

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	<p>Initial Comments</p> <p>AMENDED STATEMENT OF DEFICIENCIES 2016-07-27</p> <p>The Statement of Deficiencies dated 6/27/16 was amended to correct the Resident identifier in example 2 of Tag D338 from #5 to #1 and to change the violation level from Type A1 to Type A2 at Tag D438.</p> <p>The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigation on June 22-24, 2016 and June 27, 2016.</p>	D 000		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to maintain the floors and walls throughout the hallways on A,B, and C halls and in 3 of 11 resident bedrooms were clean and in good repair.</p> <p>The findings are:</p> <p>Observation during the initial facility tour of A and B halls on 6/22/16 from 10:30am - 10:55am revealed: -There were numerous scuff marks on the floors in A and B hallways. -There was a build-up of dust and brown and</p>	D 074	<p>Painting and floor repairs began at completion of survey and are on going</p>	8/1/16

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

TITLE

(X8) DATE

STATE FORM

8886

X1N311

If continuation sheet 1 of 129

[Signature]

[Signature]

Sept 22 2016

*Review and Accepted with addendums - BR 9/28/16
See pages 4, 13, 48, 52, 59, 61, 64, 65, 87, 114, 116, 123, 126, 98, 101, 102 for addendums.*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 074	<p>Continued From page 1</p> <p>black stains along the baseboards of the A and B hallways.</p> <p>-There were areas on the floors of A and B halls that had splotches of what appeared to be an old wax coating.</p> <p>Observation of Room #2 on A hall during the facility tour on 6/22/16 at 11:05am revealed:</p> <p>-There were scuff marks underneath the window on the wall to the right of the bedroom door.</p> <p>-There were six areas on the wall to the right of the window that had missing paint; the areas ranged from dime-sized to approximately 3 inches by 3 inches round.</p> <p>-There was a build-up of dust and brown stains along the baseboards throughout Room #2.</p> <p>-The door casing in the bathroom entry way had build-up of mildew and brown stains.</p> <p>-There was a 1 inch by 1 inch hole in the door casing, by the closet door, where the casing met the floor.</p> <p>-There was an approximately 5-inch crack between the baseboard and floor next to the closet door.</p> <p>-There was paint peeled off in several areas, and a small crack in the seam of the lower half of the wall next to the closet door.</p> <p>-The floor leading into the bathroom was missing pieces of tile next to the door casing. The floor sagged when stepped on where the tile was missing.</p> <p>Observation of Room #3 on B hall during the facility tour on 6/22/16 at 11:20am revealed:</p> <p>-There was a large, yellow wet stain on the floor leading into the bathroom.</p> <p>-The floors throughout the room had scuff marks and multiple areas where old wax appeared to be peeling off.</p>	D 074	<p><i>Flooring has been replaced. Door casing replaced, trim replaced and closet redone</i></p> <p><i>All floor tiles in this area + door jam being replaced</i></p>	<p><i>9/30/16</i></p> <p><i>9/30/16</i></p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 074	<p>Continued From page 2</p> <p>Observation of Room #12 on B hall during the facility tour on 6/22/16 at 11:50am revealed: -There were multiple areas on the walls that were missing paint. -There was a 1 inch by 1 inch area on the door that had wood missing. -The door jams were scuffed and had small areas of dry wall exposed.</p> <p>Observation throughout the survey revealed housekeeping staff mopping the hallways down the C Hall and the lobby area.</p> <p>Observations on 6/22/16 from 10:30am through 12:35pm revealed: -There was a buildup of dirt on all floors and baseboards in the hallways and resident rooms on the C Hall.</p> <p>Interview with the Maintenance Man on 6/22/16 at 11:23am revealed: -The dining room (off C Hall) floors had been stripped. -The Maintenance Man had planned to work on all the floors and baseboards in the building but had gotten side tracked with needed safety repairs.</p> <p>Interview with a Housekeeping staff on 6/23/16 at 8:00am revealed: -She worked from 6:30am-6:30pm, two days on and two days off. -She mopped the halls and the floors in residents' bedrooms every day and when needed if a spill or accident occurred.</p> <p>Interview with the Maintenance staff on 6/24/16 at 2:15pm revealed: -He received reports from the staff of anything that needed to be fixed or replaced; that was how</p>	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 074	Continued From page 3 he was notified of any repairs that were needed. -The staff would document the requests and put them in a file at the nurse's station for him to pick up each day. -He was aware of the tile floors in Room #2 and had ordered a door to go in the bathroom. -Water had ran out onto the floor from the shower and caused the tile floor to be damaged.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that toilet paper holders, windows, blinds, locks, refrigerators were kept in good repair and that the facility was free of obnoxious odors. The findings are: Observations on 6/22/16 from 10:30am through 12:35pm revealed: -There was a strong urine odor in each of the resident bathrooms on the C hall. -The toilet paper holders were broken in each of the resident bathrooms on the C Hall. -There were broken window blinds on the floor	D 079	<i>Addendum per telephone with Luanne Weeks on 9/28/16: The broken window blinds have been replaced. Toilet paper holders have been repaired. A Rankley 9/28/16</i>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 4</p> <p>next to the tub in the unisex bathroom on the C Hall.</p> <p>-The closet with resident's hygiene products with a sign "Keep Locked" was unlocked and accessible to residents who ambulated unsupervised in the hall of the Special Care Unit.</p> <p>-The closet lock was broken.</p> <p>-The window screen handle was broken off and lying on the window sill in resident room #22.</p> <p>-The automatic magnetic locks on the laundry room and kitchen door were not working.</p> <p>Observations on 6/27/16 from 5:45am through 6:05am revealed:</p> <p>-There was a strong urine odor on the C Hall.</p> <p>-There was dirt, dust and debris on the floor under both beds in resident room #23.</p> <p>Interview with the Assistant Resident Care Coordinator (RCC) on 6/22/16 at 11:49am and 1:46pm revealed:</p> <p>-He had just become aware of the broken closet door lock.</p> <p>-Maintenance had been contacted to fix the door.</p> <p>-The automatic magnetic lock on the kitchen door and laundry room door had stopped working and the company was coming 6/23/16 to fix them.</p> <p>Interview with the Maintenance Man on 6/22/16 at 1:55pm revealed:</p> <p>-He was not aware of broken window screen handle in resident room #22.</p> <p>-Most of the time he would just find things in need of repair on his own.</p> <p>-Sometimes staff would tell him but most said nothing at all.</p> <p>Confidential interview with a staff revealed:</p> <p>-There was a section on the shift report sheet to put maintenance requests.</p>	D 079	<p><i>Locks will be replaced as needed 8/15/16</i></p> <p><i>Magnetic locks repaired 8/15/16</i></p> <p><i>Rooms cleaned 8/15/16</i></p> <p><i>Doors and screens will be fixed and repaired as needed 9/20/16</i></p> <p><i>Administrator will make daily walk thru rounds to ensure that maintenance is aware of any issues and requiring attention with the facility 8/30/16</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 5</p> <ul style="list-style-type: none"> -There was also a box in the office for maintenance requests. -The Maintenance Man was supposed to check every day. <p>Interview with the Assistant Resident Care Coordinator (RCC) on 6/23/16 at 4:53pm revealed:</p> <ul style="list-style-type: none"> -Forms were developed for staff to complete for maintenance requests. -Completed forms were to be placed in a box in the office. -Unfortunately the sheets just sit there. <p>Interview with the Maintenance Man on 6/23/16 at 5:30pm revealed:</p> <ul style="list-style-type: none"> -The Maintenance Man was aware of all of the broken toilet paper holders. -The Maintenance Man had receipts for multiple replacements. -There was a resident who took the toilet paper holders and toilet paper. -For anything broken, staff fill out a form and "I fix it, I just don't get any slips." -The Administrator was responsible for overseeing Maintenance. <p>Observation of the Administrator on 6/23/16 at 5:30pm revealed the Administrator smiled during the above interview with the Maintenance Man.</p>	D 079		
D 131	<p>10A NCAC 13F .0406(a) Test For Tuberculosis</p> <p>10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health</p>	D 131		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 131	<p>Continued From page 6</p> <p>Services as 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, NC 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 ensure 9 of 9 staff sampled (A, B, C, D, E, F, G, H, and I) were tested upon employment for tuberculosis (TB) disease with the two step TB skin test in compliance with control measures adopted by the Commission for Public Health. The findings are:</p> <p>1. Review of Staff A's personnel file revealed: -Staff A was hired as a Personal Care Aide (PCA) on 1/19/15. -She was promoted to Medication Aide (MA) on 8/17/15. -There was no documentation that a TB skin test had been completed upon hire in Staff A's personnel file.</p> <p>Staff A was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of Staff B's personnel file revealed:</p>	D 131	<p><i>RN Consultant hired to administer TB test to all staff and resident per regulations</i></p> <p><i>All staff without 2 step TB test in personnel files were given Step 1 on 9/7/16 read on 9/9-9/10/16 Step 2 to be administered on 10/7/16 and read on 10/11-10/10/16.</i></p> <p><i>All new hires without TB 2 Step will be administered by Facility RN Consultant</i></p>	10/7/16
-------	---	-------	---	---------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	<p>Continued From page 7</p> <ul style="list-style-type: none"> -Staff B was hired on 5/16/09 as a Personal Care Aide (PCA). -Staff B was re-hired on 3/15/11 as a laundry staff. -Staff B was hired a third time on 1/11/16 as a PCA. -There was documentation that Staff B had a negative TB skin test on 9/9/11. -There were no other TB skin tests in Staff B's personnel file. <p>Staff B was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>3. Review of Staff C's personnel file revealed:</p> <ul style="list-style-type: none"> -Staff C was hired as a Personal Care Aide (PCA) on 4/13/16. -There was no documentation in Staff C's personnel file that a TB skin test had been completed upon hire. <p>Interview with Staff C on 6/27/16 at 6:16am revealed</p> <ul style="list-style-type: none"> -She had TB skin tests done in the past, but could not remember the dates. -Staff B was not sure if she had a TB skin test done when she started to work at the facility. <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p>	D 131	<p>See all info in regard to TB test on page 7</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	<p>Continued From page 8</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of Staff D's personnel file revealed: -Staff D was hired as a Personal Care Aide (PCA) on 12/17/15. -There was no documentation in Staff D's personnel file that a TB skin test had been completed upon hire.</p> <p>Interview with Staff D on 6/27/16 at 7:00am revealed: -Staff D had TB skin tests done before, but was not sure of dates. -It should be in her personnel file because if it was required when she was hired, she would have brought a copy in.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>5. Review of Staff E's personnel file revealed: -Staff E was hired as a dietary supervisor on 12/11/10. -Staff E was promoted to On-Site Supervisor on 6/2/14. -There was documentation that Staff E had a negative TB skin test on 7/7/11. -There was no other TB skin tests in Staff E's</p>	D 131	<p>See all info in regard to TB test on page 7</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	<p>Continued From page 9</p> <p>personnel file.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>6. Review of Staff F's personnel file revealed: -Staff F was hired as a Personal Care Aide (PCA) on 6/9/15. -There was no documentation in Staff F's personnel file that a TB skin test had been completed upon hire.</p> <p>Staff F was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>7. Review of Staff G's personnel file revealed: -Staff G was hired as a Medication Aide (MA) on 5/13/14. -There was no documentation in Staff G's personnel file that a TB skin test had been completed upon hire.</p> <p>Interview with Staff G on 6/24/16 at 2:00pm revealed:</p>	D 131	<p>See info in regard to TB test on page 7</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	<p>Continued From page 10</p> <p>-She thought she had a TB skin test since she began working at the facility. -Staff G was not sure of the date, but she thought the nurse gave her one when she first started.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>8. Review of Staff H's personnel file revealed: -Staff H was hired as a Medication Aide (MA) on 4/21/16. -There was no documentation in Staff H's personnel file that a TB skin test had been completed upon hire.</p> <p>Staff H was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>9. Review of Staff I's personnel file revealed: -Staff I was hired as a Medication Aide (MA) on 8/16/13. -There was documentation that Staff I had a negative TB skin test on 2/27/13. -There was no other TB skin tests in Staff I's</p>	D 131	<p><i>See all information in regard to TB Test on page 7</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	<p>Continued From page 11</p> <p>personnel file.</p> <p>Interview with Staff I on 6/27/16 at 10:08am revealed she thought she had only had the one TB skin test completed.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <hr/> <p>Interview with the Manager on 6/23/16 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -The Manager had been unable to locate any TB skin tests. -The previous Manager had kept them in a separate file. <p>Interview with the Administrator on 6/23/16 at 4:05pm revealed:</p> <ul style="list-style-type: none"> -Staff had TB skin tests done. -The nurse from the physician's office had been out to the facility and gave TB skin tests to all staff. -The TB skin tests were not doing any good in a separate file if the file could not be located. <p>Interview with the Administrator on 6/27/16 at 11:00am revealed:</p> <ul style="list-style-type: none"> -The Manager still had not located the TB skin tests, and she had called the physician's office to see if they had a copy on file. -The physician's office did not have a copy available. -The Administrator knew that everyone had one 	D 131	<p>See all information regarding TB Test on page 17</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 131 Continued From page 12

TB skin test completed, because if they did not have one on file, one was given.
-He was aware that a 2-step TB skin test was required.

Review of the facility's Plan of Protection dated 6/24/16 revealed:
-Facility will ask for TB tests administered by the facility physician.
-Any staff missing TB tests, a list will be made and staff required to take TB tests by facility physician.
-All new employees will also have TB tests.
-Every new employee will have TB tests, step 1 and 2 completed before hire date.

THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.

D 131

See all info regarding TB test on page 7

D 137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications

10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:
(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record review and interview, the facility failed to assure that 5 of 9 sampled staff (A, B, E, G, and H) had no substantiated findings listed on the North Carolina Health Care Personnel

D 137

All staff not having NCHC Registry checks within personnel a new check will be done

Addendum per telephone with Shanne Weeks on 9/28/16: HCPK checks were corrected in current personnel files on 6/27/16. All new hires will have HCPK checks completed upon hire by the Co-Administrator.

