

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments AMENDED STATEMENT OF DEFICIENCIES 2016-08-09 The Statement of Deficiences dated 06/20/16 was amended to add the Staff Identifier to Tag D338. The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted an annual, and complaint investigation survey on June 14 - 20, 2016. The complaint investigation was initiated by the New Hanover County Department of Social Services on 04/21/16.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action report; the Plan of Correction is solely prepared as a matter of compliance with State Law. Note: Facility has realigned entire management structure, to include supervision & monitoring of daily operations as of 6/16/16. Monitoring will include, but not limited to: RN's, LPN's, Clinical Support Team, Quality Assurance Team & Regional Director of Operations.	
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision to 1 of 5 residents sampled (#2) who exhibited wandering behaviors resulting in the resident exiting and departing the facility unsupervised. The findings are: Review of Resident #2's current FL-2 dated 05/03/16 revealed: -Diagnoses included Alzheimer's, hypothyroid,	D 270	It is the policy of Castle Creek to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Care Plans will be reviewed to ensure supervision is being provided to meet the needs of those assessed and identified with an increased risk of elopement. Chart audits conducted by the clinical team and coordinated by a Registered Nurse.	7/20/16 7/20/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Manuel Jr Regional Director of Operations 8/26/16
DATE

*POC Re-submitted 8/26/16 on Amended SOD
POC Reviewed / accepted (JD) 8/26/16*

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D 270	Continued From page 1 and hyperlipidemia. -Resident #2 was constantly disoriented. -Resident #2 was a wanderer. -Resident #2 was ambulatory. -Resident #2 required assistance with bathing and dressing. -Resident #2's recommended level of care was documented as "other/Special Care Unit (SCU)." Review of the Resident Register for Resident #2 dated 04/21/16 revealed: -Resident #2 was admitted to the facility on 04/21/16. -Resident #2 required assistance with dressing, bathing, toileting, and orientation to time and place. -Resident #2's memory was documented as "significant loss-must be directed." Review of the SCU Pre-Admission Checklist for Resident #2 dated 04/20/16 revealed Resident #2 required assistance with bathing, dressing, and orientation. Review of the "Initial Resident Assessment Plan" for Resident #2 dated 06/15/16 revealed: -Resident #2 was "sometimes disoriented." -Resident #2 was "forgetful." -Resident #2 wandered. -Resident #2 "wanders around the building checking doors, picking up things and taking them with her. She is found in other people's rooms shopping through their things." Review of the Care Notes for Resident #2 revealed there was an untimed entry dated 05/09/16 with documentation which read "It was reported that resident had an elopement." Review of the Accident/Injury Report dated	D 270	Therapeutic Alternatives provided training on wandering and elopements on 6/20/16. Registered Nurse provided additional training/education on identifying types of wandering, behaviors and interventions Training conducted: 6/20/16 Residents identified as exit seekers are being checked every 15 minutes. Safety and Security training provided to staff when exiting exterior doors to include, but not limited to ensuring the doors are properly closed and secure, ensure no unauthorized persons exit with the staff before walking away from the door.	7/20/16 7/20/16 7/20/16

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D 270	<p>Continued From page 2</p> <p>05/09/16 revealed:</p> <ul style="list-style-type: none"> -Resident #2 was "observed" by a facility employee "approximately 100 yards north of the facility." -Resident #2 was alone when found by the employee. -Resident #2 was transported back to the facility by the employee. -The date of the incident was documented as 05/09/16. -The time of the incident was documented as 11:00am. -Resident #2's family and physician had been notified of the incident. <p>Telephone interview with a Personal Care Aide (PCA) on 06/16/16 at 10:30am revealed:</p> <ul style="list-style-type: none"> -The PCA came to the facility on 05/09/16 for a strep test. -After the PCA's strep test was completed, the PCA sat outside of the facility in the parking lot inside her car, talking to another staff member. -When the PCA left the facility, the PCA observed "something" in the middle of the road "right by the church." -The PCA was not sure of the exact time but it was "maybe 10:45am-11:00am." -The PCA observed it was Resident #2 in the road and "was able to slam on breaks" -Resident #2 was "in the middle of the road walking zig zag." -Resident #2 did not act like she recognized the PCA, but the PCA was able to get Resident #2 into her car. -The PCA immediately notified the Memory Care Manager (MCM) by telephone that she found Resident #2. -The PCA took Resident #2 back to the facility and was met at the facility door by the MCM and Administrator. 	D 270	<p>During special occasion or large events where multiple persons are entering the secured area at one time, a member of management will be assigned to the front door to monitor, allow entry and exit the secured area/facility.</p>	7/20/16

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D 270	<p>Continued From page 3</p> <p>-Staff had to watch Resident #2 closely because she was confused and wandered.</p> <p>Telephone interview with a second PCA on 06/16/16 at 3:30pm revealed: -Resident #2 wandered "real bad." -Resident #2 wandered "constantly." -Resident #2 "got out" of the facility the day staff were getting TB skin tests and strep tests (05/09/16). -The PCA did not know the time Resident #2 left the facility unsupervised. -Another staff member who came to get their TB and strep tests found Resident #2 on the road and brought her back to the facility. -The PCA was on duty on 05/09/16 when Resident #2 left the facility unsupervised.</p> <p>Interview with a Medication Aide (MA) on 06/15/16 at 9:20am revealed: -The MA was on duty on 05/09/16. -Resident #2 wandered and was frequently observed at the facility exit doors. -Resident #2 went in to other residents' rooms and gathered items; Resident #2 liked to hold and carry the items. -Resident #2 was easily directed by staff. -Resident #2 exited the facility unsupervised and was returned to the facility by another staff member on 05/09/16 between 10:04am and 11:04am. -Prior to Resident #2's elopement from the facility on 05/09/16, two other residents had left the facility unsupervised. -Staff received in-service training after the elopements of the other two residents and prior to Resident #2's elopement.</p> <p>Interview with 6 additional staff members during the survey revealed:</p>	D 270		

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D 270	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Six of six staff interviewed reported Resident #2 wandered. -Resident #2 went in to other residents' rooms and sometimes took their personal belongings. -Resident #2 required frequent re-direction from staff. -Staff tried to keep Resident #2 busy by asking her to fold clothes or walk the halls with staff because she liked to help others. -Resident #2 tried to get out of the facility doors. -Resident #2 looked more like a family member than a resident. -The facility doors were kept locked and staff were required to open doors for any visitor entering or exiting to the facility. -The staff member opening any door was responsible for monitoring the door until the door was closed to assure no resident left the facility unsupervised. -The Administrator was observed by staff standing and monitoring the front/main entrance doors on 05/09/16 around the same time (approximately 11:00am) Resident #2 was found off the facility property unsupervised. -Staff thought the Administrator opened the door for a (named) family member to exit and left the door unattended; Resident #2 got out of the door at that time. -Two other residents had exited the facility unsupervised at different times within the week prior to Resident #2's elopement on 05/09/16. <p>Observation of Resident #2 on 06/14/16 at 11:18am revealed:</p> <ul style="list-style-type: none"> -Resident #2 was walking in the women's hall with another female resident, holding the resident's hand. -Resident #2 was dressed neatly and was well groomed. -Resident #2 had a steady gait. 	D 270		

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D 270	<p>Continued From page 5</p> <p>-Resident #2 opened the door to Room #30 (another resident's room).</p> <p>Interview with Resident #2 on 06/14/16 at 11:19am revealed: -Resident #2 did not know her name or the other resident's name. -Resident #2 had "been here a good many miles." -When asked if she recalled exiting the facility unsupervised, Resident #2 responded "I really don't know if anyone says anything about it." -Resident #2 smiled and mumbled incomprehensible comments at times during the interview.</p> <p>Observation of Resident #2 on 06/14/16 at 11:31am revealed: -Resident #2 opened the door to Room #34 and entered the room (Room #34 is not Resident #2's room). -Resident #2 was re-directed by a staff member to close the door and exit Room #34.</p> <p>Observation and interview of Resident #2 on 06/16/16 at 1:56pm revealed: -Resident #2 was walking on the women's with another female resident. -Resident #2 was neatly dressed and groomed. -Resident #2 said was going to work in her garden.</p> <p>Observation of Resident #2 on 06/17/16 at 4:03pm revealed: -Resident #2 was on the women's hall when she approached another resident and attempted to pull the resident by the arm to walk toward the main hall nursing staff office. -A staff member re-directed Resident #2 and told Resident #2 to "be careful" because the other resident liked to "pinch."</p>	D 270		

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D 270	<p>Continued From page 6</p> <p>-The staff member took Resident #2 and the other resident into the Activity room.</p> <p>Telephone interview with Resident #2's family member on 06/15/16 at 12:10pm revealed:</p> <p>-Resident #2 wandered "a lot."</p> <p>-Resident #2 was confused all the time and did not know where she was.</p> <p>-Resident #2 thought she still lived at home and did not know she lived at the facility.</p> <p>-"Two or three weeks ago" on a Sunday, the family member called that facility and asked that staff have Resident #2 ready to leave with her family.</p> <p>-When the family member got to the facility to pick up Resident #2, the staff did not know where Resident #2 was.</p> <p>-The family member found Resident #2 in another resident's room; Resident #2 "thought she was cleaning out the closet."</p> <p>-Resident #2 "got out" of the facility unsupervised "a month ago "</p> <p>-The family was notified by the facility on the same date that the incident occurred.</p> <p>-The family member was "confused" about how Resident #2 got out of the facility; the facility "always" had a staff member at the front door and had to use a keypad to open the door.</p> <p>-The facility was unable to provide an explanation of how Resident #2 left the facility unsupervised.</p> <p>Observation made while driving from the facility to the church where Resident #2 was found by staff on 05/09/16 revealed the distance from the facility to the church was 0.4 miles.</p> <p>Interview with the MCM on 06/15/16 at 10:45am revealed:</p> <p>-Resident #2 was a wanderer.</p> <p>-The MCM was in her office on 05/09/16 at</p>	D 270		

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D 270	Continued From page 7 approximately 11:00am when a staff member notified her by telephone that she had found Resident #2 at the church. - "There was a lot going on that day" (05/09/16) because the facility was conducting strep tests and TB skin tests for all facility staff. - The MCM was not aware of any special plans or staffing to accommodate for monitoring of the residents during the time of the staff TB and strep testing on 05/09/16. - The staff who were not scheduled to work on 05/09/16 were required to come in for testing. - The staff scheduled to work and were on duty on 05/09/16 were "on the halls;" the MCM was "unsure" how staff on duty got their testing completed. - The facility was adequately staffed on 05/09/16 at the time Resident #2 was found outside of the facility unsupervised. - The MCM thought Resident #2 had exited the facility through the front door. - On 05/09/16, the front door was operational and required a code to be punched into the keypad in order to be opened. - It was facility procedure to re-direct residents away from the doors prior to opening the doors. - Staff usually held only one of the front doors open and made sure the door was closed after each use. - Resident #2 had not lived in the facility long before she "got out" and her family had been "constantly" taking her out of the facility during that time frame. - After Resident #2 was found outside of the facility unsupervised, a family conference was conducted. - The facility requested that Resident #2's family not take her out as much so she could have time to adjust to living at the facility. - The MCM was not sure of the date, but after	D 270		

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D 270	<p>Continued From page 8</p> <p>Resident #2 left the facility unsupervised, alarms were put on all facility doors.</p> <p>-During the "prior weekend" to 05/09/16 two additional residents (not Resident #2) had eloped from the facility at different times.</p> <p>Interview with the Administrator on 05/09/16 at 3:26pm revealed:</p> <p>-Resident #2 was found by a Personal Care Aide (PCA) that day (05/09/16) at approximately 11:00am outside of the facility about 100 yards south of the church located near the facility.</p> <p>-On that same morning (05/09/16) during the time Resident #2 was found outside of the facility, 34 facility staff members were in and out of the front door of the facility for TB skin tests and throat culture/strep tests.</p> <p>-After Resident #2 was found, the facility went in to elopement drill, all facility doors were checked, and a head count of residents was completed.</p> <p>-There was one extra staff member on the schedule that day (05/09/16).</p> <p>-There had not been any additional planning or staffing related to the supervision and monitoring of the doors that day (05/09/16).</p> <p>-It was up to the MCM and the MAs supervising the halls to determine how staff would supervise the residents during the time of the TB tests and strep tests.</p> <p>Interview with the Administrator on 05/11/16 at 2:56pm revealed:</p> <p>-Resident #2 did not remember exiting the facility unsupervised (on 05/09/16).</p> <p>-The Administrator was investigating the incident.</p> <p>-The Administrator was 75% sure Resident #2 left the building between 11:00am and 11:10am on 05/09/16.</p> <p>-The Administrator thought Resident #2 had been out of the building about 10 minutes before being</p>	D 270		

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D 270	Continued From page 9 found and returned by the staff member. -The facility doors were functioning properly on 05/09/16. -Resident #2 got out of the facility unsupervised due to human error. _____ According to the facility's Plan of Protection dated 6/16/16: - Immediately the residents' care plans will be reviewed to ensure supervision is being provided to meet the needs of the residents. - Residents with assessed increased risk of elopement will be monitored using a behavior, mood, communication tracking form to be stationed at the nurses desk and reviewed daily by the staff. - Residents exhibiting an increase in exit seeking will be redirected by staff, involvement in activities, and if necessary a medical evaluation. - Staff training will be provided on redirecting and behaviors. - In the event there is a special occasion or multiple people entering the facility at one time, a member of management will be assigned to the front door to allow visitors to enter and exit the facility. THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2016.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 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.	D 273	It is the policy of Castle Creek to assure health care referral and follow-up to meet the routine and acute health care needs of residents.	

