

Division of Health Service Regulation



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2017
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NAME OF PROVIDER OR SUPPLIER
MCDOWELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
**1687 DAIRY ROAD
NEBO, NC 28761**

(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 McDowell County Department of Social Services conducted an annual survey and complaint investigation from March 28, 2017 to March 31, 2017.	D 000		
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 floors were kept in good repair in the main hallway, entrance to the main dining room, entrance to the tub room, and in rooms #102 and #103. The findings are: Observations during initial facility tour on 3/28/17 from 8:35am to 10:45am revealed: -In the shared bathroom off resident room #102, there was a 12 inch wide by 12 inch long ceramic tile with a 6 inch crack running diagonally in the tile in the entry of the bathroom. -The vinyl floor covering at the entrance to the tub room had two areas that were 1 inch wide by 1 foot long where the vinyl was worn away revealing the black under side of the vinyl. There was also a 1 inch wide by 1 foot long area of missing laminate flooring at the entrance to the bathroom. There was a second 1 inch wide by 6	D 074	<u>D074 To Correct:</u> The ceramic tile in the shared bathroom off Resident Room 102 will be repaired/replaced so there is NO crack in the tile. The Vinyl floor covering at the entrance to the tub room will be repaired/replaced so that it will not reveal the black underside of the vinyl. The missing laminate flooring at the entrance of the bathroom will be replaced. The long section of missing laminate (also at the entrance of the tub room) will be replaced. The laminate flooring in the hallway adjoining the medication room, Resident Care Coordinator's office, And laundry room will be repaired so there will be no trip hazards. The laminate flooring in the hallway outside hallway adjoining the medication room will be repaired so there will be no trip hazards. The laminate flooring at the entrance to the bathroom that was buckled will be repaired. The laminate flooring that is chipped and damaged outside the main dining room will be repaired. The laminate flooring at the entrance cont.	

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

Debra C. Kirby

TITLE

Administrator

(X6) DATE

5/8/17

STATE FORM

6896

CY5F11

If continuation sheet 1 of 31

REVIEWED and Accepted

Cathy Fitzgerald 5/17/17

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D 074	Continued From page 1 inch long section of missing laminate also at the entrance to the tub room. -The laminate flooring in the hallway adjoining the medication room, Resident Care Coordinator's office, and laundry room had too many to count areas of chipped laminate flooring posing a trip hazard to residents, staff, and visitors. -The laminate flooring in the hallway outside hallway adjoining the medication room had two pieces of laminate flooring with one broken edge on each piece of flooring posing a trip hazard to residents, staff, and guests. -The laminate flooring at the entrance to the bathroom in resident room #109 was buckled in an area 1 foot long which appeared to be due to water damage. -The laminate flooring was chipped and damaged in an area 1 inch wide and 3 inches long at the entrance to the main dining room. -The laminate floor at the entrance to room #102 was damaged and missing in one section 1 inch wide by 1 foot long and a second section 0.5 inches by 3 inches long section. -The laminate flooring in the hallway outside room #103 had a section 0.5 inches wide by 3 inch long section of missing laminate flooring. Interview with the housekeeper on 3/30/17 at 10:44am revealed: -The cracks in the floors had "been like that since I've been here." -She was hired in November 2016. Telephone interview with facility Maintenance on 3/30/17 at 1:20pm revealed: -He was maintenance for the four facilities. -He was normally in this facility one day each week to address routine work orders. -When facility staff noticed something in the facility needed repair, they would put in a work	D 074	D074 - correction cont! to room 102 that is damaged and a section missing will be repaired/replaced. The laminate flooring in the hallway outside room 103 that is missing will be replaced. <u>To Prevent:</u> The Manager will do a <u>monthly</u> walk-thru of the entire building to discover damaged flooring and report to Administrator in writing for repair. <u>To Monitor:</u> The Administrator / Administrator Designee will do <u>quarterly</u> walk-thru of the building to discover damaged flooring. <u>Completion Date:</u> 6/24/17		

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D 074	Continued From page 2 order to the main office. -He was aware of some damaged areas of laminated flooring in the facility. -"When the issues are brought to my attention, I take care of it as soon as I can." -"The finish comes off where the laminate gets wet." -"I just replace sections of it." -He had to manage routine work orders along with his other projects in all four facilities. -The main office usually prioritized his work orders and projects. Interview with an Administrator from a sister facility on 3/31/17 at 9:50am revealed: -"If something breaks down, we have work order forms." -"We send the filled out form to the main office." -If a maintenance emergency occurred, "we call the office and they will send someone." Interviews with 16 out of 22 residents revealed none of the residents had any complaints concerning the condition of flooring throughout the facility.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 maintain the furniture in good repair in 4	D 076	<u>D076 To Correct:</u> The drawer in the three drawer chest in Room 103 will be repaired and the drawer placed back on track so the drawer will slide in and out to access the contents inside the drawer easily. In Room 103 the drawer pull on the six drawer dresser will be replaced. In Room 103 the drawer pull on the two drawer night stand will be replaced. In Room 106, regarding the three drawer chest: the drawers will be repaired and placed correct.	

