

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL071017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2016
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NAME OF PROVIDER OR SUPPLIER . . . STREET ADDRESS, CITY, STATE, ZIP CODE
LINWOOD'S FAMILY CARE HOME . . . **7801 SLOCUM TRAIL**
ATKINSON, NC 28421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/29/16 and 07/12/16-07/14/16.	C 000		
C 147	<p>10A NCAC 13G .0406(a)(7) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure a state-wide criminal background check was completed for 3 of 3 staff sampled (A, B, C) upon hire in accordance with G.S. 131D-40.</p> <p>The findings are:</p> <p>Interview with the Administrator on 06/29/16 at 4:10pm revealed: -The facility had a change of ownership (CHOW) effective 01/01/16. -Staff A, B, and C had worked in the facility prior to the CHOW.</p> <p>1. Review of Staff A's personnel record revealed: -There was no record of Staff A's hire date at the facility. -There was documentation of a county criminal background screening was completed for Staff A on 05/20/14. -There was no documentation of a state wide criminal background screening for Staff A.</p>	C 147	<p>All staff has had a criminal back ground check done. All staff before working will have a criminal background did that is state-wide not just a local criminal background check</p> <p>All staff has a hire date on their applications that has been completed All resident staff will have a hire date on their applications</p>	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Arnold A. Rudge

TITLE

8/26/16

(X6) DATE

STATE FORM

6499

JX4111

If continuation sheet 1 of 86

POC reviewed/accepted

2 J. RN 8/28/16

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C 147	<p>Continued From page 1</p> <p>Interview with Staff A on 06/29/16 at 43:00pm revealed: -Staff A worked as a Medication Aide (MA) in the facility. -Staff A had only had a county criminal background screening.</p> <p>Interview with the Administrator on 06/29/16 at 3:36pm revealed: -Staff A worked in the facility (under the prior ownership and name) from February 2014 until the CHOW on 01/01/16. -Staff A's new hire date was 01/01/16, which was the effective date of the CHOW. -Staff A worked as a MA. -Staff A did not have a state-wide criminal background screening. -The Administrator did not know a state-wide criminal background screening was required.</p> <p>2. Review of Staff B's personnel record revealed: -There was no hire date documented in the record. -There was documentation dated 01/06/14 of a county background screening. -There was no documentation of a state-wide criminal background screening in Staff B's record.</p> <p>Staff B was not available for interview.</p> <p>Interview with the Administrator on 06/29/16 at 3:50pm revealed: -Staff B was hired 01/01/16 as a "floater" MA. -Staff B had not had a state-wide criminal background screening. -The Administrator did not know a state-wide criminal background screening was required.</p> <p>3. Review of Staff C's personnel record revealed: -There was no hire date documented in the</p>	C 147	<p>Staff A has had a state-wide criminal background check</p> <p>Staff B hire date has been put on their application. There has also been a state-wide criminal background check for staff B</p>	

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C 147	<p>Continued From page 2</p> <p>record.</p> <ul style="list-style-type: none"> -There was documentation dated 08/05/12 of a county background screening. -There was no documentation of a state-wide criminal background screening. <p>Staff C was not available for interview.</p> <p>Interview with the Administrator on 06/29/16 at 4:04pm revealed:</p> <ul style="list-style-type: none"> -Staff C was hired on 01/01/16 as a MA. -Staff C had a county criminal background screening. -The Administrator did not know if Staff C had a state-wide criminal background screening; if so, the screening would in Staff C's personnel file. 	C 147	<p>Staff C hire date was dated on their application and a criminal background check was done.</p>	
C 185	<p>10A NCAC 13G .0601(a) Management and Other Staff</p> <p>10A NCAC 13G .0601Mangement and Other Staff</p> <p>(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p>	C 185	<p>Administrator has made a master copy of a schedule of when staff works to be kept in the facility at all times. A copy of the schedule is being given to all staff also. As administrator all residents rights are being monitored everyday. A log is kept in each residents book and notes are being made</p>	

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C 185	Continued From page 3 Based on observations, interviews and record reviews, the administrator failed to assure the management, policies, and overall operations of the facility were in substantial compliance with the rules and statutes regarding supervision, health care, staff qualifications, and reporting of incidents resulting in violations of the residents' rights. The findings are: Noncompliance was identified in the following areas: 1. Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with the assessed needs and symptoms of 5 of 6 residents sampled (#1, #3, #4, #5, #6) with a documented history of mental illness, suicidal ideation, and being injurious to self (#1), with a documented history of mental illness and developmental disabilities (#3), with a documented history of mental illness, wandering, and being verbally and physically abusive (#4), with a documented history of mental illness and aggressive behaviors towards staff and other residents (#5), and with a documented history of mental illness and requiring assistance with orientation to time and place (#6) as evidenced dropping residents off at the library alone without a responsible person or staff (#1, #4, #6), allowing a resident to loiter at a department store (#3), and allowing a resident to wander into other residents' rooms (#5) resulting in an incident between Resident #1 and Resident #5 in which Resident #5 was charged with sexual battery of Resident #1. [Refer to Tag D243, 10A NCAC 13G. 0901 (b) Personal Care and Supervision (Type A1 Violation)].	C 185	in each book about how the resident's day is going and if there is any concerns. Staff and administration is meeting every two weeks to address any issues that are a concern. Administrator is having weekly meetings with residents to address any concerns that they have. Effective immediately all residents are being monitored and supervised at all times. No one will be left alone and monitored. Administrator is at the home five days a week if not at the home all staff can contact me and my info is available to residents and staff at all times.	

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C 185	Continued From page 4 2. Based on record reviews and interviews, the facility failed to notify a licensed healthcare provider of high risk injurious behaviors for 2 of 5 residents sampled (#1 and #5) as related to a resident reporting suicidal ideation and being sexually assaulted by another resident (#1), and a resident exhibiting behaviors such as insomnia, wandering the facility halls into other residents' rooms, having aggressive behavior towards staff, other residents, and property, and sexually assaulting another resident (#5), and failure to assure 4 of 5 residents sampled (#1, #2, #3, #5) went to medical and mental health appointments as directed by licensed health care providers. [Refer to Tag D246, 10A NCAC 13G. 0902 (b) Health Care (Type A1 Violation)]. 3. Based on record reviews and interviews the facility failed to assure 3 of 7 residents sampled (#1, #6, #7) were tested upon admission for tuberculosis (TB) with the two-step TB skin test in compliance with control measures adopted by the Commission of Public Health. [Refer to Tag D 202, 10A NCAC 13G. 0702 (a) Tuberculosis Test and Medical Examination (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to notify law enforcement immediately of an incident in which 1 of 5 residents sampled (#1) was harmed by another resident (#5). [Refer to Tag D 450, 10A NCAC 13G. 1213 (f) Reporting of Accidents and Incidents (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to assure 3 of 3 Medication Aides (MAs) sampled (A,B, and C) hired after 10/01/13 completed the mandated 5 hour, 10, hour, or 15 hour Medication Aide training. [Refer to Tag	C 185	Effective immediately all residents behavior are being monitored and writing down in their book of any concerns with their behavior. All residents behavior is being reported to their licensed healthcare provider and also documented in the book. All appointments are being kept and if any are rescheduled a reason why will be documented in their book. Three of the residents #1 #6 #7 TB skin test has been recovered from the hospital before admission and kept in their book a copy is available Law enforcement and my local DSS provider is being notified immediately of all incidents	

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C 185	<p>Continued From page 5</p> <p>D935, G.S. 131D-4.5B (b) Medication Aides Training and Competency (Type B Violation).</p> <p>The failure of the administrator to ensure systems were in place to assure residents with suicidal ideation and history of assault were monitored and not left alone; to assure residents' mental health providers were notified of aggressive and assaultive behaviors and suicide threats; and to assure residents were seen by their mental and medical health care providers at scheduled appointment times resulted in 2 of 6 residents (#1 and #5) not receiving services needed to maintain their physical and mental status. This constitutes an A1 Violation for serious neglect.</p> <p>Review of the Plan of Protection submitted by the facility on 07/13/16 revealed:</p> <ul style="list-style-type: none"> -The Administrator would be at the facility every day. -When the Administrator was not at the facility, staff could contact the Administrator by telephone at any time. -The Administrator would make sure residents did not have any concerns and residents' rights were maintained. <p>THE CORRECTION DATE OF THIS TYPE A1 VIOLATION SHALL NOT EXCEED 08/13/16.</p>	C 185	<p>Medication training has been completed 3/16/16 with needing more hours to be able to complete the hours. A class for med training has been scheduled on 14 staff that has the training can work at this time until the class is done.</p>	
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination</p> <p>(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as</p>	C 202		

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C 202	<p>Continued From page 6</p> <p>specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record reviews and interviews, the facility failed to assure 3 of 7 residents sampled (#1, #6, #7) were tested upon admission for tuberculosis (TB) with the two-step TB skin test in compliance with control measures adopted by the Commission of Public Health.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnosis included bipolar disorder, depression, and hypertension.</p> <p>Review of the Resident Register revealed Resident #1 was admitted to the facility on 01/01/16.</p> <p>Review of Resident #1's TB screening revealed: -There was documentation Resident #1 had a negative TB skin test read on 08/11/15. -There was not any documentation of additional TB skin testing in Resident #1's record.</p> <p>Interview with the Administrator on 06/29/16 at 3:02pm revealed: -The Administrator was aware of the two-step TB skin test rule. -The Administrator was aware Resident #1 only had documentation of one TB skin test in the record.</p>	C 202	<p>Residents #1 #6 #7 TB skin test was received from Vicent hospital in Kennerlyville and put in their books made available at all times</p>	

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C 202	<p>Continued From page 7</p> <p>-Resident #1 had a chest x-ray; the Administrator would attempt to locate documentation of Resident #1's chest x-ray.</p> <p>Interview with the Administrator on 07/14/16 at 5:30pm revealed:</p> <p>-Resident #1 had a 2nd TB skin test but the Administrator did not know when the second TB skin test was done.</p> <p>-The Administrator would attempt to locate documentation of Resident #1's TB skin test and fax the document to the surveyor.</p> <p>2. Review of Resident #6's current FL-2 dated 06/09/16 revealed diagnoses included schizophrenia, hypertension, and anemia.</p> <p>Review of the Resident Register revealed Resident #6 was first admitted the facility on 06/07/16.</p> <p>Telephone interview with the Administrator on 06/29/16 at 08:35am revealed Resident #6 was discharged from the facility on 06/23/16 to another local facility.</p> <p>Interview with the Administrator on 07/13/16 at 5:17pm revealed Resident #6 had moved back in to the facility for a second time on 07/08/16.</p> <p>Review of the Resident Register dated 06/07/16 revealed Resident #6 was admitted to the facility on 06/07/16; there was no Resident Register in the record for Resident #6's second admission into the facility on 07/08/16.</p> <p>Review of Resident #6's record revealed there was no documentation of any TB skin tests.</p> <p>Interview with the Administrator on 07/14/16 at</p>	C 202		

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C 202	<p>Continued From page 8</p> <p>5:30pm revealed: -The Administrator had not been able to find documentation of any TB skin tests for Resident's #6. -The Administrator would contact the facility where Resident #6 had resided for the short time for any documentation of TB skin tests for Resident #6. -If documentation of TB skin testing was located for Resident #6, the Administrator would fax the documents to the surveyor.</p> <p>3. Interview with the Administrator on 07/13/16 at 5:17pm revealed Resident #7 had just moved in to the facility that day, 07/13/16 and did not have a record at the facility.</p> <p>Interview with the Administrator on 07/13/16 at 5:54pm revealed Resident #7's record was supposed to be brought from the facility where he formerly resided to the facility "later today" (07/13/16).</p> <p>Observation on 07/14/16 at 4:30pm revealed Resident #7's record was in the facility.</p> <p>Review of Resident #7's current FL-2 dated 05/16/16 revealed diagnoses included post-traumatic stress disorder (PTSD), schizoaffective order, and autistic spectrum disorder.</p> <p>Review of the Resident Register revealed Resident #7 was admitted to the facility on 07/13/16.</p> <p>Review of Resident #7's TB skin test results revealed: -There was documentation that Resident #7 had a TB skin test placed 04/05/16 and read on</p>	C 202		

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C 202	<p>Continued From page 9</p> <p>04/07/16.</p> <p>-There was no documentation in Resident #7's record of any other TB skin test.</p> <p>Interview with the Administrator on 07/14/16 at 5:30pm revealed:</p> <p>-The Administrator did could not locate documentation of additional TB skin test for Resident #7 other than the TB skin test placed on 04/05/16 and read on 04/07/16.</p> <p>-The Administrator was aware of the rules and regulations for TB skin testes and was responsible for assuring TB skin test were completed for all residents.</p> <p>-If documentation of additional TB skin test was located for Resident #7, the Administrator would fax the documents to the surveyor.</p> <p>Review of the Plan of Protection dated 07/14/16 submitted by the facility revealed:</p> <p>-Two-step TB skin testing would be completed on all residents in accordance with the rules and recommendations.</p> <p>-No resident would be admitted into the facility without verification of TB testing in accordance with the rule and recommendations.</p> <p>THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 08/28/16.</p>	C 202		
C 221	<p>10A NCAC 13G .0705 (c) Discharge Of Residents</p> <p>10A NCAC 13G .0705 Discharge Of Residents</p> <p>(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be</p>	C 221	<p><i>Effective immediately no resident will be discharged without a 30 day notice unless their safety or other residents safety</i></p>	