9/30/16

Dr. [Signature] 9/28/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER: EASTOVER GARDENS SPECIAL CARE UNIT
STREET ADDRESS, CITY, STATE, ZIP CODE: 3017 DUNN ROAD FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	<p>Continued From page 13</p> <p>Registry (HCPR) upon hire according to G.S. 131E-256.</p> <p>The findings are:</p> <p>1. Review of the personnel file for Staff A revealed: -Staff A was hired to work as a Personal Care Aide (PCA) on 1/19/15. -There was no documentation the HCPR had been checked prior to hire in Staff A's personnel file.</p> <p>Staff A was not available for interview on 6/24/16.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of the personnel file for Staff B revealed: -Staff B was hired as a Personal Care Aide (PCA) on 5/16/09 -There was no documentation the HCPR had been checked prior to hire in Staff B's personnel file. -Staff B was re-hired on 3/15/11 to work in laundry. -There was a form in Staff B's personnel file dated 3/15/11 that listed the name of the staff, the date, and a verification number of the HCPR check. -Staff B was re-hired on 1/11/16 as a PCA. -There was no documentation the HCPR had been checked prior to hire in Staff B's personnel file.</p> <p>Staff B was not available for interview on 6/24/16.</p>	D 137	<p>Every Employee will have another complete and current NCHCR check in personnel file</p> <p>All new perceptive employees will have an NCHCR check done prior to hire</p> <p>Administrator or RCC will review personnel files quarterly to ensure all information is current Tickler forms to be produced for facility updates on info required</p>	9/30/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	<p>Continued From page 14</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>3. Review of the personnel file for Staff E revealed: -Staff E was hired on 12/11/10 as a Dietary Supervisor. -Staff E was promoted to on-site supervisor on 6/2/14. -There was a form created by the facility in Staff E's personnel file dated 12/16/10 that listed the name of the staff, the date, and a verification number of the HCPR check. -There was no documentation the HCPR had been checked prior to hire in Staff E's personnel file.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of the personnel file for Staff G revealed: -Staff G was hired as a Medication Aide (MA) on 5/13/14. -There was a form created by the facility in Staff G's personnel file dated 5/14/14 that listed the name of the staff, the date, and a verification number of the HCPR check. -There was no documentation the HCPR had been checked prior to hire in Staff G's personnel file.</p> <p>Interview with Staff G on 6/24/16 revealed she did</p>	D 137	<p>See all info in regard to NCHCR on page 14</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	<p>Continued From page 15</p> <p>not know if the HCPR verification had been done or who was responsible for completing them when staff were hired.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>5. Review of the personnel file for Staff H revealed: -Staff H was hired as a Medication Aide (MA) on 4/21/16. -There was no documentation that the HCPR had been checked prior to hire in Staff H's personnel file.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <hr/> <p>Interview with the Manager on 6/24/16 at 4:15pm revealed: -She had been a supervisor for two years. -She was responsible for verifying that there were no substantiated findings on the HCPR. -She had been obtaining HCPR verifications since she became the Manager by printing the verification page from the state website.</p> <p>Interview with the Administrator on 6/27/16 at 11:00am revealed: -The Manager was responsible for hiring new staff and ensuring that HCPR was verified prior to the new employee starting to work. -The Administrator was aware that the print out</p>	D 137	<p>See all info in regard to NCHCE on page 17</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	Continued From page 16 from HCPR showed any substantiated findings and the date the HCPR was verified. -He did not know that there was a generic form in the personnel files that included the HCPR verification information and believed it was a form the former Manager created. Review of the facility's Plan of Protection dated 6/27/16 revealed: -Health Care Personnel Registry checks were made but apparently no copies were made and an in-house documented was created to show checks were made and they are not acceptable. -Staff that handle the personnel files have already been shown how to print HCPR document in the future. -Only HCPR documents will be used in the future. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.	D 137	All HCPR checks will be updates and placed in Personnel Files and policy put in place to document HCPR finding upon application completion prior to hire	9/30/16
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure 1 of 7 sampled staff (B) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of Staff B's personnel file revealed:	D 139	Criminal Background checks will be done on any employees not having one. Information required will be gotten to office All information on new hires gotten to BOM for CR check promptly monitored by Administrator	9/30/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Staff B was hired as a Personal Care Aide (PCA) on 5/16/09. -Staff B was re-hired to work in laundry on 3/15/11. -Staff B was re-hired on 1/11/16 as a PCA. -The only criminal background check on file for Staff B was dated 3/7/11. <p>Interview with the Business Office Manager on 6/24/16 at 4:30pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for obtaining criminal background checks on new employees. -She ran the criminal background checks once she received the new hire paperwork. -She was not aware that there was not a current criminal background check in Staff B's personnel file. -She should have run a new criminal background check when Staff B was hired on 1/11/16. 	D 139		
D 150	<p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>(a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.</p>	D 150	<p>All personnel files will be reviewed for missing PCS. info will be placed in the file and PCS training needed can be taught by RN consultant.</p> <p>All new hire packets to be reviewed by administrator</p> <p>Check off form revamped to be used on employee packets to ensure compliance</p>	<p>9/30/16</p> <p>10/30/16</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 150	<p>Continued From page 18</p> <p>(b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure 1 of 5 staff (Staff A) hired by the facility after September 1, 2013, who provides personal care and directly supervises staff who provide personal care, completed an 80-hour personal care training and competency program for performing personal care. The findings are:</p> <p>Review of Staff A's personnel file on revealed: -Staff A was hired as a Personal Care Aide (PCA) on 1/19/15. -Staff A was promoted to Medication Aide/Supervisor (MA/S) on 8/17/15. -Staff A was not listed on the Health Care Personnel Registry or the Nurse Aide Registry. -There was no documentation of Staff A completing the 25-hour or 80-hour personal care training course approved by the Department. -There was no competency validation for Licensed Health Professional Support (LHPS) Personal Care Tasks on file for Staff A.</p> <p>Observation on 6/23/16 at 6:30am revealed: -Staff A was providing personal care tasks to a resident by helping a resident to ambulate with a walker down the hallway. -She was assisting the resident to the front lobby of the facility.</p>	D 150	<p>RN. Consultant to update and redo all staff skills check medication check off etc.</p> <p>All skills check list on new hires will be completed by RN during orientation</p> <p>This will be monitored by Administrator or R.C. upon orientation completion.</p>	9/30/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 150	<p>Continued From page 19</p> <p>Interview with Staff A on 6/23/16 at 6:40am revealed: -Staff A worked third shift as a MA/S. -Staff A helped the PCAs with their rounds, changed beds, assisted residents with showers, and toileted residents as needed. -Staff A had not completed any personal care training, but she had worked at other facilities as a PCA and Medication Aide.</p> <p>Interview with the Administrator on 6/24/16 at 11:00am revealed: -Staff received training during orientation and during the courses they took to become certified PCAs. -He did not know where the training certificates were or why they were not in the files. -The Manager who worked in the facility before the current manager kept various things in notebooks and those notebooks had not been located.</p>	D 150	<p>Staff is no longer employed in facility</p> <p>All perspective employees credentials will be review by R.CC or Administrator.</p>	7/27/16
D 161	<p>10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks</p> <p>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.</p>	D 161	<p>LHPS validation check offs will be done by R.N. consultant during orientation and anyone who has this missing will be re-validated</p> <p>All LHPS documentation will be reviewed and copies will be maintained by R.CC in the office for a back up</p>	8/15/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	<p>Continued From page 20</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 4 of 9 sampled staff (Staff A, B, C, and G) assigned to perform personal care tasks had been competency validated. The findings are:</p> <p>1. Review of the personnel file for Staff A revealed: -Staff A was hired to work as a Personal Care Aide (PCA) on 1/19/15. -There was no documentation of return demonstration on the clinical skills checklist of personal care tasks.</p> <p>Observation on 6/24/16 at 6:30am revealed: -Staff A physically assisted a resident to ambulate down A hall with the resident's walker. -Staff A also assisted another resident who was in her wheelchair to the lobby, by pushing the wheelchair for the resident.</p> <p>Interview with Staff A on 6/23/16 at 6:40am revealed: -Staff A had not had any specific training since being hired at the facility other than orientation. -She did not recall having a Registered Nurse (RN) perform a clinical skills checklist or observe Staff A perform personal care tasks.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:00pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of the personnel file for Staff B revealed:</p>	D 161	<p>See all info in regard to Clinical Skills and LHTPS Skills on page 20</p> <p>All employees without clinical skills check offs in files will be re-evaluated. Check offs will be done during orientation forth going.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	<p>Continued From page 21</p> <ul style="list-style-type: none"> -Staff B was hired to work as a Personal Care Aide (PCA) on 1/11/16. -Staff B had previously been employed at the facility on 5/16/09 and 5/17/11 as a PCA. -There was a clinical skills checklist completed on 7/6/11 by a Registered Nurse (RN). -There was no documentation of return demonstration on the clinical skills checklist of personal care tasks since Staff B was re-hired on 1/11/16. <p>Observation of Staff B on 6/23/16 at 7:15am revealed Staff A assisted a non-ambulatory resident to transfer from the bed to the wheelchair.</p> <p>Staff B was not available for interview on 6/24/16.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:00pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>3. Review of the personnel file for Staff C revealed:</p> <ul style="list-style-type: none"> -Staff C was hired to work as a Personal Care Aide (PCA) on 4/13/16. -There was no documentation of return demonstration on the clinical skills checklist of personal care tasks. <p>Observation of Staff C on 6/27/16 at 6:00am revealed Staff C was physically assisting a resident to ambulate down the A Hall with his walker.</p> <p>Interview with Staff C on 6/27/16 at 6:16am revealed the only training she had since starting</p>	D 161	<p>See all information in regard to Clinical and LHPs Skills checks on page 20-21</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 161	<p>Continued From page 22</p> <p>to work at the facility was on the floor with another staff.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:00pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of the personnel file for Staff G revealed: -Staff G was hired to work as a Medication Aide (MA) on 5/13/14. -There was no documentation of return demonstration on the clinical skills checklist of personal care tasks. -There was no medication clinical skills checklist is Staff G's personnel file that documented successful return demonstration of obtaining fingerstick blood sugars.</p> <p>Observation of Staff G on 6/23/16 revealed Staff G obtained finger stick blood sugars during the noon medication pass.</p> <p>Interview with Staff G on 6/24/16 at 2:00pm revealed: -She did not recall receiving any training or competency validation when she started. -She was trained by another MA, but it was medication related training.</p> <p>Refer to the interview with the Manager on 6/24/16 at 4:00pm.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p>	D 161	<p><i>See all information in regard to skills check bffs on page 20-21.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 161	Continued From page 23 The Registered Nurse (RN) consultant who was responsible for completing the competency validations was not available for interview during the survey. Interview with the Manager on 6/24/16 at 4:00pm revealed: -The former Manager kept up with the personnel files and had several notebooks that she kept things in that the Manager had been unable to locate. -Since being promoted to Manager, she was responsible for the personnel files and ensuring trainings were scheduled with the nurse consultants. Interview with the Administrator on 6/27/16 at 11:00am revealed: -Staff received training during their first week of employment. -The staff worked with first shift staff on the floor. -The nurse consultants came to the facility to do check-offs and trainings with the staff.	D 161			
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following:	D 164	The RN consultant will conduct medication classes beginning with Diabetes Education RN consultant will review med passes on each shift bi monthly	9/30/16 ongoing	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 164	<p>Continued From page 24</p> <p>(a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 5 Medication Aides (G and I) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are:</p> <p>1. Review of Staff G's personnel file revealed: - Staff G was hired on 5/13/14 as a Medication Aide (MA). - There was no documentation of any diabetes training for Staff G.</p> <p>Review of the facility's June 2016 medication administration records revealed Staff G administered insulin at least 7 out of 24 days from 6/01/16 - 6/24/16.</p> <p>Interview with the Manager on 6/24/16 at 4:00 p.m. revealed: - She did not recall if Staff G had completed any diabetes training.</p>	D 164	<p>R.N. consultant will review all diabetic training on skills re check.</p> <p>See all info in regard to diabetic training on page 24</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 164	<p>Continued From page 25</p> <ul style="list-style-type: none"> - Staff G had always administered medications, including insulin since she was hired. - The former manager kept up with the personnel files and had several notebooks that she kept things in that she had been unable to locate. - Since being promoted to Manager, she was responsible for the personnel files and ensuring trainings were scheduled with the nurse consultants. <p>2. Review of Staff I's personnel file revealed:</p> <ul style="list-style-type: none"> - Staff I was hired on 8/16/13 as a Medication Aide (MA). - There was no documentation of any diabetes training for Staff I. <p>Observation on 6/23/16 at 7:40am revealed Staff I administered insulin subcutaneously to a resident.</p> <p>Review of the facility's February 2016 medication administration records revealed Staff I administered insulin at least 16 out of 24 days from 6/1/16 - 6/24/16.</p> <p>Interview with the Manager on 6/24/16 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - She did not recall if Staff I had completed any diabetes training. - Staff I had always administered medications, including insulin since she was hired. - The former manager kept up with the personnel files and had several notebooks that she kept things in that she had been unable to locate. - Since being promoted to Manager, she was responsible for the personnel files and ensuring trainings were scheduled with the nurse consultants. 	D 164	<p>See all info regarding diabetic training on pages 24-25.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	Continued From page 26	D 234		
D 234	<p>10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as 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 review and interviews, the facility failed to ensure that 5 of 5 (#1, #2, #3, #4, and #5) sampled residents had been tested for tuberculosis (TB) disease upon admission to the facility in accordance with the Commission for Public Health. The findings are:</p> <p>1. Review of Resident #2's FL2 dated 3/10/16 revealed diagnoses included dementia, heart failure, out, insulin dependent diabetes mellitus-uncontrolled, and osteoarthritis.</p> <p>Review of the Resident Register dated 8/12/14 revealed an admission date of 8/12/14.</p> <p>There was no documentation in Resident #2's record that a TB skin test had been completed.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p>	D 234	<p>Awaiting DR Rx for TB testing following 2 step procedure to be placed and completed by R.N. consultant.</p> <p>Upon admission all new residents will have a TB test done with 2nd step to be done by facility R.N consultant within a 3 week period</p>	<p>10/15/16</p> <p>ongoing</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD
FAYETTEVILLE, NC 28301	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D.234	<p>Continued From page 27</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of Resident #4's current FL2 dated 1/26/16 revealed diagnoses included Alzheimer's dementia, frequent falls, and wrist fracture.</p> <p>Review of the Resident Register dated 12/15/14 revealed an admission date of 12/15/14.</p> <p>There was no documentation in Resident #4's record that a TB skin test had been completed.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>3. Review of Resident #1's FL-2 dated 12/28/15 revealed: -Resident #1 was admitted to the facility 12/29/15. -Diagnoses included Dementia, Macrocytic Anemia, Hypertension and Seizure Disorder.</p> <p>There was no documentation in Resident #1's record that a TB skin test had been completed.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on</p>	D 234	<p><i>See all info regarding TB test on Resident's on Page 27.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	<p>Continued From page 28</p> <p>6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of Resident #3's FL-2 dated 3/10/16 revealed diagnoses included Picks Dementia, Mood Disorder and Bladder and Bowel Incontinence.</p> <p>Review of Resident Register for Resident #3 revealed the resident was admitted to the facility on 9/15/11.</p> <p>There was no documentation in Resident #3's record that a TB skin test had been completed.</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>5. Review of Resident #5's FL-2 dated 10/15/15 revealed diagnoses included Alzheimer's Dementia, Confusion, Debility, Hallucinations and Hyperlipidemia.</p> <p>Review of Resident Register for Resident #5 revealed the resident was admitted to the facility on 6/11/13.</p> <p>Record review for Resident #5 revealed:</p> <ul style="list-style-type: none"> -There was a TB skin test placed on 6/11/13. -There was no result or reading for the TB skin test placed on 6/11/13. -There was a TB skin test placed on 7/30/13 and read as negative on 8/2/13. 	D 234	<p><i>See all info regarding TB testing on residents on page 27</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	<p>Continued From page 29</p> <p>Refer to interview with the Manager on 6/23/16 at 4:00pm.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:05pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <hr/> <p>Interview with the Manager on 6/23/16 at 4:00pm revealed: -The Manager had been unable to locate any TB skin tests. -The previous Manager had kept them in a separate file.</p> <p>Interview with the Administrator on 6/23/16 at 4:05pm revealed: -The residents had TB skin tests done. -The nurse from the physician's office had been out to the facility and gave TB skin tests to all staff and residents. -The TB skin tests were not doing any good in a separate file if the file could not be located.</p> <p>Interview with the Administrator on 6/27/16 at 11:00am revealed: -The Manager still had not located the TB skin tests, and she had called the physician's office to see if they had a copy on file. -The physician's office did not have a copy available. -The Administrator knew that everyone had a TB skin test completed, because if they did not have one on file, one was given.</p> <hr/> <p>Review of the facility's Plan of Protection dated</p>	D 234	<p><i>See all info regarding TB test for residents on page 27.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	<p>Continued From page 30</p> <p>6/24/16 revealed: -We think we have TB tests on everyone but they are not in the right place. -We will try and find them but if we can't, we will arrangements with the physician's office to come to the facility and give tests to residents and employees this week if possible or as early as we can. -We are going to create a master list of clients and employees who have TB tests and will review this list on a monthly basis to ensure all requirements are met and are current.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.</p>	D 234	<p>See all info regarding TB testing on residents on page 27</p>	
D 269	<p>10A NCAC 13F .0901(a) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that personal care, including incontinence care and bathing, was provided in accordance with the assessed needs for 5 of 9 sampled residents (#5, #6, #7, #8, #9). The findings are:</p>	D 269		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 31 Observations on 6/27/16 from 5:40am until 6:05am revealed: -There were dirty sheets with a large urine stain on the floor in the hallway outside resident room #21. -There was a strong odor of urine on the C Hall. -There was a strong urine odor coming from resident room #18. 1. Review of Resident #5's FL-2 dated 10/15/15 revealed: -Diagnoses included Alzheimer's Dementia, Confusion, Debility, Hallucinations and Hyperlipidemia. -There were check marks for constant disorientation, wanderer, ambulatory, incontinence of bladder and bowel and personal care assistance for bathing and dressing. Review of the Care Plan for Resident #5 dated 10/18/15 revealed: -Resident #5 required extensive assistance with toileting, bathing, dressing and grooming. -Resident #5 required limited assistance with eating, ambulation and transfers. -The care plan was signed by the physician. Observation on 6/22/16 at 11:44am revealed: -Resident room #23 was labeled with Resident #5's name and the door was closed. -Upon opening the door, there was a strong odor of sweat and body odor. -Resident #5 was lying in her bed on her left side with her eyes closed and the blanket pulled up to her neck. Observation on 6/27/16 6:05am revealed there was a foul odor of sweat, body odor and urine in Resident #5's room when the door was opened	D 269	Reinservice done with staff. Walk thru inspections done daily by Admin, R.C.C. or J.L.	8/16/17