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D 076	Continued From page 3 of 9 occupied resident rooms. The findings are: Observations on 3/28/17 during the initial facility tour from 8:35am to 10:40am revealed: -At 8:58am, in resident room 103, there was a three drawer chest where all of the drawers were off track and difficult to slide in and out to access the contents inside the drawers. -At 8:58am, in resident room 103, there was a six drawer dresser that was missing a pull from the second drawer down on the right side. -At 8:58am, in resident room 103, there was a two drawer night stand that was missing the left side drawer pull from the top drawer. -At 9:03am, in resident room 106, there was a three drawer chest positioned at the windows and all of the drawers were off track and difficult to slide in and out to access the contents inside the drawers. On the same chest, the cabinet door had a 1 inch wide by 6 inch long area of white paint discoloring the finish of the cabinet door. -At 9:03am, in resident room 106, there was a six drawer dresser to the right of the entrance to the bathroom that was missing a pull off the top left drawer. -At 9:04am, in resident room 106, there was a two drawer night stand that was missing the left side drawer pull from the bottom drawer. Observations on 3/30/17 at 10:02am to 10:03 am revealed: -At 10:02am, in resident room 109, there was a six drawer chest to the left of the entrance. The second drawer on the left side of the chest was off track and was missing a pull on the left side. -At 10:03am, in resident room 109, there was a two drawer night stand with the bottom drawer off track and difficult to slide in and out to access the	D 076	D076- continued back on track so they will slide in and out easily to access the contents of the drawer and the white paint that is discoloring the finish will be removed. In Room 106 the drawer pull missing from the six drawer dresser will be replaced. In Room 106 the drawer pull missing from the two drawer night stand will be replaced. In Room 109 the drawer that is off track on the six drawer chest will be repaired and placed back on track and the drawer pull that is missing will be replaced. In Room 109 the drawer that is off track in the two drawer night stand will be repaired and placed back on track so the contents of the drawer are easily accessible. In Room 105 the drawer that D076- continued		

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D 076	Continued From page 4 contents inside the drawer. Observations of resident room 105 on 3/28/17 at 8:55am revealed the top drawer on the two drawer night stand closest to the outside wall was off track. Telephone interview with facility Maintenance on 3/30/17 at 1:20pm revealed: -He was maintenance for four facilities. -He was normally in this facility one day each week to address routine work orders. -He was not aware of the missing drawer pulls and drawers being off track in rooms 103, 105, 106, and 109. -The "tracks" for the drawers in the chests and dressers would "wear out" and "if one guide is broke then they get off track." -"All that furniture was fixed last year. Everything you are telling me has been broken in the past year." -"I'll go room to room and check every piece of furniture in there." -When facility staff noticed something in the facility needed repair, they would put in a work order to the main office. -He had to manage routine work orders along with his other projects in all four facilities. -The main office usually prioritized his work orders and projects. Interview with the facility Manager on 3/28/17 at 3:50pm revealed: -She was unaware of the missing drawer pulls and drawers being off track in rooms 103, 105, 106, and 109. -She would put in a work order to the main office for Maintenance to repair the furniture. Interview with an Administrator from a sister	D 076	D076- continued is off track in the two drawer night stand will be repaired and placed back on track so the contents of the drawer are easily accessible. <u>To Prevent</u>: The Manager will conduct a <u>monthly</u> walk-thru of the entire building to locate any problems with drawer pulls that are missing and drawers that are not on track. <u>To Monitor</u>: The Administrator/Administrator Designee will conduct a <u>quarterly</u> walk-thru of the building to locate any missing drawer pulls and drawers that are not on track. Completion Date: 6/24/17	

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D 076	Continued From page 5 facility on 3/31/17 at 9:50am revealed: -"If something breaks down, we have work order forms." -"We send the filled out form to the main office." -If a maintenance emergency occurred, "we call the office and they will send someone." Interviews with 8 out of 12 residents residing in rooms 103, 105, 106 and 109 revealed none of the residents had any complaints concerning the condition of the furniture in their rooms.	D 076		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision in accordance with assessed needs and current symptoms for 1 of 4 sampled residents (Resident #7). The findings are: Review of Resident #7's current FL2 dated 6/30/16 revealed: -Diagnoses included dementia, hypertension, and a transurethral resection of the prostate for benign prostatic hyperplasia.	D 270	<u>D270</u> <u>To Correct</u> : Resident #7 was discharged from the facility on 4/26/17 to prevent any further display of inappropriate behavior. <u>To Prevent</u> : Staff will monitor All Residents <u>daily</u> for behaviors And address behaviors on an AS-needed basis. <u>To Monitor</u> : The Manager and the Resident Care Coordinator will Review shift notes,	