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C 221	<p>Continued From page 10</p> <p>made as soon as practicable when:</p> <p>(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or</p> <p>(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 3 residents sampled (#6) was provided with a notice of discharge and appeal as evidenced by discharging Resident #6 due to lack of staff and failing to notify the resident in writing of the discharge at least 30 days prior to the discharge resulting in a violation of the resident's rights.</p> <p>The findings are:</p> <p>Telephone interview with the Administrator of the facility on 06/29/16 at 07:36am revealed: -The facility had a total census of 4 residents over the last 2 months but all 4 residents had moved out of the facility within the last two weeks. -The Administrator provided the names of each of the 4 residents who had moved out of the facility over the last two weeks. -At no time during the interview on 06/29/16 at 07:36am did the Administrator mention Resident #6 ever living or being discharged from the facility.</p> <p>A second telephone interview with the Administrator of FCH A on 06/29/16 at 08:35am revealed: -The Adult Home Specialist had texted the Administrator earlier that morning (06/29/16) to</p>	C 221	<p>are At a concern or their needs can't be met by the facility. All residents will have a chance to appeal a decision if they have a concern about being discharged after their 30 day notice. No one will be discharged due to lack of staffing or sent to another home violating their rights</p>	

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C 221	<p>Continued From page 11</p> <p>ask if Resident #6 had ever lived at the facility. -The Administrator was calling the surveyor because she "forgot" to tell the surveyor Resident #6 lived in the facility during the interview earlier that day (06/29/16 at 7:35am). -Resident #6 had been discharged from the facility "last week" because "he was the only resident" there and the Administrator did not have any staff to take care of him because the Administrator's family member had been sick. -Resident #6 was not given notice of the discharge from the facility in accordance with the rule area. -The Administrator "talked" to Resident #6 about the "move" to another facility on 06/22/16. -Resident #6 was discharged from the facility on 06/23/16.</p> <p>Review of Resident #6's current FL-2 dated 06/09/16 revealed diagnoses included schizophrenia, hypertension, and anemia.</p> <p>Review of the Resident Register for Resident #6 dated 06/07/16 revealed: -Resident #6 was admitted to the facility on 06/07/16 and discharged 06/23/16. -There was documentation in Section G "Discharge/Transfer Information" beside number 4 which read Resident #6's "new address" was another family care home. -Section G contained the Administrator's signature and was dated 06/23/16. -There was no other documentation in section G of the Resident Register.</p> <p>Review of Resident #6's record revealed there was no notice of discharge or rights of appeal from the facility found in the record.</p> <p>Observation on 07/13/16 at 4:50pm revealed</p>	C 221		

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C 221	Continued From page 12 Resident #6 got out of a vehicle driven by the Administrator of the facility and went inside the facility. Interview with the Administrator on 07/13/16 at 4:55pm revealed Resident #6 moved back to the facility (a second time) on 07/08/16 because he did not get along with one of the female residents who lived at the other facility. Based on observations, interviews, and record reviews, Resident #6 was not interviewed about his admission to the facility on 06/07/16, discharge from the facility on 06/23/16, or re-admission to the facility on 07/08/16.	C 221		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .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 A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with the assessed needs and symptoms of 5 of 6 residents sampled (#1, #3, #4, #5, #6) with a documented history of mental illness, suicidal ideation, and being injurious to self (#1), with a documented history of mental illness and developmental disabilities (#3), with a documented history of mental illness, wandering, and being verbally and physically abusive (#4), with a documented history of mental illness and	C 243	Residents will be supervised according to their current needs. If any resident behavior change or is a threat to themselves or others should not sign out or be left alone for any reason. A follow up with their physician will immediately. A responsible person or guardian will be notified in 24 hours of their behavior. Staff will be with them at all times. If something occur staff is to document it in their file and their healthcare provider will be notified immediately. All incident reports has been and will be sent to our DSS	

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STATE FORM

* addendum
8/28/16

JX4111 provider. DSS providers is being called immediately or a text message is being sent to her on all incidents. All paperwork and notes will continue to be sent to them and health care provider. If Administrator is not on duty, she will be called immediately.

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C 243	<p>Continued From page 13</p> <p>aggressive behaviors towards staff and other residents (#5), and with a documented history of mental illness and requiring assistance with orientation to time and place (#6) as evidenced dropping residents off at the library alone without a responsible person or staff (#1, #4, #6), allowing a resident to loiter at a department store (#3), and allowing a resident to wander into other residents' rooms (#5) resulting in an incident between Resident #1 and Resident #5 in which Resident #5 was charged with sexual battery of Resident #1.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnoses included bipolar disorder, depression, and hypertension.</p> <p>Review of the Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 01/01/16.</p> <p>Review of Resident #1's assessment and care plan dated 03/10/16 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had a history of being suicidal and injurious to self. -Resident #1 received medications for the treatment of mental illness and received mental health services. -The assessment was signed by Resident #1's Physician Assistant (PAC) and dated 03/10/16. <p>Telephone interview with the Administrator on 06/29/16 at 07:36am revealed Resident #1 had been hospitalized for one week and would not be returning the facility.</p> <p>Telephone interview with the Administrator on 07/13/16 at 3:10pm revealed Resident #1 had</p>	C 243	<p>Residents are being encouraged to use outings to go to the library and all stores during outings with the facility.</p>	

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C 243	<p>Continued From page 14</p> <p>returned to the facility on 07/07/16 after his hospital discharge.</p> <p>Interview with the Administrator on 06/29/16 at 11:45am revealed: -Resident #1 had been hospitalized "a whole bunch of times; it's routine for [Resident #1's name]." -Resident #1 put a belt around his neck in front of a police officer, "but he doesn't mean anything by it ..." -Resident #1 was not at the facility on 06/29/16 because he had been in the hospital since 06/22/16.</p> <p>Interview with the Administrator on 06/29/16 at 12:15pm revealed: -Resident #1 liked to stay busy by using a computer or playing video games. -Resident #1 went to the county library in another town or local library almost every day to get online.</p> <p>Interview with the Administrator on 07/13/16 at 4:55pm revealed Resident #1 returned to the facility after being discharged from the hospital on 07/07/16.</p> <p>Review of the "Emergency Department (ED) Encounter" from the hospital dated 06/22/16 revealed: -Resident #1 "presents after he was found wandering today. The patient (Resident #1) was extremely upset and actually had a thumb tack attempting to ham himself ... He reportedly tried to cut himself with a thumb tack on his left forearm. -Resident #1 "states he was 'abandoned' at the library. He became very upset that he was unsupervised. He wandered away from the library."</p>	C 243			

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C 243	<p>Continued From page 15</p> <ul style="list-style-type: none"> -Resident #1 told the ED staff "I wish you would give me a pistol so I can blow my head off." -Resident #1 ran out of the ED room; the hospital called 911. -Law enforcement officers (LEOs) brought Resident #1 back in to the ED in handcuffs. -Resident #1 was anxious, agitated, and required "chemical sedation" with the medications Haldol, Ativan, and Benadryl. -The patient was involuntarily committed by the ED physician. -Resident #1 remained in the ED of the hospital until a bed was available and he could be transferred to an outside in-patient psychiatric hospital on 06/24/16. -Resident #1 "states that he isn't safe at the group home. Officers present." <p>Review of the Discharge Summary from the in-patient psychiatric hospital revealed:</p> <ul style="list-style-type: none"> -Resident #1 was admitted "on an involuntary basis" to the in-patient psychiatric unit on 06/24/16 from the local hospital and was discharged on 07/07/16 at 4:00pm back to the facility. -Resident #1 was admitted "having suicide ideations with a plan to cut himself with a thumbtack, self-injurious behaviors via hitting and scratching self ..." -Resident #1 reported engaging in self-injurious "when he is alone because he is scared" and reported "he is afraid if he is alone that he will be killed or kidnapped." -Resident #1 "does not like being left unattended, reports feeling 'deserted'." -Resident #1 "ran away because he was upset he was 'abandoned' at the library by group home staff." -Resident #1 "attempted to strangle himself with clothing." and required restraint and seclusion 	C 243		

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C 243	<p>Continued From page 16 during the hospitalization.</p> <p>Interview with the Administrator on 06/29/16 at 12:15pm revealed: -Resident #1 liked to stay busy by using a computer or playing video games. -Resident #1 went to the county library in another town or the local library almost every day to get online.</p> <p>Interview with Resident #1 on 07/13/16 at 5:10pm revealed: -Resident #1 would not answer if staff dropped him off and left him at the library (the Administrator was present in the room). -Resident #1 had not been to a day program since May 2015. -When the other residents were at the day program, Resident #1 "goes places with staff to take care of business."</p> <p>Observation on 07/13/16 at 5:12pm revealed: -Resident #1 walked to the doorway to the staff office and asked the Administrator "How did I do?" -The Administrator replied to Resident #1 "What do you mean?" -Resident #1 responded to the Administrator "talking to them" (the surveyors). -The Administrator replied to Resident #1 "don't worry about it now."</p> <p>Interview with Resident #1 on 07/13/16 at 6:38pm revealed Resident #1 stated "I don't like to get Ms. [Administrator's first name] in trouble because of all the nice things she's been doing for us."</p> <p>Interview with Resident #1 on 7/13/16 at 8:50pm revealed: -On 6/22/16, "I had been dropped off at the library by the Administrator."</p>	C 243		

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C 243	<p>Continued From page 17</p> <ul style="list-style-type: none"> -He had been dropped off a bunch of times before. -The Administrator told Resident #1 that she would be back in twenty minutes. -After one hour, Resident #1 left the library, because the Administrator had not come back. -Resident #1 walked for ten minutes to the police department. -A Deputy saw Resident #1 "walking down the street in front of the police department." -The police officer recognized Resident #1 from the FCH and asked Resident #1 what was wrong. -Resident #1 told the police officer that he was going to kill himself. -Resident #1 had a thumb tack and was cutting his arm and stabbing his arms with it. -The police officer held Resident #1 down, cuffed him, and took him to the ED. -In the ED, Resident #1 was banging his head on the wall, so the police officer got a towel and put it behind Resident #1's head. <p>Telephone interview with the Communications Director (CD) of the county Sheriff's office on 06/29/16 at 08:47am revealed Resident #1 was a "regular name" to the CD and the Sheriff's office and the facility where Resident #1 lived was a "regular name" to the CD and Sheriff's office because the Sheriff's office frequently responded to incidents at the facility.</p> <p>Telephone interview with a Deputy with the county Sheriff's office on 07/13/16 at 09:07am revealed:</p> <ul style="list-style-type: none"> -The Deputy observed Resident #1 standing outside of the Sheriff's office on 06/22/16 at approximately 09:30-10:00am "wearing blue flip flops." -The Deputy knew Resident #1 because of the multiple times of going the facility where Resident #1 lived, "we know that address by heart." 	C 243		

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C 243	<p>Continued From page 18</p> <ul style="list-style-type: none"> -Resident #1 had a history of putting a belt around his neck to attempt to harm himself and law enforcement had been required to be "hands on" with Resident #1 to get Resident #1 to the hospital. -The Deputy noticed Resident #1 "was not acting right." -Resident #1 told the Deputy he was going to jump off a bridge. -Resident #1 took a thumb tack out of his pocket and began to poke his arm with the thumb tack. -Resident #1 told the Deputy he was dropped off at the library by an employee of the facility and he did not think it was right; he was going to kill himself so he did not have to go back to the facility. -Resident #1 told the Deputy that the previous night (06/21/16) he had left the facility alone when it was dark outside and was going to go jump in a pond to drown himself, but somebody got him and took him back to the facility. -The Deputy called the local police department for assistance because the local police department had "jurisdiction." -The Deputy attempted to contact Resident #1's family but was not able to get in contact with the family. -Resident #1 told the Deputy he was hungry and had not eaten breakfast that morning (06/22/16) or supper the previous evening (06/21/16). -As soon as Resident #1 got to the hospital, "he was thankful to eat." -Law enforcement officers and the city Chief of Police were with Resident #1 "over two hours" and nobody called in a missing person report. -The Deputy called the county Department of Social Services (DSS). -A "worker" from the facility came to the ED a few hours later and told the Deputy she took Resident #1 to the library every day so he could look for a 	C 243		

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C 243	<p>Continued From page 19</p> <p>job; the Deputy could not remember the facility staff member's name.</p> <p>-The Deputy did not understand why Resident #1 would be looking for a job every day;"he's (Resident #1) not mentally competent."</p> <p>-The"worker" told the Deputy she was notified by DSS that Resident #1 was in the hospital.</p> <p>Interview with a city Police Office on 07/12/16 at 12:45pm revealed:</p> <p>-The county Sheriff's Deputy notified the Police Officer by radio on 06/22/16 of a"mental patient" outside of the Sheriff's Department trying to injure himself with a thumb tack.</p> <p>-The Officer responded to the scene and Resident #1 told the Officer he was to kill himself.</p> <p>-The Officer initiated the involuntary commitment process and transported Resident #1 to the local hospital ED.</p> <p>-Resident #1 appeared calm so law enforcement left Resident #1 at the hospital but the hospital had to call 911 for law enforcement to return because Resident #1 left the hospital</p> <p>-Resident #1 told the Officer he did not want to go back to the facility, but the Officer could not recall any specific reasons Resident #1 provided for not wanting to return to the facility.</p> <p>-Resident #1 had been dropped off at the library and was upset because he was left there.</p> <p>-Resident #1 told the Officer they shouldn't have dropped him off like that.</p> <p>Interview with the city Chief of Police on 07/14/16 at 10:15am revealed:</p> <p>-The Chief of Police responded to the scene on 06/22/16 to assist the Police Officer.</p> <p>-Resident #1 was not happy because he was"just dropped off at the library and told it would only be a few minutes."</p> <p>-Resident #1 was"agitated" because of being</p>	C 243		