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 32</p> <p>by the Personal Care Aide (PCA.)</p> <p>Observation on 6/27/16 from 6:47am until 7:09am revealed:</p> <ul style="list-style-type: none"> -When Resident #5 stood up from the bed, a strong odor of urine permeated the room. -There was a large urine stain on the disposable incontinence pad and on the bottom sheet around the pad extending from thighs to the mid back area if the resident was lying down. -The PCA removed Resident #5's clothing and a saturated attends garment which was put on the floor. -The PCA put a blouse on, wiped the genital area only, put a new attends garment on and put a skirt on Resident #5. -The body area where Resident #5 would have laid in the urine soaked bed linen was not washed. <p>Review of Personal Care Record for June 1 - 26, 2016 for Resident #5 revealed:</p> <ul style="list-style-type: none"> -There were 3 showers documented on 1st shift on 6/6/16, 6/13/16 and 6/15/16. -There were 2 sponge baths documented on 1st shift 6/8/16 and 3rd shift 6/8/16. -Routine incontinence care was documented as provided 3 times per shift on 1st and 2nd shift 6/1/16 through 6/26/16. -There was no documentation that toileting/incontinence care was provided during 3rd shift on 6/25/16. -There was no documentation that toileting/incontinence care was provided during 3rd shift on 6/1/16 and 6/2/16. -On 6/3/16, 6/4/16 and 6/12/16 through 6/21/16 it was documented that toileting/incontinence care was provided only once on 3rd shift at the end of the shift. -From 6/1/16 through 6/24/16 and 6/26/16, there 	D 269	<p><i>See all info in regard to incontinence training and protocol on pages</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 33</p> <p>was documentation that no toileting/incontinence care was provided on the 1st rounds for 3rd shift.</p> <p>Review of the facility's shower schedule revealed that Resident #5 was scheduled for a shower every Tuesday, Thursday and Saturday on 1st shift</p> <p>Interview with a 1st shift Personal Care Aide (PCA) on 6/23/16 revealed: -Resident #5 could be difficult, especially with showers and changing her clothes. -"She [Resident #5] will fight ya and curse at ya. If I give her a shower I'm a Punta for a month." -I call Resident #5's family member and that helps.</p> <p>2. Review of Resident #9's FL-2 dated 10/8/15 revealed: -Diagnoses included Alzheimer's Dementia, Respiratory System Disease, Hypertension, Dyslipidemia, Peripheral Vascular Disease, Epilepsy, Vascular Congestion in the Chest and Delirium Dementia. -There were check marks for intermittent disorientation, wanderer, semi-ambulatory, incontinence of bladder and bowel and personal care assistance for bathing and dressing.</p> <p>Review of the Care Plan for Resident #9 dated 10/8/15 revealed: -Resident #9 required extensive assistance with bathing, dressing and grooming. -Resident #9 required limited assistance with toileting, eating, ambulation and transfers. Resident #9 required only supervision with eating. -The care plan was signed by the physician.</p> <p>Observation on 6/27/16 from 7:09am until 7:30am revealed:</p>	D 269	<p><i>Facility is in the process of replacing 3rd shift. 2 qualified and credentialed SCS/MA are going thru orientation</i></p> <p><i>All shifts have been re inserviced on proper incontinent care and new policies in place regarding incontinent care</i></p> <p><i>Staff training in all areas to remain</i></p>	<p><i>9/30/16</i></p> <p><i>8/17/16</i></p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 34</p> <ul style="list-style-type: none"> -Resident #9 sat up on the edge of the bed and a strong odor of urine permeated the air. -There was a large urine stain on the disposable incontinence pad and on the bottom sheet around the pad extending from thighs to the mid back area if the resident was lying down. -The PCA removed Resident #9's clothing and a saturated attends garment. -The PCA put a blouse on, wiped the front genital area only, put a new attends garment on and put a pair of pants on Resident #9. -The body area where Resident #9 would have laid in the urine soaked bed linen was not washed. <p>Review of the facility's shower schedule revealed that Resident #9 was scheduled for a shower every Monday, Wednesday and Friday on 1st shift.</p> <p>Review of the Personal Care Record for June 1 - 26, 2016 for Resident #9 revealed:</p> <ul style="list-style-type: none"> -There were 11 showers documented as provided on 1st shift. -There was 1 sponge bath and 3 showers documented as provided on 2nd shift. -There was documentation that a sponge bath was provided daily on 3rd shift except on 6/5/16, 6/6/16, 6/25/16 and 6/26/16. -There was documentation that a shower was provided on 6/5/16 and 6/6/16 on 3rd shift. -Routine incontinence care was documented as provided 3 times per shift on 1st and 2nd shift 6/1/16 through 6/26/16 -There was no documentation for toileting/incontinence care for 3rd shift 6/25/16. -There was documentation that no toileting/incontinence care was provided on 6/1/16 for 3rd shift. -On 6/3/16 it was documented that 	D 269	<p>Staff has been re-inserviced on bathing and the proper protocol when changing, and cleaning and assurance of incontinent care with linen protocol. Rec. and of administrative write down walks during the day to ensure proper protocol</p>	8/15/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 35</p> <p>toileting/incontinence care was provided only once on 3rd shift at the end of the shift. -From 6/1/16 through 6/24/16 and 6/26/16 it was documented that there was no toileting/incontinence care provided on the 1st rounds for 3rd shift.</p> <p>Interview with a PCA on 6/27/16 at 5:45am revealed: -3rd shift PCA's were responsible for getting up 4 residents which meant a shower if it was the resident's shower day or a sponge bath if it was not their shower day. -There was a shower schedule like Monday, Wednesday and Friday or Tuesday, Thursday and Saturday. -There were only 2 residents who received showers on 3rd shift. -There were no showers on Sundays. -The PCAs were supposed to sign for bathing and showers in the Personal Care Book.</p> <p>Interview with a 1st shift PCA on 6/27/16 at 8:10am revealed: -PCAs were responsible for making sure their assigned residents got a shower on their shower day. -Showers were started after breakfast on 1st shift. -The MAs were responsible for making sure PCAs showered there assigned residents. -PCAs were responsible for completing the shower sheet each shift with which residents received a shower, shave or sponge bath. -The shower sheet was given to the MA at the end of the shift.</p> <p>Interview with a 3rd shift Medication Aide (MA)/Supervisor on 6/23/16 at 6:50am revealed: -There was a 30 minute protocol for checking</p>	D 269	<p>See all info in regard to incontinent care and monitoring on page 35</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 36</p> <p>residents. -Residents were changed if they were wet when staff checked them.</p> <p>Interview with a 1st shift MAVSIC on 6/23/16 at 2:37pm revealed: -The MAVSIC had worked on the 3rd shift. -Staff were expected to round on each resident every 30 minutes which meant to walk through and check if wet. -Staff were expected to provide toileting every 1 hour on 1st and 2nd shift.</p> <p>Interview with the Assistant Resident Care Coordinator (RCC) on 6/27/16 at 8:10am revealed: -PCAs were expected to fill out a shower sheet each shift and turn it in to the MAVSIC at the end of the shift. -The MAVSIC reviews the shower sheet, signs it and the sheets were kept in the office.</p> <p>Interview with the Manager on 6/23/16 at 4:16pm revealed: -Staff were expected to walk through and count every resident every 30 minutes. - Staff were expected to provide toileting and incontinence care every 2 hours.</p> <p>Interview with the Administrator on 6/27/16 at 11:07am revealed: -Staff were expected to provide incontinence care for residents every 2 hours unless they had trouble sleeping. -We let them sleep if that's what they need. -Every resident gets changed at 5-5:30am. -There were plenty of wipes for staff to clean residents properly.</p> <p>3. Review of Resident #8's FL-2 dated 1/25/16</p>	D 269	<p>See info in regard to staff training and inservices done on incontinent care</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 37</p> <p>revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Alzheimer's Dementia, Diabetes Mellitus, Depression, Gastroesophageal Reflux Disease and Diverticulitis. -There were check marks for constant disorientation, wanderer, verbally abusive, ambulatory (with walker hand written), incontinence of bladder and bowel and personal care assistance for bathing and dressing. <p>Review of Care Plan for Resident #8 dated 9/10/15 revealed:</p> <ul style="list-style-type: none"> -Resident #8 required extensive assistance with toileting, bathing, dressing and grooming. -Resident #8 required limited assistance with eating, ambulation and transfers. -The care plan was signed by the physician. <p>Observation on 6/22/16 at 11:12am revealed:</p> <ul style="list-style-type: none"> -Resident #8 was ambulatory in the C hall with her walker. -Resident #8 had a strong urine odor from a distance of approximately 3 feet away. <p>Observation on 6/27/16 at 6:15am revealed:</p> <ul style="list-style-type: none"> -Resident #8 was ambulatory in the C Hall with her walker wearing a hospital gown asking for help. -Initially, the Medication Aide (MA) walked past Resident #8 and then came back to assist her. -There was a saturated attends garment in the trash can in Resident #8's room. -Resident #8's bed was made. -The MA removed the hospital gown, put a sweatshirt on, removed a moderately wet attends, wiped the front of the genital area only with a wash cloth and put a new attends garment and sweatpants on Resident #8. <p>Interview with the MA on 6/27/16 at 6:15am</p>	D 269	<p>See all info in regard to reinservices and retraining of incontinent care on pages 35.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 38</p> <p>revealed: -Resident #8 was normally changed and left in the bed. -1st shift staff got resident #8 up and dressed.</p> <p>Interview with a 1st shift PCA on 6/27/16 at 8:10am revealed: -Resident #8 was not on the facility shower schedule. -Resident #8 was receiving Hospice services. -Hospice sent Personal Care Aides (PCA) to shower or bath Resident #8.</p> <p>Telephone interview with a Hospice Nurse on 6/27/16 at 12:58pm revealed: -Resident #8 was receiving hospice services which included supplemental care 3 times per week for bathing/showering. -The facility was otherwise responsible for providing personal care.</p> <p>Review of Personal Care Record for June 1 - 26, 2016 for Resident #8 revealed: -There was 1 sponge bath documented as provided on 6/1/16 for the 2nd shift. -There were 5 sponge baths documented as provided on 6/1/16 and 6/14/16 through 6/17/16 on 3rd shift. -Routine incontinence care was documented as provided 3 times per shift on 1st and 2nd shift 6/1/16 through 6/26/16 -There was no documentation that toileting/incontinence care was provided on 3rd shift 6/25/16 and 6/26/16. -There was no documentation that toileting/incontinence care was provided on 6/1/16 for 3rd shift. -On 6/2/16 through 6/9/16, 6/13/16, 6/14/16 and 6/18/16 through 6/22/16 it was documented that toileting/incontinence care was provided only</p>	D 269	<p>Staff retrained on all bathing in incontinence care See pages 33-35</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 39</p> <p>once on 3rd shift at the end of the shift. -From 6/1/16 through 6/24/16 there was documentation that no toileting/incontinence care provided on the 1st rounds for 3rd shift.</p> <p>4. Review of Resident #6's current FL2 dated 12/28/15 revealed: -Diagnoses included dementia, hyperlipidemia, cerebrovascular accident, acute renal failure, hypertension, mild anemia, eczema, depression, hyperplasia of the prostate, chronic kidney disease, post-traumatic stress disorder, and hyperlipidemia. -Resident #6 was non-ambulatory and incontinent of bowel and bladder. -Resident #6 was intermittently confused. -Resident #6 required assistance with bathing and dressing.</p> <p>Review of Resident #6's Assessment and Care Plan dated 1/7/16 revealed: -Resident #6 was totally dependent on staff for all Activities of Daily Living (ADLs) except eating. -Resident #6 was documented as a wanderer, was oriented, and had adequate memory. -Staff did all changing, gave all baths and showers, dressed and undressed the resident, performed all grooming and hygiene, and assisted with all transfers.</p> <p>Review of the shower schedule revealed Resident #6 was showered on Tuesday, Thursday, and Saturday on second shift.</p> <p>Review of the Bath List for the facility that were provided by the Assistant Resident Care Coordinator revealed: -For the week of 5/15/16, Resident #6 received a sponge bath on 5/19/16 and 5/21/16 on second shift.</p>	D 269	<p>Staff reinserviced on incontinent care and bathing. SIC will monitor to ensure proper bathing and linen changes are performed as needed.</p>	8/16/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 40</p> <p>-For the week of 5/22/16, Resident #6 received a sponge bath on 5/24/16, 5/26/16, and 5/28/16 on second shift.</p> <p>-For the week of 5/29/16, Resident #6 received a sponge bath on 5/31/16, 6/2/16, and 6/4/16 on second shift.</p> <p>-For the week of 6/5/16, Resident #6 received a sponge bath on 6/7/16, 6/9/16, and 6/11/16 on second shift.</p> <p>-For the week of 6/12/16, Resident #6 received a sponge bath on 6/14/16 and 6/16/16; Resident #6 received a shower on 6/18/16 on second shift.</p> <p>-For the week of 6/19/16, Resident #6 received a sponge bath and bed change on 6/21/16 and 6/23/16 on second shift; on 6/25/16, Resident #6 received a shower and bed change on second shift.</p> <p>Review of the June 2016 Personal Care Record available for review for Resident #6 revealed:</p> <p>-Resident #6 received a sponge bath on 6/4/16, 6/8/16, 6/9/16, 6/11/16, 6/12/16, 6/16/16, 6/25/16, and 6/26/16</p> <p>-Resident #6 was given a shower on 6/6/16, 6/13/16, and 6/14/16.</p> <p>The May 2016 Personal Care Record was not available for review.</p> <p>Observation during the facility tour on 6/22/16 at 11:40am revealed Resident #6 was sitting up in wheelchair in the lobby.</p> <p>Observation on 6/22/16 at 1:35pm revealed Resident #6 was eating lunch in the large dining room.</p> <p>Observation on 6/23/16 at 7:10am revealed:</p> <p>-The Personal Care Aide (PCA) was checking Resident #6 to see if the adult brief needed to be</p>	D 269	<p>See all info in regard to bathing on 39-40</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 41</p> <p>changed.</p> <ul style="list-style-type: none"> -Resident #6 was able to turn on his left side in his bed. -There were no red areas on Resident #6's skin. <p>Interview with the PCA assigned to Resident #6 on 6/23/16 at 7:15am revealed:</p> <ul style="list-style-type: none"> -Resident #6 was changed by the PCA every morning when he arrived on shift. -Resident #6 had a history of getting a rash on his groin area, so the staff applied a barrier cream for prevention. -Resident #6 was showered on second shift. -He did not know about sponge baths, only that Resident #6 should receive showers three times a week on second shift. -The PCA was able to provide assistance with ADLs to Resident #6 without any other staff assistance, but some staff probably needed two or three to change, transfer, and bathe Resident #6. -Residents were to be turned and changed at least every 2 hours. <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> -The staff walked in rooms to check on the residents every 30 minutes. -Residents were toileted and changed every two hours. -The residents had shower schedules, and certain residents were assigned to each shift for their baths or showers. -Resident #6 had skin breakdown, but the staff was not sure of anything being done. -The staff had not seen any cream in Resident #6's room when the staff had been assigned to Resident #6. -Resident #6 should have received a shower rather than always getting sponge baths. -Resident #6 never refused care as far as the 	D 269	<p>Staff retrained on toileting protocol, bathing, and incontinent care 8/16/16</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 42</p> <p>staff knew.</p> <p>Confidential interview with a second staff revealed: -The staff had be trained to check on the residents and do rounds every two hours. -There was a Medication Aide who did not want the PCAs to do rounds every two hours; that staff only wanted the PCAs to check on the residents when they came on shift and again before their shift ended.</p> <p>Confidential Interview with a third staff revealed: -The PCAs were supposed to provide incontinence care every two hours. -She checked on her assigned residents every 30 minutes to one hour to see if they needed anything.</p> <p>Interview with the Administrator on 6/23/16 at 4:30pm revealed: -Incontinence care was to be done every two hours. -Staff should do "walk through" every 30 minutes to check on the residents.</p> <p>Interview with the Administrator on 6/27/16 at 11:00am revealed: -Staff were supposed to do every two hour rounds to check on the residents. -The staff had shower schedules to indicate who needed a shower and on what shift; that way all residents were assigned shower days.</p> <p>Review of the Personal Care Assistant Job Description revealed: -The job objective read "your role is to assist resident with those activities of daily living that they are unable to perform without help." -Job standards read "no bed baths are to be done</p>	D 269	<p>See all info regarding bathing, toileting and incontinent care on pages 35-42</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	<p>Continued From page 43</p> <p>unless approved by supervisor with a valid reason."</p> <p>Review of Resident #6's communication notes or personal care record revealed no documentation that sponge baths were approved by a supervisor.</p> <p>5. Review of Resident #7's current FL2 revealed: -Diagnoses included dementia, hypertension, aggressive behavior, chronic headache, hyperlipidemia, and cerebrovascular accident. -Resident #7 was non-ambulatory and incontinent of bowel and bladder.</p> <p>Review of the Resident Register revealed Resident #7 was admitted on 5/12/16.</p> <p>Review of Resident #7's Assessment and Care Plan dated 5/24/16 revealed: -Resident #7 required extensive assistance with toileting, bathing, dressing, grooming, and transferring. -Resident #7 was totally dependent on staff for ambulation. -Resident #7 was documented as sometimes disoriented and forgetful.</p> <p>Review of the shower schedule revealed Resident #7 was to be bathed on Monday, Wednesday, and Friday on first shift.</p> <p>Review of the Bath List for the facility that was provided by the Assistant Resident Care Coordinator revealed: -Resident #7 received a shower on 5/28/16. -There were no other dates where a shower was documented for Resident #7.</p>	D 269	<p>R.N. Consultant continues to re-in-service all med techs on the importance of BP's and Pulse records required for medication administration re-training on hypertension. The med meds by R.N. Consultant ongoing training</p>	8/11/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 44 Review of the June 2016 Personal Care Record revealed: -The record was blank except for a sponge bath being documented as completed on 6/16/16 on third shift. Review of the May 2016 Personal Care Record for Resident #7 revealed Resident #7 received a sponge bath daily on third shift from 5/14/16-5/25/16 and 5/27/16-5/31/16. Observation during the facility tour on 6/22/16 at 11:40am revealed Resident #7 was sitting up in wheelchair in the lobby. Interview with the Administrator on 6/23/16 at 4:30pm revealed: -Incontinence care was to be done every two hours. -Staff should do "walk through" every 30 minutes to check on the residents. Confidential Interview with a third staff revealed: -The PCAs were supposed to provide incontinence care every two hours. -She checked on her assigned residents every 30 minutes to one hour to see if they needed anything. Observation of Resident #7 on 6/27/16 at 7:00am revealed: -Resident #7 was sitting in the lobby in her wheelchair. -She was wearing a thin, hospital-type gown. -There was a blanket draped over her shoulders and across her legs. -She had dried, crusty matter around her eyes and was tearful.	D 269	<i>Reinservice done with PCA staff on complete care</i>	<i>8/16/16</i>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 46 Interview with the Assistant Resident Care Coordinator on 6/27/16 at 8:10am revealed: -He did not understand why it was so difficult to accommodate the residents' requests. -It would be easy to change Resident #7 to the third shift schedule for showers. Interview with the Administrator on 6/27/16 at 11:00am revealed: -Staff were supposed to every two hour rounds to check on the residents. -The staff had shower schedules to indicate who needed a shower and on what shift; that way all residents were assigned shower days. Review of the facility's Plan of Protection dated 6/27/16 revealed: -Schedule 5am spot checks 2 days a week. -Train staff to use soiled barrel for linen and clothing, and also plastic bags for odor. -Retrain on procedures for cleansing client's entire body along with beds and mattress. -Training is scheduled for 2:00 and 3:00 July 7, 2016. -Live by the code: "People do what you inspect-not by what you expect." -Look at care and building daily by all supervisory staff. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.	D 269	<i>See info on retraining staff on bathing and personal care 39-40</i>	<i>8/11/16</i>
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 47 of residents.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to report high/low blood pressures and heart rates for 2 of 5 sampled residents (#3 and #4); failed to notify the physician of elevated blood pressure in the emergency room (ER) for a third sampled resident (#1); and failed to schedule follow up as recommended by the ER for Resident #1.</p> <p>The findings are:</p> <p>1. Review of Resident #3's FL-2 dated 3/10/16 revealed: -Diagnoses included Picks Dementia, Mood Disorder and Bladder and Bowel Incontinence. -There was an order to check blood pressures (BP) twice daily.</p> <p>Review of the March 2016 BP and Pulse Sheet for Resident #3 revealed: -There was a note to check pulse and BP twice a day before giving Metoprolol. (Metoprolol is used to treat high blood pressure, chest pain and heart failure.) -There was a note to hold medication if pulse was below 60. -There were 36 pulses documented ranging 58-101 with 26 missed opportunities for pulse checks. -There were 36 BPs documented ranging from 89-179/61-93 with 26 missed opportunities for BP checks. -On 3/1/16 at 8pm the BP was documented as</p>	D 273	<p><i>Addendum per telephone with Luann Waters m9/28/16. RN consultant providing us services to all medication aides on the importance of blood pressure and pulse checks, and to record as ordered for medication administration purposes. RN has also been training med aides on hypertension medications, and has been reviewing med passes twice monthly.</i></p> <p><i>A Rankley 9/28/16</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 48</p> <p>89/62. -On 3/6/16 at 8pm the pulse was documented as 58. -On 3/23/16 at 8am the BP was documented as 89/74.</p> <p>Review of the March 2016 Medication Administration Record (MAR) for Resident #3 revealed: -There was a preprinted order for Metoprolol Tartrate 25mg twice daily for blood pressure with a note to hold if pulse was less than 60. -The entry was initialed as given twice daily 3/1/16 through 3/31/16 except at 8am on 3/14/16 and at 8am on 3/25/16. -The Metoprolol was initialed as given on 3/1/16 at 8pm when Resident #3's BP was documented as 89/62. -The Metoprolol was initialed as given on 3/6/16 at 8pm when Resident #3's pulse was 58. -The Metoprolol was initialed as given on 3/23/16 when Resident #3's BP was documented as 89/74. -The Metoprolol was documented as given when there was no pulse or BP documented such as 3/10/16, 3/12/16 and 3/13/16 at 8am and 8pm.</p> <p>Review of the April 1-19, 2016 BP and Pulse Sheet for Resident #3 revealed: -There was a note to check pulse and BP twice a day before giving Metoprolol. -There was a note to hold medication if pulse was below 60. -There were 21 pulses documented ranging 64-89 with 17 missed opportunities for pulse checks. -There were 21 BPs documented ranging from 91-183/52-104 with 26 missed opportunities for BP checks -On 4/19/16 at 8pm the pulse was documented</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 49</p> <p>as 75 and the BP was documented as 136/64.</p> <p>Review of the April 2016 MAR for Resident #3 revealed:</p> <ul style="list-style-type: none"> -There was a preprinted order for Metoprolol Tartrate 25mg twice daily for blood pressure with a note to hold if pulse was less than 60. -The entry was initialed as given twice daily 4/1/16 through 4/19/16 at 8am and 8pm. -The Metoprolol was documented as given when there was no pulse or BP documented on 4/6/16 at 8am and 8pm and 4/15/16 through 4/19/16 at 8am. <p>Review of Communication Notes for Resident #3 revealed:</p> <ul style="list-style-type: none"> -There was no documentation the physician had been notified of Resident #3 having low BPs on 3/1/16 and 3/23/16 and a low pulse on 3/6/16. -There was documentation dated 4/20/16 that Resident #3 was found unresponsive at 6:30am. <p>Interview with a Medication Aide (MA) on 6/23/16 at 2:37pm revealed:</p> <ul style="list-style-type: none"> -The MA always checked BPs and pulses if it was on the MAR. -The results were always written on a piece of paper and didn't always get written on the BP and Pulse Sheet. -The MA just starting writing it on the BP and Pulse Sheet directly. -There was no way for anyone to know if the BP and pulse was checked and what the results were for the blank spaces on Resident #3's BP and Pulse Sheet for March and April 2016. -If the physician had been contacted it would have been documented in the communication notes. <p>Interview with the Assistant Resident Care</p>	D 273	<p>See info on medication training page 4/4</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 50</p> <p>Coordinator (RCC) on 6/23/16 at 4:53pm revealed:</p> <ul style="list-style-type: none"> -A Medication Aide had reported that BP and pulses had not been done for Resident #3 in March and April 2016. -He was not aware if anything had been done because he had just started working at the facility. -Any contact with the physician was supposed to be documented in the communication notes. <p>Interview with the Manager on 6/24/16 at 6:32pm revealed:</p> <ul style="list-style-type: none"> -The initials documenting the BP and pulse at 8pm on 4/19/16 belonged to the her. -She was filling in as a Medication Aide (MA) that evening. -The Manager did not have a comment for the blank spaces for BPs and HRs not documented. -Regarding the BP of 89/62 on 3/1/16, the Manager reported, "That is kind of low. I would have done a concern sending a faxed note to the doctor." -Any communication [faxes] with the physician was kept in the resident's chart. -There was no specific policy on what to do for low blood pressures and heart rates. -The staff who initialed giving the 3/6/16 8pm dose of Metoprolol with the pulse of 58 no longer worked at the facility. -Staff was expected to hold medication if there were written parameters. <p>Telephone interview with the Physician's Nurse on 6/27/16 at 2:21pm revealed:</p> <ul style="list-style-type: none"> -There was no way for the Nurse to know if the facility had notified the physician of high or low BPs and pulses. -There was no protocol for things like that. -The last office visit was on 4/16/16 for 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	<p>Continued From page 51</p> <p>medication management</p> <p>Refer to interview with the Assitant Resident Care Coordinator on 6/23/16 at 8:10am.