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D 273	Continued From page 10 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interview and record review, the facility failed to assure follow-up for 1 of 5 sampled residents (Resident #3) who displayed symptoms of repeated urinary tract infection which included altered mental status (increased confusion), weakness with a fall, unresponsiveness with hospitalization after a delay of 10 days in obtaining 1st urinalysis and not obtaining 2nd recommended urinalysis. The findings are: Review of Resident #3's current FL-2, dated 01/08/16, revealed diagnoses included multi-farct dementia, hypertension, depression and gastroesophageal reflux disease. Review of the Resident Register revealed the resident was admitted to the facility on 01/04/13. Interview with Resident #3's family member on 6/16/16 at 10:30am revealed: - The resident has history of repeated UTI's. The resident had several UTI's last year and had at least 2 UTI's earlier this year. - The resident never had normal symptoms but had a change of mental status (increased confusion, weakness, lethargy and not as alert) and she tended to get dehydrated. The resident was normally higher functioning (walk with only assist of walker, toilet self, eat meals without assist and able to socialize/talk to staff and other residents). - A family friend reported to family member the resident displayed these symptoms on Mother's Day when she took the resident to a restaurant to eat supper. - The family friend reported symptoms to the 2nd shift medication aide, but a U/A was never	D 273	Chart audits conducted to ensure Health Care Referral & Follow up to include comparing physician orders, medication administration record, medications on hand and follow through on all orders. Audit was monitored by Registered Nurse. Physicians were notified of any discrepancies and facility followed through with any recommendations and orders. Registered Nurse provided training on reporting change of status and acute illnesses on 6/22/16. Shift report implemented to communicate and report resident health changes. Shift report will be reviewed by the oncoming shift. Care Manager and/or Executive Director will review and initial report to ensure resident health needs are addressed. Care Manager will update the Executive Director with any acute changes. The facility reserves the right to seek emergency medical treatment for any resident management deems necessary, even if it overrides physician/nurse practitioners directive.	7/20/16 7/20/16 7/20/16 7/20/16

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D 273	<p>Continued From page 11</p> <p>obtained.</p> <ul style="list-style-type: none"> - The family member discussed concerns with the facility's Administrator, who stated he would check on the resident, but did not obtain order for a U/A. The Administrator told the family member the facility could put the resident's name on the list for the PCP to see when she was at the facility but he could not make her see Resident #3. - Around the middle of May 2016, the resident sustained a fall with skin tears which the family member believed was related to not being treated for a UTI; the resident was weaker and was more confused. - The family member was not aware of any labs obtained from 5/8/16 until 5/28/16 by the facility for urinalysis. - On 5/28/16, family member was informed by another family member the resident was transported to the local ED because she was nonresponsive and was diagnosed with a UTI. - The resident stayed in the hospital for about 3 days and was currently in a SNF for rehabilitation including PT. - The resident could not walk without assist and was weak with decreased alertness during hospital stay (admitted on 5/28/16). <p>Interview with a family friend on 6/16/16 at 3:00pm revealed:</p> <ul style="list-style-type: none"> - On Mother's Day (5/08/16), she took Resident #3 to a nearby out-of-town restaurant for dinner. - When they arrived at the restaurant the resident was sluggish and was "not acting right". - The resident was confused and was not sure of the surroundings (did not recognize she was at a restaurant). - Normally the resident ambulated with use of walker and did not require assistance, but on that evening, the resident was unsteady with the walker and required more assistance with 	D 273		

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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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D 273	<p>Continued From page 12</p> <p>ambulation.</p> <ul style="list-style-type: none"> - After the meal, the resident had to be assisted back to the car because she was unsteady and extremely confused. Her behavior was scary. - The resident's family member/responsible party was contacted and called the resident after the resident was back at the facility. - The resident's speech was slurred and she could not comprehend any of the conversation with the family member. The resident fell asleep during the telephone call. - The family member instructed the friend to report symptoms to the facility's staff because the resident may have a urinary tract infection (UTI). - The resident had a history of repeated UTI and had the same symptoms. - The family friend reported resident's symptoms to 2nd shift medication aide who stated she would report symptoms to the resident's primary medical provider. - The medication aide did not check the resident while the friend was at the facility. - The resident's family member called the facility the next day and voiced concern the resident may have a UTI and needed a urinalysis as soon as possible. - The next 2 weeks, the family friend checked on the resident 8 or 9 times due to concerns about the resident's changes, the resident continued with increased confusion, slurred speech at each visit. - The family friend discussed the resident's changes with the facility's Administrator, who stated he saw some changes in her; the resident stopped coming into his office to sit down and talk, but would only stand at the doorway and stare blankly. - The resident sustained injuries (a skin tear on her arm) from a reported fall at the facility (around the middle of the month. A family member called 	D 273		

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D 273	Continued From page 13 the facility and demanded the facility get orders for a urinalysis. - The friend did not know the results of the urinalysis because about a week later, the resident became unresponsive at the facility and was admitted to the local hospital and treated for a UTI. The resident was transferred to a skilled nursing facility and was currently at the skilled nursing facility. A facility order request dated 5/09/16 revealed: - Documentation (from the facility) requesting "an order for a U/A [urinalysis] on [Resident #3] at family's request? Vitals 128/76, R- 18, P- 72, T-98.3" - Physician/Office Notes (on the order request): "For what reason? Have there been changes to appetite? Sleep? Mood? Is she demonstrating pain? Increase or decrease in urination?" - Facility's documented response: "No changes noticed Family states resident was acting abnormal on Sunday and also states they have been talking with resident on phone and she is having trouble speaking." - Physician Orders dated 5/12/16: Monitor every shift times 5 days. Review of Resident #3's May 2016 medication administration record revealed: - Documentation of temperatures on 1st shift from 5/13/16 through 5/18/16 ranged from 97.7 to 98.6 degrees F. - Documentation of temperatures on 2nd shift from 5/13/16 through 5/18/16 ranged from 97.9 to 98.4 degrees F. - Documentation of temperatures on 3rd shift from 5/15/16 through 5/18/16 ranged from 96.1 to 97.3 degrees F. Review of documentation on facility's "Care Notes" revealed: - On 5/09/16, request an order from [primary care provider] for a U/A at family's request. Vitals	D 273		

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D 273	Continued From page 14 128/76, R 18, P 18, T 98.3. - On 5/10/16, family came in to see resident and requested U/A be done. Spoke with them and told them resident had been acting normal today. Family is stating resident not acting normal on Sunday, May 8th when they took her out. [Fax] sent to PCP on 5/9/16 requesting a U/A, no response from PCP at this time. Explained to family that we need a doctor's ok to do U/A. [Request] refaxed to PCP, still awaiting response. - On 5/12/16, received response for U/A request from PCP. New order to monitor [temperature every shift]. Did not get approval to obtain U/A. - On 5/15/15 at 12:30am, resident was found on floor on left side by her door. Resident have two skin tears that reopened. One on left arm and left knee. - On 5/18/16 at 7:00am, family friend came to visit resident today and noticed resident had a sore on left arm and left knee. Resident's [family member] called and was irate on phone with staff and threatened to call police. Family requested bed alarm. Order for bed alarm sent to PCP and U/A request refaxed. - On 5/19/16 request for [physical therapy] evaluation sent to PCP. - On 5/28/16 at 12:30pm, resident observed by aide not responding and leaning over walker. Resident was drooling from the mouth and making a snoring sound. Resident not able to be aroused. Resident's skin cool and clammy. Unable to obtain vitals; pulse faint and no [blood pressure]. Sent to [local hospital]. - On 5/28/16 at 4:30pm physician from emergency room called to get information about resident's medication and normal mental status. Physician stated resident will be admitted for UTI and resident had some volume around lungs (fluid). A facility order request dated 5/17/16 revealed:	D 273			

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D 273	<p>Continued From page 15</p> <ul style="list-style-type: none"> - Reason for Request: "Resident has been more confused the last couple of days and also had 2 recent falls. Temps are normal. May we please have an order for a U/A?" - Physician Order: (dated 5/19/16) "Medication Technician to accompany resident to obtain clean catch U/A. U/A with C and S (culture and sensitivity) if indicated". <p>Review of a laboratory report dated 5/23/16 revealed:</p> <ul style="list-style-type: none"> - The collection date was 5/18/16. - The final report for the urine culture was multiple bacterial morph types present (100,000 colonies/ml). Suggest recollection if clinically indicated. - Handwritten on the report was "recollection was done on 5/23/16". <p>Review of a local hospital report revealed:</p> <ul style="list-style-type: none"> - Resident #3 was admitted to the emergency department (ED) on 5/28/16 with altered mental status and confusion. - The resident was found to have a decreased GCS (Glasgow Coma Scale used to assess level of consciousness after brain injury) from 15 to 9. (Score of 9 - 12 indicates moderate brain injury. - Patient is unable to provide any history as to what is going on today. No reported fall. There are no other aggravating or alleviating factors. One dose of intravenous (IV) ceftriaxone, one dose of IV Rocephin and a bolus dose of normal saline (1,000 ml) was administered in the ED. - The Patient has a history of UTI's. - Urinalysis shows moderate leukocytes (white blood cells) and bacteria. Will send urine culture. Patient started on IV Ceftriaxone. - Patient admitted to hospital with diagnoses of altered mental status and acute cystitis (UTI). - The resident's admission temperature was 98.1 	D 273		

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D 273	<p>Continued From page 16</p> <p>degrees (rectal).</p> <p>- The resident's brief hospital course by problem: acute encephalopathy (syndrome of overall brain dysfunction) secondary to UTI and probable dementia. Patient admitted for decreased level of responsiveness and fevers. Workup included monitoring blood and urine cultures after U/A revealed leukocytes. Urine cultures speciated (isolated) to Kleb pna sensitive to Rocephin for which she completed a 3 day course with good clinical response. Her mentation resolved slowly. Given her age and underlying dementia, her encephalopathy will continue to take time to resolve further. Due to the infection and her poor physical reserve, she required skilled nursing facility (SNF) placement for ongoing rehabilitation at discharge. She was assessed by physical therapy as well prior to discharge with SNF recommendations.</p> <p>Review of Resident #3's urine culture laboratory results revealed:</p> <ul style="list-style-type: none"> - In 2015, the resident had 3 urinary tract infections. - In 2016, the resident had 2 urinary tract infections in January. <p>Interview with Resident #3's primary care provider (PCP) on 6/16/16 at 11:15am revealed:</p> <ul style="list-style-type: none"> - Resident #3's family reported mental status changes to a facility staff member after taking resident out to a restaurant on Mother's Day. - The staff faxed a request for an order to obtain a urine sample for a U/A, but there was no need for a U/A because the resident was not running fevers and no complaint of burning when urinating. She cannot listen to every family member's concern. - An order was given to the facility to monitor the resident's temperature every shift for 5 days. 	D 273		

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D 273	<p>Continued From page 17</p> <ul style="list-style-type: none"> - The PCP was aware the resident had a history of repeated UTI's which required treatment with antibiotics. - The PCP stated antibiotics should never be prescribed unless needed because too many antibiotics would cause the residents to become resistant to the medication. - A facility staff contacted the PCP on 5/17/16 or 5/18/16 and reported Resident #3 was having some confusion, ordered a clean catch urine sample for a U/A. Do not know results of U/A. - The PCP was aware the resident was hospitalized for treatment of a UTI, but stated she may have had a problem with fluid retention. <p>Interview with the facility's Memory Care Director (MCD) on 6/16/16 at 2:30pm revealed:</p> <ul style="list-style-type: none"> - MCD was aware of report of symptoms and request for U/A made to MA by friend of Resident #3 on 5/08/16. - MA informed MCD she had not observed symptoms reported by resident's friend. - A request for U/A was sent to the resident's PCP on 5/09/16 and the PCP ordered temperature to be monitored every shift for 5 days. - On 5/15/16 the resident was found on the floor with skin tears, reported to PCP. - On 5/18/16, the PCP ordered a clean catch urine sample for U/A and PT evaluation was ordered on 5/19/16 due to fall. - On 5/23/16 the U/A lab report came back and there were bacteria in the resident's urine with a suggestion to recollect U/A if clinically indicated. - The MCD stated she contacted the lab a few days after the medication aide reported she had obtained a 2nd clean catch urine sample and contacted the lab again today, but the lab reported there was not a 2nd urinalysis report and there was no documentation a 2nd urine sample was delivered to the lab. 	D 273		