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C 243	<p>Continued From page 20</p> <p>dropped off and stuck a "push pin" into his arm. -Resident #1 was transported to the hospital ED by the LEOs. -While in the ED, Resident #1 complained of being hungry, attempted to bang head against the wall, and had to be sedated. -It was "over two hours, closer to three hours" before anyone from the home "tried to figure out where he was" or came to the hospital.</p> <p>Interview with the Administrator on 06/29/16 at 12:15pm revealed: -The Administrator took Resident #1 to the county library in another town on 06/22/16 and left him there alone. -When the Administrator went back to the library on 06/22/16 to pick up Resident #1, he was not there. -The Administrator did not contact police to report Resident #1 missing. -The Administrator started driving around looking for Resident #1. -While the Administrator was out looking for Resident #1, she received a call from the Department of Social Services (DSS) that Resident #1 was in the hospital.</p> <p>Review of the facility's "Missing Resident" Policy revealed: -If a resident went missing, the staff on duty would notify the Administrator. -The Administrator would notify the resident's responsible person, law enforcement, and the department of social services (DSS). -The incident would be documented and the documentation would be maintained in the resident's record.</p> <p>Interview with a Library Assistant (LA) at the county library on 07/12/16 at 12:00pm revealed:</p>	C 243			

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C 243	<p>Continued From page 21</p> <ul style="list-style-type: none"> -The LA recognized Resident #1 from a description provided but could not recall his name. -Resident #1 was left alone at the library "3 to 4 times a week" for "several hours" at a time. -Resident #1 was left at the library with an "older white male." -The Administrator had "frequently" brought other individuals into the library and left them in the past; some were listed as authorized users on the Administrator's library card. -Resident #1 was not authorized on the Administrator's library card and did not have a library card of his own so he had to use a guest pass each time he came in. -The last time Resident #1 was in the library was 07/11/16; he was using the word processor and printing out dates. -The LA was unsure how long Resident #1 was in the library on 07/11/16 because she took a late lunch. -Prior to 07/11/16, the last time the LA observed the Administrator leave anyone at the library unattended was "a couple of weeks ago." <p>Interview with a second LA at the county library on 07/12/16 at 1:15pm revealed:</p> <ul style="list-style-type: none"> -The LA recognized Resident #1 by the description provided. -The LA recalled Resident #1 always used a guest pass, got on the computer, and needed a lot of assistance. -The LA could not recall the last time she observed Resident #1 in the library but it was "not that long ago." -Resident #1 was alone at the library "regularly" and stayed "a good little bit" -Resident #1 was in the library "frequently" with another older white male he sometimes called his brother, but the LA could not recall the dates or 	C 243		

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C 243	<p>Continued From page 22</p> <p>provide dates by looking it up in the computer because Resident #1 and the other male always used a guest pass.</p> <ul style="list-style-type: none"> -Neither of the individuals caused any disruption. -The LA could not recall if she had observed the Administrator with anyone else in the library or leaving anyone else at the library (other than Resident #1 and the older white male). -The library had video surveillance cameras. <p>Observation of the library's video footage dated 07/11/16 revealed:</p> <ul style="list-style-type: none"> -At 3:01pm, Resident #1 was dropped off library by a silver vehicle and walked into the library; there was no facility staff present with Resident #1 when he was dropped off. -At 3:33pm, Resident #1, got into the silver vehicle and left the library. <p>A second interview with a LA on 07/13/16 at 2:48pm revealed the LA observed the library video footage from 07/11/16 and identified Resident #1 on the video surveillance footage recorded on that date (07/11/16).</p> <p>Interview with Resident #1 on 07/13/16 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 walked to the local city library or a "friend's house" whenever he wanted to as long as he signed out first. -"Sometimes" Resident #1 forgot to sign out. -Resident #1 went to the city "depending on the weather;" Resident #1 could not walk to the library if it was too hot. -Resident #1 did not know the last time he walked to the city library. -"If I see a driver while I am walking on the road and they stop and ask me if I need a ride, I tell them where I am going and sometimes they will take me to where I am going." 	C 243		

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C 243	<p>Continued From page 23</p> <p>Observation on 07/13/16 revealed the driving distance from the facility to the city library was 2.8 miles.</p> <p>Observation at the city library on 07/12/16 at 3:08pm revealed the hours of operation for the library were 3:00pm-7:00pm Monday-Friday.</p> <p>Interview with the Librarian of the city library on 07/12/16 at 3:10pm revealed: -The Librarian recalled that a person meeting Resident #1's description came into the library alone a "few times a week" and sometimes stayed "for hours on the internet." -Resident #1 had not caused any problems. -The Librarian could not recall the last time Resident #1 had been to the library. -It was library procedure for guests to sign the Visitor Log.</p> <p>Review of the city library "Visitor Log" from 03/01/16-07/12/16 revealed: -Resident #1 signed in on the Visitor Log eleven times from 03/01/16-07/12/16. -For example: Resident #1 signed in at 5:00pm and out at 6:00pm on 03/03/16; Resident #1 signed in at 3:10pm and out at 6:00pm on 03/21/16; Resident #1 signed in at 3:03pm but did not sign out on 04/28/16; Resident #1 signed in at 3:17pm and out at 5:35pm on 05/05/16; Resident #1 signed in at 4:55pm and did not sign out on 05/18/16; and Resident #1 signed in at 3:10pm and did not sign out on 06/02/16.</p> <p>Interview with Resident #1's family member on 06/30/16 at 08:59am revealed: -Resident #1 had a history of harming himself and frequent hospitalizations. -Resident #1 was "very vulnerable" and easily</p>	C 243		

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C 243	<p>Continued From page 24</p> <p>upset from "triggers."</p> <p>-Resident #1 had "one incident or disaster after another" since being admitted to the facility but Resident #1 told the family member the facility did "anything they can to help him" so she could not say anything bad about the facility.</p> <p>Interview with Resident #1 on 7/14/16 at 4:30pm revealed: -"I want to apologize for breaking the rules and for getting [Administrator's name] in trouble." -"I lied. Now she has been wrote up. I have never been neglected or left unsupervised." -"I asked to be dropped off at the library."</p> <p>Observation of Resident #1 on 7/14/16 at 5:00pm revealed: -Resident #1 called his family member on the telephone in the kitchen. -He put the call on speaker. -Resident #1 told the family member that he was sorry he had lied to her. -The family member became upset and stated, "What is wrong [Resident #1's name]? You don't sound right." -The Administrator told Resident #1 to take the telephone off speaker so that the family member could hear him. -Resident #1 told his family member, "The state is here." -Resident #1 took the telephone off speaker and a few seconds later, Resident #1 asked the Administrator, "[Family member's name] wants to know if I have to move."</p> <p>Observation of Resident #1 at 5:40pm on 7/14/16 revealed: -Resident #1 had been outside. -He came back in the kitchen and his right hand was bleeding.</p>	C 243			

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C 243	<p>Continued From page 25</p> <ul style="list-style-type: none"> -The Administrator asked Resident #1 what had happened. -Resident #1 stated, "I hit my hand on the bricks because of what I have done." -The Administrator assisted Resident #1 to wash his hand and applied a band aid to the small abrasion just under his knuckles. -The Administrator told Resident #1, "This is just too much. If you feel like you have done something wrong, all you have to do is apologize." <p>Telephone interview with Resident #1's Physician Assistant (PAC) on 07/13/16 at 1:20pm revealed based on Resident #1's history, diagnoses, and medications, Resident #1 was "not stable enough" to be left alone at the library, stores, or walking the streets alone.</p> <p>Refer to the interview with a receptionist at Resident #1's Psychiatrist's office on 07/13/16 at 4:45pm.</p> <p>Refer to the interview with Resident #1's Licensed Clinical Social Worker (LCSW) on 07/14/16 at 07:40am.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 4:30pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>B. Review of the county 911 communications "Call Detail Information" revealed:</p>	C 243		

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C 243	<p>Continued From page 26</p> <p>-Resident #1 was documented as the caller for a call placed to 911 on 04/25/16 at 06:12am.</p> <p>-Resident #1 reported he was sexually assaulted by another male resident who lived in the facility.</p> <p>Interview with Resident #1's family member on 06/30/16 at 08:59am revealed:</p> <p>-"One or two months ago," Resident #1 told the family member an older, white male resident who lived in the facility tried to assault him.</p> <p>-Resident #1 called the police and the other resident was taken to jail.</p> <p>Refer to the interview with Resident #1 on 7/13/16 at 6:35pm.</p> <p>Refer to the interview with Resident #1 on 07/13/16 at 6:45pm.</p> <p>Refer to the interview with the Administrator on 07/01/16 at 08:55am.</p> <p>Refer to the interview with a receptionist at Resident #1's Psychiatrist's office on 07/13/16 at 10:15am.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 8:30pm.</p> <p>Refer to the interview with Resident #1's Licensed Clinical Social Worker (LCSW) on 07/14/16 at 07:40am.</p> <p>Refer to the interview with Resident #1's</p>	C 243		

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C 243	<p>Continued From page 27</p> <p>Physician Assistant (PAC) on 07/13/16 at 01:20m.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>2. Review of Resident #5's FL-2 revealed: -The FL-2 was signed by the physician but there was no date documented beside the physician's signature. -Diagnoses included schizoaffective disorder, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and edema. -Resident #5's admission date to the facility was documented as 01/20/16.</p> <p>Review of the Resident Register dated 01/21/16 revealed: -Section G contained documentation that Resident #5 was discharged from the facility on 04/29/16. -The "reason" for discharge was documented as "arrested for assault on resident."</p> <p>Review of Resident #5's assessment and care plan revealed: -The assessment date was not documented. -Resident #5 received medications and treatment for a history of mental illness. -The assessment and care plan was signed by Resident #5's physician and dated 04/07/16.</p> <p>A. Resident #5 had a history of mental illness, began to exhibit behaviors and symptoms that he did not exhibit when he was first admitted to the</p>	C 243		

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C 243	<p>Continued From page 28</p> <p>facility, had been involuntarily committed multiple times while living in the facility, and was known by facility staff to go in to other residents rooms.</p> <p>Refer to the interview with Resident #1 on 7/13/16 at 6:35pm.</p> <p>Refer to the interview with Resident #1 on 07/13/16 at 6:45pm.</p> <p>Refer to the interview with the Administrator on 07/01/16 at 08:55am.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 8:30pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>B. Telephone interview with Resident #2's family member on 07/13/16 at 10:33am revealed: -Resident #2 complained to the family member "a while ago" about Resident #5 pacing the halls and coming into her room. -Resident #5 made Resident #2 "nervous" and Resident #2 felt "uncomfortable" with Resident #5. -Resident #2 told the family member Resident #5 was going into Resident #2's room and making her nervous and uncomfortable and that the</p>	C 243		

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C 243	<p>Continued From page 29</p> <p>Administrator was aware Resident #5 was coming into her room.</p> <p>Resident #2 was not available for interview.</p> <p>Interview with the Administrator on 07/01/16 at 09:20am revealed: -"It was not safe" for the female residents who resided in the facility because Resident #5 went into their rooms at night. -Interventions implemented by the facility for Resident #5's included documenting his behavior in facility incident reports and notifying his court appointed guardian; DSS was not notified.</p> <p>Resident #5 was not available for interview.</p> <p>Telephone call to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>Interview with Resident #1 on 7/13/16 at 6:35pm revealed: -On 06/21/16, Resident #1 had packed his bags, put his belongings out the window, and left the facility.</p>	C 243		

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C 243	<p>Continued From page 30</p> <p>-Resident #1 had a lot on his mind and was upset about an incident that had occurred in the facility on 04/25/16 when another resident attempted to sexually assault him.</p> <p>-"I was about to jump in the lake and drown myself," but a neighbor who knew the Administrator saw Resident #1 at the pond and took him back to the facility.</p> <p>-It was dark outside when Resident #1 was found at the pond.</p> <p>Interview with Resident #1 on 07/13/16 at 6:45pm revealed:</p> <p>-On 04/25/16, Resident #1 was asleep when Resident #5 came into his room and got in his bed with him.</p> <p>-Resident #5 kissed Resident #1 and exposed his genitals to Resident #1.</p> <p>-Resident #1 knocked on the office door and the staff on duty told Resident #1 "not right now."</p> <p>-The staff did not come out of the office until later when Resident #5 started smoking in the bathroom.</p> <p>-The staff told Resident #1 to call the police, "but that was the staff's job."</p> <p>-The resident called the police; the police came and took Resident #5.</p> <p>-Resident #1 called the police; Resident #5 was later arrested.</p> <p>Interview with the Administrator on 07/01/16 at 08:55am revealed:</p> <p>-Resident #5 tried to kiss Resident #1 in April 2016; the Administrator was unsure of the exact date.</p> <p>-Resident #1 called the police and Resident #5 was arrested.</p> <p>-Resident #5 had a court date on 06/29/16 for "sexual battery."</p>	C 243		

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C 243	<p>Continued From page 31</p> <p>Interview with the Administrator on 07/13/16 at 8:30pm revealed: -The county DSS was aware of the incident on 04/25/16 when Resident #5 exposed his genitals and tried to kiss another resident. -The Administrator called Resident #5's guardian and was keeping documentation of his behavior for his guardian. -Staff did not implement any additional monitoring of the residents from the time of the incident on 04/25/16 until Resident #5 was discharged 04/29/16 after being arrested. -Staff knew to call 911 if needed.</p> <p>Interview with the Administrator on 07/13/16 at 5:37pm revealed Resident #5's "doctor knew" about his behaviors.</p> <p>Telephone interview with a staff member at Resident #1's psychiatrist's office on 07/13/16 at 10:15am revealed the psychiatrist was out on leave and unavailable for interview.</p> <p>Telephone interview with Resident #1's Physician Assistant (PAC) on 07/13/16 at 1:20pm revealed the PAC had not been notified about the incident on 04/25/16 between Resident #1 and Resident #5.</p> <p>Telephone interview with Resident #5's physician revealed: -The facility had never contacted the physician about Resident #5 assaulting another resident. -The physician expected to be notified of any issues of conflict or threats. -The facility "not one time" contacted the physician about any concerns with Resident #5's behavior.</p> <p>3. On the start date of the survey, observation and interview revealed Resident #4 was not</p>	C 243			

