STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023004	A. BUILDING: _____ B. WING _____	R 11/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPENVIEW RETIREMENT HOME	112 PONY BARN ROAD LAWNDALE, NC 28090 County: Cleveland

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted an annual and follow-up survey on November 25th and 26th, 2014.	D 000		
D 050	10A NCAC 13F .0305(e) Physical Environment 10A NCAC 13F .0305 Physical Environment (e) The requirements for bathrooms and toilet rooms are: (1) Minimum bathroom and toilet facilities shall include a toilet and a hand lavatory for each 5 residents and a tub or shower for each 10 residents or portion thereof; (2) Entrance to the bathroom shall not be through a kitchen, another person's bedroom, or another bathroom; (3) Toilets and baths for staff and visitors shall be in accordance with the North Carolina State Building Code, Plumbing Code; (4) Bathrooms and toilets accessible to the physically handicapped shall be provided as required by Volume I-C, North Carolina State Building Code, Accessibility Code; (5) The bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains; (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; (7) Each home shall have at least one bathroom opening off the corridor with: (A) a door of three feet minimum width; (B) a three feet by three feet roll-in shower designed to allow the staff to assist a resident in taking a shower without the staff getting wet;	D 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Ruby Wellmon — 12-30-14

1-7-15
APPROVED WITH CORRECTIONS

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D 050	Continued From page 1 (C) a bathtub accessible on at least two sides; (D) a lavatory; and (E) a toilet. (8) If the tub and shower are in separate rooms, each room shall have a lavatory and a toilet; (9) Bathrooms and toilet rooms shall be located as conveniently as possible to the residents' bedrooms; (10) Resident toilet rooms and bathrooms shall not be utilized for storage or purposes other than those indicated in Item (4) of this Rule; (11) Toilets and baths shall be well lighted and mechanically ventilated at two cubic feet per minute. The mechanical ventilation requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation; (12) Non-skid surfacing or strips shall be installed in showers and bath areas; and (13) The floors of the bathrooms and toilet rooms shall have water-resistant covering. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure 3 of the 5 common resident bathrooms, used by the 19 residents of the facility, provided privacy as evidenced by the locks on the doors not operating , doors to bathrooms did not shut completely or no signs indicating the bathroom was occupied. The findings are: During the initial tour on 11/25/14 a confidential resident interview revealed: -Locks don't work on all the bathroom doors. -Resident had been walked in on in the bathroom. -They had never told the Administrator, or any other staff about the locks not working. -Resident was aware of at least one lock that did not lock, but did not know about any of the others.	D 050	Several locks were tightened and that fixed the problem. Two locks were replaced.	12-30-14

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D 050	Continued From page 2 Observation on 11/26/14 of the facility revealed the following: -Five common bathrooms in the facility for resident use. -Out of the five common bathrooms three did not lock. -Common bathroom between mop room and room four did not lock. -Common bathroom between room four and five did not lock. -Common bathroom between room six and seven did not lock. -The door knobs on the bathroom doors that did not lock were loose. -The bathroom doors did shut securely. -There was no signage on the doors to indicate occupied or unoccupied. Interview on 11/26/14 at 9:45 am with the Administrator in Charge revealed: -He was not aware of any bathroom doors that did not lock. -No residents or staff had ever told him about the doors not being able to be locked. -He was not aware that the bathroom doors had to be lockable. -He was responsible for maintenance issues in the facility. -He would get the bathroom door locks fixed. Confidential interview with a resident revealed they did not know the doors locked, however, they had never had a problem with anyone walking in on them. They always knocked on the bathroom door before entering. A confidential interview with a second resident revealed they did not care if the bathroom doors locked or not.	D 050	I will keep a check on this problem so that it will not happen again. Will also encourage residents to shut doors while using the restrooms. maintenance DOP to begin 1-7-15	

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D 050	Continued From page 3 A common confidential interview with two residents revealed the bathroom doors not being able to lock did not bother them because people knocked to see if anyone was in the bathroom. A confidential staff interview revealed the following: -They did know that some of the bathroom doors did not lock. -They had not told the Administrator about the doors not locking. -No resident had ever spoken with them about privacy issues concerning the bathrooms. A second confidential staff interview revealed the following: -They were not aware that the bathroom doors did not lock. -No resident had ever told them about the bathroom doors not locking. -They had never seen another resident walk in on another resident in the bathroom.	D 050		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure ceilings, walls, and floors were clean and in good repair in 1 of 1 dining room, 4 of 4 common one-half baths, 1 of 1 shared	D 074		