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D 273	<p>Continued From page 18</p> <ul style="list-style-type: none"> - The MCD did not know whether the MA recollected a urine sample because the laboratory did not have a report of a 2nd urinalysis. - Facility policy was to call emergency medical service and send resident to the local ER for evaluation for reported or observed mental status changes but Resident #3 was not sent to the ER because the family reported changes and the staff did not observe changes. <p>Interview with a 2nd shift MA on 6/16/16 at 2:50pm revealed:</p> <ul style="list-style-type: none"> - On Mother's Day (5/08/16), a friend of Resident #3 took her to a restaurant for supper. - When they returned to the facility, the friend reported the resident had mental status changes (resident was acting strange and was confused) and needed a U/A done because she had a history of repeated UTI's. - MA checked on the resident and could not tell any difference in her behavior. - The next weekend (uncertain of date), the resident was found on the floor and had 2 skin tears. First aide was applied and the resident was not sent out to the emergency room. - The PCP ordered a U/A on 5/18/16 and when the results came back, the MA obtained a 2nd clean catch urine sample and placed the container in the refrigerator in the medication room and called the laboratory to pick up the sample. - The MA stated since the urine sample was obtained on the weekend, "I do not know whether they picked up the urine or not". <p>The facility's Administrator was not available for interview.</p>	D 273			

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D 273	Continued From page 19 According to the facility's Plan of Protection dated 6/16/16: - The facility's licensed nurse will educate the staff on reporting resident illness or acute changes to the supervisor-in-charge (SIC), who will record on the shift report. - The Shift report will be reviewed by the care manager and the oncoming SIC daily. - Care manager will update the Executive Director with any acute changes. If the staff or family still feels the need for the resident to be transported to the hospital, the resident will be transported even if it overrides physician/nurse practitioner's directives. THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2016.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to implement provider orders for 1 of 5 residents sampled (#5) for a dietary supplement for a resident with a	D 276	It is the policy of Castle Creek to assure documentation, implentation of written procedures, treatments or orders from a physician or other licensed health professional.	

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D 276	<p>Continued From page 20</p> <p>documented history of weight loss.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL-2 dated 03/23/16 revealed: -Diagnoses include Alzheimer's disease, hypothyroid, and mixed dyslipidemia. -Resident #5 was constantly disoriented. -Resident #5 was non-verbal and ambulatory. -Resident #5 was "total care."</p> <p>Observation of Resident #5 on 06/14/16 at 10:55am revealed: -Resident #5 was sitting in a chair in the hallway outside of her room. -Resident #5 had a gaunt appearance. -Resident #5 was dressed in a gray colored sweatshirt that had light tan and yellow colored stains on the right chest wall and right sleeve near the wrist. -Resident #5 was looking down at the floor and did not raise her head or respond when spoken to.</p> <p>Interview with a Personal Care Aide (PCA) on 06/14/16 at 10:55am revealed Resident #5 did not normally communicate verbally.</p> <p>Review of Resident #5's current Assessment and Care Plan dated 05/18/16 revealed: -Resident #5 was always disoriented. -Resident #5 was on a pureed diet with nectar thickened liquids.</p> <p>Review of the physician orders for Resident #5 revealed: -There was an order dated 09/18/15 for Mighty Shake 4 ounces between meals and at bedtime. (Mighty Shakes are a dietary supplement used for</p>	D 276	<p>New medication order process & procedure implemented to include "New Order Tracking", which includes a designated color coded system.</p> <p>Care Managers are responsible for reviewing and approving all orders. Registered Nurse provided training on the medication order processing & procedures.</p>	<p>6/22/16</p> <p>6/27/16</p>	

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D 276	<p>Continued From page 21</p> <p>individuals at nutritional risk).</p> <p>-There was an order dated 09/20/15 to weigh Resident #5 weekly.</p> <p>Review of the Progress Noted dated 09/29/16 revealed:</p> <p>-Resident #5 was being weighed weekly.</p> <p>-Resident #5's weights was documented as 108.6 pounds on 09/14/15; 105.4 pounds on 09/21/15; and 103 pounds on 09/28/15.</p> <p>Review of the "Provider Visit Form" for Resident #5 dated 10/14/15 revealed:</p> <p>-Resident #5's weight was documented as 105 pounds on 10/05/16 and 105.4 pounds on 10/14/16.</p> <p>-"No new orders."</p> <p>Review of the "Provider Visit Form" for Resident #5 dated 11/04/15 revealed:</p> <p>-Resident #5's weight was 105 pounds.</p> <p>-"No change to current treatment plan."</p> <p>Review of "Notification of Weight Loss" form for Resident #5 revealed:</p> <p>-Resident #5's weight was 102.2 pounds on 12/10/15.</p> <p>-Resident #5's weight was 92.6 pounds on 01/10/16.</p> <p>-There was an order for Mighty Shake 1 carton with meals and at bedtime; the document was signed by the Nurse Practitioner and dated 01/20/16.</p> <p>Review of Resident #5's January 2016 MARS revealed:</p> <p>-There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm.</p>	D 276		

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D 276	<p>Continued From page 22</p> <p>-Mighty Shake was documented as being administered to Resident #5 three times daily from 01/01/16-01/31/16 with the exception of the 8:00pm shake on 02/20/16.</p> <p>-There were no other entries on Resident #5's January 2016 MAR for Mighty Shake to reflect the change/order dated 01/20/16.</p> <p>-There was an entry to check Resident #5's weight weekly on Mondays.</p> <p>-Resident #5's weight was documented as 92 pounds on 01/11/16; 92.6 pounds on 01/18/16; and 93 pounds on 01/25/16; there was no weight documented on 01/04/16.</p> <p>Review of Resident #5's February 2016 MARS revealed:</p> <p>-There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm.</p> <p>-Mighty Shake was documented as being administered to Resident #5 three times daily from 02/01/16-02/29/16 with the exception of the 8:00pm shake on 02/20/16.</p> <p>-There was documentation Mighty Shake was not administered on 02/20/16 at 8:00pm because Resident #5 was in the hospital.</p> <p>-There was an entry to check Resident #5's weight weekly on Mondays.</p> <p>-Resident #5's weight was documented as 102 pounds on 02/01/16; 101.4 pounds on 02/08/16; 99 pounds on 02/15/16; 97.6 pounds on 02/22/16; and 98.4 pounds on 02/29/16.</p> <p>Review of Resident #5's March 2016 MARs revealed:</p> <p>-There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm.</p>	D 276			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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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 23</p> <p>-Mighty Shake was documented as being administered to Resident #5 three times daily from 03/01/16-03/31/16.</p> <p>-There was an entry to check Resident #5's weight weekly on Mondays.</p> <p>-Resident #5's weight was documented as 97 pounds on 03/17/16; 100 pounds on 03/14/16; 101.4 on 03/21/16; and 98.1 on 03/28/16.</p> <p>Review of Resident #5's April 2016 MARs revealed:</p> <p>-There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm.</p> <p>-Mighty Shake was documented as being administered to Resident #5 three times daily from 04/01/16-04/30/16.</p> <p>-There was an entry to check Resident #5's weight weekly on Mondays.</p> <p>-Resident #5's weight was documented as 100.2 pounds on 04/04/16; 100.2 pounds on 04/11/16; 100.1 pounds on 04/18/16; and 100 pounds on 04/25/16.</p> <p>Review of Resident #5's May 2016 MARs revealed:</p> <p>-There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm.</p> <p>-Mighty Shake was documented as being administered to Resident #5 three times daily from 05/01/16-05/31/16.</p> <p>-There was an entry to check Resident #5's weight weekly on Mondays.</p> <p>-Resident #5's weight was documented as 100 pounds on 05/02/16; 100 pounds on 05/09/16; 101 pounds on 05/16/16; 99 pounds on 05/23/16; and 101 pounds on 05/30/16.</p>	D 276		

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D 276	<p>Continued From page 24</p> <p>Review of the "Provider Visit Form" dated 06/01/16 revealed: -Resident #5's weight was documented as 97 pounds. -There was an order to "change" Resident #5's Mighty Shake supplement to 1 carton four times daily.</p> <p>Review of Resident #5's June 2016 MARs revealed: -There was an entry for Mighty Shake "drink 4 ounces between meals and every night at bedtime" with administration times 10:00am, 2:00pm, and 8:00pm with discontinued documented beside the entry, -There was an entry for Mighty Shake "drink 1 shake by mouth four times a day" with administration times of 07:00am, 12:00pm, 5:00pm, and 8:00pm. -Mighty Shake was documented as being administered to Resident #5 four times daily from 06/01/16-06/15/16. -There was an entry to check Resident #5's weight weekly on Mondays. -Resident #5's weight was documented as 98 pounds on 06/06/16 and 98 pounds on 06/13/16.</p> <p>Telephone interview with the Pharmacy Technician at the facility's contracted pharmacy provider on 06/16/16 at 2:55pm revealed: -The most current order on file at the pharmacy for dietary supplements for Resident #5 was dated 06/01/16 for Mighty Shake four times daily. -The only other order on file for dietary supplements for Resident #5 was dated 09/18/15 for Mighty Shake 4oz between meals and bedtime. -The pharmacy did not have an order on file for Resident #5 for Mighty Shake dated 01/20/16.</p>	D 276		

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D 276	<p>Continued From page 25</p> <ul style="list-style-type: none"> -The facility was responsible for faxing provider orders to the pharmacy and reviewing the electronic Medication Administration Records (MARs) for accuracy. -The contracted pharmacy did not supply Mighty Shake supplements to the facility. <p>Based on observations, record reviews, and interviews, Resident #5 was not interviewable.</p> <p>Telephone interview with Resident #5's family member on 06/16/16 at 09:20am revealed:</p> <ul style="list-style-type: none"> -The family visited Resident #5 daily. -Resident #5 had a history of weight loss. -Resident #5 would eat "eat as much as you give her." -Resident #5 was fed her meals by facility staff or a family member. -Resident #5's medical provider was aware of her weight loss. -Resident #5 had been on a dietary supplement for her weight loss and had previously been on a diet of increased portions. -Resident #5 received a shake "every once in a while;" the last time the family observed Resident #5 receive a dietary supplement shake was "a couple of weeks ago." <p>Interview with a cook on 06/16/16 at 4:07pm revealed:</p> <ul style="list-style-type: none"> -Resident #5 did not receive Mighty Shakes from the kitchen. -Resident #5 received nectar thick milk. -The kitchen kept a list of all residents' diet orders and who received supplements. <p>Interview with a Medication Aide (MA) on 06/16/16 at 2:12pm revealed:</p> <ul style="list-style-type: none"> -Resident #5 had some weight loss last year. -Staff weighed Resident #5 weekly. 	D 276		

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D 276	<p>Continued From page 26</p> <ul style="list-style-type: none"> -Resident #5 ate "really good" and received Mighty Shakes. -Kitchen staff served Resident #5 her Mighty Shakes with her meals. -The kitchen staff thickened Resident #5's Mighty Shakes. -The MAs documented the administration of the Mighty Shakes on the MARs. -The kitchen staff communicated to the MAs when/if Mighty Shakes were not given or not drank. <p>Review of the "Residents that receive Mighty Shakes between meals" list dated 06/14/16 provided by the facility revealed Resident #5's name was on the list to receive Mighty Shakes between meals.</p> <p>Interview with a second MA on 06/17/16 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -The MA did not know if Resident #5 had lost weight. -The MA had observed staff weighing Resident #5 recently. -The dining room staff administered Mighty Shakes to residents when the Mighty Shake was ordered with meals and communicated to the MA of any changes or if the shake was not given; the MA documented administration of the shakes on the MAR. -When a resident was ordered Mighty Shakes between meals, the MAs were responsible for administering the shake and documenting on the MAR. -When a resident had an order for Mighty Shake at bedtime, the MAs were responsible for administering the shake and documenting on the MAR. -The MAs got the Mighty Shakes out of the kitchen as needed. 	D 276		

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D 276	<p>Continued From page 27</p> <ul style="list-style-type: none"> -The MA knew "for a fact" Resident #5 received Mighty Shakes because the MA observed Resident #5 with a shake almost every time she worked. -The Memory Care Manager (MCM) was responsible for faxing provider orders to the pharmacy and approving the orders in the electronic MAR system so the orders appeared on the MARs. -If the MCM was not working or a MA received a verbal order, the MA who received the order was responsible for faxing the order to the pharmacy; the pharmacy transcribed the orders to the MARs. <p>Interview with a third MA on 06/20/16 at 10:38am revealed:</p> <ul style="list-style-type: none"> -The Nurse Practitioner (NP) came to the facility weekly. -It was facility procedure for the NP's weekly orders to be given to the MCM to fax to the pharmacy. -The pharmacy put the order in the system; the MCM "goes through and approves it so it will show up on the MARs." -The order transcription procedure was the same for new and discontinued orders. <p>Observation of Resident #5 during the lunch meal on 06/15/16 at 12:15pm revealed Resident #5 was served strawberry flavored supplement which was nectar thick consistency and a pureed meal.</p> <p>Observation of Resident #5 during the supper meal on 06/17/16 at 5:19pm revealed Resident #5 was served a light pink colored dietary supplement in a 4 ounce glass which was nectar thick consistency and a pureed meal.</p>	D 276		

