 15 minutes in hopes of finding out where the resident is getting alcohol. -Resident #6 had a history of fighting; a few weeks ago Resident #6 started a fight with another resident because he thought the resident had on his pants. -As of today he had not received anything regarding Resident #6 fighting yesterday.</p>	D 273		

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D 273	<p>Continued From page 30</p> <p>Telephone interview on 07/28/16 at 9:45 am with Resident #6's Primary Care Medical Practitioner revealed:</p> <ul style="list-style-type: none"> -He was unaware Resident #6 had been in a fight on 07/26/16. -Without seeing the resident, he cannot say for sure what should have been done regarding the bruises on Resident #6's face. -When a resident was assaulted and if complaining of pain, then staff should send the resident out to the emergency room. -If the resident was not complaining of pain or did not lose consciousness then staff should follow-up with a phone call. -However, the safe play, because the facility staff were unlicensed would be to send the resident with the injury out or contact the on call physician, if after office hours. -If the facility contacted the physician's office there should be documentation of the communication with the on call person in the resident's record and in their office as well. -As of today (7/28/16) there was no documentation that he can see where the facility contacted them regarding Resident #6 having an altercation on 07/26/16 and receiving an injury to the face. <p>Telephone interview on 07/29/16 at 10:11 am with the Office Manager at Resident #6's Primary Care Medical Practitioner's office revealed a check of their answering machine revealed there were no messages left by the facility on 07/26/16, 07/27/16, 07/28/16 or this morning regarding Residents #6 recent altercation with Resident #9.</p> <p>Interview on 07/28/16 at 2:20 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> -When residents get into altercations and staff were unable to break them up then law 	D 273		

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D 273	<p>Continued From page 31</p> <p>enforcement was called to keep residents apart, but the only until mental health worker arrived to assess the residents.</p> <p>-If a resident received injuries from the fight the physician was notified. She thought the Medication Aide notified the physician about Resident #6 getting hit yesterday.</p> <p>C. Review of Resident #3's current FL-2 dated 6/23/16 revealed:</p> <p>-Diagnoses included hypertension, diabetes mellitus, syndrome of inappropriate antidiuretic hormone secretion, schizophrenia, depression and bipolar disorder.</p> <p>-Physician's orders for amlodipine 10mg daily (a medication used to treat high blood pressure), benazepril 5mg daily (a medication used to treat high blood pressure), and clonidine 0.2mg three times daily (a medication used to treat high blood pressure).</p> <p>-Physician's orders to check blood pressure three times daily and to notify the physician if systolic was greater than 160 or less than 110 or if the diastolic pressure was greater than 110.</p> <p>Review of Resident #3's June 2016 eMAR revealed:</p> <p>-An entry for blood pressure to be taken three times daily, prior to the administration of clonidine 0.2mg, with parameter orders to notify the physician if systolic was greater than 160 or less than 110 or if the diastolic pressure was greater than 110 at 8:00 am, 2:00pm and 8:00 pm.</p> <p>-Resident #7's blood pressure exceeded the ordered parameters on the following days:</p> <p>-On 6/13/16, blood pressure was not documented at 2:00 pm but it was documented the clonidine was held.</p> <p>-On 6/16/16, blood pressure was documented as 166/87 at 8:00 pm.</p>	D 273		

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D 273	<p>Continued From page 32</p> <p>-On 6/17/16 it was documented Resident #7 was in the hospital.</p> <p>-On 6/18/16, blood pressure was documented as 167/84 at 8:00 pm.</p> <p>-On 6/19/16, blood pressure was documented as 166/84 at 8:00 pm.</p> <p>-On 6/29/16, blood pressure was documented as 166/84 at 2:00 pm.</p> <p>-There was no documentation on the MAR or in the electronic progress notes that the physician had been notified.</p> <p>Review of Resident #3's July 2016 eMAR revealed:</p> <p>-An entry for blood pressure to be taken three times daily, prior to the administration of clonidine 0.2mg, with parameter orders to notify the physician if systolic was greater than 160 or less than 110 or if the diastolic pressure was greater than 110 at 8:00 am, 2:00pm and 8:00 pm.</p> <p>-On 7/05/16, it was documented that Resident #7 refused clonidine and there was no blood pressure documented.</p> <p>-On 7/06/16, blood pressure was documented as 166/87 at 8:00 pm.</p> <p>-On 7/05/16, it was documented that Resident #7 refused clonidine and there was no blood pressure documented.</p> <p>-On 7/16/16, blood pressure was documented as 169/84 at 8:00 pm</p> <p>-On 7/20/16, blood pressure was documented as 166/87 at 8:00 pm</p> <p>-There was no documentation on the MAR or in the electronic progress notes that the physician had been notified.</p> <p>Review of Resident #3's record revealed there was no documentation staff had notified the medical provider of the blood pressures that exceeded the parameters or the resident's</p>	D 273		