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D 270	Continued From page 6 -The resident was intermittently disoriented and ambulatory. Review of Resident #7's Care Plan dated 7/8/16 revealed: -The resident was ambulatory with aide or device, sometimes disoriented, and forgetful needing reminders. -The resident was totally dependent on staff for bathing and grooming/personal hygiene. -The resident required extensive assistance with toileting and limited assistance with transfers. Interview with the Facility Manager on 3/30/17 at 11:40am revealed: -Resident #7 was currently on 15 minute checks "for a filthy mouth" and to "make sure he's not mean to the other residents." -"To keep him from verbally bullying other residents." 1. Review of Resident #7's Mental Health Provider note dated 3/28/17 revealed: -"Patient is treated for dementia with behavioral disturbance, insomnia, depression and anxiety." -"Per staff report, patient continues to display overtly sexual behavior and makes sexual commentary to women." Interview with Resident #6 on 3/30/17 at 11:10am revealed: -A male had "put his hand down my pants." -"I told him to stop. I forgot his name now. I pushed him away." -She had not reported the incident to staff. -"It happened in my doorway." -A male had put his hand down her pants on 3 different occasions. -Resident #6 denied being scared by the incidents.	D 270	D270 - continued behavior notes, and accident/incident reports <u>daily</u> to identify behaviors. The Manager and the Resident Care Coordinator will communicate with staff during monthly staff meetings to discuss behaviors. Identified behaviors will be addressed through contact with the appropriate mental health or medical professional. Completion Date: 4/26/17		

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D 270	Continued From page 7 Observation of Resident #7 standing in the hallway outside resident room #105 on 3/30/17 at 4:25pm revealed: -He was carrying a book and approached Resident #6 to talk to her. -Resident #6 then walked down the hall towards the facility vending machine room. -Resident #7 followed along behind Resident #6 as she walked down the hall. Interview with one Personal Care Aide revealed: -Resident #7 "is always following the women around." - "He tends to follow [Resident #6's name] when she's not in her right mind." - "He asks her if he can look down her shirt or go down her pants." - "I've heard him say these things." - "I have seen him put his hands on [Resident #6's and another female resident's name] bottoms." -Resident #6 "doesn't know what's going on and doesn't want" Resident #7's advances. - "Pretty much all of us have seen it and heard it and we try to keep the residents separated." -The inappropriate touches and comments had been reported to the Facility Manager "the first time it happened" after he "first got here." -Resident #7 "was talked to and asked not to do it anymore." -Resident #7 "still makes comments even though he's been talked to, but when we say something to him he acts like he doesn't remember." Interview with Resident #7's Primary Care Nurse Practitioner on 3/30/17 at 2:20pm revealed: -Facility staff had notified him of Resident #7's "lewd comments, but not about touching." - "He was making comments "to staff and other residents."	D 270		

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D 270	Continued From page 8 -The resident's psychiatric provider "pretty much handles that." -Issues concerning Resident #7's inappropriate behavior had been reported to the Nurse Practitioner within the last 3 weeks during one of his visits. Interview with the Facility Manager 3/30/17 at 2:32pm revealed: -She was aware upon admission Resident #7 had a history of inappropriate sexual behaviors. -"In the beginning, he was a handful." -He would "flirt" with the women and "talk dirty" to them. -We would "redirect" him. -"He's still on 15 minute checks due to his history." -"As far, as I know, he's not being inappropriate with any residents anymore." -"Nothing's been reported to me recently." -"Staff did not report him touching" Resident #6 or a second female resident "on the bottom." Telephone interview on 3/31/17 at 3:21pm with Resident #7's Guardian revealed: -"I was told about his inappropriate comments and that he would target certain individuals." -"I didn't know about him touching anyone." -She knew the facility staff were redirecting Resident #7 when his behaviors were inappropriate. -She knew Resident #7 had been talked to about his behaviors. -She knew the resident was on 15 minute checks. Interview with the Facility Manager on 3/30/17 at 2:32pm and at 4:00pm revealed: -Resident #7 was on 15 minute checks. -Resident #7 was "kinda mean to other residents like he unplugs his roommate's oxygen	D 270			

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D 270	Continued From page 9 concentrator because it's too loud." -The roommate who had his oxygen concentrator unplugged was Resident #8. -Resident #7 had not had any incidences recently of unplugging the oxygen concentrator. -Staff were checking that the oxygen concentrator was operational on their rounds. -Staff did rounds every 30 minutes at night. -"We have talked to the Guardian about his behavior and comments." 2. Review of Resident #8's current FL2 dated 3/16/17 revealed diagnoses included chronic obstructive pulmonary disease, shortness of breath, and pneumonia. Review of a physician's order for Resident #8 dated 3/17/17 revealed oxygen at 2 liters per minute nocturnal every day at bedtime. Interview with Resident #8 on 3/31/17 at 9:20am revealed: -"After I came back from the hospital they put me on oxygen at night" after a recent hospitalization due to pneumonia. -"Sometimes I need it and sometimes I don't." -Resident #7 "did unplug my radio and my oxygen. Happens all the time." -"Staff did check to see if my oxygen was plugged up a time or two." -"Usually, I just plug it back up." Interview with Resident #8's Nurse Practitioner on 3/31/17 at 9:35am revealed: -"I would like for him to have it, but he's non-compliant with oxygen a lot of the time himself." -"His oxygen saturation was good at his last visit I had with him last week." -In his opinion, it was not detrimental for Resident	D 270		