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D 276	<p>Continued From page 28</p> <p>Observation of Resident #5 on 06/17/16 at 4:05pm revealed: -Resident #5 was assisted by two staff members to the nursing staff office to be weighed at the prompt of the surveyor. -Resident #5's weight was 101.8 pounds.</p> <p>Interview with the Memory Care Manager (MCM) on 06/16/16 at 4:15pm revealed: -Resident #5 received thickened Mighty Shake supplements. -Resident #5's Mighty Shakes were thickened using a pre-measured packet of thickener. -If a resident was ordered Mighty Shakes between meals, the MAs were responsible for administering the shake and documenting on the MARs. -If a resident was ordered Mighty Shakes with meals, the dietary/kitchen staff were responsible for administering the shake to the resident during meals and the MAs were responsible for documenting on the MARs. -The MCM would check Resident #5's supplement orders and the supplement to verify Resident #5 was receiving Mighty Shakes per the provider orders.</p> <p>Interview with the MCM on 06/16/16 at 6:05pm revealed: -Upon review of the provider orders for Resident #5's Mighty Shakes, the MCM acknowledged the provider order dated 01/20/16 to change Resident #5's Mighty Shake to 1 carton with meals and at bedtime was "missed." -Resident #5 should have been receiving Mighty Shake four times daily beginning 01/20/16 but had only been receiving Mighty Shakes three times daily. -The MAs were responsible for faxing provider orders to the pharmacy.</p>	D 276		

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D 276	Continued From page 29 -After receiving the orders by fax, the pharmacy transcribed the orders onto the MARs. -The MCM would update the facility's diet list and place Resident #5 on the correct dietary supplement list. Interview with the Regional Director on 06/16/16 at 6:00pm revealed: -The MAs and MCM were responsible for faxing provider orders to the pharmacy. -The MCM was responsible for verifying provider orders. Interview with Resident #5's Nurse Practitioner (NP) on 06/16/16 at 12:59pm revealed: -Resident #5 has had a recent decline in her health status. -Resident #5 had a history of weight loss but her weight was stable now. -The NP had previously addressed Resident #5's weight loss with her family and facility staff. -Resident #5 had a good appetite and received dietary supplements.	D 276			
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: TYPE B VIOLATION Based on interviews, the facility failed to assure each resident was treated with dignity, consideration, and respect as evidenced by Staff	D 338		It is the policy of Castle Creek to assure that the rights of all residents are maintained and may be exercised without hindrance.	

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D 338	<p>Continued From page 30</p> <p>A kissing 3 of 9 residents sampled (#7, #8, #9) on the cheek, forehead, and mouth; patting 1 of 9 residents sampled on the buttocks (#7); throwing objects and using a loud voice to utter profanity causing 1 of 9 residents sampled (#6) to be awakened from sleep, shake, and cry.</p> <p>The findings are:</p> <p>Review of the facility's license effective 01/01/16 revealed the facility was licensed as a Special Care Unit (SCU) for residents with Alzheimer's and dementia.</p> <p>1. Confidential staff interviews conducted during the survey on 06/14/16-06/17/16 and 06/20/16 revealed:</p> <ul style="list-style-type: none"> -Staff A had been observed by multiple staff kissing Resident #7, Resident #8, and Resident #9 on multiple occasions. -Staff A kissed residents when he was speaking to them. -Staff A "stops and kisses" residents "as they walk by." -Family members and other residents and staff had observed Staff A kiss residents. -Staff A frequently kissed residents but had not kissed any resident "since you are here." -Staff had not reported the Staff A's behaviors because "the least little thing sets him off." -Staff did not want to cause trouble. <p>A. Review of Resident #7's current FL-2 dated 04/18/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included vascular dementia and diabetes. -Resident #7 was constantly disoriented. -The level of care recommended for Resident #7 was documented as special care unit (SCU). 	D 338	<p>Internal investigation initiated on 6/16/16 related to the allegations. Executive Director of record suspended on 6/16/16.</p> <p>24 hr report completed and submitted to the Health Care Personnel Registry.</p> <p>Investigation completed and 5 day report submitted to the Health Care Personnel Registry.</p> <p>Executive Director of record on 6/16/16 previously suspended was relieved of duty on 6/21/16.</p> <p>Resident Rights reviewed with staff or 6/22/16 by a Registered Nurse.</p> <p>Ombudsman will conduct Resident Rights Training on 7/20/16.</p> <p>Sensitivity Training will be conducted by the Ombudsman on 8/4/16.</p> <p>Training provided on avenue to report complaints or concerns utilizing complaints numbers posted for Residents, Family Members and Staff. Training conducted by Registered Nurse on 6/22/16.</p> <p>Training provided on reporting allegations of abuse, neglect or exploitation to the NC Health Care Personnel Registry. Training conducted by Registered Nurse on 6/22/16.</p>	<p>6/16/16</p> <p>6/16/16</p> <p>6/21/16</p> <p>6/21/16</p> <p>6/22/16</p> <p>7/20/16</p> <p>8/4/16</p> <p>6/22/16</p> <p>6/22/16</p>

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D 338	<p>Continued From page 31</p> <p>Confidential staff interview revealed: -The staff had observed Staff A kiss Resident #7 on the cheek, head and lips. -Staff A kissed Resident #7 "real quick" on the lips "at least one month ago."</p> <p>Confidential interview with a second staff revealed Staff A kissed Resident #7 on the "mouth maybe two months ago."</p> <p>Confidential interview with a third staff revealed: -The staff had observed Staff A kiss Resident #7 on the cheek almost every day." -Staff A walked by Resident #7 and kissed her "to get her attention, I guess."</p> <p>Confidential interview with a fourth staff revealed: -The staff observed Staff A kiss Resident #7 on the forehead "multiple times." -Staff A kissed Resident #7 "recently."</p> <p>Based on observation, record reviews, and interviews, Resident #7 was not interviewable.</p> <p>Attempts to contact Resident #7's family by telephone on two different occasions during the survey were unsuccessful.</p> <p>Refer to the confidential interviews with other residents' family members.</p> <p>Staff A was not available for interview.</p> <p>Refer to the interview with the Regional Director of Operations on 06/16/16 at 11:08am.</p> <p>B. Review of Resident #8's current FL-2 dated 02/02/16 revealed: -Diagnoses included Alzheimer's dementia, hypertension, and coronary artery disease.</p>	D 338	<p>Complaint, suggestion box established for Residents, Families or Staff to report any concerns or suggestions. Box is checked by a member of management and addressed accordingly.</p> <p>NOTE: NC Health Care Personnel Registry notified Castle Creek in a letter dated August 8, 2016 that "After carefully reviewing the reported allegations, the Department has determined that investigations will not be conducted in these cases".</p>	<p>7/1/16</p> <p>8/8/16</p>

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D 338	<p>Continued From page 32</p> <p>-Resident #8 was constantly disoriented. -The level of care recommended for Resident #8 was documented as SCU.</p> <p>Review of the Resident Register dated 04/24/15 revealed Resident #8 required assistance with orientation to time and place.</p> <p>Confidential staff interview revealed: -The staff had observed Staff A kiss Resident #8 on the cheek and head when he was speaking to her. -The last time the staff observed Staff A kiss Resident #8 was one month ago.</p> <p>Confidential interview with a second staff revealed: -The staff observed Staff A kiss Resident #8 on the cheek "all the time." -Staff A gave Resident #8 a "real quick kiss" on the lips one month ago. -"It's just inappropriate."</p> <p>Confidential interview with a third staff revealed: -The staff observed Staff A kiss Resident #8 on the cheek and forehead on multiple occasions. -The staff did not recall the last time Staff A kissed Resident #8.</p> <p>Based on observations, record reviews, and interviews, Resident #8 was not interviewable.</p> <p>Telephone interview with Resident #8's family member on 06/17/16 at 4:45pm revealed: -The family member had not observed any staff or Staff A use inappropriate behavior with any resident. -The family member was happy with the overall care Resident #8 received.</p>	D 338		

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D 338	<p>Continued From page 33</p> <p>Refer to the confidential interviews with other residents' family members.</p> <p>Staff A was not available for interview.</p> <p>Refer to the interview with the Regional Director of Operations on 06/16/16 at 11:08am.</p> <p>C. Review of Resident #9's current FL-2 dated 02/08/16 revealed diagnoses included Alzheimer's and diabetes.</p> <p>Review of the Resident Register for Resident #9 revealed: -Resident #9 was admitted to the facility on 01/21/14. -Resident #9 was forgetful; "needs reminders."</p> <p>Review of Resident #9's Assessment and Care Plan dated 07/07/15 revealed: -Resident #9 was "always disoriented." -Resident #9's memory was documented as "significant loss-must be directed."</p> <p>Observation and interview of Resident #9 on 06/16/16 at 10:17am revealed: -Resident #8 was sitting in a chair in her room holding a doll. -Resident #8 was dressed neatly. -Resident #8 did not know where she was. -Resident #8 laughed loudly when spoken to and did not answer questions. -Resident #8 was not oriented to time, place, or situation.</p> <p>Confidential staff interview revealed: -The staff had observed Staff A kiss Resident #9 on the cheek and forehead multiple times. -Staff A kissed Resident #9 last week.</p>	D 338		

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D 338	<p>Continued From page 34</p> <p>Based on observations, record reviews, and interviews, Resident #9 was not interviewable.</p> <p>Telephone interview with Resident #9's family member/Power of Attorney (POA) on 06/17/16 at 4:56pm revealed: -The POA was pleased with the overall care Resident #9 received; "it sometimes takes a while to get things done, but it does get done." -Staff treated Resident #9 "well;" the POA did not have any concerns related to the staff or management of the facility.</p> <p>Refer to the confidential interviews with other residents' family members.</p> <p>Staff A was not available for interview.</p> <p>Refer to the interview with the Regional Director of Operations on 06/16/16 at 11:08am.</p> <p>2. Confidential staff interviews conducted during the survey on 06/14/16-06/17/16 and 06/20/16 revealed Staff A was observed by staff patting Resident #7 on the buttocks on multiple occasions.</p> <p>Review of Resident #7's current FL-2 dated 04/18/16 revealed: -Diagnoses included vascular dementia and diabetes. -Resident #7 was constantly disoriented and wandered. -The level of care recommended for Resident #7 was special care unit (SCU).</p> <p>Confidential staff interview revealed: -The staff observed Staff A pat Resident #7 on the buttocks "one month ago." -Staff A's behavior was "inappropriate."</p>	D 338		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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D 338	<p>Continued From page 35</p> <p>Confidential interview with a second staff revealed: The staff observed Staff A pat Resident #7 on the buttocks "three or four times." -The last time the staff observed Staff A pat Resident #7 on the buttocks was "about two weeks ago."</p> <p>Confidential interview with a third staff member revealed: -The staff heard other staff members talking "a few months ago" about Staff A "slapping" Resident #7 on the buttocks. -The staff member could not remember the names of the staff members who were discussing the incident, but the staff members worked on first shift. -The staff had not personally observed Staff A touch Resident #7 on the buttocks. -The staff did not report the incident because it was "hearsay."</p> <p>Based on observation, record reviews, and interviews, Resident #7 was not interviewable.</p> <p>Attempts to contact Resident #7's family by telephone on two different occasions during the survey were unsuccessful.</p> <p>Refer to the confidential interviews with other residents' family members.</p> <p>Staff A was not available for interview.</p> <p>Refer to the interview with the Regional Director of Operations on 06/16/16 at 11:08am.</p> <p>3. Confidential staff interviews revealed: -On 05/09/16, Staff A used a loud voice and</p>	D 338		