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D 074	Continued From page 4 bathroom, and 3 of 12 resident rooms. The findings are: Observation of the facility during tour on 11/25/14 between 8:50am and 10:00am revealed the following: - A large area, approximately 2 feet by 2 feet, of missing and broken tiles in the right corner floor of the dining room. - A broken floor tile with 20% of the tile missing in the center of the room in resident room #7. - A hole in the sheetrock behind the door in the common half-bath beside room #7. - Peeling paint behind the commode and sink in the common half-bath beside room #7. - Large discolored areas (light green) on the walls (purple) of common shower bathroom across from room #7. - Missing baseboard tile in the common shower bathroom across from room #7. - Peeling paint behind the commode and sink in the common half-bath beside room #10. - A hole in the sheetrock behind the door in resident room #5. - Broken baseboard tile in the common tub bathroom beside resident room #5. - A build-up of mold at the head of the bathtub in the common bath beside resident room #5. - Peeling paint behind the commode and sink in the common half-bath beside room #11. - An irregularly shaped area of peeling popcorn ceiling approximately 8 inches by 4 inches in the common shower bathroom across from room #7. - The right sink in the shared bathroom between rooms #1 and #2 was heavily rusted around the edges encompassing one-third of the edge of the sink. - There were several large areas of peeling paint in the shared bathroom between rooms #1 and	D 074	[redacted] [redacted] from [redacted] Drywall is coming to facility on Jan. 5th to repair all holes and cracks. [redacted] [redacted] is replacing the floor tiles and [redacted] [redacted] from [redacted] Plumbing is replacing the sinks [redacted] [redacted] will paint where necessary. DSP will ✓ on materials. KGN Coleman	1-5-15 1-31-15

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D 074	Continued From page 5 #2. - Two missing ceramic tiles on the walls of the tub area in the shared bathroom between rooms #1 and #2. - A semi-circular shaped area of peeling popcorn ceiling approximately 4 inches by 8 inches above the tub in the shared bathroom between rooms #1 and #2. - A heavy buildup of mold and discolored caulking all around the top of the bathtub in the shared bathroom between rooms #1 and #2. - A heavy buildup of dirt on the floor around the commodes in 3 of 4 common half-baths. Interview with a resident, who resides in one of the rooms with broken tile on 11/25/14 at 9:00am revealed: - Staff clean his room and the bathrooms every day except on weekends. - The broken floor tile in the center of his room had been that way "as long as I've been here," (3 years.) Interview with a resident, who resides in one of the rooms with holes in the sheet rock on 11/25/14 at 9:35am revealed: - He had lived in the facility "6 or 7 years." - The hole in the wall behind the door (in his room) "had been there since I got here." - He had not told anyone about it (the hole in the wall), but "everybody knows about it. " - As far as he knows, they (staff) have never tried to fix the hole in the wall behind his door. - The hole didn't really bother him. - He was not sure how long the paint had been peeling off the bathroom walls. - The peeling paint in the common bathrooms bothered him, but he hadn't told any staff about it, because "they know."	D 074		

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D 074	Continued From page 6 Interview with the facility housekeeper at 9:55am on 11/25/14 revealed: - The bathrooms had "always been that way," i.e. disrepair. - She had worked at the facility for 10 years. Interview with the facility Director of Operations at 11:45am on 11/26/14 revealed: - The hole in the wall in the bathroom beside resident room #7 had been patched numerous times. - The facility did not have full time maintenance staff. - Repairs are made in the facility as quickly as possible when they are reported by staff or residents. - He had someone coming to replace the flooring in the bathrooms and dining room. Review of the facility's sanitation report dated 11/12/14 revealed: - Demerits for floors, walls, and ceilings not in good repair. - Demerits for toilets, handwashing, laundry, and bathing facilities not in good repair.	D 074		
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 A2 VIOLATION Based on observation, record reviews and	D 338		