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D 270	Continued From page 10 #8 to have gone without his oxygen. -He recommended if the oxygen concentrator was too loud that it could be plugged up in the hallway outside the room and just run a longer cord for the nasal cannula if it was disturbing other residents sharing the room. Telephone interview on 3/31/17 at 3:21pm with Resident #7's Guardian revealed: -"I was aware of the verbal bullying." -She was unaware that Resident had a been unplugging "...his roommate's oxygen machine." Interview with one evening shift personal care aide on 3/30/17 at 4:30pm revealed: -Staff checked on all residents "every 30 minutes" during the evening shift. -She had never found Resident #8's oxygen concentrator unplugged. A plan of protection was received from the facility on 3/30/17 as follows: -The facility will continue 15 minute checks and monitor more closely Resident #7. -Resident #7 has been under the care of Mental Health Provider and will continue to be followed by Mental Health provider. -Resident #7 has been under the care of a Primary Care Provider and will continue to be followed by the Primary Care Provider. -The Facility Manager will coordinate with the County Department of Social Services and Guardian to discharge for safety of others. -Arrangements will be made for placement in another facility. -Will address issues with all employees to monitor more closely to prevent incidents of inappropriate behaviors.	D 270			

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D 270	Continued From page 11 The facility failed to assure Resident #7 was supervised in accordance with his past history and current symptoms of inappropriate sexual behaviors and known unplugging of oxygen equipment of another resident. The facility's failure to supervise in accordance with Resident #7's needs exposed Resident #6 to sexual harassment and Resident #8 to not getting prescribed continuous oxygen treatment at night which was detrimental to the health, safety, and welfare of Residents #6 and #7. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 15, 2017.	D 270			
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: Based on observations, interviews and record reviews the facility failed to assure 14 residents received the 2:00pm scheduled snack by purchasing a drink (\$0.60) and snack item (\$0.50) from onsite vending machines and charging the \$1.10 to their personal account. The findings are:	D 338	<u>D 338 To Correct:</u> Snacks for All Residents will be provided in the Dining Room by the facility cooks at 10am, 2pm, And 7:30 pm. <u>To Prevent:</u> The Manager or Supervisor-in-Charge will monitor all snack times daily to ensure that all residents are offered a snack at the appropriate times. <u>To Monitor:</u> The Administrator/ Administrator Designee will monitor snack times at least quarterly to ensure all residents		

D 338 continued

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/31/2017
NAME OF PROVIDER OR SUPPLIER MCDOWELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1687 DAIRY ROAD NEBO, NC 28761			
(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 12 Review of facility's census records revealed a daily census of 22 residents from 3/28/17 to 3/31/17. Review of the facility's 2017 "store account" log revealed: -There were 14 residents listed on the store account log for January, February and March, 2017 who were charged \$1.10 per day for a drink and snack. -The logs were organized into weeks beginning the week of 12/30/16 through the week of 3/20/17 (8 weeks). -Of the 14 residents, 7 were charged \$7.70 per week (daily), 7 were charged \$4.40 per week for 4 weeks and \$3.30 for 4 weeks (every other day). Observations on 3/28/17 at 1:45pm and 3/29/17 at 1:50pm revealed: -The cooks were asking residents what drink and snack they wanted for their 2 o'clock snack. -The cooks purchased drinks and snacks from the onsite vending machines. Observation on 3/29/17 at 2:05pm revealed staff rang a cow bell and yelled out "store call" to notify residents it was snack time. Observations on 3/30/17 of the cook revealed: -At 1:57pm the cook was at the snack vending machine, referenced the store credit list, placed \$1 in the machine and purchased a snack item. -At 2:03pm the cook moved to the drink machine and repeated the process. -At 2:11pm the cook delivered a drink and snack to a resident in their room, then went to the dining room, placed the drinks and snacks at the each resident's table. -At 2:17pm a resident announced in the hallway, "store call day room". All residents went to the	D 338	<i>D338- continued</i> <i>are receiving appropriate snacks at the designated times. Resident interviews will be conducted.</i> <i>Completion Date: 3/31/17</i>		

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D 338	Continued From page 13 dining room and had their "store credit" drink and snack or a snack provided by the facility. Interview with the Cook on 3/30/17 at 2:25pm revealed: -Snack time was 3 times per day, at 10:00am, 2:00pm and 7:30pm. -Store call was at 2:00pm everyday. -It was the cook's responsibility to manage "store call". -The residents used to receive the money and purchase their own drink and snack. -The facility changed it because residents on special diets would not purchase the correct drink and snack. -They "had trouble because a pureed (diet) resident would purchase potato chips." -It had been "quite a while" since the cook started purchasing the drinks and snacks. -If a resident did not want a drink or snack from the vending machine [was not on store call], cook would provide them with a drink and snack. -There were "13 residents today for store call and tomorrow there will be 8 residents". -She did not know what determined the number of residents who had store call on a day to day basis. -The cook had a list from the Facility Manager and they would go to each resident, ask what they wanted from the vending machines and purchase those items for them. -The cook received money from the Facility Manager. -If any resident was still hungry, they "would provide" something else for them to eat. Interview with the second cook on 3/31/17 at 9:15am revealed: -Snack time was 3 times per day, at 10:00am, 2:00pm and 7:30pm.	D 338			