</p> <p>Refer to interview with a Medication Aide (MA) on 6/24/16.</p> <p>Refer to telephone interview with the Pharmacy Director on 6/24/16 at 1:24pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:07am.</p> <p>2. Review of Resident #1's FL-2 dated 12/28/15 revealed diagnoses included Dementia, Macrocytic Anemia, Hypertension and Seizure Disorder.</p> <p>Review of an incident report dated 6/11/16 for Resident #1 revealed: -There was documentation that Resident #1 had seizure activity and was sent to the emergency room (ER.) -There was documentation under "Status of Resident after ER/Hospital" to follow up with primary physician.</p> <p>Review of Shift Notes dated 6/11/16 for 3rd shift revealed a hand written note for Resident #1 to follow up with primary doctor.</p> <p>Review of ER record dated 6/11/16 for Resident #1 revealed: -A discharge note documenting staff [name] at facility [name] informed of BP and informed that patient needs her schedule BP [blood pressure] medications, staff verbalizes understanding. Staff also informed that patient should return for new/worsening symptoms and needs to follow</p>	D 273	<p><i>Addendum per telephone with Luanne weber on 9/28/16: A new transport driver has been hired. The RCC is responsible for ensuring follow-up appointments are scheduled and that the residents are transported to their appointments. Blaney 9/28/16</i></p>		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	<p>Continued From page 52</p> <p>with primary care physician this week.</p> <p>-BP in the ER was 152/80, 158/114, 155/100 and 176/89.</p> <p>Review of the communication notes for Resident #1 revealed:</p> <p>-There was no documentation that staff notified the physician of the ER visit and BP concerns.</p> <p>-There was no documentation that Resident #1 was seen by the physician between 6/11/16 and 6/27/16.</p> <p>Interview with the Assistant Resident Care Coordinator (RCC) on 6/24/16 at 1:55pm revealed:</p> <p>-The Assistant RCC did not know how to tell if a resident had been seen by the physician when he came to the facility.</p> <p>-There was no list or notes that he was aware of.</p> <p>-The facility did not keep track of that information.</p> <p>-The physician did not have a set schedule. He might say he was coming on this day and not show up until that day.</p> <p>Telephone interview with the physician's nurse on 6/27/16 at 2:21pm revealed:</p> <p>-There was no documentation available that the physician was made aware of the ER visit and concerns for Resident #1.</p> <p>-The facility should have scheduled an appointment and that was not done.</p> <p>-The facility was expected to schedule appointments if there were problems that needed to be addressed before the physician's next scheduled visit to the facility.</p> <p>Refer to interview with the Assistant Resident Care Coordinator on 6/23/16 at 8:10am.</p> <p>Refer to interview with a Medication Aide (MA) on</p>	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	<p>Continued From page 53</p> <p>6/24/16.</p> <p>Refer to telephone interview with the Pharmacy Director on 6/24/16 at 1:24pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:07am.</p> <hr/> <p>Interview with a Medication Aide (MA) on 6/24/16 revealed:</p> <ul style="list-style-type: none"> -If it was documented on the MAR, MAs were responsible for checking BPs and pulses. -It depended on the resident what was done for high or low results. -If a BP was high, staff were supposed to notify the physician. -If the BP was over 170 staff would go ahead and give prescribed blood pressure medications as ordered. -If the BP or pulse was low 3 consecutive times, staff would fax results to the physician. -Most residents had specific orders on what to do and the residents who did not usually had normal BPs. -The facility had a policy that 3 consecutive BPs over 140 were faxed to the physician. <p>Telephone interview with the Pharmacy Director on 6/24/16 at 1:24pm revealed:</p> <ul style="list-style-type: none"> -The Physician, Pharmacist and Licensed Health Professional Support (LHPS) Nurse saw the residents as a team monthly at the facility. -The Physician was out of the country at this time. <p>Interview with the Administrator on 6/27/16 at 11:07am revealed:</p> <ul style="list-style-type: none"> -Staff knew what was expected of them. -Staff had all gone to nurse's aide school/Certified 	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	<p>Continued From page 54</p> <p>Nurse's Aide school and had credentials but that don't mean nothing. - "They don't respect what you don't inspect."</p> <p>3. Review of Resident #4's current FL2 dated 1/26/16 revealed: -Diagnoses included Alzheimer's dementia, frequent falls, and wrist fracture. -Resident #4 was constantly disoriented. -There was a physician's order for Losartan 100mg daily (Losartan is an antihypertensive used to lower high blood pressure). -There was a physician's order for Amlodipine 5mg daily (Amlodipine is a calcium channel blocker used to treat high blood pressure.) - There was a physician's order for Hydralazine 50mg twice daily (Hydralazine is a vasodilator used to treat high blood pressure.)</p> <p>Review of a physician's order dated 3/14/16 revealed to check blood pressure twice daily and report to physician if blood pressure is lower than 100 systolic or 50 diastolic.</p> <p>Review of Resident #4's Medication Administration Record (MAR) for April 2016 revealed: -There was an entry to check blood pressure twice daily and report to physician if blood pressure is lower than 100 systolic or 50 diastolic. -The scheduled times on the MAR to obtain the blood pressure readings were 9:00am and 9:00pm. -The blood pressures were obtained twice daily except for 4/17/16-4/26/16 when Resident #4 was hospitalized.</p> <p>Review of the blood pressure log for April 2016 revealed:</p>	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 55</p> <ul style="list-style-type: none"> -There were 6 readings that were below 100 systolic or 50 diastolic. -These readings ranged from 83/42-98/65. -There was no documentation that the physician was notified of the blood pressure readings. <p>Review of Resident #4's MAR for May 2016 revealed:</p> <ul style="list-style-type: none"> -There was an entry to check blood pressure twice daily and report to physician if blood pressure is lower than 100 systolic or 50 diastolic. -The scheduled times on the MAR to obtain the blood pressure readings were 9:00am and 9:00pm. -There was no staff initials on the MAR that the blood pressures were obtained. <p>Review of the blood pressure log for May 2016 revealed:</p> <ul style="list-style-type: none"> -There were 21 readings that were below 100 systolic or 50 diastolic. -There were 7 times that the blood pressure was not obtained with no reason documented. -The documented readings ranged from 78/63-99/55 -There was no documentation that the physician was notified of the blood pressure readings. <p>Review of Resident #4's MAR for June 2016 revealed:</p> <ul style="list-style-type: none"> -There was an entry to check blood pressure twice daily and report to physician if blood pressure is lower than 100 systolic or 50 diastolic. -The scheduled times on the MAR to obtain the blood pressure readings were 8:00am and 4:00pm. -The blood pressures were obtained twice daily from 6/1/16-6/21/16. -There was an entry for Losartan 100mg daily, but the entry was lined through and "discontinued" 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 56</p> <p>per physician 6/17/16" was written next to it.</p> <p>Review of the blood pressure log for June 2016 revealed:</p> <ul style="list-style-type: none"> -There were 14 readings that were below 100 systolic or 50 diastolic from 6/1/16-6/21/16. -The documented readings ranged from 73/50-99/67. -There was no documentation that the physician was notified of the blood pressure readings. <p>Review of subsequent physician orders revealed:</p> <ul style="list-style-type: none"> -There was an order to "D/C Losartan 100mg due to low bp (blood pressure)." -The order was not dated. <p>Interview with a Medication Aide (MA) on 6/23/16 at 7:35am revealed:</p> <ul style="list-style-type: none"> -Blood pressure readings were logged on the log sheet with the MAR. -The MAs documented in the care notes if the physician was contacted. -If the blood pressure reading was low and there was no parameter to hold a medication, the MA would discuss the blood pressure with the Assistant Resident Care Coordinator. <p>Review of the Care Notes for Resident #4 revealed no documentation the physician was notified of the blood pressure readings obtained on Resident #4 from April-June 2016.</p> <p>Refer to interview with the Assistant Resident Care Coordinator on 6/23/16 at 8:10am.</p> <p>Review of a notice to staff that was displayed in the nurse's station revealed:</p> <ul style="list-style-type: none"> -"After 3 consecutive blood pressure readings above 140/80, fax the 3 readings to the resident's doctor immediately." 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	<p>Continued From page 57</p> <p>-The notice was dated 5/18/16, and signed by the Assistant Resident Care Coordinator.</p> <p>Interview with the same MA on 6/23/16 at 2:45pm revealed:</p> <ul style="list-style-type: none"> -If there were blanks on the blood pressure logs, the MAs probably checked the blood pressure and forgot to document the reading. -The MA would write the readings she obtained on "my paper" and go back to the log to document the reading. -The MA may have forgot to document her readings. <p>Telephone interview with the nurse at the physician's office on 6/23/16 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -The physician was out of town until July 8, 2016. -The staff at the facility should fax over any blood pressure readings, especially if the readings were as low as 73/50. -The nurse knew that the facility had called a few times, but she did not see where the facility staff had faxed over any blood pressure readings for Resident #4. -The facility staff needed to let the physician know if the blood pressure readings were lower than his set parameter, because he would likely admit the resident to the hospital to monitor her blood pressure and adjust medications. <p>Refer to interview with the Assistant Resident Care Coordinator on 6/23/16 at 8:10am.</p> <p>Interview with the Assistant Resident Care Coordinator on 6/23/16 at 8:10 am revealed:</p> <ul style="list-style-type: none"> -Blood pressure readings should be documented on the log sheet with the MARs. -If there were parameters to call the physician, then the MAs should be calling the physician if 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 273	<p>Continued From page 58</p> <p>they obtain readings below the parameter. -The MAs should be documenting when they call the physician. -If there were several low or high readings, the Assistant Resident Care Coordinator had asked the MAs to fax the readings to the physician as indicated on the notice in the nurse's station.</p> <hr/> <p>Review of the facility's Plan of Protection dated 6/24/16 revealed: -Retraining of Med Techs will be administered. -Orders for parameters will be posted and reviewed with Med Aide staff. -BP reading will be checked weekly and any BP's out of parameter will be faxed to the doctor as soon as possible. -If any staff fails to comply with parameter order, it is grounds for dismissal.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.</p>	D 273		
D 282	<p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that work areas, walls and floors in the kitchen were kept clean and free of dirt and grease build up, spills and contamination.</p>	D 282	<p>Addendum per telephone with LuAnne Weeks 9/28/16. Deep cleaning will be done in the kitchen. The dietary staff are cleaning the kitchen work areas & floors daily. The Facility Manager will monitor the kitchen for cleanliness daily. BR Bailey 9/28/16</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 282	Continued From page 59 The findings are: Observations on 6/22/16 from 12:35pm through 1:25pm revealed: -There was a grease and grime buildup on kitchen appliances, walls and cabinets in the kitchen. -There was dust, dirt and debris underneath sinks and counters in the kitchen. -There was dirt and grease build up in the corners and underneath pantry shelves. -There was blood from thawing meat on the floor in the walk in refrigerator outside. Interview with the Dietary Staff on 6/22/16 at 12:35pm revealed: -The dietary person was responsible for cleaning the kitchen and the floors. -The floors were done 1-2 times daily. -"I don't go scrubbing on my hands and knees or nothing though." Interview with the Administrator on 6/27/16 at 11:07am revealed: -Kitchen staff were responsible for cleaning the kitchen and the kitchen floors. -The Assistant Resident Care Coordinator, the Manager, and the Administrator were responsible for the kitchen being kept clean.	D 282			
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least	D 287			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 287	<p>Continued From page 60</p> <p>a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that table service included a non-disposable place setting consisting of a knife, fork, and spoon for 2 of 3 meals observed.</p> <p>The findings are: Observation of the lunch meal on 6/22/16 at 1:20pm revealed: -There were 24 residents in the large dining room. -Five residents had plastic spoons. -The residents were served barbecue pork, French fries, slaw, and ice cream.</p> <p>Interview with a Personal Care Aide (PCA) on 6/22/16 at 1:35pm revealed: -The facility ran out of spoons all the time. -The kitchen staff brought in the plastic spoons to be served with the table setting.</p> <p>Interview with a resident in the dining room on 6/22/16 at 1:37pm revealed: -The residents were served with plastic spoons a lot of times. -The residents were given metal forks and knives all of the time.</p> <p>Interview with the Dietary Manager on 6/22/16 at 2:00pm revealed: -The facility had a problem keeping spoons. -Residents would grab the spoons or throw the spoons away.</p>	D 287	<p>Addendum per telephone with Duanni Weeks on 9/28/16:</p> <p>There is adequate supply of non disposable place settings and have been since & during the survey in full. The kitchen full of silverware. 3rd shift staff are being responsible for rolling silverware for breakfast, and 1st shift assist with rolling silverware for lunch & dinner.</p> <p>Shawley 9/28/16</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 287	<p>Continued From page 61</p> <p>-She had told the Administrator, and the Administrator would replace the spoons, but it happened over and over.</p> <p>Observation of the kitchen on 6/22/16 at 2:05pm revealed approximately ten spoons in a bin underneath the sink.</p> <p>Observation of the breakfast meal on 6/23/16 at 7:45am revealed: -There were 8 residents in the small dining room. -Six residents were being fed by staff with plastic spoons.</p> <p>Interview with a PCA on 6/23/16 at 7:50am revealed: -It was usually not a problem to have all non-disposable silverware, but there were times when plastic spoons were given to the staff to serve the residents. -The PCA thought the kitchen staff ran out of spoons.</p> <p>Interview with the Dietary Manager on 6/23/16 at 7:55am revealed: -"I had plastic spoons, so that is what I am using." -The plastic spoons were bought to use, so she thought she would use them until the spoons were gone.</p> <p>Interview with a Medication Aide (MA) on 6/23/16 at 2:45pm revealed: -She did not know why plastic spoons were used. -The MA had found spoons in residents' rooms. -Today, the MA saw plenty of metal spoons on the food cart, so she was not sure why the staff served the residents with plastic spoons.</p> <p>Interview with the Administrator on 6/23/16 at 4:00pm revealed:</p>	D 287			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HALD26055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 287	<p>Continued From page 62</p> <ul style="list-style-type: none"> -He had purchased six boxes of plastic spoons "last week." -The MAs used the plastic spoons when they gave medicines, especially if they needed to crush a resident's medication. -Either the kitchen staff was not paying attention or the residents were hoarding the metal spoons. -The staff should be serving the residents with non-disposable spoons. <p>Observation on 6/23/16 at 8am revealed:</p> <ul style="list-style-type: none"> -13 residents in the main dining room were given plastic spoons for the breakfast meal. -There were regular spoons on the meal cart. <p>Interview with the Dietary Manager on 6/22/16 at 1:46pm revealed:</p> <ul style="list-style-type: none"> -Spoon and forks get thrown away when plates were cleared from the table. -The Dietary Manager had just got a fresh supply of spoons from the back office. <p>Interview with a Personal Care Aide (PCA) on 6/23/16 at 8:08am revealed:</p> <ul style="list-style-type: none"> -There were not enough silver spoons for all the residents. -The PCA would just grab whatever came out of the spoon container on the meal cart. <p>Confidential interview with a staff revealed:</p> <ul style="list-style-type: none"> -Staff did not know why plastic spoons were used. -The facility would replace missing spoons and the spoons would go missing again. -Staff would find spoons in resident rooms. -Staff was not sure why plastic spoons were used when silverware spoons were right on the food cart. 	D 287			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 287	Continued From page 63 Interview with the Administrator on 6/23/16 at 4pm revealed: -The Administrator did not know what was happening to all the spoons, whether staff or residents were taking them. -The Administrator had just bought a box of spoons for the facility. -The Administrator kept a box of plastic spoons on hand "just in case."	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve water to 35 residents during the breakfast meal. The findings are: Observations on 6/23/16 from 8:00am through 8:30am revealed: -Residents were served breakfast in the main dining room beginning at 8am. -The last resident completed the breakfast meal at 8:30am. -There was no water served to any resident during the breakfast meal. Confidential interview with a staff revealed: -Residents were supposed to get water with each	D 306	Addendum per telephone with Suanne Weeks on 9/28/16: Water is being served with all meals to all residents. Dietary staff have been re-trained on the rules/regulations regarding serving water at each meal to each resident. Sparkley 9/28/16	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER: **EASTOVER GARDENS SPECIAL CARE UNIT**
STREET ADDRESS, CITY, STATE, ZIP CODE: **3017 DUNN ROAD FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 306	Continued From page 64 meal. -Staff gave water with medications also. -Staff encouraged water because residents could be "quick to get a UTI [urinary tract infection.]" Interview with the Administrator on 6/23/16 at 4:16pm revealed: -There was a water fountain in the front lobby area of the facility for residents. -If residents asked for water staff gave it to them. -Water was supposed to be served with each meal.	D 306		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to follow its established routine and expectation of every 30 minute safety checks and every 2 hour incontinence checks for every resident by allowing a resident (#3), to go unchecked for a period of 2 1/2-7 hours and was reported as found with rigor mortis by EMS (Emergency Medical Service) first responders; and failed to protect residents from abuse by allowing staff, who had been reported to be aggressive and abusive with residents while providing care, to continue to work at the facility as the Supervisor after 1 of 3 sampled residents was slapped (Resident #2), and 2 of 3 sampled	D 338	Addendum with telephone with Duann Weeks on 9/28/16 : RN consultant is providing personal care training to all staff to include incontinent care, bathing, and feeding. Staff are providing incontinent care every 2 hours + performing waist checks every 30 minutes. The alleged staff is no longer employed at the facility. BRadley 9/28/16 All allegations of abuse + neglect are being well documented by administrator + reported to HPR. BRadley 9/28/16	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 338	<p>Continued From page 65</p> <p>residents were assaulted, resulting in injuries and requiring emergency room visits (Residents #1 and #5).</p> <p>The findings are:</p> <p>1. Review of Resident #3's FL-2 dated 3/10/16 revealed: -Diagnoses included Picks Dementia, Mood Disorder and Bladder and Bowel Incontinence. -Check marks were entered for non-ambulatory, wanderer and does not communicate.</p> <p>Telephone interview with a former Personal Care Aide (PCA) staff on 6/24/16 at 3:57pm: -The PCA was working at the facility the night that Resident #3 died [4/19/16 into 4/20/16]. -Resident #3 had not been checked by assigned staff from approximately 11:30pm until 5-5:30am. -The assigned PCA found the resident dead at approximately 5:30am. -It was an "unspoken rule" at the facility that when staff came in for 3rd shift they could sleep or do "whatever they wanted to do."</p> <p>Review of EMS report dated 4/20/16 revealed: -EMS was called at 6:53am and with the resident at 6:59am on 4/20/16. -"Staff advises that they saw the resident sleeping 3-2.5 hours ago." -"Staff advises this morning they went in to resident room to wake her up for breakfast when they noticed resident was not breathing and had no pulse." -"Staff went to call 911. Staff advises that they moved resident from the bed to the ground to perform CPR." -"Walked inside the room to find fireman performing CPR. Placed patient in ECG [electrocardiogram] monitor to find asystole [no</p>	D 338			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 66</p> <p>heart rhythm]."</p> <p>-Resident extremities are cold to touch and there is cyanosis noted around patient lips, fingers and toes."</p> <p>-Per staff patient was acting her normal self last night. Staff advises that resident was wheelchair bound and nonverbal."</p> <p>-The report documented "Obvious death - Rigor Mortis" next to primary impression and signs and symptoms.</p> <p>Review of Communication Notes dated 4/20/16 at 6:30am for Resident #3 revealed:</p> <p>-"Last minute rounds at far [four] thirty staff member [name] checked every bed and every room and [Resident #3 name] was laying in bed on her left side."</p> <p>-"[Staff name] then proceeded to get B hall residents up dry and changed. [Staff name] went to [Resident #3's name] room last and that was around 6:30am."</p> <p>-"[Staff name] proceeded to get her roommate up, dressed and to the toilet, in the mean time [Staff name] went over to [Resident #3 name] to get her dry and changed and noticed she was unresponsive."</p> <p>-"[Staff name] then went to get the Med Tech [Staff A's name] then [Staff name] and [Staff A's name] proceeded to [Resident #3 name] room together than another Med Tech came in [Resident #3 name] room to see what was going on, [Med Tech name] called 911 and 911 was giving us steps to take such as CPR [cardiopulmonary resuscitation] until the paramedics arrived."</p> <p>-The note was signed by 2 staff.</p> <p>Telephone interview with a PCA on 6/27/16 at 10:17am revealed:</p> <p>-The PCA reported she was working 3rd shift on</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 67</p> <p>4/19/16 into 4/20/16 and there was "not much to say" about the night Resident #3 died.</p> <ul style="list-style-type: none"> -Resident #3 was on the PCA's assigned hall that night. -PCA's were expected to do 30 minute rounds on each resident on 3rd shift. -The PCA had checked Resident #3 at 4:30am and "she was fine." -The PCA started morning rounds at 5am and saved Resident #3 for last because it was her shower day on 1st shift. -The PCA started providing personal care for Resident #3's roommate 1st at approximately 6:30-6:45am. -The PCA reported, "When I checked [name of Resident #3] I thought she had a seizure cuz her eyes were open and she was warm." -The PCA called to Resident #3 and when there was no answer the PCA went and got the MA/S and "took the proper precautions, called EMS and what not." -Every 30 minute rounds were done throughout the night. <p>Interview with the 1st shift Medication Aide (MA)/Supervisor (S) on 6/23/16 at 2:37pm revealed:</p> <ul style="list-style-type: none"> -The MA/S had arrived to work for 1st shift early at approximately 6:30am on 4/20/16. -A personal care aide (PCA) reported to the MA/S and the 3rd shift MA/SIC that Resident #3 was unresponsive. -The MA/S could not recall the exact time only that it was between 6:30am and 7am. -The MA/S checked Resident #3 and found no pulse. -The MA/S called 911 while the 3rd shift MA/S started CPR on Resident #3. -EMS responders arrived at the facility within 2 minutes or so since they are right up the road. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 68</p> <p>"In the midst of everything, someone let the Manager know and she was here." -Resident #3 was "fine the day before."</p> <p>Interview with a 3rd shift MA/S on 6/23/16 at 6:40am revealed: -The MA/S was on duty for 3rd shift 4/19/16 into 4/20/16. -Resident #3 passed away in her sleep. -On last rounds, between 4:30am-5:00am, the PCA found her. -The PCA was very upset and came to the MA/S. -We called EMS and the sheriff came as well. -Resident #3 had gotten worse with her disease. -There was a "30 minute protocol" on 3rd shift, meaning each resident was checked and those who were wet were changed. -The 30 minute protocol went from 11:30pm until 5:30am nightly. -At 5:30am staff started getting residents up and ready for breakfast.</p> <p>Interview with the 1st shift MA/S on 6/27/16 at 9:45am revealed: -Resident #3 was on the floor when staff performed CPR. -Staff had been instructed to place the resident on the floor to perform CPR by the 911 operator. -Resident #3 was a petite woman and was easily moved from her bed to the floor by 2 staff.</p> <p>Interview with the Assistant Resident Care Coordinator (ARCC) on 6/23/16 at 4:53pm revealed: -The ARCC was not present when Resident #3 died. -The ARCC was informed by staff that Resident #3 had been gotten up for breakfast and staff "went back to check on her and she was dead." -The ARCC thought Resident #3 was found dead</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 69</p> <p>"right at switch off between 3rd and 1st shift [7am]."</p> <p>Interview with the Manager and Administrator on 6/23/16 at 4:16pm revealed: -Staff were expected to do checks or walk through and count all residents every 30 minutes on the 2nd and 3rd shifts. -Staff were expected to perform incontinence care for incontinent residents every 2 hours.</p> <p>Interview with the Manager on 6/24/16 at 6:32pm revealed: -The initials for vital signs documented for 8pm on 4/19/16 for Resident #3 belonged to the RCC. -The Manager was working as the MA/S for 2nd shift on 4/19/16. -Resident #3 was her usual self that evening.</p> <p>Interview with the Administrator on 6/27/16 at 11:07am revealed: -Staff were expected to provide incontinence care for residents every 2 hours except those who had trouble sleeping. -Staff were expected to check every resident in the building at 5-5:30am to make sure they were clean and dry.</p> <p>2. Review of Resident #1's FL-2 dated 12/28/15 revealed: -Diagnoses included Dementia, Macrocytic Anemia, Hypertension and Seizure Disorder. -There were check marks beside wanderer, semi-ambulatory utilizing a wheelchair, incontinence of bladder and bowel and personal care assistance for bathing, feeding and dressing.