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D 273	<p>Continued From page 33</p> <p>refusals for June or July 2016.</p> <p>Interview with Resident #3 on 7/28/15 at 1:00 pm revealed he did have his blood pressure taken three times daily, but did not know what the results had been or when staff notified his physician.</p> <p>Interview with a first shift Medication Aide (MA) on 7/25/16 at 11:27 am revealed: -MAs were responsible for taking the BP and calling the physician. -Resident #3's ordered blood pressure parameters had been increased in March 2016 and she had not had to report elevated pressures since then. -If she had obtained an elevated blood pressure she would call the physician and document the blood pressure and that she had called the physician. -If she did not receive a response she would keep calling the physician until she received a response. -She did not know if the physician had been notified Resident #3 had elevated blood pressures because she did not obtain elevated pressures and could not speak for other MAs.</p> <p>Interview with a second shift MA on 7/26/16 at 5:39 pm revealed: -She had notified Resident #3's physician about elevated blood pressures a few months back and did not know if she documented this. -She did not remember Resident #3's blood pressure being elevated above the set parameters and had not called his physician in the last two or three months. -She "must have overlooked" the times when his blood pressure had exceeded the parameters. -She would call the on-call physician had she</p>	D 273		

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D 273	<p>Continued From page 34</p> <p>identified the blood pressures exceeded the ordered parameters.</p> <p>Interview with the Resident Care Coordinator (RCC) on 7/28/16 at 1:40 pm revealed:</p> <ul style="list-style-type: none"> -She expected the MAs to call the physician if blood pressures exceeded the ordered parameters. -If the MAs did contact the physician, she expected the MAs also to report this to her. -She was unaware that Resident #3 had blood pressures in June and July 2016 that exceeded the ordered parameters. -She checked the blood pressures monthly at the end of each month. -The MAs that obtained the elevated blood pressures should have notified the on-call physician as well as herself. -If they did not get a response the MA or she would call the physician back. <p>Interview with the Administrator on 7/29/16 at 12:17 pm revealed:</p> <ul style="list-style-type: none"> -There was no set chain of command and they all just communicate and work as a team. -She expected whoever obtained the blood pressure to notify the physician, if the physician ordered to notify him if a blood pressure exceeded the ordered parameters. <p>Telephone interview with Resident #3's Primary Care Medical Practitioner on 7/28/16 at 9:30 am revealed:</p> <ul style="list-style-type: none"> -No one had notified him that Resident #3's blood pressures were elevated in June or July 2016. -It was possible they notified one of the other practitioners while they were on-call. -He expected the facility staff to report the elevated blood pressures and he expected the staff to document if they called him. 	D 273		

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D 273	<p>Continued From page 35</p> <p>-If they did not document that they called, then they did not call.</p> <p>Telephone interview with the Office Manager at Resident #3's Primary Care Medical Practitioner's office on 7/28/16 at 9:59 am revealed there were no phone calls to their on-call practitioners in regards to Resident #3's elevated blood pressures in June or July 2016.</p> <hr/> <p>The facility's failure to notify Resident #2's physician regarding scrotum redness and an open area on the buttock resulted in a delay in treatment that could result in further breakdown, infection and further pain for the resident. The facility failed to notify Resident #6's physician of a facial injury which resulted from a physical altercation, and the facility failed to notify Resident # 3's physician of the resident's blood pressures above the physician ordered parameters, which were if systolic was greater than 160 or if the diastolic pressure was greater than 110. The failure to notify the residents' physicians was detrimental to the health, safety and welfare of the residents.</p> <hr/> <p>The facility did not provide an acceptable Plan of Protection for residents nor a date by which this violation shall be corrected.</p>	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</p>	D 276		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	<p>Continued From page 36</p> <p>orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure physician's orders were implemented for 1 of 6 sampled residents (Resident #7) regarding monthly urine drug screens.</p> <p>The findings are:</p> <p>Review of Resident #7's current FL2 dated 9/17/15 revealed diagnoses included major depressive disorder (recurrent, severe and without psychosis), alcohol use disorder, cannabis use and alcoholic pancreatitis.</p> <p>Review of Resident #7's record revealed: -A hand written, signed physician order dated 4/21/16 to obtain "Urine Drug Screens (UDS) monthly and when resident displays abnormal behavior, certainly after he leave the facility and displays abnormal behavior - drug test". -A hand-written, signed physician order dated 5/09/16 "obtain drug screen". -A hand written, signed physician order dated 7/21/16 for "urine drug screens each month, notify office if patient leaves the facility and returns drunk."</p> <p>Further review of Resident #7's record revealed: -A UDS laboratory report dated 3/29/16 which was positive for clonazepam (which Resident #7 was not prescribed) and THC (tetrahydrocannabinol, a marijuana metabolite) unable to complete testing due to unknown interference.</p>	D 276		