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D 338	Continued From page 14 -Store call was at 2:00pm everyday. -The cooks managed store call and were responsible to assure residents on a special diet received an appropriate snack. -They used to give the residents store call (\$1.10) at 2:00pm but it had now changed to its current method. -The current method was "easy, efficient and without resident congestion" (around the vending machines). -The current method is where the cooks will purchase the drink and snack for those residents participating in store call. -This started during the "summer of 2016". -She had been working at the facility for 3 years and there had always been store call. -If a resident did not want store call, then they would provide the resident with a snack and drink. Interview with an Administrator from a sister facility on 3/31/17 at 9:50am revealed: -Store call had been "happening for years". -The facility provided snacks for the residents. Interview with the Facility Manager on 3/30/17 at 3:15pm revealed: -Snack time was 3 times per day, at 10:00am, 2:00pm and 7:30pm. -Store call was at 2:00pm everyday. -The "cook does store call and snacks in the dining room". -Store call "is where they (residents) get their \$1.10, if they have it". -The facility provided snacks so "no one goes without" [a snack]. -When going on outings residents could purchase their own snacks and have at snack time. -She discussed with the new residents if they wanted to participate in store call either daily or	D 338			

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D 338	Continued From page 15 every other day. -If they did she set up a log for them and would give a weekly log to the kitchen staff. -She "goes over (store call) almost daily" with the residents. -Store call had been going on for "at least 10 years". -"If a resident wanted to keep the \$1.10 in their pocket, they can keep it in their pocket." Confidential interviews with five residents during the initial tour on 3/28/17 revealed: -3 of 5 residents reported receiving snacks everyday at 10am, 2pm, and 7:30pm. -Snacks are offered "sometimes twice" a day. "They don't always offer a snack but, I guess it's there if I wanted it." -"We have snacks everyday." Confidential interviews with six residents regarding the 2:00pm store call snack revealed: -"I get a drink and a cookie everyday at 2 o'clock." -"It wouldn't cost as much for the drinks and snacks if I could buy them elsewhere." -One resident was given store call "every other day and he liked it. It's okay the way it is." -One resident was "happy" with store credit. -Another resident liked the drink and snack at 2:00pm. -One resident "liked it the way it was".	D 338		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the	D 421	<u>D421 To Correct:</u> Management of Resident Funds will be conducted in the facility by the Manager of the facility. Residents are currently signing for every transaction made on their personal financial ledgers. <u>To Prevent:</u> The Manager will ensure <u>daily</u> that all cost	

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D 421	Continued From page 16 resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a record of each transaction involving the use of the resident's personal funds was maintained in the home and was signed by the resident and two witnesses at least monthly verifying the accuracy of the disbursements for 3 of 4 sampled Special Assistance residents (Resident #2, #3, and #5) who managed their own personal funds. The findings are: A. Review of Resident #5's current FL2 dated 12/2/16 revealed: -Diagnoses included dementia, borderline intellectual functioning, schizophrenia, chronic kidney disease stage 3, and chronic obstructive pulmonary disease. -The resident was intermittently disoriented. -The resident required extensive assistance with bathing, feeding, and dressing. Review of Resident #5's Resident Register signed 4/18/06 revealed: -The resident was admitted on 4/18/06. -The resident was his own responsible person. -The resident had signed next to the following statement "I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the	D 421	<u>D421</u> - Continued Receipts for money spent by residents are signed and that <u>all</u> ledger entries to withdraw or deposit personal money are signed by the residents. To Monitor: Administrator/ Administrator Designee will review financial records <u>monthly</u> to ensure compliance. Completion Date: 5/31/17		

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D 421	Continued From page 17 right to examine my account or to withdraw this request at any time." Review of Resident #5's 2016 personal funds accounting ledger revealed: -There was a beginning balance of \$1,052.12. -Each month from January 2016 through December 2016, \$66 was posted on the ledger, for a 12 month total amount of \$792. -Each month from January 2016 through December 2016, a pharmacy payment was posted on the ledger, for a 12 month amount of \$216.27. -There were 4 entries posted on the ledger for "cash to store account" (1/4/16, 5/11/16, 6/23/16, and 11/1/16), for a total amount of \$200. -There was documentation in the initial column where the staff member who managed the funds had initialed each entry however, there was no documentation Resident #5 had initialed in agreement or signed as having been seen by the resident. Review of Resident #5's 2017 personal funds accounting ledger revealed: -There was a beginning balance of \$1,470.30 on 1/1/17. -Each month from January 2017 through March 2017, \$66 was posted on the ledger, for a 3 month amount of \$198. -Each month from January 2016 through March 2017, a pharmacy payment was posted on the ledger, for a 3 month amount of \$42.34. -There were no entries on the ledger for "cash to store account" for 2017. -There was documentation in the initial column where the staff member who managed the funds had initialed each entry however, there was no documentation Resident #5 had initialed in agreement or signed as having been seen by the	D 421		