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D 338	<p>Continued From page 36</p> <p>profanity and threw objects against the wall in his office resulting in loud noise which caused Resident #6 to cry.</p> <p>-On 05/09/16, the facility conducted strep throat testing and a resident had eloped from the facility unsupervised.</p> <p>-Staff A was "screaming at everyone" and throwing stuff after the Resident who eloped was returned to the facility by a staff member.</p> <p>-A "whole bunch of residents" observed Staff A's behavior on 05/09/16.</p> <p>-Staff A was "very rude and scared a lot of people" on 05/09/16.</p> <p>-Staff A got frustrated and "says things he does not need to say" to residents and staff such as "yelling" at staff to "come get" a resident out of his office.</p> <p>-Staff heard Staff A's voice saying "a lot of curse words" and stuff hitting the wall coming from Staff A's office on 05/09/16.</p> <p>-Staff A's office door adjacent to the hallway was cracked; staff and "plenty of residents" were in the hallway and observed/heard Staff A's behavior.</p> <p>-Staff was "shocked" by Staff A's behavior in front of the residents.</p> <p>-Later that same day, (05/09/16) Staff A was putting his personal belongings in boxes and slamming doors.</p> <p>-Staff observed Staff A picking up a broken glass picture frame off of the floor of his office on 05/09/16.</p> <p>-The day after the incident the Regional Director came to the facility.</p> <p>Review of Resident #6's current FL-2 dated 01/05/16 revealed:</p> <p>-Diagnoses included vascular dementia, insomnia, and hypertension.</p> <p>-Resident #6 was intermittently disoriented.</p>	D 338		

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D 338	<p>Continued From page 37</p> <p>-The level of care recommended for Resident #6 was documented as "other/SCU" (special care unit).</p> <p>Review of the Resident Register dated 01/06/15 revealed Resident #6 required assistance with orientation to time and place.</p> <p>Observation during the initial facility tour on 06/14/16 revealed Resident #6 resided in a room which was located one door down from Staff A's office on the opposite side of the hallway.</p> <p>Confidential staff interview revealed: -The staff observed Resident #6 crying "real bad" on 05/09/16 when Staff A was screaming and throwing stuff. -Resident #6 did not like loud noises. -Another staff member was able to calm Resident #6 down on 05/09/16. -The staff member had not observed Staff A throw objects at any time other than on 05/09/16. -The staff member had observed Staff A use profanity in the presence of residents on other occasions but Staff A was not "cursing at residents."</p> <p>Confidential interview with a second staff revealed: -Staff A was cursing and yelling at two staff members on 05/09/16. -The staff member heard a "real loud" noise coming from Staff A's office on 05/09/16. -Resident #6 was crying and expressing to the staff member that she did not like loud noises. -Resident #6 was "shaking, scared, and crying hysterically" on 05/09/16 for "a few minutes." -"My heart went out to her (Resident #6)." -One family member and one resident had complained to the staff member about Staff A's</p>	D 338		

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D 338	<p>Continued From page 38</p> <p>behavior.</p> <p>Confidential interview with a third staff revealed: -Staff A was cursing and threw a tool box against the wall on 05/09/16 because he was angry because of the resident elopement. -Resident #6 was affected by Staff A's behavior on 05/09/16; Resident #6 was awakened from sleep. -The loud noises startled Resident #6. -Resident #6 was crying and said "it was too much noise" and she didn't know what was going on. -Staff were able to calm Resident #6 and re-direct her. -The staff did not know if Staff A was aware that Resident #6 was affected by his behavior on 5/09/16.</p> <p>Confidential interview with a fourth staff revealed: -On 05/09/16, Staff A was throwing items and using expletive language in a louder than normal voice; staff and residents heard and observed the incident. -The staff observed Resident #6 crying and saw another staff member with Resident #6. -The staff went outside the building and called the "corporate hotline" to report Staff A's behavior. -The staff left a message for the hotline that the staff felt like residents and staff were "not safe." -Nobody from corporate ever contacted the staff member after the message was left on the corporate hotline.</p> <p>Based on observations, record reviews, and interviews, Resident #6 was not interviewable.</p> <p>Telephone interview with Resident #6's family member on 06/20/16 T 10:00am revealed: -The care Resident #6 received at the facility was</p>	D 338		

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D 338	<p>Continued From page 39</p> <p>up and down, the facility had a "rotating door" of staff, and the family wanted to move Resident #6 out of the facility.</p> <ul style="list-style-type: none"> -The family lived out of state but visited every 3 or 4 months. -Resident #6 did not like loud noises. -The family did not mention knowledge of the incident which occurred on 05/09/16. -The family member had left "over 20" messages for Staff A the prior week and previous few weeks and Staff A had not returned her calls. -Some facility staff were "unprofessional" but the family did not know the names of the staff members. <p>Confidential telephone interview with a licensed health care professional (HCP) contracted by the facility revealed:</p> <ul style="list-style-type: none"> -The HCP was in the facility on 05/09/16. -The HCP heard loud noises coming from Staff A's office on 05/09/16. -The HCP observed Staff A using profanity and slamming doors in the presence of providers, staff, and residents on 05/09/16. -The HCP was "quite concerned" about Staff A's behavior on 05/09/16. -The HCP observed Resident #6 in the hallway crying requiring staff to check on Resident #6. -The HCP was sure Resident #6 heard Staff A's loud cursing. -The HCP documented notes regarding the incident on their cell phone. <p>Review of the documentation provided by the HCP's from the cell phone notes dated 05/09/16 revealed:</p> <ul style="list-style-type: none"> -Resident #6 was crying on 05/09/16. -Staff A "screamed obscenities" at the HCP; the HCP felt threatened. -The HCP heard Staff A yell obscenities at two 	D 338		

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D 338	<p>Continued From page 40</p> <p>named staff members. -Two staff reported feeling unsafe to the HCP.</p> <p>Staff A was not available for interview.</p> <p>Refer to the confidential interviews with other residents' family members.</p> <p>Refer to the interview with the Regional Director of Operations on 06/16/16 at 11:08am.</p> <p>_____ Confidential telephone interview with a family member of a resident revealed: -The family member denied complaints about Staff A or other facility staff. -The family member felt like they could share any concerns they had with Staff A.</p> <p>Confidential telephone interview with a second family member of a resident revealed: -Staff A did not interact with the residents and stayed mostly in his office. -Staff A "seemed nice" when the family met him. -The family did not have any complaints about Staff A and other staff.</p> <p>Confidential interview with a third family member of a resident revealed Staff A seemed to be "involved;" the family member did not share any concerns regarding Staff A's behavior.</p> <p>Interview with the Regional Director of Operations (RDO) on 06/16/16 at 11:08am revealed: -The RDO was Staff A's immediate supervisor. -The RDO was aware of Staff A's behavior on 05/09/16 but was not aware of any resident being affected by Staff A's behavior on 05/09/16. -The RDO was notified about the incident on 05/09/16 by the facility's Licensed Health</p>	D 338		

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D 338	<p>Continued From page 41</p> <p>Professional Support Registered Nurse (LHPS RN) on 05/09/16.</p> <ul style="list-style-type: none"> -The LHPS RN reported Staff A was packing his belongings and was going to leave the facility. -The LHPS RN reported being concerned about Staff A's yelling, swearing, and commotion coming from Staff A's office. -The RDO spoke with Staff A by telephone on 05/09/16 and told Staff A to "get it together or leave." -Staff A was "irate" on 05/09/16 because a resident eloped from the facility unsupervised that day (05/09/16). -The RDO sent an Administrator from another facility located in a nearby county to the facility that day (05/09/16). -The RDO traveled to the facility the following day (05/10/16). -The RDO was unaware that any resident had been affected by Staff A's behavior on 05/09/16 until the time of the interview on 06/16/16 at 11:08am. -If the RDO had known that a resident was affected by Staff A's behavior, the incident would have been addressed differently. -The RDO was unaware of any incidents of Staff A kissing residents or patting residents on the buttocks until the time of the interview of 06/16/16 at 11:08am. -The RDO was unaware of any calls being received on the corporate hotline regarding Staff A's behaviors and no staff member employed in the facility had ever reported any inappropriate behavior by Staff A to him (the RDO). -The corporate policy would be followed regarding allegations about Staff A's behaviors; Staff A would be reported to the Health Care Personnel Registry according to the rules and policy. 	D 338		

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PRINTED: 08/25/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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D 338	<p>Continued From page 42</p> <p>2. Review of Resident #1's current FL-2 dated 4/5/16 revealed: -Diagnoses included dementia without behaviors, hyperglycemia, diabetes mellitus II, chronic kidney disease (stage 3), anxiety, anemia, gastroesophageal reflux disease, posttraumatic stress disorder, obesity, hyperlipidemia, and hypothyroidism. -Resident is ambulatory. -Resident is intermittently disoriented.</p> <p>Review of care notes for Resident #1 revealed entry dated 4/15/16 at 9:00am describing the following: - " Resident was standing in front of nurse's station asking questions about his wife. MCM answered questions for resident. Resident walked away. Resident returned 10 minutes later to reask question. Resident was taking to a staff member when resident started to get frustrated, thought no one was paying any attention to resident. Resident thought the staff member was mocking them because staff member happened to be laughing at the computer. Resident took out cellphone and called daughter to say that the staff member was laughing at them. Resident family member ask resident to describe what the staff member was wearing and staff name. The staff member gave a funny name because she was joking with resident. Resident became agitated saying staff member was disrespecting resident. MCM was present. There was no disrespect going on. "</p> <p>Interview with MCM on 6/16/16 at 2:25pm revealed: -MCM talked with Resident #1 at nursing station as Resident #1 asked questions about his spouse. -Dietary staff was sitting at computer laughing.</p>	D 338		

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D 338	<p>Continued From page 43</p> <ul style="list-style-type: none"> -Resident #1 thought dietary staff was laughing at him and became upset. -Resident #1 called his daughter. -Resident #1 asked dietary staff there name and dietary staff responded "puddingthang." -MCM talked with dietary staff as incident was not appropriate as staff cannot talk to residents like that. -MCM reported incident to ED on 4/15/16 (day of incident). <p>Telephone interview with dietary staff on 6/17/16 at 1:45pm revealed:</p> <ul style="list-style-type: none"> -Recalls no knowledge of an incident with Resident #1. -MCM has not had to talk to dietary staff about being inappropriate with residents. -Dietary staff would never talk ugly to a resident or be disrespectful to a resident. <p>Interview with Resident #1's family member on 6/17/16 at 1:52pm revealed:</p> <ul style="list-style-type: none"> -On 4/15/16 at 8:55am, Resident #1 called and was upset with a staff person as resident felt staff member was laughing at resident. -While on phone with Resident #1, family member could hear giggling in the background. <p>Interview with Regional Director of Operations on 6/17/16 at 2:37pm revealed:</p> <ul style="list-style-type: none"> -No documentation of personnel issue regarding dietary staff and Resident #1 regarding 4/15/16 incident. -It is unacceptable for a staff member to be disrespectful to a resident. <p>Resident #1 was not able to be interviewed as resident is no longer at facility.</p>	D 338		

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NAME OF PROVIDER OR SUPPLIER
CASTLE CREEK MEMORY CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
**4724 CASTLE HAYNES ROAD
CASTLE HAYNE, NC 28429**

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D 338	<p>Continued From page 44</p> <hr/> <p>According to the facility's Plan of Protection dated 6/16/16:</p> <ul style="list-style-type: none"> - Management will initiate internal investigation related to the allegations. - Staff A will be suspended pending investigation. - A 24 hour and a 5 day Health Care Personnel report will be completed and submitted. - Facility will arrange and provide Resident Rights training. <p>THE CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED AUGUST 4, 2016.</p>	D 338		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <ol style="list-style-type: none"> (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the prescribing physician and in accordance with the facility's policies and procedures for 2 of 5 sampled residents as evidenced by Resident # 4 not</p>	D 358	<p>It is the policy of Castle Creek to assure the preparation and administration of medications, prescriptions and non-prescriptions and treatments are in accordance with orders by a licensed prescribing practitioner.</p>	

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D 358	<p>Continued From page 45</p> <p>receiving medications such as Gabapentin, Medizine, Diazepam and Seroquel on multiple occasions for multiple days due to the medications not being available and Resident # 1 not receiving insulin timely due to shortage of staffing.</p> <p>The findings are:</p> <p>1. Review of Resident #4's current FL-2 dated 4/14/16 revealed: -Diagnoses included Alzheimer's Dementia, Hypercholesterolemia, Benign Pro-static Hypertrophy, Migraine, Carpal Tunnel Syndrome, Hypertension, Dizziness and giddiness. -Resident is ambulatory. -Resident is constantly disoriented and a wanderer.</p> <p>Review of Resident #4's Resident Register revealed resident was admitted to facility on 3/18/16.</p> <p>Review of Resident #4's Initial Resident Assessment Plan, dated 3/25/16, revealed: -Resident has a primary diagnosis of Dementia. -He requires a lot of redirecting from the doors and other areas of the building. -He has dizzy spells, and when that occurs you will see him walking around like he is drunk. At that time facility staff monitors resident.</p> <p>Review of Resident #4's pre-admission FL-2, dated 3/14/16, revealed orders for the following: -Amlodipine Besylate 10 mg 1 tablet once a day (prescribed for cardiovascular diseases) -Diazepam 5 mg 1 tablet twice a day (prescribed for anxiety) -Gabapentin 100 mg 1 tablet three times a day (prescribed for behaviors)</p>	D 358	<p>MAR's and medication carts reviewed to ensure all residents have their prescribe medications. Implemented on 6/20/16 and will continue on a weekly basis.</p> <p>New medication order process & procedure implemented to include "New Order Tracking", which includes a designated color coded system. Care Managers are responsible for reviewing and approving all orders. Registered Nurse provided training on the medication order processing & procedures.</p>	<p>8/4/16 on-going</p> <p>6/22/16</p>