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D 276	<p>Continued From page 37</p> <ul style="list-style-type: none"> -A UDS laboratory report dated 5/11/16 which was positive for THC. -There were no results of a UDS for April, June or July. -There were no documented refusals for UDSs. <p>Interview with a Medication Aide (MA) on 7/28/16 at 1:30 pm revealed:</p> <ul style="list-style-type: none"> -If she or another MA received a laboratory order they would make sure the Resident Care Coordinator (RCC) received a copy and put a copy of the order in the laboratory book. -The laboratory representative came every Wednesday to the facility and collected all of the specimens and transported them to the laboratory. -The results were faxed to the Business Office Manager (BOM) and the results went into a server and copies of the results were brought down to the RCC and she gave them to the physician. -She did not recall an order for monthly UDSs dated 4/21/16 for Resident #7. -She knew he had UDSs in the past but was unable to recall the dates. <p>The RCC was responsible for ensuring ordered laboratory tests were completed.</p> <p>Interview with the RCC on 7/28/16 at 1:56 pm revealed:</p> <ul style="list-style-type: none"> -The MAs are expected to put all laboratory orders in the laboratory book. -A copy of the laboratory orders go in the laboratory book and on Tuesday the laboratory sheets were filled out by herself or the MA. -On Wednesday, a laboratory representative would come to the facility and obtain the specimens and transport them to the laboratory. -The results were returned to the facility via email and the BOM printed the results out and put them 	D 276		

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D 276	<p>Continued From page 38</p> <p>into the laboratory folder.</p> <p>-She or the MA would then go through the results and look for abnormal results and if there were any they would call and fax the physician.</p> <p>-If a resident refused a laboratory test the physician would have been notified.</p> <p>-If Resident #7 refused the UDS the physician should have been notified.</p> <p>Interview with the Administrator on 7/28/16 at 12:20 pm revealed:</p> <p>-For all standing laboratory orders she had a spreadsheet which indicated what laboratory tests were due for all the residents and this spreadsheet ensured those tests were obtained as ordered.</p> <p>-For special or new orders the RCC was responsible for to ensure they were completed and the MAs helped her.</p> <p>-She would expect that the RCC and MAs document any refusal of laboratory tests and the physician be notified.</p> <p>Interview with Resident #7 on 7/27/16 at 5:28 pm revealed:</p> <p>-He did not know why other drugs such as clonazepam showed up on his UDS.</p> <p>-He did drink alcohol and smoke marijuana and did not drink or smoke at the facility, rather he went out with friends.</p> <p>-He was not going to drink or take other drugs anymore because it was not worth it to lose his pain medication.</p> <p>-His doctor would discontinue his narcotic pain medication that he took four times a day if his UDS was positive for anything.</p> <p>-He did not remember a UDS in June and did not refuse a UDS in June or July, but had probably refused UDS screens in the past.</p>	D 276		

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D 276	Continued From page 39 Interview with Resident #7's Primary Care Practitioner on 7/28/16 at 9:30 am revealed: -He ordered monthly UDSs for Resident #7 so he could monitor what he was actually taking because he could not treat Resident #7's chronic pain if he was going to use other illegal substances or alcohol. -Resident #7 did have a history of using illegal substances and he suspected Resident #7 was taking medications prescribed for other residents at the facility. -The residents were good at "cheeking" and hiding medications and then they would give them to other residents. -In a facility like this, he expected the MAs sit the residents down and observe them taking their medication. -They may have missed obtaining a UDS in April and June but he re-ordered the monthly UDSs on 7/21/16.	D 276		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (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. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide forks and	D 287		