</p> <p>Telephone interview with a former staff on 6/24/16 at 3:57pm revealed:</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 70</p> <ul style="list-style-type: none"> -Former staff reported witnessing incident on 4/26/16 with Staff A and Resident #1. -Staff A was trying to get Resident #1 up and dressed but Resident #1 was taking too long picking out her clothes. -Staff A told Resident #1 "I ain't got time to fool around with you. I'm in a [expletive] hurry." -Resident #1 was in her wheelchair, had rolled over to her closet and stood looking through her clothes when Staff A "tried to snatch her and make her sit down but she missed the wheelchair and fell and hit her head on the floor." -Staff A told EMS that Resident #1 had a seizure but she didn't. -The incident was reported to the Manager by another staff. <p>Review of Communication Notes for Resident #1 dated 4/26/16 at 5:30am revealed:</p> <ul style="list-style-type: none"> -"I gave [Resident #1 name] a bath. I assist her in the chair - she then proceeded to her closet for a change of clothes." -"Resident was standing for about 15 minutes looking through her closet. I began to start AM care for her roommate [name]." -"My back was away from resident [Resident #1 name] - I heard her fall and a loud thump." -"I turn around and saw that the resident had fell backwards and hit her head on the floor." -"I immediately assist her after checking for injuries. No bleeding or open wounds to the head." -"I call for a aide to stay with [Resident #1 name] I immediately call 911." -Documentation signed by Staff A. <p>There were no incident report dated 4/26/16 for Resident #1 available for review.</p> <p>Review of hospital records dated 4/26/16 for</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 71</p> <p>Resident #1 revealed: -Resident arrived on 4/26/16 at 6:31am. -There was documentation of history of present illness: "From [name of facility], had fall backwards while dressing self, witnessed. No signs of trauma noted. Denies LOC [loss of consciousness] per facility staff. Client history of dementia." -Emergency room physician documented, "not initially witness but seen on floor." -CT scan imaging impression: no acute intracranial abnormality.</p> <p>Interview with Staff A on 6/23/16 at 6:50am revealed: -Staff A recalled Resident #1 "having a seizure." -"I was helping another resident and she [Resident #1] was standing in the closet and just fell." -After Staff A gave Resident #1 a bath, Resident #1 was in the closet. -Staff A did not see Resident #1 fall because she was helping Resident #1's roommate. -Staff A saw her on the floor "seizing out." -All incidents were documented on Communication Notes kept in the resident record.</p> <p>Interview with the Responsible Person for Resident #1 on 6/27/16 at 12:19pm revealed: -Resident #1 had not been at the facility long enough to say whether there were positive or negative experiences. -Resident #1 had only been in the facility for 3-4 months. -The responsible party was unable to talk at the time.</p> <p>Interview with the Manager on 6/23/16 at 4:30pm revealed: -She had not had any reports of abuse or</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 72</p> <p>mistreatment toward a resident.</p> <p>-She was aware of the incident involving Resident #1, but was told the resident had a seizure.</p> <p>-There had not been staff concerns reported to her about staff treating residents roughly.</p> <p>-If she had knowledge of staff abusing residents or mistreating residents, she would report them to the Administrator or she would be in trouble.</p> <p>Interview with the Administrator on 6/24/16 at 5:20pm revealed:</p> <p>-He was not aware of any incident with Resident #1.</p> <p>-He knew she had a history of seizures, but did not know anything about a fall or possible staff mistreatment.</p> <p>-"You can't rely on what Resident #1 says."</p> <p>Interview with the Manager on 6/24/16 at 5:20pm revealed:</p> <p>-She was not aware of an incident involving Resident #1 other than Resident #1 being sent to the Emergency Room a few weeks ago for seizures.</p> <p>-The Manager felt that Resident #1 would be able to report if anyone had mistreated her.</p> <p>Refer to Telephone interview with a former staff on 6/24/16 at 3:57pm.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to confidential interview with a second staff.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:16pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:07am.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 73</p> <p>Refer to review of the Personal Care Aide Job Description.</p> <p>Refer to review of the facility's Personnel Policies and Procedures Manual.</p> <p>3. Review of Resident #5's FL-2 dated 10/15/15 revealed: -Diagnoses included Alzheimer's Dementia, Confusion, Debility, Hallucinations and Hyperlipidemia. -There were check marks beside constant disorientation, wanderer, ambulatory, incontinence of bladder and bowel and personal care assistance for bathing and dressing.</p> <p>Interview with a Personal Care Aide (PCA) on 6/27/16 at 5:45am revealed: -Resident #5 didn't speak good English and she was confused. -Resident #5 was already agitated and confused and not aware that staff were trying to get her changed. -The whole incident could have been avoided if Staff A and Staff C had just waited 30 minutes for her to calm down. -Resident #5 "struggled" with Staff A and Staff C and fell backwards hitting her head. -The PCA reported the incident to the Manager. -The Manager was nonchalant about the incident and told the PCA sometimes you have to be a little aggressive with the residents.</p> <p>Interview with Staff A on 6/23/16 at 6:50am revealed: -It took a couple of people to change clothes for Resident #5 because she was combative. -On 6/2/16 (third shift), Resident #5 went into the bathroom and a male resident was already in the bathroom.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 74</p> <p>-Staff A and Staff C tried to pull Resident #5 back out and "she slipped going back while we was holding her."</p> <p>-It seemed as though Resident #5 had "just lost her balance and hit her head on the floor."</p> <p>-Staff A and Staff C were still holding Resident #5 but she was moving and trying to get away and fell back and hit her head on the floor."</p> <p>-An incident report had been completed and Staff A attempted to notify Resident #5's Responsible Person.</p> <p>There were no incident reports for Resident #5 available for review.</p> <p>Interview with Staff C on 6/24/16 at 11:00am revealed:</p> <p>-Resident #5 was combative with everybody and takes other resident's clothes.</p> <p>-It took 3 staff to change her.</p> <p>-On 6/2/16 (third shift), staff had changed Resident #5 and she "walked right out the room."</p> <p>-There was a male resident in the bathroom and Resident #5 walked in.</p> <p>-Staff C and Staff A each had one of Resident #5's arms.</p> <p>-Staff C did not know how it happened but right at the door Resident #5 fell backwards into the hallway.</p> <p>Review of Communication Notes for Resident #5 dated 6/2/16 at 12:50am revealed:</p> <p>-"Med Tech [Staff A's name] and staff [name of Staff C and 2nd Personal Care Aide (PCA)] assist with taking 12 pieces of clothes off resident [Resident #5 name] in her room."</p> <p>-"A few minutes later resident [name of male resident] went to use the men's bathroom and resident [Resident #5 name] went in behind him."</p> <p>-"We was assisting her out of the bathroom, she</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 75</p> <p>was scratching and fighting staff. The resident [Resident #5 name] slipped and fell in the hallway - C and bumped her head." -"Med Tech immediately contacted EMS [Emergency Medical Services] and left message for [name of family member] on answering machine."</p> <p>Review of Hospital Records for Resident #5 dated 6/2/16 revealed: -Resident #5 was admitted to the Emergency Room (ER) at 1:49am. -There was documentation of history of present illness: "From [name of facility], complained of having fall onto floor from standing position per staff. Denies LOC [loss of consciousness]. Noted hematoma to upper center rear head." -CT Scan imaging impression of posterior left parietal scalp hematoma.</p> <p>Observation on 6/27/16 at 6:47am revealed: -Staff C was in Resident #5's room attempting to get her up and changed. -Resident #5 was agitated, pacing next to the bed, speaking loudly in Spanish and holding onto her clothing so it could not be removed. -Staff C was speaking authoritatively to Resident #5 counting the number of shirts and sweaters Resident #5 was wearing saying "You have 8 on and you can't have that." -Resident #5 then began to say "I can take care of myself," and headed towards the room door to leave. -Staff C was standing behind the door and blocked it from opening more than 6 inches while Resident #5 aggressively tried to pull open the door with her hand wrapped around the edge of the door while the door moved back and forth nearly closing on her hand. -Staff C stated this was what Resident #5 did all</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D-338	<p>Continued From page 76</p> <p>the time.</p> <ul style="list-style-type: none"> -Staff C did not attempt to calm resident or walk away to decrease Resident #5's agitation. -Staff C repeated to Resident #5 that she needed to get changed and she was not leaving the room. -A PCA from 1st shift arrived in the room and instantly Resident #5 changed her demeanor to cooperative and expressed happiness in seeing the PCA. <p>Interview with the Manager on 6/23/16 at 4:16pm revealed:</p> <ul style="list-style-type: none"> -The Manager was aware of Resident #5 falling on 6/2/16. -"She [Resident #5] was trying to get in the bathroom with a man and fell." -The Manager did not see Resident #5 fall on the video footage, she did not fall in the hallway and there was no camera in the bathroom. -Resident #5 was very combative; she will fight, scream and dig her nails into you especially with changing her and showering. <p>Interview with the Assistant Resident Care Coordinator (ARCC) on 6/23/16 at 4:53pm revealed:</p> <ul style="list-style-type: none"> -Incident reports were completed for falls or any incident where a resident gets hurt. -Completed incident reports were faxed to the Department of Social Services. -Resident concerns were reported by staff to the RCC. <p>Interview with the Administrator on 6/23/16 at 5:15pm:</p> <ul style="list-style-type: none"> -The Administrator was reviewing video footage of 6/2/16 from 12:30 - 1am. -The Administrator pointed out Staff A and stated "That's the one they say pushed her [Resident 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 77</p> <p>#5]."</p> <p>-The Administrator reported, "Yes, I was aware of the incident. I looked at the footage before. There's no fall on the camera."</p> <p>Observation of video footage for 6/2/16 at 12:42 - 12:50am revealed:</p> <p>-There were 3 staff and Resident #5 walking toward the bathroom.</p> <p>-There were only shadows and light from the bathroom visible for several minutes.</p> <p>-Resident #5 walked out of the bathroom area with 1 staff person holding her arm while she was rubbing her the back of her head.</p> <p>-There was no fall in the hallway on the camera footage.</p> <p>Refer to Telephone interview with a former staff on 6/24/16 at 3:57pm.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to confidential interview with a second staff.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:16pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:07am.</p> <p>Refer to review of the Personal Care Aide Job Description.</p> <p>Refer to review of the facility's Personnel Policies and Procedures Manual.</p> <p>4. Review of Resident #2's FL2 dated 3/10/16 revealed:</p> <p>-Diagnoses included dementia, heart failure, gout, uncontrolled insulin dependent diabetes mellitus,</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 78</p> <p>and osteoarthritis.</p> <ul style="list-style-type: none"> -Resident #2 was ambulatory. -She was verbally abusive, intermittently confused, and wandered. <p>Confidential staff interview revealed:</p> <ul style="list-style-type: none"> -Resident #2 came out into the hall looking for her television remote. -The staff could not recall the specific date, but knew it was sometime in February. -Staff A told Resident #2 not to start her [used profanity]. -Resident #2 grabbed Staff A's cup of water and tried to throw it at Staff A. -Later on that night, Staff A threw water on Resident #2 when Resident #2 came walking back down the hall. -At that point, the argument started. -Staff A told Resident #2 if Resident #2 hit her, she (Staff A) would hit her back. -The staff did not know if Staff A hit Resident #2, but Staff A did push Resident #2 in the hall by the medication room. -The incident with Staff A pushing Resident #2 was not seen on camera, but the incident with the water being thrown was seen on camera. <p>Confidential interview with a second staff revealed:</p> <ul style="list-style-type: none"> -If incidents occurred or if staff had concerns about how residents were treated, staff reported them to the Manager. -Nothing was ever done when the staff reported to the Manager. -Staff A was too aggressive with the residents, had no patience to work with the residents who had dementia, and was easily aggravated. <p>Confidential interview with a third staff revealed:</p> <ul style="list-style-type: none"> -Resident #2 had asked Staff A for something. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 79</p> <p>and Staff A yelled at the resident.</p> <ul style="list-style-type: none"> -Resident #2 reached inside the nurse's station and grabbed a cup of water that was sitting on the desk. -Resident #2 threw water in Staff A's face and Staff A hit Resident #2 as a result. -It made Staff A mad and she said something like, "if you hit me, I will hit you." -Resident #2 was upset and tried to walk away, but Staff A pushed her and hit Resident #2's arm. -Staff A said she pushed Resident #2 to calm Resident #2 down. <p>Confidential interview with a fourth staff revealed:</p> <ul style="list-style-type: none"> -There had been concerns in the past with staff from third shift, but she thought most of them had left. -The staff did not feel like the Manager did anything when staff made reports about incidents involving residents. -The staff would write up incidents and nothing was done. -If the staff reported incidents to the Assistant Resident Care Coordinator, things were looked into and systems put in place. <p>Interview with Staff A on 6/23/16 at 6:40am revealed:</p> <ul style="list-style-type: none"> -She worked on third shift as the Medication Aide/Supervisor. -She had concerns about some of the staff who had worked third shift, but they no longer worked at the facility. -Staff A was firm with her job and the new staff did what she said. -Staff A would not tolerate staff mistreating residents. -She had never mistreated a resident or handled them roughly. -Some residents were difficult. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 80</p> <p>-"I don't know if you've heard the name [Resident #2's name], but she was very combative with residents and staff."</p> <p>-Resident #2 threw water on Staff A.</p> <p>-Staff A could not remember what was going on or why Resident #2 threw the water on her, but Resident #2 reached inside the window and threw the water at her.</p> <p>-Resident #2 was escorted back to her room by another staff.</p> <p>-If there are concerns about residents or incidents that occur, staff was to immediately notify the Manager.</p> <p>-When residents were upset, Staff A tried to calm them down, "sweet talked them," and let them know it would be okay.</p> <p>Review of the Communication Notes in Resident #2's record documented by Staff A (Medication Aide) revealed:</p> <p>-On 2/23/16, Staff A documented an entry at 2:30am that "[Resident #2's name] had been verbally abusive, threatening staff on 11pm-7am shift, pacing back and forth, and using profanity."</p> <p>-"At 2:00am, [Resident #2's name] kept coming to the office window and pulling it back as hard as she could. Accusing staff of stealing remote control and talking about her. I asked [Resident #2's name] to go to her room with that nonsense. She became very verbal (sic) abusive/combative and physical toward staff. She reached into the window and picked up staff's cup and threw it at med tech [Staff A's name]. This behavior went on til (sic) 4am."</p> <p>-A late entry was documented at 4:10am by Staff A that read "[Resident #2's name] woke several residents with loud profanity and tried to break office window by banging on it and pulling it back very hard."</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 338	<p>Continued From page 81</p> <p>There was no incident report available for review of this incident.</p> <p>Telephone interview with Resident #2's family member on 6/23/16 at 2:30pm revealed: -Resident #2 lived at the facility for nearly two years. -She had always been combative toward others. -The family member did not know what to do, but she did not blame anyone at the facility for Resident #2's behavior. -The family member visited every week or as often as she could. -The family member never noticed any bruises or scratches on Resident #2. -Resident #2 would tell the family member that "you had to watch out, people were out to get her." -Resident #2 never called any names, but the family member noticed that she would say things and be accusatory on occasion no matter where she was living.</p> <p>Interview with the Manager on 6/23/16 at 4:30pm revealed: -She had not had any reports of abuse or mistreatment toward a resident. -There had not been staff concerns reported to her about staff treating residents roughly. -If she had knowledge of staff abusing residents or mistreating residents, she would report them to the Administrator or she would be in trouble. -The incident that happened a while back with Resident #2 throwing water was seen on the video, but there was nothing that occurred beyond Resident #2 throwing the water at Staff A.</p> <p>Interview with the Administrator on 6/23/16 at 4:40pm revealed: -The episode with Resident #2 and the water was</p>	D 338			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 82</p> <p>not reported to the Health Care Personnel Registry (HCPR). -There was nothing to report. -The video footage went back nine weeks or so and there was nothing on the video that indicated abuse. -The video only showed Resident #2 throwing water on Staff A; there was no footage that indicated Staff A threw water on Resident #2. -The Administrator did not interview any staff about the incident. -It took five months to get Resident #2 out of the facility. -Resident #2 was mean. -The only incident he had reported to HCPR recently was pertaining to a staff who was terminated for not changing two residents before her shift was over.</p> <p>Interview with the Administrator on 6/24/16 at 5:20pm revealed: -He had never been told to report to HCPR if he did not substantiate the allegation. -He had reported an incident in the past and HCPR did nothing. -He was not reporting Staff A to HCPR because he had already investigated the incident; she never threw water on Resident #2.</p> <p>Refer to Telephone interview with a former staff on 6/24/16 at 3:57pm.</p> <p>Refer to confidential interview with a staff.</p> <p>Refer to confidential interview with a second staff.</p> <p>Refer to interview with the Administrator on 6/23/16 at 4:16pm.</p> <p>Refer to interview with the Administrator on</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 83</p> <p>6/27/16 at 11:07am.</p> <p>Refer to review of the Personal Care Aide Job Description.</p> <p>Refer to review of the facility's Personnel Policies and Procedures Manual.</p> <p>Telephone interview with a former staff on 6/24/16 at 3:57pm: -Abuse of residents (#1, #5 and #2) by Staff A had been reported to the Manager by more than 1 staff. -The Manager told staff she did not know how to handle Staff A or what to say to her. -Staff A was bold and admitted slapping a resident to the Manager saying "Yeah I slapped her." -Staff were afraid of Staff A because she was intimidating. -Staff A had been hostile toward staff saying "Your mother f***ing a** better not fall asleep tonight cuz I'm a get your a** fired," while yelling in staff face who had reported abuse of Resident #1.</p> <p>Confidential interview with a staff revealed: -Staff was not sure what 3rd shift actually did. -Everyone says that Staff A does not treat residents like they should be treated. -Everyone talks about Staff A being mean to the residents. -Staff could not recall specific incidents and declined to name "everyone."</p> <p>Confidential interview with a second staff revealed: -If staff had concerns about a resident or how a resident was being treated, it was reported to the MAVS and written on the shift notes. -The MAVS was responsible for reporting</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 84</p> <p>concerns to the Manager.</p> <ul style="list-style-type: none"> -Staff have been reported to the Manager for not doing good work but nothing gets done about it. -The Manager has a personal relationship with some staff and does not "step up." <p>Interview with the Administrator on 6/23/16 at 4:16pm revealed:</p> <ul style="list-style-type: none"> -Generally, employee concerns went to the Manager but the Assistant RCC was often involved because he was "more professional" and the Manager "just wanted everybody to like her." -There were no incidents of staff abusing residents reported except by a former employee in retaliation. -It was the former employee who was the problem and she was reported to the Health Care Personnel Registry. -The former staff walked out twice on residents who were wet, refused to go back and change them saying she did not work for free. -There were staff who were loud and just was "just how they are." -There were residents who were abusive and combative toward staff. -There were cameras in every hallway, the nurse's station, dining rooms and none in resident rooms or bathrooms. -The camera system held 9 weeks of footage. -Anytime something happened the Administrator, Manager or Assistant RCC could check the footage. <p>Interview with the Administrator on 6/27/16 at 11:07am revealed:</p> <ul style="list-style-type: none"> -The Administrator expected staff to walk away and let a resident who was agitated calm down. -Staff had credentials, nurse's aide school/Certified Nurse's Assistant but it didn't mean anything. 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 85</p> <ul style="list-style-type: none"> -They get 3 days training on 1st shift with the best employees so they're trained right. -The facility did their own Special Care Unit training when staff started work. <p>Review of the Personal Care Assistant Job Description revealed:</p> <ul style="list-style-type: none"> -The job objective read "your role is to assist resident with those activities of daily living that they are unable to perform without help." -Job duties read "observe and report changes in resident's physical condition, conduct room checks and resident rounds, and report incidents/accidents to supervisor and document." -Emergency preparedness read "respond to and act appropriate in an emergency." <p>Review of the facility's Personnel Policies and Procedures Manual revealed:</p> <ul style="list-style-type: none"> -Right #4 read "to be free of mental and physical abuse, neglect, and exploitation." -The interpretation of this right read "managers are responsible for exercising all reasonable care in selecting staff who will not be abusive and for dismissing any staff member who inflicts abuse..." <p>Review of the facility's Plan of Protection dated 6/24/16 revealed:</p> <ul style="list-style-type: none"> -We are going to create a new checklist of clients that are in the final stages of dementia or who has hospice services. -Bed checks will be required every 30 minutes with the aide going in the room and check to ensure the client is breathing, not just a look in. -This policy change will be permanent. -More extensive training during orientation about abuse and neglect. -If any allegation of neglect or abuse is mentioned, Nurse Aide Registry will be utilized if required. -More extensive observation on halls, rooms, and 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 86 common areas by supervision. -Creating a checklist for training that will document a chain of training, including who trained who. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 27, 2016.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that medications such as Alendronate, Zolpidem, Lorazepam, Clonazepam and Biotene were administered as ordered for 3 of 5 sampled residents. (Residents #1, #3 and #5) The findings are: 1. Review of Resident #1's FL-2 dated 12/28/15 revealed diagnoses included Dementia, Macrocytic Anemia, Hypertension and Seizure Disorder. a. Review of a physician's order dated 4/27/16 for Resident #1 revealed an order for Alendronate	D 358	Addendum on telephone with Luanae Weeks on 9/28/16. RN consultant is reviewing med pass bi-monthly and training med aides on the importance of correctly administering medications. MARs are being reviewed by the supervisor at shift change for missed documentation before passing of keys. The RCC is interviewing MARs weekly. Medication clinical skills are also being re-evaluated. - BR/MLK 8/1/16 → ongoing	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 87</p> <p>70mg once every week. (Alendronate is used to treat Osteoporosis and prevent bone fractures.)</p> <p>Review of Resident #1's April 2016 Medication Administration Record (MAR) revealed there was no entry for Alendronate.</p> <p>Review of Resident #1's May 2016 MAR revealed there was no entry for Alendronate.</p> <p>Review of Resident #1's June 2016 MAR revealed:</p> <ul style="list-style-type: none"> -A preprinted entry for Alendronate 70mg once every week on Monday at 8am. -The entry was initialed as given daily at 8am 6/1/16 through 6/22/16. <p>Observation of medications on hand for Resident #1 on 6/23/16 at 12:25pm revealed an unopened box of 4 tablets of Alendronate labeled with Resident #1's name and a dispense date of 4/27/16.</p> <p>Interview with a Medication Aide (MA) on 6/23/16 at 12:25pm revealed:</p> <ul style="list-style-type: none"> -Medications given once weekly were usually highlighted on the MAR. -The Manager reviewed and completed the MARs each month for all the residents. <p>Interview with the Assistant Resident Care Coordinator (RCC) on 6/23/16 at 4:00pm revealed he did not think Resident #5 had received Alendronate daily because there was an unopened box of 4 tablets on the medication cart.</p> <p>Interview with the Pharmacist on 6/24/16 at 1:24pm revealed:</p> <ul style="list-style-type: none"> -Alendronate 4 tablets was dispensed on 4/27/16 and 5/31/16. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 88</p> <p>-4 tablets was 1 month's supply. -Alendronate was used to treat brittle bones or Osteoporosis to reduce bone fractures.</p> <p>Interview with the Manager on 6/24/16 at 6:32pm revealed: -There was no Alendronate stored in her office for Resident #1. -The MAs must have just signed for it [Alendronate] on the MAR.</p> <p>b. Review of Resident #1's FL-2 dated 12/28/15 revealed an order for Clonazepam 0.25mg 2 tablets twice daily. (Clonazepam is used to treat anxiety.)</p> <p>Review of a physician's order dated 1/4/16 for Resident #1 revealed an order for Clonazepam 0.25mg twice daily.</p> <p>Review of Resident #1's April 2016 Medication Administration Record (MAR) revealed a preprinted entry for Clonazepam 0.25mg twice daily at 8am and 8pm with initials documenting each dose 4/1/16 through 4/30/16 was given.</p> <p>Review of Resident #1's May 2016 MAR revealed a preprinted entry for Clonazepam 0.25mg twice daily at 8am and 8pm with initials documenting each dose 5/1/16 through 5/31/16 was given.</p> <p>Review of Resident #1's June 2016 MAR revealed a preprinted entry for Clonazepam 0.25mg twice daily at 8am and 8pm with initials documenting each dose 6/1/16 through 6/22/16 was given.</p> <p>Observation of medications on hand for Resident #1 on 6/23/16 at 12:25pm revealed there were 49</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