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D 421	Continued From page 18 resident. Review of Resident #5's store account ledger revealed: -There was a beginning balance of \$17.67 on 2/16/16. -The ledger entries began for the week of 2/16/16 to 2/29/16 and the last weekly entry was dated 3/20/17 to 3/26/17. -There were 4 deposits listed on the ledger (5/11/16, 6/30/16, 11/1/16, 12/27/16) totaling \$200. -There were weekly entries for a total spent amount of \$216.10. -The median amount Resident #5 was given most frequently for store purchases per week was \$3.30. -There was documentation in the initial column where the staff member who managed the store account had initialed each entry however, there was no documentation Resident #5 had initialed in agreement or signed as having been seen by the resident. Review of Resident #5's purchase detail ledger for store account disbursement for 1/30/17 to 3/26/27 revealed: -There were detailed entries about what was purchased for each day. -Two staff initials were present verifying each entry. -There was no resident initial or signature on any of the entries. Interview with Resident #5 on 3/29/17 at 12:30pm and 1:30pm revealed: -"Can you buy me a drink?" -"We don't have store call until two o'clock." -"The water is bad here. I haven't had a drink in 4 days."	D 421		

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D 421	Continued From page 19 Observation on 3/29/17 at 2:05pm revealed staff rang a cow bell and yelled out "store call" to notify residents. Interview with Resident #5 on 3/30/17 at 10:36am revealed: -He didn't know if the facility staff showed him how much personal fund money he had or what it had been spent on. -He had never been shown how much his pharmacy bills were by the facility staff. - "I don't get money. I get a drink and a cookie everyday at 2 o'clock." - "I don't get enough money." -He stated he had been taken out by the facility staff to buy a "hamburger and drink." - "I'm alright for clothes. I would like to have a new pair of tennis shoes and a shirt." -The facility had never put a television in Resident #5's room. "I would like a record player. I would like a TV or a record player." - "I usually get to watch TV in the day room, but I would like a radio. I would like to have a couple sweaters." Refer to the interview with the Facility Manager on 3/28/17 at 10:30am and 3/31/17 at 8:45am. Refer to the interview with an Administrator from a sister facility on 3/28/17 at 11:40am. B. Review of Resident #3's current FL2 dated 3/27/17 revealed diagnoses included chronic obstructive pulmonary disease, schizophrenia, and pneumonia. Review of Resident #3's Resident Register signed 3/5/13 revealed: -The resident was admitted on 1/9/12.	D 421			

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D 421	Continued From page 20 -The resident was his own responsible person. -The resident had signed next to the following statement "I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time." Review of Resident #3's 2016 personal funds accounting ledger revealed: -There was a beginning balance of \$1,958.22. -Each month from January 2016 through December 2016, \$251.00 was posted on the ledger, for a 12 month total of \$3,012.00. -Each month from January 2016 through December 2016, a pharmacy payments were posted on the ledger, for a 12 month amount of \$216.27. -There were 5 entries posted on the ledger for "cash to store account" (1/4/16, 2/11/16, 5/11/16, 6/23/16, 11/1/16, 2/1/17) for a total amount of \$810.00. -There was documentation in the initial column where the staff member who managed the funds had initialed each entry however, there was no documentation Resident #3 had initialed in agreement or signed as having been seen by the resident. Review of Resident #3's 2017 personal funds accounting ledger revealed: -There was a beginning balance of \$ 2,283.70 on 1/1/17. -Each month from January 2017 through March 2017 there were entries for personal funds for the amount of \$255.00 for a total of \$765.00. -Each month from January 2016 through May 2016, a pharmacy payment was posted on the	D 421		

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D 421	Continued From page 21 ledger for a 5 month amount of \$76.49. -There was 1 entry on 2/1/17 on the ledger for "cash to store account" for 2017 for the amount of \$100.00. -There was documentation in the initial column where the staff member who managed the funds had initialed each entry however, there was no documentation Resident #3 had initialed in agreement or signed as having been seen by the resident. Review of Resident #3's store account ledger revealed: -There was a beginning balance of \$139.04 on 2/6/17. -The ledger entries began for the week of 2/6/17 to 2/12/17 and the last weekly entry was dated 3/20/17 to 3/26/17. -There was 1 deposit listed on the ledger (\$700.00 3/6/17) totaling \$815.94. -There were weekly entries for a total spent amount of \$7.70 a week. -The median amount Resident #3 was given most frequently for store purchases \$7.70. -There was documentation in the initial column where the staff member who managed the store account had initialed each entry however, there was no documentation Resident #3 had initialed in agreement or signed as having been seen by the resident. Review of Resident #3's purchase detail ledger for store account disbursement for 1/30/17 to 3/26/27 revealed: -There were detailed entries about what was purchased for each day. -Two staff initials were present verifying each entry. -There was no resident initial or signature on any of the entries.	D 421		

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D 421	Continued From page 22 Observation on 3/29/17 at 2:05pm revealed staff rang a cow bell and yelled out "store call" to notify residents. Interview with Resident #3 on 3/30/17 at 11:00 am revealed: -"I get \$1.10, I am not worried about that." -"I am aware of my surroundings." -The resident had no complaints. Refer to the interview with the Facility Manager on 3/28/17 at 10:30am and 3/31/17 at 8:45am. Refer to the interview with an Administrator from a sister facility on 3/28/17 at 11:40am. C. Review of Resident #2's current FL2 dated 12/7/16 revealed: -Diagnoses included dementia with psychosis, Mental Retardation, Paranoid Schizophrenia, Scoliosis and Osteoarthritis. -The resident was documented as constantly disoriented. -The resident was documented as requiring assistance with bathing, grooming and toileting. Review of Resident #2's Resident Register signed 1/6/2012 revealed: -The resident was admitted on 1/6/2012. -The resident was his own responsible person. -The resident had signed next to the following statement "I, as resident or the resident's Legal guardian/payee, request that the management of this home handle my personal funds. I understand that the funds are available for my use during regular office hours and that I have the right to examine my account or to withdraw this request at any time."	D 421			