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D 338	Continued From page 7 interviews, the facility failed to assure Resident #4 was free of exploitation as evidenced by Resident #4 providing housekeeping care and some personal care for the facility Administrator at the Administrator's home. The findings are: Review of Resident #4's current FL-2 dated 6/24/14 revealed: - Diagnoses that included paranoid schizophrenia. - Medication orders included: Ativan 2 mg twice daily, Depakote 500 mg 2 at bedtime, Haloperidol 10 mg at bedtime, Trazadone 150 mg at bedtime (Ativan is prescribed for treatment of anxiety disorders, Depakote is prescribed for treatment of manic episodes of bi-polar disorders, Haloperidol is prescribed for treatment of acute schizophrenia, and Trazodone is prescribed for treatment of anxiety, sleep and depression.) Review of Resident #4's care plan dated 6/3/14 documented the resident required supervision in eating, bathing, dressing, grooming and moderate assistance with medication monitoring and administration. Review of Resident #4's resident register revealed a date of admission of 8/31/09. Further record review revealed Resident #4 received mental health services and did not have a guardian. During survey conducted 11/25/14, Resident #4 was interviewed during tour of the facility at 8:45 am and revealed: - She had lived at facility for 5 years. - She stayed overnight at home of the	D 338		

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D 338	Continued From page 8 Administrator. - She performed housework in the home of the Administrator. Observation of food service on 11/25/14 at 12:00 pm revealed: - Resident #4 took plate of food out of facility and across the road to Administrator's house. - Resident #4 returned to facility to eat lunch with other residents. Interview with Director of Operations (DOP) on 11/25/14 at 2:15 pm revealed: - He was aware that Resident #4 had been taking meals to Administrator and had stayed some at night with the Administrator at her home for about 6 weeks. - Resident #4 was taking meals and staying at night for a couple of weeks before Director of Operations became aware. - The DOP did not feel Resident #4 should be doing these tasks and was not consulted by Administrator. - The DOP and the Administrator are family members. Interview with Resident #4 on 11/25/14 at 2:40 pm revealed: - "Administrator was old and had been sick." - Resident had been staying at the Administrator's home every night for last couple of months. - Resident swept, mopped kitchen floor, turned mattress over and changed sheets for the Administrator. - Resident sometimes dusts, but "does whatever Administrator needs to be done." - Administrator bought resident a carton of cigars the other day. - Resident was not paid for staying with Administrator or cleaning her home.	D 338		

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D 338	Continued From page 9 - Resident takes breakfast, lunch, and supper to Administrator's home daily. - Resident goes over to Administrator's home around 6:30 pm after receiving her nighttime medications and stays until 5 am or 6 am the next morning. - Resident slept in a "supply room" on one side of king sized bed. - Administrator told Resident #4, "a black man broke into my home one time and held me at gun point," and that was the reason the Administrator was scared to stay alone at night. Interview with Administrator on 11/25/14 at 4:25 pm revealed: - Administrator knew she was not supposed to have Resident #4 stay in her home. - Administrator had someone (a resident) stay with her a few times before Resident #4, but stopped that. - Resident #4 brought food from the facility three times daily across the road to the home of the Administrator for the Administrator's consumption. - Resident #4 had mopped the floor but "doesn't do a whole lot of work." - Resident #4 had washed dishes "one or two times but leaves water running wide open" and the Administrator would rather wash the dishes herself. - The Administrator doesn't depend on Resident #4 for a "whole lot." - Resident #4 heard Administrator talk about hiring someone to stay with her and Resident #4 offered to stay and help. - Administrator felt safer when Resident #4 stayed with her. - Administrator bought Resident #4 cigarettes "maybe two times and a co-cola." - Administrator was sick with diarrhea a couple of	D 338		

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D 338	Continued From page 10	D 338		

weeks ago and Resident #4 got up during night and "helped clean me up."
- Administrator gave Resident #4 food sometimes while she staying in the Administrator's home.
- Administrator does not pay Resident #4 for staying or assisting with household duties.
- Administrator allows Resident #4 to sleep in a bedroom near the Administrator's bedroom.
- The bedroom Resident #4 slept in is also used for storage of chemicals (cleaning agents) to be used in the facility as needed.
- The Administrator felt safer at night having someone stay overnight as her home had been broken into and she was held at gun point about 10 years ago.
- Resident #4 left Administrator's home around 5 am or so.
- The Administrator was still in bed when resident left in the mornings.

Observation of the bedroom located in Administrator's home where Resident #4 slept revealed:
- Resident #4 can only sleep on one side of the bed because the other side was covered with pillows.
- The room had multiple shopping bags filled with dish detergent, Ajax, and Pine-Sol located on the floor.
- Multiple containers of Clorox bleach, laundry detergent, and isopropyl alcohol were located on the floor.