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C 243	<p>Continued From page 32</p> <p>residing at the facility; the Administrator reported Resident #4 had been discharged from the facility after damaging property and being arrested and incarcerated. During the course of the survey and prior to the exit date (07/14/16), Resident #4 was observed residing at the facility. Interviews revealed Resident #4 was bailed out of jail by the Administrator and returned to the facility on 07/07/16.</p> <p>Review of Resident #4's current FL-2 dated 03/09/16 revealed diagnoses included schizoaffective disorder, mood disorder, and attention deficit hyperactivity disorder (ADHD).</p> <p>Review of Resident #4's Assessment and Care Plan dated 03/09/16 revealed: -Resident #4 had a history of schizophrenia, depression, insomnia, and ADHD and received mental health service and medications for the treatment of mental illness. -Resident #4 had a history of wandering. -Resident #4 had a history of being verbally and physically abusive. -The assessment and care plan was signed by Resident #4's Physician Assistant (PAC) and dated 03/09/16.</p> <p>Review of a legal document in Resident #4's record dated 01/03/12 revealed Resident #4 had a court appointed guardian.</p> <p>Review of the "Comprehensive Clinical Assessment" completed by Resident #4's mental health (MH) provider dated 04/26/16 revealed: -Resident #4's diagnoses included schizophrenia and pervasive development disorder; Resident #4 had psychiatric problems "his entire life." -Resident #4 had a history of at least 8 suicide attempts; last attempt was in August 2015.</p>	C 243		

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C 243	<p>Continued From page 33</p> <p>-Resident #4's social judgement was "severely impaired."</p> <p>-Resident #4 "feels he has to do things because they tell him to. Whether 'they' are internal or external is unclear, probably both."</p> <p>Interview with the Administrator on 06/29/16 at 3:07pm revealed:</p> <p>-Resident #4 had a history of being hospitalized and being in jail prior to his admission date to the facility.</p> <p>-Resident #4 was a "firecracker" and "flew off the handle at times."</p> <p>-Resident #4 got along with other residents but did not get along with facility staff.</p> <p>-Resident #4 moved in to the facility on 02/26/16 after living at the previous facility for only two weeks (in February 2016) because he could not get along with the residents of that facility.</p> <p>-Resident #4 lived at the facility until "he went to jail."</p> <p>-On 06/15/16, Resident #4 was arrested for punching walls and damaging property at the facility.</p> <p>-Resident #4 was still "in jail" and would not be returning to the facility.</p> <p>-On 06/13/16, Resident #4 dented the transportation van of the psychosocial rehabilitation (PSR) program he had been attending and was suspended from the PSR program from 06/14/16-06/17/16.</p> <p>Review of the "Client Disciplinary Notice" from Resident #4's PSR program dated 06/13/16 revealed:</p> <p>-Resident #4 walked off the facility grounds, refused staff directives to calm down ..., and also damaged property by kicking a dent in the transportation van" on 06/13/16.</p> <p>-Resident #4 was suspended from the PSR</p>	C 243		

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C 243	<p>Continued From page 34</p> <p>program from 06/14/16-06/17/16.</p> <p>Interview with Resident #4 on 07/13/16 at 5:25pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 had been in jail"2 to 3 weeks." -The Administrator bailed Resident #4 out of jail and"is trying to help me." -Staff did not leave Resident #4 alone at the facility or drop him off anywhere unsupervised. <p>Observation of the library's video footage dated 7/11/16 revealed:</p> <ul style="list-style-type: none"> -At 3:01pm, Resident #4 was dropped off with Resident #1 and #6 at the library by a silver vehicle. -At 3:02pm, Resident #4 walked inside the bathroom. -At 3:04pm, Resident #4 walked out of the bathroom, talked to Resident #1, and went to the help desk. -From 3:06pm-3:31pm, Resident #4 was seated at the computer. -At 3:31pm, the silver vehicle arrived, and Residents #4 and #6 walk to the vehicle. -At 3:33pm, Resident #4 walked back into the library, got Resident #1, and the three residents got into the vehicle and left the library. <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 4:30pm.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>4. Review of Resident #6's current FL-2 dated</p>	C 243		

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C 243	<p>Continued From page 35</p> <p>06/09/16 revealed diagnoses included schizophrenia, hypertension, and anemia.</p> <p>Review of the Resident Register for Resident #6 dated 06/07/16 revealed: -Resident #6's first admission to the facility was on 06/07/16. -Resident #6 required assistance with orientation to time and place.</p> <p>Review of Resident #6's record revealed: -There was no assessment and care plan in the record. -There was no Resident Register in the record for Resident #6's second admission to the facility on 07/08/16.</p> <p>Review of the hospital "After Care Plan" dated 06/06/16 revealed: -Resident #6 was admitted to the hospital on 05/11/16 and discharged on 06/07/16. -The primary diagnosis was "schizophrenia, chronic with acute exacerbation."</p> <p>Interview with the Administrator on 07/01/16 at 08:55am revealed: -Resident #6 liked to talk to himself and smoke. -Resident #6 got "aggressive and agitated with white ladies."</p> <p>Interview with the Administrator on 07/13/16 at 4:55pm revealed Resident #6 moved back to the facility (a second time) on 07/08/16 because he did not get along with the white female resident who lived at the other facility.</p> <p>Observation of Resident #6 on 07/13/16 at 5:10pm revealed: -Resident #6 was standing outside of the facility alone on the right side of the house smoking a</p>	C 243		

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C 243	<p>Continued From page 36</p> <p>cigarette.</p> <p>-Resident #6 was calm and looked at the ground or straight ahead.</p> <p>-Resident #6 was talking to himself but the surveyor could not determine what Resident #6 was saying.</p> <p>-When told hello, Resident #6 appeared calm and responded hello.</p> <p>Observation of the library's video footage dated 7/11/16 revealed:</p> <p>-At 3:01pm, Resident #6 was dropped off with Resident #1 and #4 at the library by a silver vehicle.</p> <p>-At 3:02pm, Resident #6 walked inside the library, got a drink of water from the fountain, and sat down in the lobby.</p> <p>-From 3:05pm-3:07pm, Resident #6 walked around outside.</p> <p>-He came back into the library and sat inside the lobby at 3:07pm,</p> <p>-At 3:12pm, Resident #6 walked back outside until 3:19pm, when he came back inside the library for water.</p> <p>-He went to the bathroom from 3:19pm, and then walked back outside.</p> <p>-There was no camera footage of Resident #6 until 3:26pm, when he walked back up the steps and was walking along the ramp outside.</p> <p>-At 3:30pm, he walked back inside the library lobby.</p> <p>-At 3:31pm, the silver vehicle arrived, and Resident #6 walked to the vehicle and got inside.</p> <p>Based on observations, record reviews, and interviews, Resident #6 was not interviewed.</p> <p>Resident #6's family was not available for interview during the survey.</p>	C 243		

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C 243	<p>Continued From page 37</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 4:30pm.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>5. Review of Resident #3's FL-2 dated 03/18/16 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, anemia, and Marfan's syndrome. -Resident #3 required "prompting" with bathing, dressing, and feeding. -Resident #3 was admitted to the facility on 01/07/16.</p> <p>Review of the Resident #3's assessment and care plan dated 03/10/16 revealed: -Resident #3 was had a history of mental illness and developmental disabilities. -Resident #3 was forgetful and needed reminders. -The care plan was signed by Resident #3's PAC and dated 03/10/16.</p> <p>Interview with the Administrator on 06/29/16 at 2:18pm revealed: -Resident #3 moved in to the facility on 01/07/16. -Resident #3 went to the hospital on 05/17/16 and never returned to the facility due to an issue with her Medicaid.</p> <p>Review of Incident/Accident Report dated 03/11/16 revealed: -There was no time documented on the report. -Resident #3 was taken to the hospital by the</p>	C 243		

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C 243	<p>Continued From page 38</p> <p>county Sheriff's Department. -A sheriff's office "came to [facility name] to let us know that he was taking [Resident #3's name] to the hospital because she had been drinking and now saying she wanted to kill herself. She was at the [discount store name] from when she signed out to go to the store.</p> <p>Telephone interview with a Deputy of the county Sheriff's Department on 07/11/16 at 5:35pm revealed the Deputy had been notified by county emergency medical services (EMS) staff that a female meeting Resident #3's description who resided in the facility had been observed by EMS loitering at the department store late at night on multiple occasions but the Deputy could not recall the dates of the loitering or the dates he was notified.</p> <p>Interview with the Administrator on 06/29/16 at 2:35pm revealed: -On 05/17/16 Resident #3 went to the hospital for "suicidal thoughts." -Resident #3 had been going to a local discount department store and was "loitering." -Resident #3 had been picked up at the local discount store by law enforcement "a few times." -The department store told Resident #3 she could not stay at the store and the store called 911. -Resident #3 was transported to the hospital from the store. -The Administrator could not remember how she was notified about the store calling 911 and Resident #3 being admitted to the hospital on 05/17/16. -The Administrator had previously reported Resident #3's loitering behaviors to her probation officer. -"She was her own responsible person."</p>	C 243		

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C 243	<p>Continued From page 39</p> <p>Resident #3 had been discharged from the facility to another facility at the time of the survey and was not available for interview.</p> <p>Telephone interview with Resident #3's family member on 07/13/16 at 8:10pm revealed the family member thought Resident #3 liked living in the facility but she moved out of the facility and into another facility in order to be closer to her family.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 4:55pm. -"She was her own responsible person."</p> <p>Telephone interview with Resident #3's PAC on 07/13/16 at 1:20pm revealed based on Resident #3's history of schizoaffective disorder and intellectual disability, the PAC would not expect to see Resident #3 out walking alone unsupervised to stores or elsewhere.</p> <p>Refer to the interview with the Administrator on 07/13/16 at 6:00pm.</p> <p>Refer to the confidential interview with the Licensed Health Care Professional.</p> <p>Refer to the Resident Contract.</p> <p>_____ Interview with the Administrator on 07/14/16 at 4:30pm revealed: -The Administrator had not dropped off or left any resident unsupervised since 06/22/16 when she dropped Resident #1 off at the library and left him. -After the Administrator was notified by the surveyor of documentation received by the surveyors that Resident #1, Resident #4, and Resident #6 had been dropped off and left</p>	C 243			

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C 243	<p>Continued From page 40</p> <p>unattended at the county library earlier in the week, the Administrator acknowledged dropping Resident #1, Resident #4, and Resident #6 at the library for on 07/11/16 for 30-45 minutes; the Administrator was not sure of the time the residents were dropped off at the library. -The Administrator did not know "it was a problem to leave them (residents) alone until now."</p> <p>Interview with the Administrator on 07/13/16 at 6:00pm revealed: -Residents were not left in the facility unsupervised. -The facility only had 4 other staff besides the Administrator; the Administrator was at the facility "a lot." -The facility did not use employee schedules; the Administrator could not provide documentation of when each staff worked. -The Administrator paid staff in cash, therefore there were no payroll records available to document that staff were present to supervise the residents. -The Administrator did not have any documentation to show that staff were available to supervise and assist residents as needed.</p> <p>Confidential telephone interview with a licensed health care professional revealed: -The LHCP was concerned for the residents who lived in the facility because they had been observed walking the streets alone and had general complaints of not being treated well or taken care of by the facility. -The LHCP thought it would "be best to close" the facility</p> <p>Review of the facility's "Resident Contract" revealed: -The facility provided services to include "24 hour</p>	C 243			

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C 243	<p>Continued From page 41</p> <p>monitoring." -The facility"does not offer services, no can we meet the needs of individuals who pose a direct threat to the health of others ..."</p> <p>The failure of the facility to supervise residents in the facility by allowing a resident (Resident #5) who had a history of aggressive and assaultive behaviors to sexually assault another resident (Resident #5); and dropping off a resident, who has a known history of suicide attempt and feelings of being"abandoned" and"deserted" when being alone without staff, at a public library with no staff to monitor, created opportunities for Resident #1 to deliberately inflict self-harm. This noncompliance resulted in serious neglect.</p> <p>Review of the Plan of Protection submitted by the facility on 07/13/16 revealed: -All residents would be monitored/supervised by staff when going to public places. -All residents would be transported to their destinations by staff. -All residents would not be left alone at the facility or go anywhere alone without staff to ensure safety.</p> <p>CORRECTION DATE OF THIS TYPE A1 VIOLATION SHALL NOT EXCEED 08/13/16.</p>	C 243		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by:</p>	C 246		