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D 287	Continued From page 40 knives as necessary for meals for residents to consume their meals. The findings are: Based on observation, interview and record review, the facility failed to treat resident with respect, consideration, and dignity, and full recognition of his or her individuality by failing to provide forks and knives as appropriate for meals for residents to consume their meals resulting in residents being unable to cut up their food and residents not having the necessary eating utensils for consumption of some foods such as pancakes, meat, and spaghetti. [Refer to Tag 911 G. S. 131D-21(1) Residents Rights (Unabated Type B Violation)]	D 287		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure residents were treated with respect, consideration and dignity related to an "activity work program" that was punitive based on the residents' behaviors.	D 338		

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D 338	<p>Continued From page 41</p> <p>The findings are:</p> <p>Interviews with residents revealed that some residents work in the facility for a maximum of one hour a day, to earn \$1.00 of store credit per day and receive a maximum of \$5.00 store credit per week.</p> <p>Review of the Activity Work Program (AWP) - Agreement to Participate Form revealed:</p> <ul style="list-style-type: none"> -AWP is part of the facility's activity program. -Any resident could participate. -The objective of the program was to help all residents become involved in the community. -Residents were able to participate on a voluntary basis and able to discontinue participation at any time. -AWP was not considered a job. -The participants were required to follow participation guidelines and in return could receive credit in the Activity store for each day they participate with a limit of \$5.00 of credit per week. -The type of individual activity was determined by the resident with the assistance of the activity director. -The activity chosen would be specific in content and have a time frame for participation. -Any staff member who observed a resident participating in their AWP activity during their time frame would sign the AWP participation form. -Residents who had difficulty participating in an activity without disruptive behavior would not be allowed to participate in the activity. -Residents who were disruptive to other residents or staff would become ineligible to participate in this activity or only have limited participation. -The level of available participation was determined weekly by the Activity Director 	D 338		

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D 338	<p>Continued From page 42</p> <p>(AD)and/or management.</p> <p>Review of the current AWP resident duty roster revealed: -There were 26 participants. -Duties included: End 400 smoking area clean up, bulletin board, external pest observation, wiping railings, meal set-up, activity clean up, sweeping outside, med dayroom furniture, breakfast trash was changed to outside clean up for one resident, activity assistant, floors, trash assistant, morning activities and evening activities, basketball court, store assistant, store cart, sweeping outside.</p> <p>Review of 5 different residents AWP Time Sheets revealed: -A time sheet dated 3/23/16, 4/06/16, 4/20/16 and 5/11/16 indicated a resident was eligible for 5 days of participation and the activity detail was "good behavior". -A time sheet dated 5/18/16 indicated a resident was eligible for 3 days of participation and the activity detail was "pm activities". -A time sheet dated 5/18/16 indicated a resident was eligible for 2 days of participation and the activity detail was "activity clean up". -A time sheet dated 5/25/16 indicated a resident was eligible for 4 days of participation and the activity detail was "as needed". -A time sheet dated 5/25/16 indicated a resident was eligible for 4 days of participation and the activity detail was "trash".</p> <p>Interview with Resident #4 on 7/25/16 at 12:15 pm revealed: -They received one dollar a day or five dollars a week to work in the store. -He did this to get extra store credit. -They sold cigarettes, candies and sodas but it did not always work out that he got what he</p>	D 338		

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D 338	<p>Continued From page 43</p> <p>wanted.</p> <p>-He took out the trash on Friday and separated his shoulder.</p> <p>A second interview with Resident #4 on 7/27/16 10:28 am</p> <p>-"Taking out the trash was assigned to me".</p> <p>-"If I had my health I would participate in the activity work program because it has a purpose".</p> <p>-The purpose was to help the kitchen staff to take out the food debris.</p> <p>-He thought management did take hours away from people if they "acted up" but that never happened to him.</p> <p>Interviews with 7 residents at various dates and times regarding the AWP revealed:</p> <p>-One resident used to participate in AWP but did not anymore because it was not worth it.</p> <p>-A second resident participated in the AWP so he could get cigarettes and he would not participate if there was no payment like store credit.</p> <p>-A third resident helped with the activities and earned 3 hours of store credits a week because that's all she wanted to do. She would participate in the AWP if there was not store credit because she believes activities are good for people. If a resident presents with bad behavior then management would take the work away and they would not able to earn store credit. She had been doing 5 hours a week but her hours were reduced because she was mean to other residents and she has remained at three hours per her choice.</p> <p>-A forth resident participated in the AWP by mopping and received store credit and would not participate in AWP if there was no store credit or some type of payment system.</p> <p>-A fifth resident worked the AWP program 6 days for \$5.00 credit at facility store. He would do the AWP program if the \$5.00 store credit was not</p>	D 338		