EASTOVER GARDENS SPECIAL CARE UNIT **3017 DUNN ROAD**
FAYETTEVILLE, NC 28301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 89</p> <p>tablets of Clonazepam in a box labeled with Resident #1's name and dispense date of 9/17/15 for 120 tablets.</p> <p>Review of pharmacy dispensing records for Resident #1 revealed 60 tablets of Clonazepam 0.25mg had been dispensed on 11/4/15, 11/30/15, 1/4/16, 2/3/16, 3/2/16, 3/28/16, 5/3/16 and 5/31/16.</p> <p>Review of the Controlled Substance Administration Record for Resident #1 dated 3/23/16 revealed: -A preprinted label with Resident #1's name and dispense date of 3/23/16 for 60 tablets of Clonazepam 0.25mg. -There was documentation for 60 tablets being administered 4/21/16 at 8pm through 5/21/16 at 8am.</p> <p>Review of the Controlled Substance Administration Record for Resident #1 dated 5/3/16 revealed: -A preprinted label with Resident #1's name and dispense date of 5/3/16 for 60 tablets of Clonazepam 0.25mg. -There was documentation for 60 tablets being administered 5/21/16 at 8pm through 6/20/16 at 8am.</p> <p>Review of the Controlled Substance Administration Record for Resident #1 dated 5/3/16 revealed: -A preprinted label with Resident #1's name and dispense date of 5/3/16 for 60 tablets of Clonazepam 0.25mg. -A hand written entry for a beginning count of 56 tablets. -There was documentation for 6 tablets being administered 6/20/16 at 8pm through 6/23/16 at</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 90</p> <p>Barn with 50 tablets remaining.</p> <p>Observation of medications kept in Manager's Office for Resident #1 on 6/24/16 at 6:32pm revealed:</p> <ul style="list-style-type: none"> -An open box with a pharmacy label indicating Resident #1's name, Clonazepam 0.25mg with a dispense date of 9/17/15 for 120 tablets and 60 tablets remaining in the box. -An unopened box with a pharmacy label indicating Resident #1's name, Clonazepam 0.25mg with a dispense date of 3/2/16 for 60 tablets. - An unopened box with a pharmacy label indicating Resident #1's name, Clonazepam 0.25mg with a dispense date of 5/31/16 for 60 tablets. <p>Refer to interview with the Pharmacy Technician on 6/24/16 at 10:42am. Refer to interview with the Pharmacist on 6/24/16 at 1:24pm. Refer to interview with the Manager on 6/24/16 at 6:32pm.</p> <p>2. Review of Resident #3's FL-2 dated 3/10/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Picks Dementia, Mood Disorder and Bladder and Bowel Incontinence. -There was an order for Lorazepam 0.5mg 3 times daily. (Lorazepam is used to treat anxiety.) <p>Review of Resident #3's March 2016 Medication Administration Record (MAR) revealed a preprinted entry for Lorazepam 0.5mg 3 times daily at 6:30am, 2:30pm and 10:30pm with initials documenting each dose 3/1/16 through 3/31/16 was given.</p> <p>Review of Resident #3's April 2016 MAR revealed</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	<p>Continued From page 91</p> <p>a preprinted entry for Lorazepam 0.5mg 3 times daily at 6:30am, 2:30pm and 10:30pm with initials documenting each dose 4/1/16 through 4/20/16 at 6:30am (except 4/19/16 at 2:30pm) was given.</p> <p>Review of pharmacy dispensing records for Resident #3 revealed 90 tablets of Lorazepam 0.5mg had been dispensed on 11/4/15, 11/30/15, 1/6/16, 2/1/16, 2/29/16 and 3/22/16.</p> <p>Review of the Controlled Substance Administration Record for Resident #3 dated 2/29/16 revealed: -A preprinted label with Resident #3's name and dispense date of 2/29/16 for 90 tablets of Lorazepam 0.5mg on 2 forms. -There was documentation for 60 tablets being administered 3/10/16 at 2:30pm through 3/30/16 at 6:30am. -There was an attached photocopy of an empty bubble pack labeled with Resident #3's name, dispense dated of 2/29/16 for 90 tablets of Lorazepam 0.5mg with 30 empty pill bubbles.</p> <p>There was no Controlled Substance Administration Record for Resident #3 for 3/1/16 at 6:30am through 3/10/16 at 6:30am.</p> <p>Review of the Controlled Substance Administration Record for Resident #3 dated 2/1/16 revealed: -A preprinted label with Resident #3's name and dispense date of 2/1/16 for 90 tablets of Lorazepam 0.5mg. -There was documentation for 30 tablets being administered 4/10/16 at 6:30am through 4/20/16 at 6:30am.</p> <p>There was no Controlled Substance Administration Record for Resident #3 for 3/30/16</p>	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL028055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER: **EASTOVER GARDENS SPECIAL CARE UNIT**
STREET ADDRESS, CITY, STATE, ZIP CODE: **3017 DUNN ROAD FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 92</p> <p>at 2:30pm through 4/9/16 at 10:30pm.</p> <p>Review of Communication Notes dated 4/20/16 at 6:30am for Resident #3 revealed: -It appears the resident was not checked from 4:30 until 6:30am. -The note was signed by the Personal Care Aide and the Medication Aide.</p> <p>Review of EMS report for Resident #3 dated 4/20/16 revealed EMS found Resident #3 deceased, cold and with Rigor Mortis at approximately 7am on 4/20/16 at the facility.</p> <p>According to the April 2016 MAR for Resident #3, the 6:30am dose of Lorazepam 0.5mg was given when Resident #3 was deceased.</p> <p>Review of Medications Returned to Pharmacy Form dated 4/21/16 for Resident #3 revealed: -90 tablets of Lorazepam which had been dispensed on 3/22/16, were documented as returned to the pharmacy on 4/25/16. -Facility and pharmacy staff signatures were on the form.</p> <p>Interview with a Medication Aide (MA) on 6/23/16 at 3:30pm revealed there were no medications for Resident #3 on the medication cart.</p> <p>Refer to interview with the Pharmacy Technician on 6/24/16 at 10:42am.</p> <p>Refer to interview with the Pharmacist on 6/24/16 at 1:24pm.</p> <p>Refer to interview with the Manager on 6/24/16 at 6:32pm.</p> <p>3. Review of Resident #5's FL-2 dated 10/15/15</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 93</p> <p>revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Alzheimer's Dementia, Confusion, Debility, Hallucinations and Hyperlipidemia. -There was an order for Zolpidem 5mg daily at bedtime. (Zolpidem is used to treat insomnia.) <p>a. Review of Resident #1's May 2016 MAR revealed a preprinted entry for Zolpidem 5mg daily at 8pm with initials documenting each dose from 5/1/16 through 5/31/16 was given.</p> <p>Review of Resident #1's June 2016 MAR revealed a preprinted entry for Zolpidem 5mg daily at 8pm with initials documenting each dose from 6/1/16 through 6/22/16 was given.</p> <p>Review of the Controlled Substance Administration Record for Resident #5 dated 1/6/16 revealed:</p> <ul style="list-style-type: none"> -A preprinted label with Resident #5's name and dispense date of 1/6/16 for 30 tablets of Zolpidem 5mg. -There was documentation for 30 tablets being administered 4/25/16 at 8pm through 5/25/16 at 8pm. <p>Review of the Controlled Substance Administration Record for Resident #5 dated 2/1/16 revealed:</p> <ul style="list-style-type: none"> -A preprinted label with Resident #5's name and dispense date of 2/1/16 for 30 tablets of Zolpidem 5mg. -There was documentation for 28 tablets being administered 5/26/16 at 8pm through 6/22/16 at 8pm with 2 tablets remaining. <p>Observation of medications on hand for Resident #5 on 6/23/16 at 12:15pm revealed a bubble pack with 2 remaining tablets labeled as Zolpidem 5mg</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 94</p> <p>with Resident #5's name, and a dispense date of 2/1/16.</p> <p>Interview with a Medication Aide (MA) on 6/23/16 at 12:15pm revealed: -The MA did not know why the Zolpidem was dated 2/1/16. -Refills for medications were kept in the Manager's office. -Resident #5 had 1 bubble pack left of Zolpidem.</p> <p>Review of pharmacy dispensing records for Resident #5 revealed 30 tablets of Zolpidem were dispensed on 12/4/15, 1/6/16, 2/1/16, 3/1/16 and 3/25/16.</p> <p>Interview with a second MA on 6/24/16 at 5:10pm revealed Resident #5 received Zolpidem each night.</p> <p>Observation of medications kept in Manager's Office for Resident #5 on 6/24/16 at 6:32pm revealed a bubble pack with a pharmacy label indicating Resident #5's name, Zolpidem 5mg with a dispense date of 3/23/16 for 30 tablets.</p> <p>Interview with the Pharmacist on 6/24/16 at 1:24pm revealed: -Zolpidem was last dispensed 4/25/16 and was not renewed by the physician. -If given correctly, the medication would have run out by now. -There certainly should not be card [bubble pack] in the facility from 2/1/16.</p> <p>b. Review of Resident #5's FL-2 dated 10/15/15 revealed an order for Biotene oral rinse 1 capful daily. (Biotene is a mouthwash used to treat dry mouth.)</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 95</p> <p>Review of Resident #1's May 2016 MAR revealed a preprinted entry for Biotene 1 capful daily at 8am with initials documenting each dose from 5/1/16 through 5/31/16 was given.</p> <p>Review of Resident #1's June 2016 MAR revealed a preprinted entry for Biotene 1 capful daily at 8am with initials documenting each dose from 6/1/16 through 6/22/16 was given.</p> <p>Observation of medications on hand for Resident #5 on 6/23/16 at 12:15pm revealed: -There was approximately 1/4 bottle of Biotene labeled with Resident #5's name and a dispense date of 12/11/14. -There were no other bottles of Biotene at the facility.</p> <p>Interview with the Medication Aide (MA) on 6/23/16 at 12:15pm revealed: -The MA did not know the Biotene was dated 12/11/14. -The Biotene was given every day to Resident #5.</p> <p>Review of pharmacy dispensing records for Resident #5 revealed Biotene 237ml was last dispensed on 7/10/15.</p> <p>Interview with a second MA on 6/24/16 at 5:10pm revealed: -The MAs were responsible for administering medications documented on the MAR. -Resident #5 was supposed to receive Biotene daily on 1st shift.</p> <p>Interview with the Pharmacist on 6/24/16 at 1:24pm revealed one bottle of Biotene if given as ordered would not last that long (from 12/11/14.)</p> <p>Refer to interview with the Pharmacy Technician</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 96</p> <p>on 6/24/16 at 10:42am.</p> <p>Refer to interview with the Pharmacist on 6/24/16 at 1:24pm.</p> <p>Refer to interview with the Manager on 6/24/16 at 6:32pm.</p> <p>Interview with the Pharmacy Technician on 6/24/16 at 10:42am revealed all medications for the facility were batch filled every month except as needed, liquid, cream and powder medications.</p> <p>Interview with the Pharmacist on 6/24/16 at 1:24pm revealed:</p> <ul style="list-style-type: none"> -All medications should be given from a current card (bubble pack.) -Each card was one month's supply. -Medications were delivered to the Manager's office each month where they were kept stored and locked. -The Pharmacist rounds monthly with the Physician and his Nurse at the facility. -The Pharmacist checks medications kept in the refrigerator and medication carts. -The Pharmacist, Physician and Nurse also conduct trainings for staff at the facility. <p>Interview with the Manager on 6/24/16 at 6:32pm revealed:</p> <ul style="list-style-type: none"> -The Manager kept a log book of Controlled Medications received from the pharmacy. -As soon as a medication was received from the pharmacy it was documented in her book. -When a package was put on the medication cart/given to staff, staff initialed and the manager initialed in her book. -The Manager did not keep track of the date bubble packs were put on the medication 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 97 cart/given to staff. -When medications were running low, the Manager contacted the Pharmacy Technician. The Administrator was present for the interview with the Manager on 6/24/16 at 6:32pm and had no specific comment.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 130 .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse of 3 residents (#1, #2, #5) by a staff person (Staff A) to the Health Care Personnel Registry. The findings are: Interview with the Manager on 6/23/16 at 4:30pm revealed: -She had not had any reports of abuse or mistreatment toward a resident. -There had not been staff concerns reported to her about staff treating residents roughly. -If she had knowledge of staff abusing residents or mistreating residents, she would report them to the Administrator or she would be in trouble.	D 438	Addendum on telephone with Duanne Weeks 9/28/16: Staff is no longer employed at the facility. Any report of abuse or neglect will be investigated by the facility and reported to the HPR using the 24 hour + 5 day reports. The Administrator will be responsible for conducting investigations + reporting to HPR. <i>Shalley 9/28/16</i>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	<p>Continued From page 98</p> <ul style="list-style-type: none"> -The incident that happened a while back with Resident #2 throwing water was seen on the video, but there was nothing that occurred beyond Resident #2 throwing the water at Staff A. -She had not had any reports of abuse or mistreatment toward a resident. -There had not been staff concerns reported to her about staff treating residents roughly. -If she had knowledge of staff abusing residents or mistreating residents, she would report them to the Administrator or she would be in trouble. <p>Interview with the Administrator on 6/23/16 at 4:16pm revealed:</p> <ul style="list-style-type: none"> -Generally employee concerns went to the Manager but the Assistant RCC was often involved because he was "more professional" and the Manager "just wanted everybody to like her." -There were no incidents of staff abusing residents reported except by a former employee in retaliation. -It was the former employee who was the problem and she was reported to the Health Care Personnel Registry (HCPR.) -The former staff walked out twice on residents who were wet, refused to go back and change them saying she did not work for free. -It's been months since the facility had to report any staff to the HCPR. -Staff A had not been reported because there was nothing to report. -There were staff who were loud and just was "just how they are." -There were residents who were abusive and combative toward staff. -There were cameras in every hallway, the nurse's station, dining rooms and none in resident rooms or bathrooms. -The camera system held 9 weeks of footage. 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	<p>Continued From page 99</p> <p>-Anytime something happened the Administrator, Manager or Assistant RCC could check the footage.</p> <p>Interview with the Administrator on 6/23/16 at 4:40pm revealed:</p> <p>-The episode with Resident #2 and the water was not reported to the Health Care Personnel Registry (HCPR).</p> <p>-There was nothing to report.</p> <p>-The video footage went back nine weeks or so and there was nothing on the video that indicated abuse.</p> <p>-The Administrator did not interview any staff about the incident.</p> <p>-It took five months to get Resident #2 out of the facility.</p> <p>-The only incident he had reported to HCPR recently was pertaining to a staff who was terminated for not changing two residents before her shift was over.</p> <p>Interview with the Administrator on 6/23/16 at 5:15pm:</p> <p>-The Administrator was reviewing video footage of 6/2/16 from 12:30 - 1am.</p> <p>-The Administrator pointed out Staff A and stated "That's the one they say pushed her [Resident #5]."</p> <p>-The Administrator reported, "Yes, I was aware of the incident. I looked at the footage before. There's no fall on the camera."</p> <p>-The facility investigated the incident with Resident #5 and there was nothing on the camera.</p> <p>Interview with the Administrator on 6/24/16 at 5:20pm revealed:</p> <p>-He had never been told to report to HCPR if he</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