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C 246	<p>Continued From page 42</p> <p>TYPE A1 VIOLATION</p> <p>Based on record reviews and interviews, the facility failed to notify a licensed healthcare provider of high risk injurious behaviors for 2 of 5 residents sampled (#1 and #5) as related to a resident reporting suicidal ideation and being sexually assaulted by another resident (#1), and a resident exhibiting behaviors such as insomnia, wandering the facility halls into other residents' rooms, having aggressive behavior towards staff, other residents, and property, and sexually assaulting another resident (#5), and failure to assure 4 of 5 residents sampled (#1, #2, #3, #5) went to medical and mental health appointments as directed by licensed health care providers.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on record reviews and interviews, Resident #1 had a history of over thirty hospitalizations for reports of wanting to harm himself by the age of 21, was discharged from a Psychosocial Rehabilitation Program (PSR) for wanting to harm himself and others, has been involuntarily committed numerous times, and was well known to county sheriff officers due to his history, frequency of the county sheriff's office responding to incidents at the facility, and multiple interactions between Resident #1 and law enforcement. Based on observation, record reviews, and interviews the facility failed to provide the services needed to maintain Resident #1's mental and physical health. <p>Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnoses included bipolar disorder, depression, and hypertension.</p> <p>Review of the Resident #1's Resident Register</p>	C 246		

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C 246	<p>Continued From page 43</p> <p>revealed: -Resident #1 required assistance with scheduling appointments. -Resident #1 was admitted to the facility on 01/01/16.</p> <p>Review of Resident #1's assessment and care plan dated 03/10/16 revealed: -Resident #1 had a history of being suicidal and injurious to self. -Resident #1 received medications for the treatment of mental illness and received mental health services. -The assessment was signed by Resident #1's Physician Assistant (PAC) and dated 03/10/16.</p> <p>Telephone interview with the Administrator on 06/29/16 at 07:36am revealed Resident #1 had been hospitalized for one week and would not be returning the facility.</p> <p>Telephone interview with the Administrator on 07/13/16 at 3:10pm revealed Resident #1 had returned to the facility on 07/07/16 after his hospital discharge.</p> <p>Interview with Resident #1's family member on 06/30/16 at 08:59am revealed: -Resident #1 had a history of harming himself and frequent hospitalizations. -Resident #1 was "very vulnerable" and easily upset from "triggers." -Resident #1 had "one incident or disaster after another" since being admitted to the facility but Resident #1 told the family member the facility did "anything they can to help him" so she could not say anything bad about the facility.</p> <p>A. Review of the "Emergency Department (ED) Encounter" for Resident #1 dated 05/23/16</p>	C 246		

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C 246	<p>Continued From page 44</p> <p>revealed: -The chief complaint was documented as "involuntary commitment." -Resident #1 tried "to choke himself with the belt. This was prevented by police presence." -Resident 1 was "actively suicidal with a plan to choke himself."</p> <p>Review of Resident #1's record revealed there was no documentation of any licensed health care provider being notified about Resident #1 attempting to choke himself on 05/23/16.</p> <p>Review of the "Emergency Department (ED) Encounter" from the hospital dated 06/22/16 revealed: -Resident #1 "presents after he was found wandering today. The patient (Resident #1) was extremely upset and actually had a thumb tack attempting to harm himself ...He reportedly tried to cut himself with a thumb tack on his left forearm. -Resident #1 told the ED staff "I wish you would give me a pistol so I can blow my head off." -The patient was involuntarily committed by the ED physician.</p> <p>Interview with Resident #1 on 7/13/16 at 6:35pm revealed: -On 06/21/16, Resident #1 packed his bags and left the facility. -Resident #1 had a lot on mind and was thinking about an incident that occurred on 04/25/16 when another resident assaulted him. -"I was about to jump in the lake and drown myself." -A neighbor who knew the Administrator found Resident #1 at the pond and took him back to the facility.</p>	C 246		

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C 246	<p>Continued From page 45</p> <p>Review of Resident #1's record revealed there was no documentation of a licensed health care provider being notified about his suicidal thoughts on 06/21/16 and 06/22/16.</p> <p>Interview with the Administrator on 06/29/16 at 11:35am revealed: -The facility staff did not usually document when Resident #1 said he was going to harm himself, "he doesn't mean anything by it. He wants attention." -There was no documentation in Resident #1's record of staff notifying his physician about Resident #1's behaviors because the physician was made aware whenever Resident #1 got to the hospital and Resident #1 told the physician himself at his regular and follow up appointments.</p> <p>Telephone interview with Resident #1's Physician Assistant (PAC) on 07/13/16 at 1:20pm revealed: -The facility had not ever notified the PAC of Resident #1 having suicidal ideation. -The PAC would expect Resident #1's MH provider to be notified of any suicidal ideation. -If the facility had notified the MH provider, the PAC would be able review to the documentation in Resident #1's record because Resident #1's MH provider was in the same practice as the PAC.</p> <p>Telephone interview with a receptionist at Resident #1's Psychiatrist's office on 07/13/16 at 4:45pm revealed the Psychiatrist was unavailable because he was out on leave.</p> <p>B. Interview with Resident #1 on 7/13/16 at 6:45pm revealed: -Resident #1 was sexually assaulted by Resident #5 on 04/25/16. -Resident #1 called the police.</p>	C 246		

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C 246	<p>Continued From page 46</p> <p>Interview with the Administrator on 07/01/16 at 08:55am revealed: -Resident #5 tried to kiss Resident #1 in April 2016; the Administrator was unsure of the exact date. -Resident #1 called the police and Resident #5 was arrested. -Resident #5 had a court date on 06/29/16 for "sexual battery."</p> <p>Telephone interview with Resident #1's family member on 06/30/16 at 08:59am revealed: -Resident #1 told her he was assaulted "1-2 months" by another resident who lived in the home. -Resident #1 called 911 and the other resident was arrested and was still in jail. -The family member did not know the other resident's name. -The facility had not notified the family member "or acknowledge if it did or did not take place." -The incident "really upset" Resident #1.</p> <p>Review of Resident #1's record revealed there was no documentation of the medical or MH provider being notified of Resident #1's assault.</p> <p>Telephone interview with Resident #1's Physician Assistant (PAC) on 07/13/16 at 1:20pm revealed the facility had not notified the PAC of Resident #1 being assaulted.</p> <p>Telephone interview with a receptionist at Resident #1's Psychiatrist's office on 07/13/16 at 4:45pm revealed the Psychiatrist was unavailable because he was out on leave.</p> <p>C. Review of the hospital "After Care Hospital Plan" dated 04/05/16 revealed:</p>	C 246		

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C 246	<p>Continued From page 47</p> <ul style="list-style-type: none"> -Resident #1 was admitted to the psychiatric unit on 03/29/16 and discharge on 04/05/16. -The diagnoses included history of autism spectrum disorder, bipolar disorder, and depression. -Resident #1 was scheduled for a follow up appointment with his mental health provider on 04/12/16 at 1:00pm. <p>Review of an untitled document received from Resident's MH office dated 04/22/16 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was evaluated by his psychiatrist on 04/12/16. -Resident #1 "will return for a therapy appointment on 04/19/16 ..." <p>Review of the "Appointment History" for Resident #1 revealed Resident #1 was a "no show" to the therapy appointment with his Licensed Clinical Social Worker (LCSW)/counselor on 04/19/16 at 1:45pm.</p> <p>Telephone interview with a staff member of Resident #1's MH provider's office on 06/30/16 at 11:48am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was a "no show" to an appointment with LCSW/counselor on 04/19/16 at 1:45pm. -Resident #1 had an appointment with the psychiatrist on 06/14/16 at 1:45pm. -On 06/14/16 at 1:41pm, the staff recalled that [Administrator's name] called and said she needed to reschedule the appointment on 06/14/16 at 1:45pm. -The appointment on 06/14/16 was rescheduled to 06/21/16; Resident #1 came to the appointment on 06/21/16. -Resident #1 had arrived late for scheduled appointments. <p>Review of the "Appointment History" for Resident</p>	C 246			

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C 246	<p>Continued From page 48</p> <p>#1 revealed: -Resident #1 was a "no show" to the therapy appointment with his Licensed Clinical Social Worker (LCSW)/counselor on 04/19/16 at 1:45pm. -"Rescheduled" was documented for Resident #1's appointment on 06/14/16 at 1:45.</p> <p>Telephone interview with Resident #1's Licensed Clinical Social Worker (LCSW) on 07/14/16 at 07:40am revealed: -Resident #1 had been hospitalized over thirty times for threats of self-harm. -Resident #1 had missed a few appointments but the facility was usually good about bringing him to his appointments.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 4:55pm.</p> <p>Refer to the review of the "Resident Contract."</p> <p>2. Interview and record review revealed Resident #5 had a history mental illness and exhibiting symptoms and behaviors that he did not exhibit upon his admission into the facility such as insomnia, aggressive behavior toward staff and other residents, and going in to other residents' rooms. Based on record reviews, and interviews the facility failed to provide the services needed to maintain his mental and physical health.</p> <p>Review of Resident #5's FL-2 revealed: -The FL-2 was signed by the physician but there was no date documented beside the physician's signature. -Diagnoses included schizoaffective disorder, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and edema.</p>	C 246		

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C 246	<p>Continued From page 49</p> <p>-Resident #5's admission date to the facility was documented as 01/20/16.</p> <p>Review of the Resident Register dated 01/21/16 revealed:</p> <p>-Section G contained documentation that Resident #5 was discharged from the facility on 04/29/16.</p> <p>-The "reason" for discharge was documented as "arrested for assault on resident."</p> <p>-Resident #5 required assistance with scheduling appointments.</p> <p>Review of Resident #5's assessment and care plan revealed:</p> <p>-The assessment date was not documented.</p> <p>-Resident #5 received medications and treatment for a history of mental illness.</p> <p>-The assessment and care plan was signed by Resident #5's physician and dated 04/07/16.</p> <p>Interview with the Administrator on 07/01/16 at 09:20am revealed:</p> <p>-Resident #5 was "very nice" and "calm" when he first moved in to the facility; "then it seemed like he gradually got worse."</p> <p>-About 1-2 months before he moved out, Resident #5 was not sleeping, walking the halls all night, cursing, going in other residents' rooms, and stealing other residents' belongings.</p> <p>-Resident #5 tried to fight other residents and staff.</p> <p>-Resident #5 "walked off and went to neighbors' houses" and "hitchhiked" to another town; he was brought back to the facility by police.</p> <p>-Resident #5 had 3 different guardians while living in the facility; the Administrator notified his guardians about his behaviors.</p> <p>-The Administrator documented Resident #5's behaviors on incident reports.</p>	C 246		

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C 246	<p>Continued From page 50</p> <p>-Resident #5 had been involuntarily committed multiple times and been hospitalized multiple times while living in the facility.</p> <p>-The Administrator thought Resident #5 "was vomiting up his meds (medications) on purpose" which correlated to when Resident #5 started exhibiting behaviors he did not exhibit when he first moved in.</p> <p>Review of Resident #5's record revealed there was no documentation of a licensed health care provider being notified about the behaviors or symptoms exhibited by Resident #5.</p> <p>Refer to the Interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>A. Review of the Emergency Department (ED) Provider Notes dated 02/26/16 revealed: -Resident #5 "presents with law enforcement and IVC (involuntary commitment) papers." -Resident #5 "became verbally and physically abusive" at his group home and had been "destroying the place." -Resident #5 denied suicidal ideation but "states that he is having thoughts he wants to hurt the people with whom he is living at the group home." -Resident #5 was transferred from the ED to an in-patient psychiatric hospital.</p> <p>Review of the hospital "After Care Hospital Plan" for Resident #5 dated 03/17/16 revealed Resident #5 was admitted to the in-patient psychiatric unit on 02/27/16 and discharge on 03/17/16.</p> <p>Review of Resident #5's record revealed there was no documentation Resident #5's health care</p>	C 246		

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C 246	<p>Continued From page 51</p> <p>providers were notified of his verbally and physically abusive behaviors or hospitalization from 02/26/16-03/17/16.</p> <p>Telephone message to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Resident #5 was not available for interview.</p> <p>Refer to the Interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>B. Review of an Accident/Incident Report dated 04/18/16 revealed: -Resident #5 smelled like liquor on 04/11/16 after going to store but he denied drinking alcohol. -On the previous Wednesday (04/13/16), Resident #5's behavior "started getting a little worse." -On Thursday (04/14/16), Resident #5 did not sleep. -On Friday (04/15/16), Resident #5 "started a fight" with another resident, and was "talking, cussing and not sleeping." -The staff had been trying to contact Resident #5's court appointed guardian "all weekend" about his behavior. -Resident #5's guardian completed IVC paperwork for Resident #5 on 04/18/16; or hospitalization form 02/26/16- Resident#5 was sent to the hospital and discharged back to the facility. -Resident #5 told staff he did not want to be "kicked out." -"Staff told him (Resident #5) his behavior had to change."</p>	C 246		

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C 246	Continued From page 52 Review of the ED Provider Notes dated 04/18/16 revealed: -Resident #5 "presents secondary to being placed on IVC paperwork by a worker at his group home." -The IVC paperwork contained documentation that Resident #5 "refuses to take his medication, is very aggressive towards staff and peers, and is wandering around town." -Resident #5 denied thoughts of wanting to hurt himself but admitted to "striking a worker after an altercation today." Review of the ED Provider Notes dated 04/15/16 revealed Resident #5 was evaluated for back pain and discharged 04/15/16. Review of the ED Provider Notes dated 04/21/16 revealed Resident #5 was evaluated for left chest wall pain and discharged on 04/21/16. Review of the ED Provider Notes dated 04/26/16 revealed: -Resident #5's chief complaint was head laceration after falling. -Resident #5 received 6 sutures to the laceration above the right eyebrow. -Resident #5 was discharged 04/26/16. Review of Resident #5's record revealed: -There was no documentation Resident #5's health care providers were notified of Resident #5 refusing medications, wandering, or aggressiveness towards staff and peers. -There was no documentation Resident #5's health care providers were notified about his behaviors and symptoms on 04/11/16-04/18/16 that were documented in the Accident/Incident Report dated 04/18/16. -There was no documentation Resident #5's	C 246			