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D 338	<p>Continued From page 44</p> <p>offered because he liked to keep busy . -A sixth resident worked the AWP 5 days a week because it was something to keep himself occupied. His duties included sweeping, cleaning his room, and making his roommates bed. He got \$5.00 every Thursday to spend at the facility store. If he did not get \$5.00 store credit he would do something else to make money so he could get drinks, chips, cigarettes, cigars, and coffee. -A seventh resident worked the AWP, his responsibility was after each meal take the trash out in the kitchen. He received \$5.00 store credit. He could buy cigarettes, and other "stuff." If he did not get \$5.00 store credit he was not sure if he would participate in the AWP. If he had bad behaviors would get \$5.00 credit taken away for the whole week. His \$5.00 credit had never been taken from him, but he knew a couple of people that had their \$5.00 credit taken away for bad behaviors.</p> <p>An interview with a Medication Aide on 7/27/16 revealed: -Residents would ask for a signature on the AWP Time sheet and she would only sign for them if she observed the activity being performed by the residents. -The signatures on the time sheet were significant because they represented the acknowledgment of participation and the resident would be awarded store credit based on the signed time sheets.</p> <p>Interview with the Activity Director (AD) on July 26, 2016 at 4:47 pm revealed: -She had been the AD for approximately six months and she was a certified AD. -The store credit was meant to be a "thank you" more than anything and she thought that most</p>	D 338		

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D 338	<p>Continued From page 45</p> <p>residents would still participate if there was not store credit.</p> <p>-The activity detail for the AWP was limited to an hour a day and only 5 days a week.</p> <p>-The got \$1.00 store credit for each hour of participation.</p> <p>-If a resident had serious behavioral issues such as cursing at staff or walking off the eligible days for participation would be reduced.</p> <p>-One resident's hours were restricted to three hours a week because she pulled a computer off the desk and it fell to the floor.</p> <p>A second interview with the AD on 7/27/16 at 5:08 pm revealed:</p> <p>-The activity detail "good behavior" was defined as the resident not starting fights with staff and other residents.</p> <p>-They stopped the activity detail of "good behavior s few months ago" because management did not feel it was appropriate for the AWP.</p> <p>-One resident had their hours reduced to 4 hours per week because he had issues walking off.</p> <p>-A second resident's hours were reduced for cursing at staff.</p> <p>-A third resident was calling other residents mean names and her hours were reduced to three and those hours have stayed at three per the residents choice.</p> <p>Interview with the Assistant Operations Manager on 7/26/16 at 4:03 pm revealed:</p> <p>-The AWP program was based of 10A NCAC 13F .0905 (g) where the facility must provide meaningful activities that the resident enjoy doing.</p> <p>-One resident would sweep and sweep because that was what she enjoyed doing. She swept the floors well over the one hour allotted but do so because she enjoyed sweeping.</p> <p>-A vast majority of the residents had simple tasks</p>	D 338		

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D 338	<p>Continued From page 46</p> <p>such as moving cigarette butts from one place to another.</p> <p>-The staff did not check to make sure the task was completed as housekeeping was responsible for the actual work.</p> <p>-The residents received a participation prize of \$5.00 of store credit.</p> <p>-A lot of the AWP was in place prior to his working there, but he has fought to keep it because it offered the residents something to do when they wanted to do it rather than a scheduled activity such as bingo at 4:00 pm.</p> <p>-The residents find out about the AWP by talking to other residents or by reading it on the activity calendar.</p> <p>-The activity detail may not be meaningful to us but if the residents that participated felt they have added something then that was meaningful to them.</p> <p>-A resident might be asked not to participate if they were disruptive just the same way they might be asked to leave bingo if they were disruptive.</p> <p>-No one had ever been denied participation.</p> <p>A second interview with the Assistant Operations Manager on 7/28/16 at 10:53 am revealed:</p> <p>-The residents pick the activity detail they want to participate in and the activity detail can be changed per the resident's request.</p> <p>-There was not a physical assessment to determine if a resident was physically appropriate for the activity detail.</p> <p>-Activity details could include: cleaning the smoking areas, pushing barrels of linens, cleaning windows in the kitchen, nightly cleaning in common areas, cleaning the basketball areas, store assistant, cleaning furniture, helping the soda representative with putting sodas in the machine, messenger (assisting with communication from one staff member to</p>	D 338		