D 438 Continued From page 100

did not substantiate the allegation.

- He had reported an incident in the past and HCPR did nothing.
- He was not reporting Staff A to HCPR because he had already investigated the incident; she never threw water on Resident #2.
- He was not aware of any incident with Resident #1.
- He knew she had a history of seizures, but did not know anything about a fall or possible staff mistreatment.
- "You can't rely on what Resident #1 says."

Refer to Tag D0338, 10A NCAC 13F. 0909 Resident Rights. (Type A1 Violation)].

Review of the facility's Plan of Protection dated 6/24/16 revealed:

- Nurse Aide Registry reporting will begin immediately.

CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 27, 2016.

D 438

Addendum on telephone with Luanne Weeks on 9/28/16: Staff hired will be required to have had a minimum of 6 hours of Alzheimer's / dementia training. The Co-Administrator will be training staff on the 7 types of dementia, behavior, and bathing/feeding difficult residents which will encompass the 20 hours of training required within 6 months of hire.

D 468 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train

10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training

The facility shall assure that special care unit staff receive at least the following orientation and training:

(1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a

D 468

of training required within 6 months of hire.

B. Rainey 9/28/16

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	<p>Continued From page 101</p> <p>plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.</p> <p>(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.</p> <p>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure that 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) assigned to perform duties in the special care unit (SCU) received 6 hours of orientation training within the first week of employment and 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) received 20 hours of training within six months of employment. The findings are:</p> <p>1. Review of the personnel file for Staff A revealed: -Staff A was hired to work as a Personal Care Aide (PCA) on 1/19/15. -Staff A was promoted to work as a Medication</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	<p>Continued From page 102</p> <p>Aide (MA) on 8/17/15.</p> <p>-There was no documentation of the required 6 hour or 20 hour SCU training in Staff A's personnel file.</p> <p>Interview with Staff A on 6/23/16 at 6:40am revealed:</p> <p>-Staff A had not had any specific training since being hired at the facility other than orientation.</p> <p>-Staff A had worked with dementia residents in the past.</p> <p>-She had worked with "difficult" residents at the facility who were combative with other residents and staff.</p> <p>-When a resident was upset or aggressive, Staff A would try to calm the resident down, "sweet talk" to the resident, and let the resident know that things would be okay.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of the personnel file for Staff C revealed:</p> <p>-Staff C was hired to work as a Personal Care Aide (PCA) on 4/13/16.</p> <p>-There was no documentation of the required 6 hour SCU training in Staff C's personnel file.</p> <p>Interview with Staff C on 6/27/16 at 6:16am revealed the only training she had since starting to work at the facility was on the floor with another staff.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>3. Review of the personnel file for Staff D</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	<p>Continued From page 103</p> <p>revealed: -Staff D was hired to work as a Personal Care Aide (PCA) on 12/17/15. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff D's personnel file.</p> <p>Interview with Staff D on 6/27/16 at 7:00am revealed: -She was trained by another staff on the floor when she started, but does not recall any additional SCU training. -She had been assigned to train a new staff today (6/27/16).</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of the personnel file for Staff E revealed: -Staff E was hired to work as a dietary supervisor on 12/11/10. -Staff E was promoted to On-Site Supervisor/Manager on 6/2/14. -There was a certificate that Staff E had completed 2 hours of dementia training in March 2011 and an additional 2 hours in April 2011. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff E's personnel file.</p> <p>Interview with Staff E on 6/24/16 at 4:00pm revealed: -She knew she had SCU training during her employment. -The former Manager kept up with the personnel files and had several notebooks that she kept things in that Staff E had been unable to locate. -Since being promoted to Manager, Staff E was</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	<p>Continued From page 104</p> <p>responsible for the personnel files and ensuring trainings were scheduled with the nurse consultants.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>5. Review of the personnel file for Staff F revealed: -Staff F was hired to work as a Personal Care Aide (PCA) on 6/9/15. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff F's personnel file.</p> <p>Staff F was not available for interview on 6/24/16.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>6. Review of the personnel file for Staff G revealed: -Staff G was hired to work as a Medication Aide (MA) on 5/13/14. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff G's personnel file.</p> <p>Interview with Staff G on 6/24/16 at 2:00pm revealed: -She did not recall receiving any SCU training when she started, but she had worked with dementia residents in the past. -She was trained by another MA, but it was medication related training.</p> <p>Refer to the interview with the Administrator on</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	<p>Continued From page 105</p> <p>6/27/16 at 11:00am.</p> <p>7. Review of the personnel file for Staff H revealed: -Staff H was hired to work as a Medication Aide (MA) on 4/21/16. -There was no documentation of the required 6 hour SCU training in Staff H's personnel file.</p> <p>Interview with Staff H on 6/27/16 at 6:50am revealed she had only been paired with another staff and trained on the floor when she started.</p> <p>Refer to the interview with the Administrator on 6/27/16 at 11:00am.</p> <p>8. Review of the personnel file for Staff I revealed: -Staff I was hired to work as a Medication Aide (MA) on 8/16/13. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff I's personnel file.</p> <p>Interview with Staff I on 6/27/16 at 10:08am revealed: -She did not recall taking an SCU courses. -She had taken what the facility had told her to take. -Staff I had worked with mental health and dementia residents for years.</p> <p>The Registered Nurse (RN) consultant who was responsible for completing the competency validations was not available for interview during the survey.</p> <p>Refer to the interview with the Administrator on</p>	D 468		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 468	Continued From page 106 6/27/16 at 11:00am. Interview with the Administrator on 6/27/16 at 11:00am revealed: -Staff received training during their first week of employment. -The staff worked with first shift staff on the floor, so that would be considered their 6 hours of SCU training. -The nurse consultants came to the facility to do check-offs and trainings with the staff. Review of the facility's Plan of Protection dated 6/24/16 revealed: -New PCAs are trained by working employees for 3 shifts before they are allowed to work on their own. -We are going to create documentation showing who and the number of hours in training. -Create a time file on all requirements to ensure all staff stays current. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.	D 468			
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.	D911			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D911	<p>Continued From page 107</p> <p>This Rule is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure that 1 of 1 resident sampled (#7) was treated with respect, consideration, dignity, and the right to privacy by not providing care according to the resident's request. The findings are:</p> <p>Review of Resident #7's current FL2 dated 5/25/16 revealed: -Diagnoses included dementia, hypertension, aggressive behavior, chronic headache, cerebrovascular accident, and hyperlipidemia. -Resident #7 was non-ambulatory and totally dependent on staff.</p> <p>Review of Resident #7's Care Plan dated 5/25/16 revealed: -Resident #7 was sometimes disoriented and forgetful. -Resident #7 required extensive assistance with toileting, bathing, dressing, grooming, and transferring.</p> <p>Review of the Shift Shower list revealed Resident #7 was to be showered on first shift on Monday, Wednesday, and Friday.</p> <p>Observation of Resident #7 on 6/27/16 at 7:00am revealed: -Resident #7 was sitting in the lobby in her wheelchair. -She was wearing a thin, hospital-type gown. -There was a blanket draped over her shoulders and across her legs. -She had dried, crusty matter around her eyes and was tearful.</p> <p>Interview with Resident #7 on 6/27/16 at 7:20am revealed:</p>	D911	<p><i>Addendum via telephone with Shuanne Weems on 9/28/16: Staff have been re-trained on bathing and protocol for ensuring uninterrupted care. - Braskley 9/28/16</i></p> <p><i>Shower schedules have been changed and policy put in place to ensure resident dignity. Rec and Administrator will be making random rounds on different shifts to ensure compliance. - Braskley 9/28/16</i></p> <p><i>Resident rights training is a part of staff orientation. RN consultant has provided re-training to all staff on resident rights. Braskley 9/28/16</i></p>	<p><i>8/15/16</i></p> <p><i>8/17/16</i></p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
EASTOVER GARDENS SPECIAL CARE UNIT