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D 421	Continued From page 23 Review of a signed statement from Resident #2's Nurse Practitioner dated 3/26/15 revealed: - "Resident has severe psychotic issues and or severe cognitive impairments." - "Resident is in a secure facility and is unable to leave the facility due to being unable to make decisions on their own that assure their safety and prevent others from exploiting them." Review of Resident #2's 2016 personal funds accounting ledger revealed: - There was a beginning balance of \$392.75. - Each month from January 2016 through December 2016, except for October 2016, \$66 was posted on the ledger, for an 11 month total amount of \$726. - The October 2016 entry on the ledger was documented as "no October personal funds". - Each month from January 2016 through December 2016, a pharmacy payment was posted on the ledger, for a 12 month amount of \$308.26. - There were 5 entries posted on the ledger for "cash to store account" (1/4/16, 2/11/16, 5/11/16, 6/23/16, and 11/1/16), for a total amount of \$320. - There was documentation in the initial column where the staff member who managed the funds had initialed each entry however, there was no documentation Resident #2 had initialed in agreement or signed as having been seen by the resident. Review of Resident #2's 2017 personal funds accounting ledger revealed: - There was a beginning balance of \$530.52 on 1/1/17. - Each month from January 2017 through March 2017, \$67 was posted on the ledger, for a 3 month amount of \$201. - Each month from January 2017 through March	D 421		

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STATE FORM

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D 421	Continued From page 24 2017, a pharmacy payment was posted on the ledger, for a 3 month amount of \$86.17. -There was one entry on the ledger for "cash to store account" (3/29/17) for \$60.00. -There was no documentation in the initial column where the staff member who managed the funds had initialed each entry and there was no documentation Resident #2 had initialed in agreement or signed as having been seen by the resident. Review of Resident #2's store account ledger revealed: -There was a beginning balance of \$50.29 on 2/16/16. -The ledger entries began for the week of 2/16/16 to 2/29/16 and the last weekly entry was dated 3/20/17 to 3/26/17. -There were 6 deposits listed on the ledger (5/11/16, 6/23/16, 8/2/16, 8/1/16 to 9/11/16, 11/1/16, 12/27/16) totaling \$358.42. -There were weekly entries for a total spent amount of \$310.24. -The median amount Resident #2 was given most frequently for store purchases per week was \$3.30. -There was documentation in the initial column where the staff member who managed the store account had initialed each entry however, there was no documentation Resident #2 had initialed in agreement or signed as having been seen by the resident. Review of Resident #2's purchase detail ledger for store account disbursement for 1/30/17 to 3/26/17 revealed: -There were detailed entries about what was purchased for each day. -Two staff initials were present verifying each entry.	D 421			

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NAME OF PROVIDER OR SUPPLIER MCDOWELL HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1687 DAIRY ROAD NEBO, NC 28761		
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D 421	Continued From page 25 -There was no resident initial or signature on any of the entries. Interview with Resident #2 on 3/29/17 at 1:53pm and 3/30/17 at 10:00am revealed: -No one had ever gone over his finances with him. -He would like to have someone go over his finances with him. -He did not know how much money he had in his account. -He would like to have "more than \$1.10 per day" (store credit). -Staff would tell him how much money he had when going shopping at a community store. -No one went over with him what bills were paid from his account. -He had never been shown how much his pharmacy bills were by the facility staff. Refer to the interview with the Facility Manager on 3/28/17 at 10:30am and 3/31/17 at 8:45am. Refer to the interview with an Administrator from a sister facility on 3/28/17 at 11:40am. _____ Interview with the Facility Manager on 3/28/17 at 10:30am and 3/31/17 at 8:45am revealed: -The residents personal funds ledgers were not kept in the facility, but at a sister facility. -The Administrator from the sister facility was the one who kept the accounting of the residents personal funds disbursements. -She was only responsible for keeping the records of the store account disbursements to the residents. -If the resident's needed access to more cash to purchase things than the small amounts held in their store credit accounts, she would write a	D 421			

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D 421	Continued From page 26 check for the items the residents wanted to buy at the store and just notify the Administrator at the sister facility to deduct the check amount from the resident's account. -The residents were able to access their store call once everyday at 2pm. -Residents did not sign or initial entries on the store call ledgers. -Residents used their store call accounts to purchase items from the facility vending machines and to purchase cigarettes from the facility. -Limited amounts of cash were on hand in the facility due to a history of a former staff person's embezzlement of resident's funds. -The Administrator had assigned the Administrator from the sister facility to manage the funds because she was family and trusted her. Interview with an Administrator from a sister facility on 3/28/17 at 11:40am revealed: -"I handle the residents accounts for them. I handle their personal funds." -"The residents direct deposit into the [local bank name]." -"Then once the office receives the information both checks for each resident have come in, usually on the 5th or 6th of the month, the main office faxes down to us the list of what each resident received in personal funds." -"Then I enter the amount onto the resident account sheet." -"Then the same day I subtract their pharmacy bills." -"Then throughout the month if [Facility Manager's name] takes them shopping or anything like that or copays for doctor's visits or Medicare Part premiums" were deducted from the personal funds balances.	D 421			