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D 358	<p>Continued From page 46</p> <p>-Meclizine 25 mg ½ tablet a day as needed (prescribed for dizziness/vertigo)</p> <p>Review of physician orders for Resident #4, dated 3/25/16, revealed: -Medication Aide (MA) requested clarification of resident's medications orders. -Physician clarified that Meclizine 25 mg ½ tablet (12.5 mg) by mouth daily as needed is for Vertigo. -Order was signed by the physician.</p> <p>Review of physician orders for Resident #4, dated 3/29/16, revealed: -A request for an order for physical therapy evaluation -Order was signed by the physician.</p> <p>Review of physician orders for Resident #4, dated 3/30/16, revealed: -MA notified physician the resident is agitated and exit seeking, and requested a " PRN to take the edge off " . -Order for Xanax 0.5 mg 1 tablet three times a day, as needed for anxiety/agitation, was signed by physician.</p> <p>Review of physician orders for Resident #4, dated 3/31/16, revealed: -Add Seroquel 25 mg 1 time a day at bedtime -Hold Amlodipine 10 mg for 7 days -Order was signed by the physician.</p> <p>Review of March 2016 Electronic Medication Administration Record (EMAR) for Resident #4 revealed documentation of the following: -Amlodipine 10 mg daily to be administered at 8:00 a.m. Documentation of MA initials with circles indicating 10 missed doses of Amlodipine from 3/19/16 through 3/28/16. -Documented reasons for missed doses of Amlodipine were "</p>	D 358	<p>Training provided on medication policy and actions to be taken should a resident run out of medications or medications are not provided in a timely manner by the family. Management will be available for administration and the back up pharmacy will be utilized. Training conducted by a Registered Nurse on 6/22/16. 8/4/16</p> <p>Care Manager will assure that adequate medication staff are scheduled and on duty to provide proper medication administration as order by physician. Schedules will be reviewed daily to ensure coverage. Executive Director will monitor compliance. 8/4/16</p> <p>Quick MAR (electronic medication administration record) will be reviewed daily by the medication aide to ensure medications are administered as ordered. 8/4/16</p> <p>Care Managers will review Quick Mar weekly for compliance. Any discrepancies found are followed up Care Manager and addressed accordingly per procedure. 8/4/16</p>	8/4/16 8/4/16 8/4/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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D 358	<p>Continued From page 47</p> <p>withheld per doctor orders " and " withheld awaiting clarification " .</p> <p>-Alprazolam (Xanax) 0.5 mg tablet, 1 tablet by mouth three times a day, as needed for anxiety/agitation starting 3/31/16. Documentation reflected no doses of Alprazolam were given in March 2016.</p> <p>-Meclizine 25 mg tablet ½ tablet by mouth daily, as needed for vertigo. Documentation reflected no doses of Meclizine were given in March 2016.</p> <p>Review of March 2016 Care Notes for Resident #4 revealed:</p> <p>-On 3/18/16, a telephone message was left with resident's family member to bring resident's Amlodipine 10 mg and Meclizine 25 mg. Resident was without this medication and the pharmacy does not provide it.</p> <p>-On 3/30/16, Resident had been agitated and exit seeking since family came to visit. Order was given for Xanax 0.5 mg three times a day as needed for anxiety/agitation. Prescription was faxed to pharmacy.</p> <p>Review of physician orders for Resident #4, not dated, revealed:</p> <p>-Discontinue Seroquel 25 mg at noon</p> <p>-Start Seroquel 50 mg at noon</p> <p>Interview with Memory Care Manager (MCM) on 6/16/16 at 2:20 p.m. revealed the physician orders for Resident #4, not dated, were received sometime in April 2016.</p> <p>Review of Physician's Orders for Resident #4, dated 4/7/16, revealed:</p> <p>-Amlodipine 10 mg tablet daily</p> <p>-Diazepam 5 mg tablet twice a day</p> <p>-Gabapentin 100 mg capsule three times a day</p> <p>-Alprazolam (Xanax) 0.5 mg tablet three times a</p>	D 358	<p>Training provided on monitoring signs and symptoms of adverse actions due to changes in medication regimen, documentation and reporting to the primary care physician.</p>	7/16/16 & 7/20/16

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D 358	<p>Continued From page 48</p> <p>day as needed for anxiety/agitation</p> <p>2. Review of Resident #1 's current FL-2 dated 4/5/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included dementia without behaviors, hyperglycemia, diabetes mellitus II, chronic kidney disease (stage 3), anxiety, anemia, gastroesophageal reflux disease, posttraumatic stress disorder, obesity, hyperlipidemia, and hypothyroidism. -Resident is ambulatory. -Resident is intermittently disoriented. -Humalog sliding scale before meals and at bedtime. -Humalog 100 unit/ml inject 10 units before meals. <p>Subsequent order dated 4/6/16 revealed Humalog 10 units before meals and at bedtime per sliding scale 200-249 - 2 units, 250-299 - 4 units, 300-349 - 6 units, 350-400 - 8 units, greater than 400 - 10 units and notify provider.</p> <p>Review of April 2016 EMar (Electronic Medication Administration Record) revealed:</p> <ul style="list-style-type: none"> - Humalog 10 units before meals and at bedtime per sliding scale 200-249 = 2 units, 250-299= 4 units, 300-349 = 6 units, 350-400 = 8 units, greater than 400 = 10 units and notify provider. -Times to be administered were scheduled for 7:00am, 11:30am, 4:30pm, and 8:00pm. <p>Review of April 2016 Vital Signs sheet from EMAR revealed:</p> <ul style="list-style-type: none"> -4/9/16 Humalog 2 units was administered at 10:23pm as blood sugar was documented as 236. -4/10/16 Humalog 4 units was administered at 9:53pm as blood sugar was documented as 287. 	D 358		

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D 358	<p>Continued From page 49</p> <p>Review of Daily Schedule and Assignments for 4/9/16 and 4/10/16 revealed: -Two medication aides scheduled for 7:00am-7:00pm. -One medication aide scheduled from 7:00pm-7:00am. -No medication aide was scheduled for 7:00pm-11:00pm</p> <p>Interview with medication aide on 6/16/16 at 4:08pm revealed: -Medication aide does not know if someone called out for the 7:00pm-11:00pm shift or if schedule was left blank on 4/9/16 and 4/10/16. -Medication aide was the only MA to administer 8:00pm medications for both halls on 4/9/16 and 4/10/16. -MA starts 8:00pm medication pass at 7:00pm. Medications were administered between 7:00pm and 8:30pm. -8:00pm medication pass is the heaviest medication pass. -MA does not recall being late administering medications on 4/9/16 and 4/10/16.</p> <p>Interview with MCM on 6/16/16 at 4:25pm revealed: -On 4/9/16 and 4/10/16, the facility had one medication aide scheduled from 7:00pm-7:00am. -The facility did not schedule a MA on 4/9/16 and 4/10/16 from 7:00pm-11:00pm. -The 7:00pm-11:00pm shift is used to get MAs their 40 hours. -MCM has the ability to adjust schedule but did not adjust because it would mean staff would have overtime. -The 8:00am and 8:00pm are the heaviest med passes.</p> <p>Resident #1 did not return back to the facility after</p>	D 358		

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D 358	Continued From page 50 being sent to local hospital for high blood sugars on 4/20/16. _____ According to the facility's Plan of Protection dated 6/20/16: - The Interim Administrator will review MAR's and medication carts to ensure all residents have their prescribed medications, to begin today. - Staff will be inserviced on medication policy and if residents run out of medications or medications are not provided on time by the family, the back up pharmacy will be called. - Weekly MAR to medication cart audits will be conducted. - Medications will be reordered 7 days prior to running out. - The bucket system for orders will be implemented to ensure medication and all other others are followed. - All the above steps will be monitored by the MCD weekly. THE CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED AUGUST 04, 2016.	D 358		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406		

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D 406	<p>Continued From page 51</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow up on medication review recommendations for 6 of 6 sampled residents (#5 #13, #14, #15, #16 and #17) with medication for diabetes (#13 and #15), medication for hypothyroidism (#14), medication for hypertension (#16), medication for hypokalemia (#17), and antipsychotic medication (#5). The findings are:</p> <p>1. Review of Resident #13's FL-2 dated 6/16/16 revealed: - Diagnoses included dementia and diabetes mellitus. - There was an order for Levemir Flex touch injectable, inject 30 units subcutaneous, every evening with dinner.</p> <p>Review of a pharmacist "Note to Attending Physician/Prescriber" dated 5/17/16 revealed: - Pharmacist noted the resident blood sugars were running high and the resident's current Levemir dose was 30 units every evening with dinner. - The pharmacist questioned whether a dose increase would benefit this resident (on the Note To Attending Physician/Prescriber). - The document did not have a response or a signature from the Physician/Prescriber.</p> <p>Review of Resident #13's May 2016 and June 2016 medication administration records (MARs) revealed: - Levemir 30units was documented as administered once daily at 5:00pm. - There was no documentation the recommendation to change the dose of Levemir was forwarded to the physician/prescriber.</p>	D 406	<p>It is the policy of Castle Creek to assure action is taken as needed in response to the medication review and documented including that the physician or appropriate health professional has been informed of the findings.</p> <p>Upon receipt of the pharmacy reviews, the Executive Director will provide a copy to the Care Manager to address the recommendations. Care Manager will be responsible for reviewing the pharmacy recommendations, forwarding to the primary care practitioner, tracking and documenting actions-response, processing and approving orders.</p> <p>Compliance will be monitored by the Executive Director, Quality Assurance Team, Regional Director & Clinical Support Team.</p>	<p>8/4/16</p> <p>8/4/16</p>

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D 406	<p>Continued From page 52</p> <p>Refer to interview with the Memory Care Director on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for interview.</p> <p>2. Review of Resident #14's current FL-2 dated 08/13/15 revealed: - The resident's diagnoses included vascular dementia and hypothyroidism. - There was an order for Levothyroxine 75mcg, 1 every day.</p> <p>Review of a pharmacist "Note to Attending Physician/Prescriber" dated 5/17/16 revealed: - The pharmacist noted the resident's labs from 03/01/16 showed a TSH of 0.26 and currently she was on Levothyroxine 75mcg every day. - The pharmacist recommended decreasing Levothyroxine to 50mcg every day and recheck TSH in 6 to 10 weeks. - There was no documentation the recommendation to increase the dose of Levothyroxine had been forwarded to the physician/prescriber.</p> <p>Review of Resident #14's May 2016 and June 2016 medication administration records (MARs) revealed Levothyroxine 75mcg was documented as administered every day at 8:00am.</p> <p>Refer to interview with the Memory Care Director on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional</p>	D 406		

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D 406	<p>Continued From page 53</p> <p>Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for interview.</p> <p>3. Review of Resident #15's current FL-2 dated 04/18/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included multi-infarct dementia and diabetes mellitus. - There was an order for Lantus Flexpen, inject 60 units subcutaneously every morning at 8:00am. <p>Review of a pharmacist "Note to Attending Physician/Prescriber" dated 5/17/16 revealed:</p> <ul style="list-style-type: none"> - The pharmacist noted the resident was currently on Lantus, 60 units, every morning and Novolog before meals. The blood sugars have been fluctuating throughout the day. - The pharmacist recommended changing the Lantus to 2 times a day (split dose). - There was no documentation the recommendation to change the dose of Lantus to 2 times a day had been forwarded to the physician/prescriber.. <p>Review of Resident #15's May 2016 and June 2016 medication administration records (MARs) revealed Lantus 60 units was documented as administered every day at 8:00am.</p> <p>Refer to interview with the Memory Care Director on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for</p>	D 406		

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D 406	<p>Continued From page 54</p> <p>interview.</p> <p>4. Review of Resident #16's current FL-2 dated 02/19/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included Alzheimer's dementia and hypertension. - There was an order for Metoprolol Tart 25mg, one half tablet, by mouth every day. <p>Review of a pharmacist "Note to Attending Physician/Prescriber" dated 5/17/16 revealed:</p> <ul style="list-style-type: none"> - The pharmacist noted the resident had an active scheduled order for Metoprolol Tart 25mg, one half tablet every day. The tartrate formulation was usually dosed 2 times a day for around the clock coverage. - The pharmacist recommended changing the Metoprolol Tart to 2 times a day. - There was no documentation the recommendation to change the dose of Metoprolol to 2 times a day had been forwarded to the physician/prescriber. <p>Review of Resident #16's May 2016 and June 2016 medication administration records (MARs) revealed Metoprolol Tart 25mg, one half tablet was documented as administered every day at 8:00am.</p> <p>Refer to interview with the MCD on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for interview.</p>	D 406		