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C 246	<p>Continued From page 53</p> <p>health care providers were notified complaints, behaviors, and symptoms related to his hospitalizations on 04/15/16, 04/18/16, 04/21/16, or 04/26/16.</p> <p>Telephone message to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Resident #5 was not available for interview.</p> <p>Refer to the Interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>C. Interview with the Administrator on 07/01/16 at 08:55am revealed Resident #5 made Resident #2 "uncomfortable" because he went into her room.</p> <p>Resident #2 was not available for interview.</p> <p>Telephone interview with Resident #2's family member on 07/13/16 at 10:33am revealed: -Resident #2 complained to the family member "a while ago" about Resident #5 pacing the halls and coming into her room. -Resident #5 made Resident #2 "nervous" and Resident #2 felt "uncomfortable" with Resident #5. -The Administrator was aware of Resident #5 going into Resident #2's room and making her nervous and uncomfortable.</p> <p>Interview with the Administrator on 07/01/16 at 09:20am revealed: -"It was not safe" for the female residents who resided in the facility because Resident #5 went into their rooms at night; the Administrator notified</p>	C 246		

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C 246	<p>Continued From page 54</p> <p>Resident #5's about moving him out of the facility.</p> <p>Review of Resident #5's record revealed there was no documentation of a licensed healthcare provider being notified of Resident #5's wandering or going in to other resident's rooms.</p> <p>Telephone message to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Resident #5 was not available for interview.</p> <p>Refer to the Interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>D, Interview with Resident #1 on 7/13/16 at 6:45pm revealed: -On 4/25/16, Resident #1 had an issue with Resident #5. -Resident #5 bothered Resident #1 while Resident #1 was sleeping. -"[Resident #5's name] came in my room, got in bed with me, held on to me, and was tongue kissing me." -Resident #1 pushed Resident #5 and told Resident #5 to get off of him. -"[Resident #5's name] told me he had something for me, and [Resident #5's name] dropped his pants and showed me his sex organs." -Then, the police came and took Resident #5.</p> <p>Interview with the Administrator on 07/01/16 at 08:55am revealed: -Resident #5 tried to kiss Resident #1 in April 2016; the Administrator was unsure of the exact date.</p>	C 246		

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C 246	<p>Continued From page 55</p> <p>-Resident #5 had been arrested and had a court date on 06/29/16 for "sexual battery."</p> <p>Review of Resident #5's record revealed: -There was no documentation about the incident that occurred on 04/25/16 in the record. -There was no documentation of Resident's health care provider's being notified about the incident that occurred on 04/25/16.</p> <p>Interview with the Administrator on 07/13/16 at 8:30pm revealed: -The county DSS was aware of the incident on 04/25/16 between Resident #5 and Resident #1. -The Administrator called Resident #5's guardian and was keeping documentation of his behavior for his guardian.</p> <p>Telephone message to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Resident #5 was not available for interview.</p> <p>Refer to the Interview with the Administrator on 07/13/16 at 5:37pm.</p> <p>Refer to the interview with Resident #5's physician.</p> <p>_____ Interview with the Administrator on 07/13/16 at 5:37pm revealed Resident #5's doctor was aware of his behaviors.</p> <p>Telephone interview with Resident #5's physician revealed: -Resident #5 became a patient of the physician in July 2015; the physician last evaluated Resident #5 in April 2016.</p>	C 246		

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C 246	<p>Continued From page 56</p> <ul style="list-style-type: none"> -The physician saw Resident #5 every two months but "for a while I could not locate him" for follow up. -The last time that the physician was aware of Resident #5 going to the hospital was in February 2016. -The facility had not notified the physician with concerns about Resident #5's medications. -The facility had never notified the physician about Resident #5 having insomnia, exhibiting aggressive behavior towards staff or other residents, or sexually assaulting another resident. -The facility "not one time" notified the physician with any concerns. -The physician expected to be notified of any issues of conflict or threats; the physician would have considered changing Resident #5's medications. <p>E. Review of the hospital "After Care Hospital Plan" for Resident #5 dated 03/17/16 revealed:</p> <ul style="list-style-type: none"> -Resident #5 was admitted to the psychiatric unit on 02/27/16 and discharge on 03/17/16. -Resident #5 had a follow up appointment scheduled for 03/22/16 at 09:00am. <p>Review of the "Patient Chart Report" and "Appointment History" revealed Resident #5 was a "no show" for the "hospital follow-up" appointment on 03/22/16 at 09:00am.</p> <p>Refer to the telephone interview with a Medical Records staff at the medical and MH provider's central office on 06/30/16 at 2:30pm.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 4:55pm.</p> <p>Refer to the review of the "Resident Contract."</p>	C 246		

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C 246	<p>Continued From page 57</p> <p>3. Review of Resident #2's FL-2 dated 03/30/16 revealed diagnoses included schizophrenia, impulse disorder, mood disorder, and heart failure.</p> <p>Review of the Emergency Department (ED) Provider Notes dated 01/20/16 revealed: -Resident #2's chief complaint was increased anxiety due to depression. -Resident #2 was not able to stay at her day program that day (01/20/16) because the group home staff told her she had a doctor's appointment. -Resident #2 "states that the staff told her she had a doctor's appointment and then they told her she did not have a doctor's appointment. -Resident #2 was upset and "wanted to cut herself with a broken DVD."</p> <p>Telephone interview with a Medical Records staff member at Resident #2's physician office on 06/29/16 at 10:06am revealed Resident #2's medical and mental health (MH) providers were in the same practice.</p> <p>Telephone interview with a staff member of Resident #2's MH provider on 06/30/16 at 11:48am revealed: -The staff recalled who Resident #2 was and that she had been late to appointments and missed appointments. -Resident #2 had an appointment scheduled on 04/03/16 at 1:45pm to see the psychiatrist and therapist; Resident #3 arrived to the appointment at 2:03pm and could not be seen.</p> <p>Resident #2 was not available for interview.</p> <p>Refer to the telephone interview with a Medical Records staff at the medical and MH provider's</p>	C 246		

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C 246	<p>Continued From page 58</p> <p>central office on 06/30/16 at 2:30pm.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 4:55pm.</p> <p>Refer to the review of the "Resident Contract."</p> <p>5. Review of Resident #3's FL-2 dated 03/18/16 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, anemia, and Marfan's syndrome. -Resident #3 was admitted to the facility on 01/07/16.</p> <p>Review of the Resident #3's assessment and care plan dated 03/10/16 revealed: -Resident #3 had a history of mental illness and developmental disabilities. -Resident #3 was forgetful and needed reminders. -The care plan was signed by Resident #3's PAC and dated 03/10/16.</p> <p>Telephone interview with a Medical Records staff member at Resident #3's physician office on 06/29/16 at 10:06am revealed: -Resident 3's medical and mental health (MH) providers were in the same practice. -Resident #3 received medical and MH services from the practice.</p> <p>Review of a Patient Chart Report and Appointment History from the physician's/MH provider's office for Resident #3 revealed: -Resident #3 was seen by a licensed provider for a "new patient" appointment on 2/2/16. -She was seen by a licensed provider on 3/3/16 for a follow-up. -On 3/9/16, Resident #3 was scheduled for a follow-up with the Physician Assistant (PA), but</p>	C 246		

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C 246	<p>Continued From page 59</p> <p>was documented as a "now show".</p> <p>-Resident #3 saw the PA on 3/10/16 for a follow-up.</p> <p>-She was scheduled for a follow-up with the PA on 3/23/16, but was documented as a "no show".</p> <p>-Resident #3 was scheduled for a "new patient-psychiatry" appointment on 4/6/16 and a follow-up appointment on the same day, but was documented as "rescheduled".</p> <p>-On 5/2/16, Resident #2 was documented as a "no show" for a follow-up appointment.</p> <p>-On 5/17/16, the "new patient-psychiatry" appointment was scheduled, and Resident #3 was documented as a "no show".</p> <p>Resident #3 was not available for interview.</p> <p>Refer to the telephone interview with a Medical Records staff at the medical and MH provider's central office on 06/30/16 at 2:30pm.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 4:55pm.</p> <p>Refer to the review of the "Resident Contract."</p> <hr/> <p>Telephone interview with a Medical Records staff member at the medical and MH provider's central office on 06/30/16 at 2:30pm revealed:</p> <p>-Documentation of "no show" on the "Appointment History" meant the patient did not arrive at the facility for the appointment and was not evaluated by the provider.</p> <p>-Documentation of "rescheduled on the "Appointment History" meant the appointment was rescheduled by the patient or the office.</p> <p>Interview with the Administrator on 06/29/16 at</p>	C 246		

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C 246	<p>Continued From page 60</p> <p>4:55pm revealed: -The Administrator took all residents to their medical and MH appointments. -No resident had missed any medical appointments except when they were in the hospital. -The Administrator rescheduled appointments for any resident who missed an appointment due to hospitalization. -The Administrator could not recall any resident missing any specific appointments or any specific dates of any missed appointments.</p> <p>Review of the facility's "Resident Contract" revealed the facility provided services including "scheduling and transportation to doctor's appointments."</p> <p>The facility neglected to notify appropriate health care providers of Resident #1's suicidal ideation and Resident #5 becoming aggressive towards staff and peers, wandering in to other residents' rooms, and assaulting another resident. The facility failed to assure residents went to medical care and mental health care appointments as directed by licensed health care providers. This noncompliance constitutes a TYPE A1 VIOLATION for serious harm and neglect.</p> <p>Review of the Plan of Protection submitted by the facility on 07/13/16 revealed: -The Administrator would assure all doctor's appointments were kept. -If there was any reason an appointment was not kept, documentation would be maintained for the missed appointment. -All appointments would be scheduled at a time that was manageable for the staff and residents. -The medical provider would be notified of all changes in behavior.</p>	C 246		

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C 246	Continued From page 61	C 246		
C 301	<p>10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services</p> <p>10A NCAC 13G .0906 Other Resident Services</p> <p>(f) Visiting.</p> <p>(1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator;</p> <p>(2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home;</p> <p>(3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party;</p> <p>(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.</p>	C 301	<p>Addendum 8/28/16:</p> <p>The resident sign out log will be maintained per licensure rules and facility policies.</p> <p>9/8/28/16</p>	

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C 301	<p>Continued From page 62</p> <p>This Rule is not met as evidenced by: Based on interviews and review of the Resident Sign Out Log, the facility to assure the whereabouts of 4 of 5 residents sampled (#1, #3, #4, #5) was maintained as evidenced by not maintaining a thorough and complete record of the residents' departure date, departure time, expected time of return, and name and telephone number of the responsible party.</p> <p>The findings are:</p> <p>Review of the facility's "Visitation Policy" revealed: -Residents were expected to sign in and out. -"A sign out register shall be maintained for scheduled visits and other scheduled absences which includes the resident's departure time, expected time of return, and the name and telephone number of the responsible party.</p> <p>Observation and review of 9 pages of untitled documents identified by the Administrator as the Resident Sign-Out Log (RSOL) revealed: -Eight of the nine pages were not in chronological order by date and/or did not contain documentation of the dates the resident was signing out of the facility. -Four of the nine pages were wrinkled and/or torn. -Five pages did not contain directions or prompts on what was required to be documented on the log. -Three of the nine pages had handwritten sections for documentation of "name", "date", time out, and time in. -There was no responsible party or telephone number documented for any resident's sign out from the facility. -Only one of the 9 pages had a section for documentation of the residents' destination.</p>	C 301		

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C 301	<p>Continued From page 63</p> <p>-For example: Page one had "2016" handwritten on the top of the page; there was documentation of four different resident's signing out on thirteen occasions, but there was no documentation on any of the thirteen occasions to indicate the day or month that the resident was signing out; there was no time documented for the resident's return seven times on page one; the residents destination was not documented on any occasion on page one; there was no responsible party or telephone documented anywhere on page one..</p> <p>-For example: Pages two and three were written on a red file folder and contained documentation of two different residents signing out on twelve occasions on various dates such as 01/02/16, 03/14/16, 05/31/16, and 06/13/16; the residents had documented returning to the facility on only four of the twelve occasions after signing out; no responsible party or telephone number was documented anywhere on pages two and three.</p> <p>1. Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnoses included bipolar disorder, depression, and hypertension.</p> <p>Review of Resident #1's assessment and care plan dated 03/10/16 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had a history of being suicidal and injurious to self. -Resident #1 received medications for the treatment of mental illness and received mental health services. -The assessment was signed by Resident #1's Physician Assistant (PAC) and dated 03/10/16. <p>Interview with Resident #1 on 07/13/16 revealed:</p> <ul style="list-style-type: none"> -Resident #1 would sign out of the facility and to walk to the library. -Resident #1 tried to always sign out when he left the facility but sometimes he "forgot" to sign out. 	C 301		