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D 338	Continued From page 47 another), store cart, wiping hand rails, taking out the trash, dining room set up, activity assistant, keeping their own room clean and "keep it up" which included that the resident keep doing what they were doing. -The residents would volunteer for the AWP and they would never be "stuck" with a task they did not want to perform. -If a resident was overly disruptive then there was limited participation in the future. -The residents that were disruptive would be denied the activity they were currently participating and that behavior would not affect other activities included in the AWP hours. -The credit earned could not be taken away from the residents only future participation hours could be reduced. -The AWP was not meant to be a behavior modification tool. -The AD was solely responsible for determining the hours of participation. -The kitchen staff was aware of what the resident assignments were. -Tasks were not switched around but he signed papers for residents without observing the activity detail being performed. -Any staff member that witnessed the resident performing the task could sign off on the AWP time sheet.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 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	D 358		

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D 358	<p>Continued From page 48</p> <p>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: Based on observation, interview and record review, the facility failed to assure Norco (a narcotic used to control pain) was administered as ordered for 1 of 5 sampled residents (Resident #4).</p> <p>The findings are:</p> <p>Review of Resident #4's current FL2 dated 1/21/16 revealed the resident's diagnoses included psychotic disorder and mood disorder.</p> <p>Review of Resident #4's Care Plan dated 3/02/16 revealed: -The resident had a history of traumatic brain injury. -The resident was documented as independent with toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.</p> <p>Interview with Resident #4 on 7/26/16 at 8:35 am revealed: -He had injured his arm "last Friday." -He had "dislocated his shoulder." -He could not move his left arm at all. -It was difficult for him to shower and put on clothing. -He had informed two Medication Aides about his pain last week and the Medication Aides had gotten an order for a mobile x-ray. -The Medication Aides had been giving him Tylenol for the pain in his shoulder, but he continued to have pain and was not able to move his left arm.</p>	D 358		

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D 358	<p>Continued From page 49</p> <p>Review of Resident #4's medication standing orders dated 3/17/16 revealed an order for Tylenol 500mg 1 tab every 6 hours as needed pain.</p> <p>Review of Resident #4's July 2016 Medication Administration Record (MAR) on 7/26/16 revealed: -A computer generated entry for Tylenol 500mg 1 tab every 6 hours as needed for pain. -Tylenol was documented administered for 10 occurrences from 7/22/16 to 7/26/16.</p> <p>Review of Resident #4's x-ray of the left shoulder dated 7/22/16 revealed there was "no acute fracture or dislocation or subluxation" and the "visualized bony structures appear unremarkable."</p> <p>Interview with the Resident Care Coordinator (RCC) on 7/26/16 at 1:15 pm revealed: -She had called Resident #4's physician at 11:00am that morning (7/26/16) to inform them that Resident #4 was continuing to have pain in his left arm and could not move the arm. -The physician had not yet returned the call. -She was sending Resident #4 to the local emergency department for further evaluation of his left shoulder. -"Maybe they will do some more tests."</p> <p>Review of Resident #4's emergency room discharge summary dated 7/26/16 revealed: -The resident presented with "left shoulder pain after he lifted a heavy bag of trash Friday evening." -On examination the resident was "unable to lift the arm or flex the elbow due to severe pain about the shoulder area." -The resident was "not able to perform range of</p>	D 358		

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D 358	<p>Continued From page 50</p> <p>motion of the shoulder due to significant pain." -The diagnosis was "shoulder strain."</p> <p>Review of Resident #4's computed tomography (a non-invasive scan which produces x-ray images) scan of the left shoulder dated 7/26/16 revealed: -Old fracture deformity of the humeral head. -A "large loose bone fragment anterior to the humeral head measuring 2.0 X 0.6 cm." -"Joint effusion."</p> <p>Review of Resident #4's prescription dated 7/26/16 revealed Norco 325mg/5mg 1 tab every 6 hours as needed for pain.</p> <p>Interview with the RCC on 7/27/16 at 9:40 am revealed: -Resident #4's emergency room evaluation showed he had "an old injury to his shoulder and a bone fragment." -"They gave him Norco for pain and a sling to wear." -"He's refusing to wear the sling." -"He says he doesn't want to take the Norco, because it will constipate him, even though I told him we get could something to help with his bowels." -I have scheduled him a follow-up for tomorrow at 10:00am with an orthopedist.</p> <p>Observation of Resident #4 on 7/27/16 at 10:41 am revealed: -The resident was lying on his back on top of his bed. -The sling for his arm was lying on the floor beside the resident's bed.</p> <p>Interview with Resident #4 on 7/27/16 at 10:41 am revealed:</p>	D 358		