Interview with Resident #4 at 10:26 am on 11/26/14 revealed:
- Resident #4 stated "I'm glad not to have to stay with Administrator now," and "I don't want to feel responsible for Administrator."
- Resident #4 stated no longer having to stay with the Administrator at night "took a load off my

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D 338	Continued From page 11	D 338		

mind."
- Resident #4 stated she had been taking bedtime medications at 6:30 pm and then going over to Administrator's home. (Per review of the resident's medication administration record, the evening medications were scheduled for 7 pm.)
- The medications made Resident #4 sleepy and she has to go straight to bed.
- Resident #4 worried she would not be able to hear Administrator during night if she called for assistance due to her medications.
- Facility staff washed Resident #4's clothes, assisted her with bathing, and administered her medications.
- Resident #4 stated she once needed an as needed (PRN) medication (Ibuprofen 800mg) during night, had to cross the road from Administrator's home and come into facility at 3 am to obtain the needed medication. (Ibuprofen is a medication used to treat pain and inflammation.)
- Resident #4 began staying with Administrator when Administrator was sick.
- The Administrator called the facility, asked facility staff to send someone to come and help her. Resident #4 offered to to go and help the Administrator.
- The Administrator called out at night for assistance from Resident #4 when needed, (in the Administrator's home.)
- The resident had taken Administrator water during night.
- The resident had to get up and clean Administrator when Administrator had diarrhea and "messed all over everything."
- Resident #4 stated, "I don't know what I would have done if I woke up and Administrator was dead. I worried about that a lot."
- The resident did not tell anyone she worried about helping Administrator because "I felt sorry"

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D 338	Continued From page 12 for Administrator. - Resident #4 would rather someone else be responsible for taking food to Administrator 3 times daily. Per observation on 11/25/14, the Administrator's home was approximately 50 yards from the from the entrance to the facility across a secondary, dead end state maintained road. Review of Resident #4's psychiatric progress note dated 10/18/14 revealed: - Resident complained of mild anxiety, "best described as restless." - The duration of these symptoms was "a few months." - Onset of symptoms was gradual and constant. - The resident had no findings or symptoms of depression, psychosis, mania, or irritability. - The resident's mood appears to be content, and resident was oriented to place, time, and situation. - The resident's memory seemed intact. - The resident had a fair insight and judgement appears to be fair. - No medication changes were made at this time. - The nurse practitioner encouraged the resident to participate in physical and cognitive leisure activities. - The nurse practitioner recommended increasing social interaction to help with mood, anxiety, and cognition. An attempt to contact the psychiatric nurse practitioner prior to exit from the facility was unsuccessful. _____ On November 25, 2014, the facility provided the following plan of protection:	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 13 - Resident #4 will only be allowed to visit the Administrator. - Resident #4 will no longer be able to spend the night at the Administrator's home. - Resident #4 will not perform any household chores for the Administrator. - No other residents will be allowed to do what the current resident (#4) had been doing for the Administrator. THE DATE OF CORRECTION FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2014.	D 338	No residents will be allowed or asked to help the Administrator or any other staff member in any way that may be considered exploitation. Resident #4 has not been exploited in any fashion since the survey. I, Kevin Wellmon - AIC, will also assure this will not happen again.	11-26-14
D914	G.S. 131D-21(4) Declaration of Residents' Rights 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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure Resident #4 was free from exploitation by the Administrator of the facility. The findings are: Based on observation, record reviews and interviews, the facility failed to assure Resident #4 was free of exploitation as evidenced by Resident #4 providing housekeeping care and some personal care for the facility Administrator at the Administrator's home. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights, (Type A2 Violation.)]	D914		

Shook, Linda

From: Shook, Linda
Sent: Thursday, January 08, 2015 12:42 PM
To: Tom Ensley (Tom.Ensley@clevelandcounty.com)
Cc: Davis, Harold; Burns, Pam S
Subject: OPENVIEW RETIREMENT HOME - CLEVELAND COUNTY
Attachments: Openview Retirement 2014-12-30 POCA-3Z5N11.pdf

Please find attached copy of the approved "Amended" Plan of Correction (POC) for the above referenced facility.

Thank you.

Linda Y. Shook, Processing Assistant
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Division of Health Service Regulation
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