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D 406	<p>Continued From page 55</p> <p>5. Review of Resident #17's current FL-2 dated 04/18/16 revealed:</p> <ul style="list-style-type: none"> - The resident's diagnoses included Alzheimer's dementia, congestive heart failure and edema. - There were orders for Furosemide 20mg, 1 tablet by mouth, daily at 8:00am and Potassium Chloride 10meq ER, 1 tablet, 2 times a day at 8:00am and 8:00pm. <p>Review of hospital discharge orders dated 05/05/16 revealed Furosemide 20mg was discontinued.</p> <p>Review of a pharmacist "Note to Attending Physician/Prescriber" dated 5/17/16 revealed:</p> <ul style="list-style-type: none"> - The pharmacist noted Furosemide 20mg was discontinued in the hospital, but the resident still has an active order for potassium 10meq 2 times a day. - The pharmacist recommended discontinuing Potassium 10meq 2 times a day since the resident was no longer on a potassium wasting diuretic. - There was no documentation the recommendation to change the dose of Lantus to 2 times a day had been forwarded to the physician/prescriber. <p>Review of Resident #15's May 2016 and June 2016 medication administration records (MARs) revealed Lantus 60 units was documented as administered every day at 8:00am.</p> <p>Refer to interview with the Memory Care Director on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional</p>	D 406		

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D 406	<p>Continued From page 56</p> <p>Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for interview.</p> <p>6. Review of Resident #5's current FL-2 dated 03/23/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses include Alzheimer's disease, hypothyroid, and mixed dyslipidemia. -Resident #5 was constantly disoriented.- -Resident #5 was non-verbal and ambulatory. -Resident #5 was "total care." -There was a medication order for Risperidone 0.5mg three times daily. <p>Observation of Resident #5 on 06/14/16 at 10:55am revealed:</p> <ul style="list-style-type: none"> -Resident #5 was sitting in a chair in the hallway outside of Room #27. -Resident #5 did not respond verbally when spoken to. -Resident #5 had a light yellow colored band/bracelet on her left wrist. <p>Interview with a Personal Care Aide (PCA) on 06/14/16 at 10:55am revealed:</p> <ul style="list-style-type: none"> -Resident #5 did not normally communicate verbally. -Resident #5 had on the yellow bracelet because she was at risk for falls. -Resident #5 had not had any recent falls. <p>Review of Resident #5's record revealed:</p> <ul style="list-style-type: none"> -There was documentation that pharmaceutical reviews had been completed for Resident #5 quarterly by a licensed consulting Pharmacist. -There was documentation by a consulting Pharmacist dated 05/16/16 to consider decreasing Resident #2's Risperidone dose to 0.25mg three times daily due to Resident #2's recent fall history. 	D 406		

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D 406	<p>Continued From page 57</p> <p>-There was documentation by the consulting Pharmacist dated 02/23/16 that there were no recommendations for Resident #5.</p> <p>Review of the "Care Notes" for Resident #5 revealed:</p> <p>-From the time of the previous pharmaceutical review completed 02/23/16 to the most current pharmaceutical review completed 05/16/16, Resident #5 was found on the floor or fell a total of 6 times.</p> <p>-03/12/16: another resident bumped Resident #5 with a wheelchair, causing Resident #5 to fall on her "bottom;" Resident #5 was not injured.</p> <p>-03/14/16: Resident #5 was found on the floor uninjured.</p> <p>-03/23/16: Resident #5 was found on the floor with a "bump" on her head.</p> <p>-04/03/16: Resident #5 was found on the floor uninjured.</p> <p>-04/09/16: Resident #5 was found on the floor with a "knot" on her head and was sent to the hospital emergency department.</p> <p>-05/07/16: Resident #5 was found on the floor uninjured.</p> <p>Review of the "Note to Attending Physician/Prescriber" for Resident #2 revealed:</p> <p>-The form was not dated.</p> <p>-"The resident has recently experienced several falls. She is currently on Risperidone 0.5mg" three times daily. "Would you consider decreasing Risperidone to 0.25mg" three times daily.</p> <p>-In the section "Physician/Prescriber Response" there was no documentation or response from the provider.</p> <p>Interview with the facility's Regional Protocol Registered Nurse on 06/17/16 at 3:45pm</p>	D 406		

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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 406	<p>Continued From page 58</p> <p>revealed:</p> <ul style="list-style-type: none"> -The facility had not followed up with the provider on the Pharmacist's recommendation for Resident #5 dated 05/16/16. -A "stack" of pharmaceutical reviews completed in May 2016 had been found on the previous Administrator's desk earlier that morning (06/17/16). -The Memory Care Manager had faxed the pharmacy review recommendations to the provider for follow up as soon as possible. <p>Interview with the facility Memory Care Director on 6/17/16 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - The MCD was responsible for following up on all pharmacy recommendations. -When the pharmacy reviews were completed by the facility's pharmacy consultant in May 2016, she was not working at the facility. - The MCD came back to work at the facility a few weeks after the pharmacy review was completed in May 2016. - The facility's Administrator never gave the MCD the pharmacy reviews/recommendation for May 2016. - The MCD found the pharmacy reviews/recommendations on the Administrator's desk today (06/17/16). -All recommendations had been faxed to the prescribing providers today (06/17/16). <p>Interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy reviews/recommendations completed on 05/16/16 and 05/17/16 were discovered on the Administrator's desk earlier that day (06/17/16). -The MCD was not aware the Administrator kept the pharmacy reviews/recommendations on his desk. 	D 406		

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D 406	<p>Continued From page 59</p> <p>-The MCD had faxed all of the pharmacy recommendations dated 05/16/16 to the prescribing providers that day (06/17/16) and would be responsible for following up on the pharmacy recommendations.</p> <p>Refer to interview with the Memory Care Director on 06/17/16 at 3:15pm.</p> <p>Refer to interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm.</p> <p>The facility's Administrator was not available for interview.</p> <hr/> <p>Interview with the facility Memory Care Director on 6/17/16 at 3:15pm revealed:</p> <ul style="list-style-type: none"> - When the pharmacy reviews which were completed by the facility's pharmacy consultant in May 2016 were completed, she was not working at the facility. - The MCD came back to work at the facility a few weeks after the pharmacy review was completed in May 2016. - The facility's Administrator never gave her the pharmacy reviews/recommendation. - The MCD found the pharmacy reviews/recommendations on the Administrator's desk today and all recommendations were faxed to the primary care providers today. - The MCD was responsible for following up on all pharmacy recommendations. <p>Interview with the facility's Regional Director of Operations on 6/17/16 at 4:20pm revealed:</p> <ul style="list-style-type: none"> - The pharmacy reviews/recommendations 	D 406		

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D 406	Continued From page 60 completed in May 2016 were discovered on the Administrator's desk today. - The MCD was not aware the Administrator kept the pharmacy reviews/recommendations on his desk. - The MCD discovered the reviews today since the Administrator was suspended on 06/16/16. - The MCD has faxed all of the recommendations to the primary care providers today. - The MCD will be responsible for following up with all pharmacy recommendations.	D 406		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the county department of social services of incidents requiring referral for emergency medical evaluation for 3 of 5 residents sampled (#4, #10, #11). The findings are: A. Review of Resident #4's current FL-2 dated 4/14/16 revealed: -Diagnoses included Alzheimer's Dementia, hypercholesterolemia, benign prostatic hypertrophy, migraine, carpal tunnel syndrome, hypertension, and dizziness and giddiness.	D 451	It is the policy of Castle Creek to notify the county department of social service of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral to emergency medical evaluation, than first aid.	

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D 451	<p>Continued From page 61</p> <p>-Resident is ambulatory. -Resident is constantly disoriented and a wanderer.</p> <p>Review of care notes for Resident #4 revealed entry dated 5/1/16 describing the following: -8:15am- Resident had an altercation with another resident then proceeded to swing at staff members. Resident was sent to the ER (Emergency Room) for evaluation. Resident refused vital signs.</p> <p>Review of Accident/Injury Report for Resident #4 revealed: -Date of accident or incident was 5/1/16 at 7:15am in hallway. -Resident had an altercation with another resident, proceeded to swing at staff members. -Resident was sent to ER. -Status of Resident after ER/Hospital documented as diagnoses of medical screening exam; dementia with behavioral disturbance. -Regulatory agency notified was DSS by fax. No date/time was indicated.</p> <p>Refer to interview with Memory Care Manager on 5/19/16 at 3:55pm.</p> <p>Refer to interview with Regional Director of Operations on 6/17/16 at 2:15pm.</p> <p>Refer to interviews with Protocol in Quality Assurance Nurse on 6/20/16 at 10:30am and 11am.</p> <p>Refer to review of local county DSS reports.</p> <p>B. Review of Resident #10's FL-2 dated 1/15/16 revealed: -Diagnoses of vascular dementia, several mental</p>	D 451	<p>Reports will be completed on resident incidents or accidents requiring medical evaluation or treatment greater than first aid will completed, reviewed by QA Nurse and management, submitted to the county dept of social services via fax with a confirmation of attached.</p> <p>Executive Director and Regional Director will monitor for compliance. QA Team and Clinical Support Team will review during site visits.</p>	<p>8/4/16</p> <p>8/4/16</p>

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D 451	<p>Continued From page 62</p> <p>retardation, seizure disorder, mild cerebral palsy, swallowing disorder, acid reflux disease, and hyponatremia. -Resident is ambulatory. -Resident is constantly disoriented.</p> <p>Review of care notes for Resident #10 revealed entry dated 5/5/16 describing the following: -Resident was sent to ER because of left arm causing constant pain and swelling and bruising.</p> <p>Subsequent care notes entry for Resident #10 dated 5/5/16 revealed: -11:50pm- Resident returned back from ER with no new orders. Resident diagnoses was closed displaced transverse fracture of shaft of left humerus.</p> <p>Review of Accident/Injury Report for Resident #10 revealed: -Date of accident or incident was 5/5/16 at 8:00pm. -Resident; Left arm causing constant pain to resident. -Resident was sent to ER. -Regulatory agency notified was DSS by fax. No date/time was indicated.</p> <p>Refer to interview with Memory Care Manager on 5/19/16 at 3:55pm.</p> <p>Refer to interview with Regional Director of Operations on 6/17/16 at 2:15pm.</p> <p>Refer to interviews with Protocol in Quality Assurance Nurse on 6/20/16 at 10:30am and 11am.</p> <p>Refer to review of local county DSS reports.</p>	D 451		

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D 451	<p>Continued From page 63</p> <p>C. Review of Resident #11's FL-2 dated 1/14/16 revealed: -Diagnoses of Alzheimer's, atrial fibrillation, disease of brain. -Resident is ambulatory. -Resident is constantly disoriented and a wanderer.</p> <p>Review of care notes for Resident #11 revealed entry dated 5/5/16 describing the following: -3:28pm- Resident was found on the floor bleeding from mouth when EMS moved resident.</p> <p>Review of Accident/Injury Report for Resident #11 revealed: -Date of accident or incident was 5/5/16 at 3:20pm in activity room. -Resident observed laying on floor bleeding from mouth on left side. -Resident was sent to ER. -Regulatory agency notified was DSS by fax. No date/time was indicated.</p> <p>Refer to Review of Incident Report book on 5/19/16 at 2:40pm..</p> <p>Refer to interview with Memory Care Manager on 5/19/16 at 3:55pm.</p> <p>Refer to interview with Regional Director of Operations on 6/17/16 at 2:15pm.</p> <p>Refer to interviews with Protocol in Quality Assurance Nurse on 6/20/16 at 10:30am and 11am</p> <p>Refer to review of local county DSS reports.</p> <hr/> <p>Review of the facility's Incident Report book on</p>	D 451		

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D 451	<p>Continued From page 64</p> <p>5/19/16 at 2:40 pm. reveleaed no incident/accident reports in the section of the book labeled May.</p> <p>Interview with Memory Care Manager (MCM) on 5/19/16 at 3:55pm revealed:</p> <ul style="list-style-type: none"> -No fax confirmations were found showing incident reports were faxed to DSS could be located for Residents #4, #10, and #11. -Fax confirmation should be attached to incident report along with an email where incident report was sent to facility Protocol in Quality Assurance Nurse for review. -The MCM is responsible for faxing the incident reports to DSS if the incident is a reportable. <p>Interview with Regional Director of Operations on 6/17/16 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -No fax confirmations were found for indicating incident reports for Residents #4, #10, and #11 were sent to DSS. -MCM is responsible for sending incident reports to Protocol in Quality Assurance Nurse and to DSS. -Fax confirmation and copy of email indicating incident report was went to Protocol in Quality Assurance Nurse are to be attached to incident report and filed in incident report book. <p>Interview with Protocol in Quality Assurance Nurse on 6/20/16 at 10:30am revealed:</p> <ul style="list-style-type: none"> -MCM is responsible for sending incident report to her for review. -Protocol in Quality Assurance Nurse is responsible for reviewing incident reports. -If incident report is a reportable incident, the MCM is responsible for faxing incident report to DSS. -Fax confirmation and copy of email indicating incident report was sent to Protocol in Quality Assurance Nurse are to be attached to incident 	D 451		