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D 358	<p>Continued From page 51</p> <p>-Going to the emergency room was "a complete waste of time." -"Nothing got done." -The resident's pain was "not really" under control. -The pain in his arm was affecting his sleep and appetite. -"The pain pills haven't come in." -"I do have a sling. The sling is too uncomfortable. I don't want to wear it."</p> <p>Observation on 7/27/16 at 10:47 am of the medication cart revealed there were no Norco 5mg/325mg tablets on hand for Resident #4.</p> <p>Interview with a Medication Aide on 7/27/16 at 10:48 am revealed: -The Norco for Resident #4 had been submitted to the backup pharmacy on 7/26/16. -"I will be going to get it shortly." -"He's asked for [a Norco] this morning and I gave him Tylenol."</p> <p>Interview with the Administrator and RCC on 7/27/16 at 10:55 am revealed: -Resident #4 had gotten back from the emergency room at "a little before 6pm" on 7/26/16. -The facility pharmacy cut off time to fill medications to be delivered to the facility the same day was 2pm. -The Medication Aide who worked on 7/26/16 at 6pm would have been responsible for getting the Norco prescription filled from backup pharmacy for Resident #4.</p> <p>Review of Resident #4's July 2016 MAR on 7/27/16 revealed one documented administration of Norco 5/325mg 1 tablet on 7/27/16 at 2:05 pm.</p>	D 358		

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D 358	<p>Continued From page 52</p> <p>Interview with a second Medication Aide on 7/29/16 at 8:15 am revealed:</p> <ul style="list-style-type: none"> -She had been working as a medication aide when staff had returned with Resident #4 on 7/26/16 from the emergency room. -The prescription for Norco for Resident #4 had been faxed to the facility pharmacy as soon as the resident had returned to the facility. -"First shift had said he was complaining of pain and that's why they took him to the emergency room." -The facility pharmacy had then called the medication into backup pharmacy. -The medication was "picked up early" on 7/27/16 for Resident #4. <p>Telephone interview with the facility pharmacy on 7/29/16 at 10:45 am revealed:</p> <ul style="list-style-type: none"> -The Norco order for Resident #4 had been received by the pharmacy on 7/26/16 at 5:36 pm. -"Doesn't look like we got a request for fill from backup until 7/27/16." -"We try to get pain medicine as quickly as possible." 	D 358		
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION</p> <p>Based on these findings, the previous Type B Violation was not abated.</p>	D911		

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D911	<p>Continued From page 53</p> <p>Based on observation, interview and record review, the facility failed to treat resident with respect, consideration, and dignity, and full recognition of his or her individuality by failing to provide forks and knives as appropriate for meals for residents to consume their meals resulting in residents being unable to cut up their food and residents not having the necessary eating utensils for consumption of some foods such as pancakes, meat, and spaghetti.</p> <p>The findings are:</p> <p>Observation on 7/27/16 at 8:15 am of the breakfast meal revealed: -37 place settings of a napkin and spoon. -4 place setting had plastic spoons. -The meal consisted of pancakes, cream of wheat, and eggs.</p> <p>Observation on 07/27/16 at 12:30 pm of the lunch revealed: -41 place settings of a napkin and spoon. -The meal consisted of country steak; mashed potatoes; spinach; pineapple/pear fruit mix; slice of bread; milk, tea, and water. -At 12:40 pm the Medication Aide walked throughout the dining room with two spoons offering to cut up resident steak using the spoons. -Two residents allowed her to cut up steak using spoons. -Most residents declined the offer by the MA to cut up the steak. -No residents ate with their fingers, or appeared to have difficulty cutting the steak up.</p> <p>Confidential interviews with eleven residents revealed:</p>	D911		

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D911	<p>Continued From page 54</p> <ul style="list-style-type: none"> -One resident revealed the facility only allowed a spoon at meals and that made her feel like a child. -She asked for even a plastic knife or fork and was told by staff she could not have plastic because residents might hurt each other. -Two other residents said spoons were always given at meals. -Staff told them no forks and knives were allowed because people could stab each other. -They had not observed residents using a fork or knife to hurt other, but staff told them residents could get hurt if given a fork and knife. -A fourth resident said some meals were easy to eat with a spoon but a fork would help. A fork and knife would be nice to cut pancakes. -He was used to eating meals with a spoon. -A fifth resident said he only get a spoon to eat his meal. -It was hard to eat foods like spaghetti and noodles using a spoon because it falls off spoon. -He was okay with that because the facility had been that way for 4 years and 20 days. -A sixth resident revealed he got only spoons with meals because people always take the forks and stab others with them. -He had been at the facility 10 years, so the stabbing must have happened before he came to the facility. -Not sure how he feels about spoon only, some foods he needed a fork to eat. -A seventh resident was okay with a spoon, but a fork would be alright for some meals. -An eighth resident said "They give us spoons. No knives or forks. They feel if we had knives or forks they would stab each other." -A ninth resident said "Spoons. That's all. I would like to have forks, but they won't do it." -A tenth resident said "One spoon. That's all we get. Most of the time, I get a plastic spoon. You 	D911		