STREET ADDRESS, CITY, STATE, ZIP CODE
**3017 DUNN ROAD
FAYETTEVILLE, NC 28301**

(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
D911	<p>Continued From page 108</p> <ul style="list-style-type: none"> -She was embarrassed. -She had never been treated like that in her life. -"They got me up and left me up here like this with all these men around." -She wanted to get dressed before she ate breakfast. <p>Interview with a Personal Care Aide (PCA) on 6/27/16 at 7:25am revealed:</p> <ul style="list-style-type: none"> -She was assigned to Resident #7 for first shift. -Third shift staff put the gown on Resident #7 to remind first shift staff that she was to have a shower. -She would check on Resident #7. <p>Observation of the large dining room at 7:50am on 6/27/16 revealed Resident #7 was sitting in her wheelchair at the table dressed in the hospital gown; the blankets remained draped over her shoulders and across her legs.</p> <p>Interview with the Medication Aide (MA) on 6/27/16 at 7:51 am revealed:</p> <ul style="list-style-type: none"> -The gowns were not reminders. -First shift staff, the PCAs, knew which residents were assigned to get showers. -The third shift staff would put the gown on Resident #7 because Resident #7 would not let the staff shower her if they got her dressed first and took her to breakfast. -After breakfast, the PCA would assist Resident #7 with a shower and get her dressed, if Resident #7 would allow it. -The MA would talk with the Manager about changing Resident #7 's shower schedule to third shift, so she would be bathed and dressed before breakfast. <p>Interview with the Assistant Resident Care Coordinator on 6/27/16 at 8:10am revealed:</p>	D911		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D911	<p>Continued From page 109</p> <p>-He did not understand why it was so difficult to accommodate the residents' requests. -It would be easy to change Resident #7 to the third shift schedule for showers.</p> <p>Interview with the Administrator on 6/27/16 at 11:00am revealed: -The staff had a shower schedule that they went by to ensure all residents were showered. -If a resident does not want a shower or requests a shower at a different time, the staff should accommodate the resident's request.</p> <p>Review of the facility's Personnel Policies and Procedures Manual revealed: -Right #1 read "to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy." -The interpretation of this right read "staff of the facility should speak courteously to the residents at all times. Staff members needs to be aware of and sensitive to problems, feelings, and needs of the residents. Staff should ensure the privacy of a resident's body at all times."</p>	D911		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents received care and</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D912	<p>Continued From page 110</p> <p>services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to test for tuberculosis, tuberculosis test, medical examination and immunization, Health Care Personnel Registry, personal care and supervision, health care, special care unit training, and medication aides training and competency.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on record reviews and interviews, the facility failed to ensure 9 of 9 staff sampled (A, B, C, D, E, F, G, H, and I) were tested upon employment for tuberculosis (TB) disease with the two step TB skin test in compliance with control measures adopted by the Commission for Public Health. [Refer to Tag D0131, 10A NCAC 13F.0406(a) Test for Tuberculosis. (Type B Violation)]. 2. Based on record review and interview, the facility failed to assure that 5 of 9 sampled staff (A, B, E, G, and H) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire according to G.S. 131E-256. [Refer to Tag D0137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications. (Type B Violation)]. 3. Based on record review and interviews, the facility failed to ensure that 5 of 5 (#1, #2, #3, #4, and #5) sampled residents had been tested for tuberculosis (TB) disease upon admission to the facility in accordance with the Commission for Public Health. [Refer to Tag D0234, 10A NCAC 13F. 0703(a) Tuberculosis Test, Medical Exam, and immunizations. (Type B Violation)]. 	D912			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D912	Continued From page 111 4. Based on observations, interviews, and record reviews, the facility failed to ensure that personal care, including incontinence care and bathing, was provided in accordance with the assessed needs for 5 of 9 sampled residents (#5, #6, #7, #8, #9). [Refer to Tag D0269, 10A NCAC 13F. 0901(a) Personal Care and Supervision. (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to report high/low blood pressures and heart rates for 2 of 5 sampled residents (#3 and # 4), failed to notify the physician of elevated blood pressure in the emergency room (#3), failed to notify the physician of low blood pressures (#4), and failed to schedule follow up as recommended by the ER for a third sampled resident (#1.) [Refer to Tag D0273, 10A NCAC 13F. 0902(b) Health Care. (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure that 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) assigned to perform duties in the special care unit (SCU) received 6 hours of orientation training within the first week of employment and 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) received 20 hours of training within six months of employment. [Refer to Tag D0468, 10A NCAC 13F. 1309(1)(2)(3)(4) Special Care Unit Staff Orientation and Train. (Type B Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 medication aides (A, F, G, H) sampled who administered medications had completed the 5 hour and 10 hour or the 15 hour state approved	D912			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 112. medication administration courses as required, 3 of 6 medication aides (A, G and H) completed the medication aide clinical skills checklist, and 1 of 6 (A) had passed the medication test. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides, Training and Competency (Type B Violation)].	D912		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that residents were free of physical abuse and neglect related to Resident Rights, Health Care Personnel Registry and Personal Care and Supervision.</p> <p>The findings are:</p> <p>1. Based on observations, interviews and record reviews, the facility failed to follow its established routine and expectation of every 30 minute safety checks for every resident and every 2 hour incontinence checks by allowing a resident (#3), to go unchecked for a period of 2 1/2-7 hours and was reported as found with rigor mortis by EMS (Emergency Medical Service) first responders; and the facility failed to protect residents from abuse by allowing staff who had been reported to be aggressive and abusive with residents while providing care to continue to work at the facility as the Supervisor after 3 of 3 sampled residents were assaulted, resulting in injuries and requiring emergency room visits (Residents #1 and #5) and</p>	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D914	Continued From page 113 slapped (Resident #2). [Refer to Tag D0338, 10A NCAC 13F. 0909 Resident Rights. (Type A1 Violation)]. 2. Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse of 3 residents (#1, #2, #5) by a staff person (Staff A) to the Health Care Personnel Registry. [Refer to Tag D0438, 10A NCAC 13F. 1205 Health Care Personnel Registry. (Type A1 Violation)].	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 6 sampled medication aides (G and I) completed the state mandated annual infection control course. The findings are:	D934	Addendum per telephone with Luann Weeks on 9/28/16. The RN consultant and new pharmacist will be providing annual infection control training. The Co-Administrator will be responsible for overseeing that trainings are completed annually. B. Rainey RN 9/28/16	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D934	<p>Continued From page 114</p> <p>1. Review of the personnel record for Staff G revealed: -Staff G was hired to work as a Medication Aide on 5/13/14. -There was no documentation of completion of the state mandated annual infection control course.</p> <p>Interview with Staff G on 6/24/16 at 2:00pm revealed she did not recall completing an infection control course since she had been a Medication Aide.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>2. Review of the personnel file for Staff I revealed: -Staff I was hired to work as a Medication Aide on 8/16/13. -There was no documentation of completion of the stated mandated annual infection control course.</p> <p>Interview with Staff I on 6/27/16 at 10:08am revealed: -She was not sure if she had taken the state infection control course. -Staff I had taken whatever the facility had required her to take.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Interview with the Manager on 6/24/16 at 4:15pm revealed: -She was not sure what happened to certificates and paper work in the personnel files. -The Manager prior to her taking over in 2014 had</p>	D934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D934	Continued From page 115 Kept things in notebooks and the current Manager was unable to locate the documentation for various things. -She felt sure the trainings had been done by the nurse consultants that came to the facility.	D934		
D935	<p>G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</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 	D935	<p>Addendum via telephone with Luanne Weeks on 9/28/16:</p> <p>The RN consultant is re-validating all medaides' clinical skills checklist, and completing all newly hired medaides' checklist. The Co-Administrator will be responsible for ensuring that med exams are taken within the time frames as stated in the regulations.</p> <p><i>B. Plank</i> 9/28/16</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(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
D935	<p>Continued From page 116</p> <p>administration.</p> <p>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</p> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 medication aides (A, F, G, H) sampled who administered medications had completed the 5 hour and 10 hour or the 15 hour state approved medication administration courses as required, 3 of 6 medication aides (A, G and H) completed the medication aide clinical skills checklist, and 1 of 6 (A) had passed the medication test.</p> <p>The findings are:</p> <p>1. Review of Staff A's personnel file revealed: -She was hired as a Personal Care Aide on 1/19/15. -She was promoted to Medication Aide (MA) on 8/17/15. -She did not pass the written medication aide exam on 6/20/2003. -There was no documentation of the 5 hour, 10 hour, or 15 hour state approved medication administration courses for Staff A nor was there a</p>	D935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D935	<p>Continued From page 117</p> <p>medication aide clinical skills checklist completed.</p> <p>Interview with Staff A on 6/23/16 at 6:40am revealed:</p> <ul style="list-style-type: none"> -She worked on third shift as a Medication Aide/Supervisor. -There were currently no medications to administer on third shift since one resident passed away a few months ago; that resident had a 6:30am medication. -Staff A administered medications occasionally if a resident required "as needed" medication. -She was qualified to pass medications and had worked as a MA at a previous employer. <p>Review of the June 2016 medication administration records revealed Staff A had not documented administration of medications this month.</p> <p>Review of the Shift Notes dated 6/24/16 revealed:</p> <ul style="list-style-type: none"> -Staff A had signed the form as the "Med-Tech" on duty for third shift. -There were three Personal Care Aides on duty for third shift. -Staff A documented that a resident was "given 2 tabs Hydroxyzine 25mg at 1:20am for anxiety/no sleep." -Review of the resident's Medication Administration Record revealed no documentation that he had received the medication. <p>Interview with the Administrator on 6/24/16 at 6:50 p.m. revealed:</p> <ul style="list-style-type: none"> -Staff A was hired from a facility that stated she had been giving medications to their residents. -The Administrator did not understand how that employer could state Staff A was certified to give medications when she had not passed the test. 	D935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(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	
D935	<p>Continued From page 118</p> <p>-Staff A had not passed the test on 6/20/2003. -The Manager, Staff E, would fill in on third shift as the MA until Staff A was qualified.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>2. Review of Staff F's personnel file revealed: -She was hired as Personal Care Aide on 6/9/15. -She was promoted to Medication Aide (MA) on 5/11/16. -She passed the written medication aide exam on 2/21/2003. -There was no medication aide employment verification for Staff F or a completed medication clinical skills checklist. -There was documentation of the 5 hour state approved training completed on 4/26/16.</p> <p>Observation during the survey on 6/22/16 and 6/23/16 revealed Staff F administered medications in the special care unit during second shift on 6/22/16 and 6/23/16.</p> <p>Review of the June 2016 medication administration records revealed Staff F documented administration of medications.</p> <p>Staff F was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p>	D935			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D935	<p>Continued From page 119</p> <p>3. Review of Staff G's personnel file revealed: -She was hired as Medication Aide (MA) on 5/13/14. -She passed the written medication aide exam on 2/17/13. -There was no medication aide employment verification for Staff G. -There was no documentation of a completed medication clinical skills checklist.</p> <p>Observation during the survey on 6/22/16, 6/23/16, and 6/24/16 revealed Staff G administered medications in the special care unit during first shift.</p> <p>Interview with Staff G on 6/24/16 at 2:00pm revealed she had worked as a MA in the past and thought she had completed the medication clinical skills checklist which should be in her employee file.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <p>4. Review of Staff H's personnel file revealed: -She was hired as Medication Aide (MA) on 4/21/16. -She passed the written medication aide exam on 4/11/13. -There was one medication aide employment verification for Staff G dated "3/2016." -There was no documentation of a completed medication clinical skills checklist or the 5/10 or 15 hour training.</p>	D935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D935	<p>Continued From page 120</p> <p>Interview with Staff H on 6/27/16 at 5:50am revealed: -She did not have any medications ordered routinely on third shift, but would give "a prn" if a resident requested. -She passed the written medication aide exam on three years ago and had taken the 15 hour training course.</p> <p>Review of the May and June Medication Administration Records revealed no entries that Staff H had administered any routine or as needed medications.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Administrator on 6/27/16 at 11:00am.</p> <hr/> <p>Interview with the Manager on 6/24/16 at 4:15pm revealed: -She hired new staff and was responsible for the personnel files, including making sure that the MAs were qualified to give medications. -The Assistant Resident Care Coordinator (RCC) had been hired to help her. -The Nurse Consultant who did the Licensed Health Professional Support tasks usually came to the facility when needed to provide staff trainings and complete skills checklists. -She was unable to locate any records or files that the previous Manager had kept in various notebooks in -The previous Manager was not getting the training done as required.</p> <p>Interview with the Administrator on 6/27/16 at</p>	D935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(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	
D935	<p>Continued From page 121</p> <p>11:00am revealed:</p> <ul style="list-style-type: none"> -The previous Manager was not getting things done. -Her responsibilities had included hiring new staff and making sure the necessary documents were in the personnel files. -The current Manager had been trying to keep up with everything, but the Administrator had to bring in the Assistant RCC to help with the resident care plans, FL2s, and orders. -He thought the staff were qualified to administer medications, -He had showed the Manager and the Assistant RCC how to access the Medication Aide website to check for test dates, and he had explained what was required of the MAs to ensure they were qualified. <p>Review of the facility's Personnel Policies and Procedure Manual revealed staff of the facility must be qualified for the jobs they perform.</p> <hr/> <p>Review of the facility's plan of protection dated 6/6/24/16 revealed:</p> <ul style="list-style-type: none"> -Every Medication Aide employee will have a NC Adult Care Med Aide Certificate upon hiring, the 5/10/15 hour training, and medication validation. -Facility will continue monitoring Medication Aide skills and ensuring certificates are placed in personnel files by administration. -Medication Aides will not pass meds until qualifications are in files and completed. <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2016.</p>	D935			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980 D980	<p>Continued From page 122</p> <p>G.S. § 131D-25 Implementation</p> <p>G.S. 131D-25 Implementation</p> <p>Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to provide appropriate care and services, failure to ensure residents were free of abuse and neglect, and the failure to provide the services necessary to maintain the residents' physical and mental health as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes, which is the responsibility of the administrator. The findings are:</p> <p>1. Based on record reviews and interviews, the facility failed to ensure 9 of 9 staff sampled (A, B, C, D, E, F, G, H, and I) were tested upon employment for tuberculosis (TB) disease with the two step TB skin test in compliance with control measures adopted by the Commission for Public Health. [Refer to Tag 0131, 10A NCAC 13F.0406(a) Test for Tuberculosis. (Type B Violation)].</p> <p>2. Based on record review and interview, the</p>	D980 D980	<p>Addendum via telephone with Luanne Weeks on 9/28/16:</p> <p>The Administrator with assistance from the Co-Administrator will be responsible for implementing the state rules and regulations, and ensuring that all staff are abiding by the state rules + regulations. The Administrator will ensure that all new hires receive Resident Rights training, and that all existing staff are re-trained on Resident Rights.</p> <p>Shalley 9/28/16</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D980	<p>Continued From page 123</p> <p>facility failed to assure that 5 of 9 sampled staff (A, B, E, G, and H) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire according to G.S. 131E-256. [Refer to Tag D0137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications. (Type B Violation)].</p> <p>3. Based on record review and interviews, the facility failed to ensure that 5 of 5 (#1, #2, #3, #4, and #5) sampled residents had been tested for tuberculosis (TB) disease upon admission to the facility in accordance with the Commission for Public Health. [Refer to Tag D0234, 10A NCAC 13F. 0703(a) Tuberculosis Test, Medical Exam, & Immunizations. (Type B Violation)].</p> <p>4. Based on observations, interviews, and record reviews, the facility failed to ensure that personal care, including incontinence care and bathing, was provided in accordance with the assessed needs for 5 of 9 sampled residents (#5, #6, #7, #8, #9). [Refer to Tag D0269, 10A NCAC 13F. 0901(a) Personal Care and Supervision. (Type B Violation)].</p> <p>5. Based on observations, interviews and record reviews, the facility failed to report high/low blood pressures and heart rates for 2 of 5 sampled residents (#3 and #4), failed to notify the physician of elevated blood pressure in the emergency room (#3), failed to notify the physician of low blood pressures (#4), and failed to schedule follow up as recommended by the ER for a third sampled resident (#1.) [Refer to Tag D0273, 10A NCAC 13F. 0902(b) Health Care. (Type B Violation)].</p> <p>6. Based on observations, interviews and record reviews, the facility failed to follow its established</p>	D980			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/27/2016
NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D980	Continued From page 124 routine and expectation of every 30 minute safety checks for every resident and every 2 hour incontinence checks by allowing a resident (#3), to go unchecked for a period of 2 1/2-7 hours and was reported as found with rigor mortis by EMS (Emergency Medical Service) first responders; and the facility failed to protect residents from abuse by allowing staff who had been reported to be aggressive and abusive with residents while providing care to continue to work at the facility as the Supervisor after 3 of 3 sampled residents were assaulted, resulting in injuries and requiring emergency room visits (Residents #1 and #5) and slapped (Resident #2). [Refer to Tag D0338, 10A NCAC 13F. 0909 Resident Rights. (Type A1 Violation)]. 7. Based on record reviews and interviews, the facility failed to report and investigate known allegations of abuse of 3 residents (#1, #2, #5) by a staff person (Staff A) to the Health Care Personnel Registry. [Refer to Tag D0438, 10A NCAC 13F. 1205 Health Care Personnel Registry. (Type A1 Violation)]. 8. Based on observations, interviews, and record reviews, the facility failed to ensure that 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) assigned to perform duties in the special care unit (SCU) received 6 hours of orientation training within the first week of employment and 8 of 9 sampled staff (Staff A, C, D, E, F, G, H, and I) received 20 hours of training within six months of employment. [Refer to Tag D0468, 10A NCAC 13F. 1309(1)(2)(3)(4) Special Care Unit Staff Orientation and Train. (Type B Violation)]. 9. Based on observations, interviews, and record reviews, the facility failed to assure 4 of 6 medication aides (A, F, G, H) sampled who	D980			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 125 administered medications had completed the 5 hour and 10 hour or the 15 hour state approved medication administration courses as required, 3 of 6 medication aides (A, G and H) completed the medication aide clinical skills checklist, and 1 of 6 (A) had passed the medication test. [Refer to Tag D935, G.S. 131D-4.5B(b) Adult Care Home Medication Aides, Training and Competency (Type B Violation)]. Review of the facility's Personnel Policies and Procedures Manual revealed the Resident Care Coordinator has the responsibility and authority for managing the facility; the Administrator is the final authority governing the facility and establishing its policies. Review of the facility's plan of protection dated 6/27/16 revealed: -Reference all plans of protection. -Administrator with the assistance of the Manager and Assistance Resident Care Coordinator will bring all violations in compliance. -Create documents to monitor and show progress in all areas. THE CORRECTION DATE FOR THIS A1 VIOLATION SHALL NOT EXCEED JULY 27, 2016.	D980		
D992	G.S. § 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home	D992	<i>Addendum via telephone with Luanne Weer on 9/28/16. Drug screens are being done upon hire by the Business Office Manager and Facility Manager.</i>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D992	<p>Continued From page 126</p> <p>licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure examination and screening for the presence of controlled substances were performed for 3 of 7 staff (A, F, and G) that were hired after 10/01/13. The findings are:</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D992	<p>Continued From page 127</p> <p>1. Review of Staff A's personnel file revealed: - Staff A was hired as a Personal Care Aide (PCA) on 1/19/15. - There was a consent form for a urine drug screen signed by Staff A. - There was no documentation of the urine controlled substance exam and screening being completed.</p> <p>Staff A was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Business Office Manager on 6/24/16 at 4:30pm.</p> <p>2. Review of Staff F's personnel file revealed: - Staff F was hired as a Personal Care Aide (PCA) on 6/9/15. - There was a consent form for a urine drug screen signed by Staff F. - There was no documentation of the urine controlled substance exam and screening being completed.</p> <p>Staff F was not available for interview on 6/24/16.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Business Office Manager on 6/24/16 at 4:30pm.</p> <p>3. Review of Staff G's personnel file revealed: - Staff G was hired as a Medication Aide (PCA) on 5/13/14. - There was a consent form for a urine drug</p>	D992		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/27/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER EASTOVER GARDENS SPECIAL CARE UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 DUNN ROAD FAYETTEVILLE, NC 28301
---	---

(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
D992	<p>Continued From page 128</p> <p>screen signed by Staff G.</p> <ul style="list-style-type: none"> - There was no documentation of the urine controlled substance exam and screening being completed. <p>Interview with Staff G on 6/24/16 at 2:00pm revealed she did not recall receiving a drug screen when she was hired.</p> <p>Refer to interview with the Manager on 6/24/16 at 4:15pm.</p> <p>Refer to interview with the Business Office Manager on 6/24/16 at 4:30pm.</p> <hr/> <p>Interview with the Manager on 6/24/16 at 4:15pm revealed:</p> <ul style="list-style-type: none"> - She was responsible for personnel files. - She completed drug screenings upon hire. <p>Interview with the Business Office Manager on 6/24/16 at 4:30pm revealed:</p> <ul style="list-style-type: none"> - She was responsible for ensuring drug screens were completed on all new hires. - She kept the drug screen results on file in her office. - The facility did not begin drug screenings until July 2015. <p>Interview with the Administrator on 1/29/16 at 5:50pm. revealed:</p> <ul style="list-style-type: none"> - Staff A was hired as a PCA, but Staff A no longer works here. - The Administrator did not realize Staff A had not done the urine screening. - The Administrator did not know why the drug screening had not been completed. 	D992		