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C 301	<p>Continued From page 64</p> <p>Review of nine pages of untitled documents identified by the Administrator as the Resident Sign-Out Log on 06/29/16 revealed:</p> <ul style="list-style-type: none"> -Resident #1 signed out a total of 45 times; there was no responsible party or telephone number documented on any of the 45 times Resident #1 signed out. -There were 15 times when Resident #1 signed but did not include a destination. -There were 8 times when Resident #1 signed out but did not sign back in. -There were nine dates that Resident #1 signed out of the facility for three hours or more. -For example: On 03/18/16 from 08:30am-12:00pm, Resident #1 signed out to a (named) discount store; On 03/25/16 from 9:05am-12:00pm, Resident #1 signed out to the park; on 04/09/16 from 9:30am-12:00pm and 12:00pm-3:00pm, Resident #1 signed out to the library; 04/11/16 from 12:45pm-9:00pm, Resident #1 signed out to a local (named) discount store; On 06/01/16 from 4:20pm-7:25pm, Resident #1 signed out to the (named) discount store; on 06/08/16 from 12:00pm-5:00pm, Resident #1 signed out to a discount store (named). -There were two occasions when Resident #1 signed out more than 3 hours without a date documented: Resident #1 signed out to the library from 2:00pm-7:00pm (there was no date documented); Resident #1 signed out to the park from 08:10am-12:20pm (there was no date documented). -On 04/28/16 from 2:00pm-5:00pm Resident #1 signed out to the library; Resident #1 had signed in on the city library visitor log at 3:03pm on 04/28/16. On 05/13/16 from 1:00pm-5:00pm, Resident #1 signed out to the library; Resident #1 signed in on to the city library visitor log at 3:00pm. 	C 301		

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C 301	<p>Continued From page 65</p> <p>Refer to the interview with the Administrator on 06/29/16 at 12:15pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 between 5:37pm-6:00pm.</p> <p>2. Review of Resident #4's current FL-2 dated 03/09/16 revealed diagnoses included schizoaffective disorder, mood disorder, and attention deficit hyperactivity disorder (ADHD).</p> <p>Review of Resident #4's Assessment and Care Plan dated 03/09/16 revealed: -Resident #4 had a history of schizophrenia, depression, insomnia, and ADHD and received mental health service and medications for the treatment of mental illness. -Resident #4 had a history of wandering. -Resident #4 had a history of being verbally and physically abusive. -The assessment and care plan was sign by Resident #4's Physician Assistant (PAC) and dated 03/09/16.</p> <p>Review of a legal document in Resident #4's record dated 01/03/12 revealed Resident #4 had a court appointed guardian.</p> <p>Interview with Resident #4 on 07/13/16 at 5:25pm revealed Resident #4 signed out of the facility whenever he left.</p> <p>Review of untitled documents identified by the Administrator as the facility's Resident Sign-Out Log revealed Resident #4 had only signed out on the RSOL one time: the date was not documented; no responsible party or telephone number was documented; "4:31pm" was documented as the "time-out" but no "time-in"</p>	C 301		

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C 301	Continued From page 66 was documented. Refer to the interview with the Administrator on 06/29/16 at 12:15pm. Refer to the interview with the Administrator on 07/13/16 between 5:37pm-6:00pm. 3. Review of Resident #3's FL-2 dated 03/18/16 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, anemia, and Marfan's syndrome. -Resident #3 required "prompting" with bathing, dressing, and feeding. -Resident #3 was admitted to the facility on 01/07/16. Review of the Resident #3's assessment and care plan dated 03/10/16 revealed: -Resident #3 was had a history of mental illness and developmental disabilities. -Resident #3 was forgetful and needed reminders. -The care plan was signed by Resident #3's PAC and dated 03/10/16. Review of Incident/Accident Report dated 03/11/16 revealed: -There was no time documented on the report. -Resident #3 was taken to the hospital by the county Sheriff's Department. -A sheriff's office "came to [facility name] to let us know that he was taking [Resident #3's name] to the hospital because she had been drinking and now saying she wanted to kill herself. She was at the [discount store name] from when she signed out to go to the store. Review of untitled documents identified by the Administrator as the facility's Resident Sign-Out	C 301		

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C 301	<p>Continued From page 67</p> <p>Log revealed:</p> <ul style="list-style-type: none"> -Resident #3 signed out at 2:40pm on an undocumented date; Resident #3's destination and return was not documented; no responsible party or telephone number was documented. -On 01/28/16, Resident #3 signed out at 2:30 (am or pm was not unspecified); a responsible party was not documented; there was no documentation that Resident #3 returned to the facility. -Resident #3 signed out of the facility on two other occasions which included a time of sign-out but did not include the date of the sign out, destination, responsible party, or return to the facility. -There was no documentation dated 03/11/16 of Resident #3 signing out of the facility. <p>Interview with the Administrator on 06/29/16 at 2:35pm revealed:</p> <ul style="list-style-type: none"> -Resident #3 had been going to a local discount department store and was "loitering." -Resident #3 had been picked up at the local discount store by law enforcement "a few times." -The Administrator had previously reported Resident #3's loitering behaviors to her probation officer. -"She was her own responsible person." <p>Resident #3 had been discharged from the facility to another facility at the time of the survey and was not available for interview.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 12:15pm.</p> <p>Refer to the interview with the Administrator on 07/13/16 between 5:37pm-6:00pm.</p> <p>4. Review of Resident #5's FL-2 revealed:</p>	C 301		

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C 301	<p>Continued From page 68</p> <ul style="list-style-type: none"> -The FL-2 was signed by the physician but there was no date documented beside the physician's signature. -Diagnoses included schizoaffective disorder, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and edema. -Resident #5's admission date to the facility was documented as 01/20/16. <p>Review of Resident #5's assessment and care plan revealed:</p> <ul style="list-style-type: none"> -The assessment date was not documented. -Resident #5 received medications and treatment for a history of mental illness. -The assessment and care plan was signed by Resident #5's physician and dated 04/07/16. <p>Review of 9 pages of untitled documents identified by the Administrator as the RSOL revealed:</p> <ul style="list-style-type: none"> -Resident #5 signed out twelve times; there was no responsible party documented for any of the twelve times Resident #5 signed out. -There was no date documented on three of the twelve times Resident #5 signed out. -There was no time documented out or in on two of the twelve sign outs. -There was no destination documented on five of Resident #5's twelve sign outs. <p>Resident #5 was not available for interview.</p> <p>Telephone call to Resident #5's court appointed guardian on 07/13/16 at 11:02am was not returned.</p> <p>Refer to the interview with the Administrator on 06/29/16 at 12:15pm.</p>	C 301		

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C 301	Continued From page 69 Refer to the interview with the Administrator on 07/13/16 between 5:37pm-6:00pm. Interview with the Administrator on 06/29/16 at 12:15pm revealed: -All residents were supposed to sign out if they left the facility. -When residents required transportation outside of the facility, they walked or staff transported them. -Staff could not stop residents from leaving the leaving the facility because it was their right to leave. Interview with the Administrator on 07/13/16 between 5:37pm-6:00pm revealed: -The staff on duty was supposed to monitor the resident sign out sheets. -If a resident was gone "a long time" staff went to look for them. -The Administrator acknowledged the resident sign out log had not been monitored "like it should be." -The Administrator made a new resident sign out log after the surveyor reviewed the log on 06/29/16. -Residents were not left in the facility unsupervised.	C 301		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	C 330	Administrator will make all changes for new orders when a resident medication has been changed and sent to the pharmacy immediately. Residents	

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C 330	<p>Continued From page 70</p> <p>which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the failed to administer a blood pressure medication as ordered to 1 of 7 residents sampled (#1).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 03/10/16 revealed: -Diagnoses included depression, bipolar disorder, and hypertension. -There was a medication order for Atenolol 25mg. twice daily. (Atenolol is a medication used to treat elevated blood pressure).</p> <p>Review of the hospital Discharge Summary dated 07/07/16 revealed there was a physician order for Atenolol 25mg once daily at 9:00am.</p> <p>Review of Resident #1's July 216 Medication Administration Records revealed: -There was a preprinted entry for Atenolol 25mg twice daily with administration times at 8:00am and 4:00pm. -Staff initialed the MAR as documentation of administering Atenolol 25mg. twice daily at 8:00am and 4:00pm from 07/08/16-07/13/16.</p> <p>Review of Resident #1's physician orders did not reveal an order to obtain blood pressure readings.</p> <p>Interview with the Administrator on 07/13/16 at 6:30pm revealed: -The Administrator was responsible for faxing physician orders to the pharmacy and</p>	C 330	<p>medication changes will be done and reviewed to make sure there is no medication error. If and error occur staff is to notify Administration first and then the pharmacy and health care provider will also be notified immediately. The JY rights when administering giving meds should be followed at all times.</p>	

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421
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C 330 : Continued From page 71
 transcribing the orders to the MARs.
 -The Administrator must have missed the hospital discharge order dated 07/07/16.
 -Resident #1 had been receiving Atenolol 25mg twice daily since his discharge from the hospital.
 -Resident #1 should only be receiving Atenolol 25mg once daily.
 -Resident #1 had not had any complaints since his hospital discharge.
 -The Administrator would fax the order dated 07/07/16 to the pharmacy and update Resident #1's MARs.

C 330

C 448 10A NCAC 13G .1213 (e) Reporting Of Accidents And Incidents
 10A NCAC 13G .1213 Reporting Of Accidents And Incidents
 (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:
 (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
 This Rule is not met as evidenced by:
 Based on interviews and record reviews, the facility failed to notify the responsible person or contact person of 2 of 3 residents sampled (#1,

C 448

All residents responsible party or guardian will be notified when there is a change in residents behavior. Their guardian and responsible person will be notified and documented on all accidents and incidents within 24 hours. It will be documented in all residents book if their responsible party was available and it will be kept in all their books.

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C 448	<p>Continued From page 72</p> <p>#2) of incidents of injury or illness requiring hospital medical treatment and hospitalization.</p> <p>The finding are:</p> <p>1. Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnoses included depression, bipolar disorder, and hypertension.</p> <p>Review of the Resident Register revealed Resident #1 was admitted to the facility on 01/01/16.</p> <p>Review of the hospital "After Care Instructions" dated 02/29/16 revealed: -Resident was hospitalized in an in-patient psychiatric unit from 02/22/16-02/29/16. -The diagnosis was increased depression.</p> <p>Review of the hospital "After Care Hospital Plan" dated 04/05/16 revealed: -Resident was admitted to the psychiatric unit on 03/29/16 and discharged on 04/05/16. -The diagnoses included history of autism spectrum disorder, bipolar disorder, and depression.</p> <p>Review of the hospital "After Care Hospital Plan" dated 05/31/16 revealed: -Resident #1 was admitted to the psychiatric unit on 05/25/16 and discharged 05/31/16. -Diagnoses included bipolar disorder and depression.</p> <p>Interview with the Administrator on 06/29/16 at 11:45am revealed Resident #1 was not at the facility on 06/29/16 because he had been in the hospital since 06/22/16. -The Administrator did not know which hospital Resident #1 was admitted to.</p>	C 448		

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C 448	Continued From page 73 Review of Resident #1's record revealed there was no documentation in the record of the facility notifying Resident #1's contact person/family member of his hospitalizations from 02/22/16-02/29/16, 03/29/16-04/05/16, 05/25/16-05/31/16, or 06/22/16. Interview with Resident #1's family member on 06/30/16 at 08:59am revealed: -Resident #1 had a history of harming himself and frequent hospitalizations. -Resident #1 called the family member every night. -The facility had "never" called her when Resident #1 was in the hospital. -When/If Resident #1 did not call the family member, the family member knew to call the facility to check on him. -The facility would tell her "we had to IVC (involuntarily commit) him." -"Somebody" called her on 06/26/16 or 06/27/16 to notify her that Resident #1 was in the hospital; the family member did not know if it was the hospital or the facility who called to notify her Resident #1's hospitalization on 06/22/16. Interview with the Administrator on 06/29/16 at 4:38pm revealed: -The hospital did not tell the Administrator which hospital Resident #1 was in; she did not know which hospital Resident #1 was in due to Resident #1's "privacy." -Resident #1's family did not know he had been in the hospital since 06/22/16. -The Administrator had called Resident #1's family (she did not know what date) but "didn't leave a message." -Resident #1 called the family member daily. -Resident #1's family member always called the	C 448		

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C 448	<p>Continued From page 74</p> <p>Administer when/if she did not hear from Resident #1. -The facility did not contact Resident #1's family when he was hospitalized because Resident #1 notified his family.</p> <p>2. Review of Resident #2's FL-2 dated 03/30/16 revealed diagnoses included schizophrenia, impulse disorder, mood disorder, and heart failure.</p> <p>Interview with the Administrator on 06/29/16 at 2:10pm revealed: -Resident #2 was admitted to the facility on 05/04/15 (prior to the CHOW) and lived in the facility after the CHOW until moving out into an apartment on 06/01/16.</p> <p>Review of the Emergency Department (ED) Notes dated 02/01/16 revealed Resident #2 was evaluated in the ED for a self inflicted laceration on her right thigh.</p> <p>Review of the "Hospital After Care Plan" dated 02/19/16 revealed Resident #2 was hospitalized in the in-patient psychiatric unit from 02/17/16-02/29/16.</p> <p>Review of the Psychiatric History and Physical Exam dated 03/14/16 revealed Resident #2 was hospitalized in the in-patient psychiatric unit from 03/01/16-03/14/16.</p> <p>Interview with the Administrator on 06/29/16 at 2:55pm revealed Resident #2 went to the hospital on 05/17/16 and did not return to the facility after the hospitalization.</p> <p>Review of Resident #2's record revealed there was no documentation in the record of Resident</p>	C 448		

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C 448	<p>Continued From page 75</p> <p>#2's contact person being notified when she was hospitalized.</p> <p>Telephone interview with Resident #2's family member on 06/20/16 at 12:13pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 had been hospitalized on many occasions because she was bipolar and harmed herself and others if things did not "go her way." -The facility never called the family member when Resident #2 went to the hospital or was hospitalized. -Resident #2 cut her leg and had to get stitches; the facility did not notify the family member. -The family member always found out that Resident #2 was in the hospital whenever Resident #2 called her. -The family member recalled one incident "a few months ago" when Resident #2 had been in the hospital "at least a week" and nobody from the facility contacted her; Resident #2 "finally called her." <p>Resident #2 was discharged from the facility on 06/01/16 and was not available for interview.</p> <p>Multiple telephone calls to Resident #2 during the survey were not returned.</p> <p>Interview with the Administrator on 06/29/16 at 2:25pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 had a history of cutting herself prior to admission into the facility. -Resident #2 cut herself two times while living in the facility (on 11/10/15 and 02/01/16) and was sent to the hospital emergency room. -Resident #2 had been in the hospital "multiple times." -The Administrator did not notify Resident #2's family when she cut herself or was hospitalized. -When Resident #2 was hospitalized, Resident #2 	C 448		