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D911	<p>Continued From page 55</p> <p>would think I would get a regular spoon."</p> <p>Review of 10 of 10 residents records revealed a preprinted typed form with hand written the resident's name, dated 03/17/16, physician's signature, and date of signature. The form stated "With a mentally ill resident a fork or knife can be used as a weapon. The following physician's order allows the resident to have only a spoon at each meal."</p> <p>Observation on 7/26/16 at 9:10 am of the kitchen storage area revealed: -2 each boxes of 36 forks. -2 each boxes of 36 knives.</p> <p>Interview on 7/26/16 at 9:33 am with the Operations Manager revealed: -She had talked with the medical physician about discontinuing the order for spoons and implementing knives and forks, but due to liability he did not want to stop the spoon only order.</p> <p>Telephone interview on 07/26/16 at 10:10 am with the Primary Care Medical Practitioner revealed: -He was concerned for residents at the facility because they were always fighting. -There was a lot violence at the facility and residents were afraid to tell when they were getting beat up. -His fear is if allowed a knife or fork residents will go for the "juggler" with the knife or fork. -He did not feel comfortable discontinuing the spoon only order to residents' mental status.</p> <p>Second telephone interview on 07/28/16 at 9:40 am with the Primary Care Medical Practitioner revealed: -The order for spoons only had been in place for at least the two years he covered the facility.</p>	D911		

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D911	<p>Continued From page 56</p> <p>-He had not completed an assessment for each resident related to their mental status and how having a fork or knife was dangerous.</p> <p>-He can write some type of assessment for each resident but he was concerned if he allowed a reliable resident to have a fork and knife, then an unreliable resident could use it to hurt someone then he would be person to blame.</p> <p>-If he allowed fork and knives the facility would have to increase staff supervision to almost one per resident.</p> <p>Interview on 07/26/16 at 12:45 pm with the first shift Medication Aide (MA) revealed:</p> <p>-There were some residents she would be concerned with using a fork or knife as a weapon.</p> <p>-She was not concerned about every resident but residents like, Resident #3, at meal time would get upset and hurt someone.</p> <p>Telephone interview on 07/27/16 at 5:08 pm with the Mental Health Nurse Practitioner revealed:</p> <p>-The order for spoons, no fork and knife was in place when he started working at the agency.</p> <p>-He had not assessed each resident under his care for mental health related to the nonuse of fork and knife.</p> <p>-No one had asked him to assess residents to allow forks and knives.</p> <p>_____</p> <p>The facility failed to ensure residents were treated with respect, consideration, dignity and recognition of his or her individuality by failing to provide forks and knives when needed for meals resulted in residents having to use spoons to cut up foods, such as meats, use spoons to eat foods such as pancakes and spaghetti. The facility contends that if residents were provided a knife or fork the utensils would be used as weapons by residents, however, there is no documented</p>	D911		

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D911	Continued From page 57 evidence or individualized assessments to indicate that residents would not be able to utilize eating utensils in a safe manner. The facility's failure to provide residents with forks and knives for food to be cut up or consumed appropriately is detrimental to the safety and welfare of the residents. _____ The facility did not provide an acceptable Plan of Protection for residents nor a date by which this violation shall be corrected.	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and health care. The findings are: A. Based on interviews, record reviews, and observations, the facility failed to assure staff provided supervision in accordance with 1 of 6 residents (Resident #8) assessed needs and current symptoms resulting in Resident #8	D912		

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D912	<p>Continued From page 58</p> <p>leaving the facility property multiple times and walking into traffic. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type B Violation)].</p> <p>B. Based on interview and record review, the facility failed to notify the physician for 3 of 5 sampled residents regarding scrotum redness, open area on the buttocks (Resident #2), a resident's high blood pressures with physician ordered parameters (Resident #3) and a facial injury incurred during a physical altercation within the facility. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Unabated Type B Violation)].</p>	D912		