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D 451	<p>Continued From page 65</p> <p>report before being filed in incident report book.</p> <p>Subsequent interview with Protocol in Quality Assurance Nurse on 6/20/16 at 11:00am revealed:</p> <p>-Incident Report dated 5/1/16 for Resident #4 was received by Protocol in Quality Assurance Nurse was received on 5/10/16, sent back to MCM on 5/10/16 to be forwarded to DSS.</p> <p>-Incident Report dated 5/5/16 for Resident #10 was received by Protocol in Quality Assurance Nurse was received on 5/10/16, sent back to MCM on 5/10/16 to be forwarded to DSS.</p> <p>-Incident Report dated 5/5/16 for Resident #11 was received by Protocol in Quality Assurance Nurse was received on 5/5/16, sent back to MCM on 5/6/16 to be forwarded to DSS.</p> <p>Review of the local county DSS reports revealed the county DSS had not been notified of incidents regarding Resident #4 (dated 5/1/16), Resident #10 (dated 5/5/16) and Resident #11 (dated 5/5/16).</p>	D 451		
D 464	<p>10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan</p> <p>10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan</p> <p>In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:</p> <p>(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of</p>	D 464	<p>It is the policy of Castle Creek to assure an individualized assessments and care plans are completed within 30 days of admission.</p>	

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D 464	Continued From page 66 cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 residents sampled (#2) had an individualized assessment and care plan completed within 30 days of admission to the facility which provided a description of the resident's behaviors, level of daily living skills, and degree of cognitive impairment. The findings are: Review of Resident #2's current FL-2 dated 05/03/16 revealed: -Diagnoses included Alzheimer's, hypothyroid, and hyperlipidemia. -Resident #2 was constantly disoriented. -Resident #2 was a wanderer. -Resident #2 was ambulatory. -Resident #2 required assistance with bathing and dressing. -Resident #2's recommended level of care was documented as "other/Special Care Unit (SCU)." Review of the Resident Register for Resident #2 dated 04/21/16 revealed: -Resident #2 was admitted to the facility on 04/21/16. -Resident #2 required assistance with dressing,	D 464	Chart audits completed to include, but not limited to review of the special care unit profile and care plan. Any missing individual assessments, care plans or discrepancies have been corrected.	7/20/16

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D 464	<p>Continued From page 67</p> <p>bathing, toileting, and orientation to time and place. -Resident #2's memory was documented as "significant loss-must be directed. "</p> <p>Review of the SCU Pre-Admission Checklist for Resident #2 dated 04/20/16 revealed Resident #2 required assistance with bathing, dressing, and orientation.</p> <p>Review of Resident #2's record on 06/15/16 revealed there was no Assessment and Care Plan in the record.</p> <p>Interview with the Memory Care Manager (MCM) on 06/15/16 at 4:00pm revealed Resident #2 did not have a current Assessment and Care Plan.</p> <p>Interview with 9 staff members during the survey revealed: -Nine of nine staff interviewed reported Resident #2 wandered. -Resident #2 would go into other residents' rooms and sometimes took their personal belongings. -Resident #2 required frequent re-direction from staff. -Resident #2 tried to get out of the facility doors. -Resident #2 had exited and left the facility unsupervised on 05/09/16, was found walking in the road by a staff member, and brought back to the facility that same day (05/09/16).</p> <p>Interview with the MCM on 06/16/16 at 1:55pm revealed: -The MCM was responsible for completing the resident assessment and care plans. -The MCM was aware that the assessment and care plan should be completed within 30 days of admission to the facility and quarterly thereafter. -The MCM completed Resident #2's assessment</p>	D 464		

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D 464	<p>Continued From page 68</p> <p>and care plan the previous day (06/15/16).</p> <p>Review of the "Initial Resident Assessment Plan" for Resident #2 dated 06/15/16 revealed:</p> <ul style="list-style-type: none"> -Resident #2 was "sometimes disoriented." -Resident #2 was "forgetful." -Resident #2 wandered. -Resident #2 "wanders around the building checking doors, picking up things and taking them with her. She is found in other people's rooms shopping through their things." -The care plan was signed by the MCM and dated 06/15/16. -The care plan was signed by Resident #2's health care provider and dated 06/15/16. <p>Interview with the Managing Executive Director/Registered Nurse on 06/20/16 at 11:00am revealed:</p> <ul style="list-style-type: none"> -Resident care plans were done within 30 days of admission and reviewed quarterly for significant changes in the resident's condition. -The Care Managers were responsible for completing each resident's assessment and care plan. -The resident care plans generated task sheets in the facility's Quick Medication Administration Record (QMAR) system. -The Personal Care Aides (PCAs) were supposed to sign off on each resident's tasks on the task sheets daily. -The Medication Aides (MAs) or Supervisor were supposed to verify the tasks sheets were completed daily. 	D 464		
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:</p>	D911	<p>It is the policy of Castle Creek to assure Residents are treated with respect, dignity, and full recognition of this or her individuality and right to privacy.</p>	

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D911	Continued From page 69 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to treat residents with respect, consideration and dignity. The findings are: Based on interviews, the facility failed to assure each resident was treated with dignity, consideration, and respect as evidenced by the Staff A kissing 3 of 9 residents sampled (#7, #8, #9) on the cheek, forehead, and mouth; patting 1 of 9 residents sampled on the buttocks (#7); throwing objects and using a loud voice to utter profanity causing 1 of 9 residents sampled (#6) to be awakened from sleep, shake, and cry. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911	Refer to Plan of Correction for Tag D 0338, 1 OA NCAC 13F .0909.	8/4/16	
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to provide care and services which are adequate, appropriate and in	D912			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/20/2016
NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429		
(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	
D912	Continued From page 70 compliance with relevant federal and state laws and rules and regulation. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to provide supervision to 1 of 5 residents sampled (#2) who exhibited wandering behaviors resulting in the resident exiting and departing the facility unsupervised. [Refer to Tag 027, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the prescribing physician and in accordance with the facility's policies and procedures for 2 of 5 sampled residents as evidenced by Resident # 4 not receiving medications such as Gabapentin, Meclizine, Diazepam and Seroquel on multiple occasions for multiple days due to the medications not being available and Resident # 1 not receiving insulin timely due to shortage of staffing. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on interview and record review, the facility failed to assure follow-up for 1 of 5 sampled residents (Resident #3) who displayed symptoms of repeated urinary tract infection which included altered mental status (increased confusion), weakness with a fall, unresponsiveness with hospitalization after a	D912	It is the policy of Castle Creek to provide care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation. 1 . Refer to Plan of Correction for Tag D 027, 1 OA NCAC 13F.0901 (b) 2.Refer to Plan of Correction for Tag D 0358, 10A NCAC 13F .1004(a) 3. Refer to Plan of Correction Tag D 0273, 10A NCAC 13F .0902(b)	7/20/16	8/4/16
				7/20/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL065034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/20/2016
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NAME OF PROVIDER OR SUPPLIER CASTLE CREEK MEMORY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 4724 CASTLE HAYNES ROAD CASTLE HAYNE, NC 28429
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D912	Continued From page 71 delay of 10 days in obtaining 1st urinalysis and not obtaining 2nd recommended urinalysis. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 4. Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to ensure residents were treated with dignity, consideration, and respect and the failure to provide appropriate care and services services as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A2 Violation)].	D912	4. Refer to the Plan of Correction under Tag D 980, G.S. 131 D-25	7/20/16
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to ensure residents were treated	D980	It is the policy of Castle Creek and the responsibility of the administrator for implementing the provisions of G.S. 131 D-25 and provide appropriate training to staff to implement the declaration of resident rights.	

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D980	<p>Continued From page 72</p> <p>with dignity, consideration, and respect and the failure to provide appropriate care and services services as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. The findings are:</p> <p>1. Based on observations, record reviews, and interviews, the facility failed to provide supervision to 1 of 5 residents sampled (#2) who exhibited wandering behaviors resulting in the resident exiting and departing the facility unsupervised. [Refer to Tag 027, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].</p> <p>2. Based on interview and record review, the facility failed to assure follow-up for 1 of 5 sampled residents (Resident #3) who displayed symptoms of repeated urinary tract infection which included altered mental status (increased confusion), weakness with a fall, unresponsiveness with hospitalization after a delay of 10 days in obtaining 1st urinalysis and not obtaining 2nd recommended urinalysis. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].</p> <p>3. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the prescribing physician and in accordance with the facility ' s policies and procedures for 2 of 5 sampled residents as evidenced by Resident # 4 not receiving medications such as Gabapentin, Meclizine, Diazepam and Seroquel on multiple</p>	D980	<p>1. Refer to Plan of Correction for Tag 027, 10A NCAC 13F .0901(b)</p> <p>2. Refer to Plan of Correction for Tag 0273, 10A NCAC 13F .0902(b)</p> <p>3. Refer to Plan of Correction for Tag 0358, 10 A NCAC 13F .1004(a)</p>	<p>7/20/16</p> <p>7/20/16</p> <p>8/4/16</p>

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D980	<p>Continued From page 73</p> <p>occasions for multiple days due to the medications not being available and Resident # 1 not receiving insulin timely due to shortage of staffing. [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].</p> <p>4. Based on interviews, the facility failed to assure each resident was treated with dignity, consideration, and respect as evidenced by the Staff A kissing 3 of 9 residents sampled (#7, #8, #9) on the cheek, forehead, and mouth; patting 1 of 9 residents sampled on the buttocks (#7); throwing objects and using a loud voice to utter profanity causing 1 of 9 residents sampled (#6) to be awoken from sleep, shake, and cry. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].</p> <p>5. Based on record reviews and interviews the facility failed to notify the county department of social services of incidents requiring referral for emergency medical evaluation for 3 of 5 residents sampled (#4, #10, #11). [Refer to Tag 0451, 10A NCAC 13F .1212(a) Reporting Incident and Accident].</p> <p>6. Based on observations, record reviews, and interviews, the facility failed to implement provider orders for 1 of 5 residents sampled (#5) for a dietary supplement for a resident with a documented history of weight loss. [Refer to Tag 0276, 10A NCAC 13F .0902(c)(4) Health Care].</p> <p>7. Based on record review and interview, the facility failed to follow up on medication review</p>	D980	<p>4. Refer to Plan of Correction for Tag 0338, 10A NCAC 13F .0909.</p> <p>5. Refer to Plan of Correction for Tag 0451, 10A NCAC 13F .1 212(a)</p> <p>6. Refer to Plan of Correction for Tag 0276, 10A NCAC 13F .09029c)(4)</p> <p>7. Refer to Plan of Correction for Tag 0406, 10A NCAC 13F .1009(b)</p>	<p>8/4/16</p> <p>8/4/16</p> <p>8/4/16</p> <p>8/4/16</p>

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D980	Continued From page 74 recommendations for 6 of 6 sampled residents (#5 #13, #14, #15, #16 and #17) with medication for diabetes (#13 and #15), medication for hypothyroidism (#14), medication for hypertension (#16), medication for hypokalemia (#17), and antipsychotic medication (#5). [Refer to Tag 0406, 10A NCAC 13F .1009(b) Pharmaceutical Care]. 8. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 residents sampled (#2) had an individualized assessment and care plan completed within 30 days of admission to the facility which provided a description of the resident's behaviors, level of daily living skills, and degree of cognitive impairment. [Refer to Tag 0464, 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan]. 9. Based on observation, interview and record review the facility failed to treat residents with respect, consideration and dignity. [Refer to Tag 911, G.S. 131D-21(1) Declaration of Resident Rights]. 10. Based on interview, record review and observation, the facility failed to provide care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation. [Refer to Tag 912, G.S. 131D-21(2) Declaration of Resident Rights]. _____ According to the facility's Plan of Protection dated	D980	8. Refer to Plan of Correction for Tag 0464, 10A NCAC 13F .1307 9. Refer to Plan of Correction for Tag 91 , G.S. 1310-21(1) 10. Refer to Plan of Correction for Tag 912, G.S. 131-0(2)	8/4/16 8/4/16 8/4/16	

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D980	<p>Continued From page 75</p> <p>6/20/16:</p> <ul style="list-style-type: none"> - On 6/16/16, Staff A was suspended and relieved of duty and will not be returning to the facility. - The facility structure and oversight will be reorganized. Certified administrator will be assigned to manage the facility. <p>Support team assigned to conduct audits of each department and address any areas of concern. Refer to Plan of Protections for Health Care 6/16/16; Resident Rights 6/16/16; and Supervision/elopement 6/16/16.</p> <p>THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED JULY 20, 2016.</p>	D980	<p>NOTE: Correction date for Type A-2's July 20, 2016. Correction date for Type B's August 4, 2016.</p>	