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C 448	Continued From page 76 notified her family herself. Review of the facility's "Policy and Procedures" revealed the "resident's responsible person or contact person listed on the Resident Register will be notified of any accident/incident requiring "referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid."	C 448		
C 450	10A NCAC 13G .1213 (f) Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting Of Accidents and Incidents (f) When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to notify law enforcement immediately of an incident in which 1 of 5 residents sampled (#1) was harmed by another resident (#5). The findings are: Review of Resident #1's current FL-2 dated 03/10/16 revealed diagnoses included bipolar disorder, depression, and hypertension.	C 450		

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C 450	<p>Continued From page 77</p> <p>Interview with Resident #1 on 7/13/16 at 6:45pm revealed: -On 4/25/16, Resident #5 came in to his room and exposed his genitals to Resident #1. -Resident #1 knocked on the office door and the staff stated "not right now." -The staff did not come out of the office until Resident #5 started smoking in the bathroom. -Resident #1 told the staff about the incident then and staff told Resident #1 to call the police, "but that was the staff's job."</p> <p>Review of the county 911 communications "Call Detail Information" revealed: -Resident #1 was documented as the caller for a call placed to 911 on 04/25/16 at 06:12am. -Resident #1 reported he was sexually assaulted by another male resident who lived in the facility.</p> <p>Interview with the Administrator on 07/13/16 at 5:37pm revealed: -The facility procedure in an emergency was to call 911 "ASAP" (as soon as possible). -All staff were trained and knew to call 911.</p> <p>Interview with the Administrator on 07/13/16 at 8:30pm revealed the Administrator was not at the facility at the time of the incident between Resident #5 and Resident #1 on 4/25/16 and had no knowledge of staff not calling the police right away.</p> <p>The staff on duty on 04/25/16 was not available for interview.</p> <p>Interview with the Administrator on 07/14/16 at 4:40pm revealed residents were encouraged by staff to call 911 when they required assistance "to give their point of view."</p>	C 450		

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C 450	<p>Continued From page 78</p> <p>Interview with the Administrator on 07/14/16 at 5:30pm revealed: -If there was an emergency, the Administrator expected staff to call 911 then call her. -The Administrator had no knowledge of any instances when there was a delay in calling 911 during an emergency. -The Administrator expected the facility's policies and procedures to be followed at all times.</p> <p>Interview with a county Sheriff's Deputy on 07/14/16 at 3:35pm revealed: -The Deputy recalled responding to 911 calls at the facility when staff did not even know that a resident had called 911. -Residents had complained to the Deputy about employees being mean to them and locking them out.</p> <p>Observation on 07/13/16 at 08:52pm revealed: -There was a preprinted sign hanging on the bulletin board in the kitchen (on the right side of the refrigerator) which read "Effective immediately: All Resident [sic] No one is to go outside the door after 10pm. And not before 06:30am. If you go outside after hours you will be locked out!" -The sign was not dated.</p> <p>Interview with the Administrator on 07/13/16 at 8:32pm revealed: -The sign had been hanging on the bulletin board since before the change of ownership was effective o 01/01/16. -The Administrator did not know how long the sign had been hanging on the bulletin board. -Residents were not locked out of the facility.</p> <p>Interview with the Administrator on 07/14/16 revealed the Administrator had removed the sign</p>	C 450		

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C 450	Continued From page 79 from the kitchen bulletin board which read residents would be locked out if because she "wouldn't lock them out." _____ Review of the Plan of Protection submitted on 07/13/16 revealed: -The facility's policy and procedure for accident/incidents and emergencies would be followed. -The Administrator would notify the health care providers, guardians, contact persons, and DSS within 24 hours of any incident/accident. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 08/13/16.	C 450		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 observations and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to TB skin testing, reporting of accidents and incidents, and staff qualifications. The findings are:	C 912		

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C 912	<p>Continued From page 80</p> <p>1. Based on record reviews and interviews the facility failed to assure 3 of 7 residents sampled (#1, #6, #7) were tested upon admission for tuberculosis (TB) with the two-step TB skin test in compliance with control measures adopted by the Commission of Public Health. [Refer to Tag D202, 10A NCAC 13G.0702 (a) Tuberculosis Test and Medical Examination (Type B Violation)].</p> <p>2. Based on record reviews and interviews, the facility failed to notify law enforcement immediately of an incident in which 1 of 5 residents sampled (#1) was harmed by another resident (#5). [Refer to Tag D450, 10A NCAC 13G.1213 (f) Reporting of Accidents and Incidents (Type B Violation)].</p> <p>3. Based on record reviews and interviews, the facility failed to assure 3 of 3 Medication Aides (MAs) sampled (A,B, and C) hired after 10/01/13 completed the mandated 5 hour, 10, hour, or 15 hour Medication Aide training. [Refer to Tag D935, G.S. 131D-4.5B (b) Medication Aides Training and Competency (Type B Violation)].</p>	C 912		
C 914	<p>G.S 131D-21(4) Declaration Of Resident's Rights</p> <p>Every resident shall have the following rights:</p> <p>4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 6 of 6 (#1, #2, #3, #4, #5, #6) residents sampled were free of neglect as evidenced by failing to provide supervision to 5 of 6 residents sampled (#1, #3, #4, #5, and #6), failing to notify appropriate licensed health care providers for 2 of 5 residents</p>	C 914		

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C 914	<p>Continued From page 81</p> <p>sampled (#1 and #5) for high risk injurious behaviors towards themselves, staff, and other residents, failing to assure 4 of 5 residents sampled (#1, #2, #3, #5) went to health care appointments are directed by licensed health care providers, and failing to assure the management, policies, and overall operations of the facility were in substantial compliance with the rules and statutes regarding supervision and health care which is the responsibility of the Administrator.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on observations, record reviews, and interviews, the facility failed to provide supervision to 5 of 6 residents sampled (#1, #3, #4, #5, and #6) with a documented history of mental illness, suicidal ideation, and being injurious to self (#1), a documented history of mental illness, wandering, and being verbally and physically abusive (#4), a documented history of mental illness and developmental disabilities (#3) and a documented history of mental illness and required assistance with orientation to time and place (#6) as evidenced by allowing residents to sign out of the facility to walk to the library, store, and other locations without supervision for various lengths of time and dropping off residents and leaving them unsupervised at the library, and failing to supervise a resident with a documented history of mental illness and known to wander in to other residents' rooms and become aggressive towards staff and other residents (#5) resulting in an incident between Resident #5 and Resident #1 in which Resident #1 was assaulted by Resident #5. [Refer to Tag D243, 10A NCAC 13G.0901 (b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on record reviews and interviews, the 	C 914		

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C 914	Continued From page 82 facility failed to assure health care referral and follow up was provided as evidenced by failing to notify a licensed healthcare provider of high risk injurious behaviors for 2 of 5 residents sampled (#1 and #5) as related to a resident reporting suicidal ideation and being sexually assaulted by another resident (#1), and a resident exhibiting behaviors such as insomnia, wandering the facility halls into other residents' rooms, having aggressive behavior towards staff, other residents, and property, and sexually assaulting another resident (#5), and failure to assure 4 of 5 residents sampled (#1, #2, #3, #5) went to medical and mental health appointments as directed by licensed health care providers. [Refer to Tag D246, 10A NCAC 13G. 0902 (b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the administrator failed to assure the management, policies, and overall operations of the facility were in substantial compliance with the rules and statutes regarding supervision, health care, staff qualifications, and reporting of incidents resulting in violations of the residents' rights. [Refer to Tag D185, 10A NCAC 13G. 0601 (a) Management and Other Staff (Type A1 Violation)].	C 914			
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform	C935			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL071017	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2016
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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421
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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
C935	<p>Continued From page 83</p> <p>any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record reviews and interviews, the</p>	C935		

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C935	<p>Continued From page 84</p> <p>facility failed to assure 3 of 3 Medication Aides (MAs) sampled (A,B, and C) hired after 10/01/13 completed the mandated 5 hour, 10, hour, or 15 hour Medication Aide training.</p> <p>The findings are:</p> <p>1. Review of Staff A's personnel record revealed: -There was no record of Staff A's hire date or job title in the record. -There was documentation that Staff A passed the MA test on 07/07/14. -There was validation of clinical skills for medication administration dated 03/04/16. -There was no documentation of Staff A completing the 5, 10, or 15 hour Medication Aide Training.</p> <p>Interview with the Administrator on 06/29/16 at 3:36pm revealed: -Staff A was hired as a MA on 01/01/16. -Staff A had worked in the facility prior to the CHOW as a Personal Care Aide/MA from February 2014 until the CHOW. -The Administrator was unaware of the required 5, 10, or 15 hour MA training.</p> <p>Interview with Staff A on 06/29/16 at 4:00pm revealed: -Staff A was hired 01/01/16 as a MA in the facility and had also worked in the facility prior to the CHOW. -Staff A had last administered medications "maybe a month ago." -Staff A did not know if he had completed to 5, 10, or 15 hour MA training. -Staff A recalled completing infection control training and receiving some training related to "insulin safety" but was not sure what the training was called or when it was.</p>	C935			

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C935	<p>Continued From page 85</p> <p>Review of the facility's April 2016 Medication Administration Records (MARS) revealed Staff A's initials were documented as administering medications to Resident #1 and Resident #2 in April 2016.</p> <p>Review of the facility's May 2016 MARS revealed Staff A's initials were documented as administering medications to Residents#1, Resident #2, and Resident #3 in May 2016.</p> <p>Interview with Administrator on 06/29/16 at 4:10pm revealed: -Staff A last administered medications at the facility on 05/16/16. -The Administrator would schedule the MA training for all MAs.</p> <p>2. Review of Staff B's personnel record revealed: -There was no hire date or job title documented in the record. -There was documentation that Staff B passed the MA test on 01/26/12. -There was validation of clinical skills checklist for medication administration dated 12/07/13. -There was no documentation of Staff B completing the 5, 10, or 15 hour Medication Aide Training.</p> <p>Interview with the Administrator on 06/29/16 at 3:50pm revealed: -Staff B was hired 01/01/16 as a "floater" MA. -Staff B worked currently as a MA in another local family care home. -The Administrator did not know if Staff B had the 5, 10, or 15 hour MA training. -The Administrator was unaware of the rule areas related to MA qualifications.</p>	C935			

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C935	<p>Continued From page 86</p> <p>Review of the April 2016 MARS revealed Staff B's initials were documented as administering medications to Resident #1, Resident #2, and Resident #3 in April 2016.</p> <p>Review of the May 2016 MARS revealed Staff B's initials were documented as administering medications to Resident #1, Resident #2, and Resident #3 in May 2016.</p> <p>Review of the June 2016 MARS revealed Staff B's initials were documented as administering medications to Resident #1 and Resident #3 in June 2016.</p> <p>Staff B was not available for interview.</p> <p>Interview with the Administrator on 06/29/16 at 4:10pm revealed: -Staff B last administered medications in the facility on 06/17/16. -The Administrator would schedule MA training for all MAs.</p> <p>3. Review of Staff C's personnel record revealed: -There was no hire date or job title documented in Staff C's record. -There was documentation that Staff C passed the MA test on 05/15/12. -There was validation of clinical skills checklist for medication administration dated 03/22/12. -There was no documentation of Staff C completing the 5, 10, or 15 hour Medication Aide Training.</p> <p>Interview with the Administrator on 06/29/16 at 4:04pm revealed: -Staff C was hired as MA on 01/01/16. -Staff C worked in the home prior to the CHOW as a MA.</p>	C935			

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NAME OF PROVIDER OR SUPPLIER LINWOOD'S FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7801 SLOCUM TRAIL ATKINSON, NC 28421		
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C935	<p>Continued From page 87</p> <ul style="list-style-type: none"> -Staff C worked as a MA at four other local facilities. -Staff C last administered medications at the facility on 06/19/16. -The Administrator was unaware of the rules related to MA qualifications and did not know about the 5, 10, or 15 hour training. <p>Review of the May 2016 MARs revealed Staff C's initials were documented as administering medications to Resident #1, Resident #2, and Resident #3 in May 2016.</p> <p>Review of the June 2016 MARs revealed Staff C's initials were documented as administering medications to Resident #1 and Resident #3 in June 2016.</p> <p>Staff C was not available for interview.</p> <p>Interview with the Administrator on 06/29/16 at 4:10pm revealed:</p> <ul style="list-style-type: none"> -The Administrator would schedule MA training for all MAs. -The Administrator was responsible for staff records. <p>Review of the Plan of Protection submitted by the facility dated 06/29/16 revealed:</p> <ul style="list-style-type: none"> -The MAs would complete the training "immediately." -The MAs would not be allowed to administer medications until the training was completed. -The Administrator would assure all MAs met the qualifications required before starting to work as a MA in the facility. <p>CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 08/28/16.</p>	C935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL071017

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: _____
B. WING: _____

(X3) DATE SURVEY
COMPLETED

C
07/14/2016

NAME OF PROVIDER OR SUPPLIER

LINWOOD'S FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**7801 SLOCUM TRAIL
ATKINSON, NC 28421**

(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