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D 421	Continued From page 27 -"Then the [Facility Manager's name] will call and say so and so wants to go shopping do they have money?" -"They also have a store account. [Facility Manager's name] keeps the store account book." -"Everyday every resident gets \$1.10 to their store account." -"The Facility Manager "goes over [their store accounts] with them so the residents know how much personal fund money they have." -"I then bring the book over for them to sign." -"But to be honest, I don't always get over here every month" for the residents to sign them. -"The records are offsite."	D 421			
D 423	10A NCAC 13F .1104(e) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (e) All or any portion of a resident's personal funds shall be available to the resident or his legal representative or payee upon request during regular office hours, except as provided in Rule .1105 of this Subchapter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure all or any portion of 3 of 4 sampled residents (Resident #2, #3, and #5) personal funds were available to the residents during regular office hours. The findings are: Review of the sampled residents' personal funds accounts was completed on 3/31/17 with the following findings: -Resident #2 had a balance of \$585.35 in his	D 423	<u>D423 To Correct:</u> Residents will have access to funds upon request during regular office hours. <u>To Prevent:</u> The manager will ensure <u>daily</u> that there is enough cash on hand to make personal money available to residents when requested during regular office hours. <u>To Monitor:</u> The Administrator/Administrator Designee will monitor <u>quarterly</u> Resident's cost -		

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D 423	Continued From page 28 offsite account and a balance of \$58.93 in his store call account. -Resident #3 had a balance of \$1,958.22 in his offsite account and a balance of \$799.44 in his store call account. -Resident #5 had a balance of \$1,626.05 in his offsite account and a balance of \$1.57 in his store call account. Interview with the Facility Manager on 3/28/17 at 10:30am and 3/31/17 at 8:45am revealed: -Limited amounts of cash were on hand in the facility due to a history of a former staff person's embezzlement of resident's funds. -She kept enough cash on hand to cover store call needs for residents. -If the resident's needed access to more cash to purchase things than the small amounts held in their store credit accounts, she would write a check for the items the residents wanted to buy at the store and just notify the Administrator at the sister facility to deduct the check amount from the resident's account. -The residents were able to access their store call once everyday at 2pm. -Residents used their store call accounts to purchase items from the facility vending machines and to purchase cigarettes from the facility. Interview with the Facility Manager on 3/29/17 at 10:45am revealed all she kept on hand in the facility of the residents' personal funds was "one dollar bills and dimes to have cash for store credit for vending." Interview with an Administrator from a sister facility on 3/28/17 at 11:40am revealed: -"I handle the residents accounts for them. I handle their personal funds."	D 423	<i>D423 - Continued</i> <i>personal account records and conduct interviews with residents to ensure that personal funding has been made available</i> <i>Completion Date: 4/3/17</i>	

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D 423	Continued From page 29 - "The residents direct deposits into the [local bank name]." - "Then once the office receives the information that both checks for each resident have come in usually on the 5th or 6th of the month the main office faxes down to us the list of what each resident received in personal funds." - "Then I enter the amount onto the resident account sheets." - "Then the same day I subtract their pharmacy bills." - "Then throughout the month if [Facility Manager's name] takes them shopping or anything like that or copays for doctor's visits or Medicare Part premiums" were deducted from the personal funds balances. - "Then the [Facility Manager's name] will call and say so and so wants to go shopping do they have money?" - "They also have a store account. [Facility Manager's name] keeps the store account book." - "Everyday every resident gets \$1.10 to their store account." - The Facility Manager "goes over [their store accounts] with them so the residents know how much personal fund money they have." - "I then bring the book over for them to sign." - "But to be honest, I don't always get over here every month" for the residents to sign them. - "The records are offsite." Interviews with six residents regarding access to their personal funds revealed: - The Facility Manager "as we go along in [local discount store name], she tells us how much money we have left. Then she pays for it out of our check." - "I'm given \$3.20 per day." - "I don't get money. I get a drink and a cookie everyday at 2 o'clock."	D 423		

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D 423	Continued From page 30 - "It wouldn't cost as much for the drinks and snacks if I could buy them elsewhere." - One resident was given store call "every other day and he liked it. It's okay the way it is." - One resident thought he received \$66 per month, yet "no one goes over" his finances with him. It was not important for him to know the amount of money in his account, he had "no need" for money at other times. - One resident was "satisfied" with how his finances were handled. He had never asked for money at any other time, he "had no need to" and was happy with store credit.	D 423	D914- To Correct: Resident #7 was discharged from the facility on 4/26/17 to prevent any further display of inappropriate behavior. To Prevent: Staff will monitor all Residents daily for behaviors and address behaviors on an as needed basis. To Monitor: The Manager and the Resident Care Coordinator will review shift notes, behavior notes, and accident/incident reports daily to identify behaviors. The Manager and the Resident Care Coordinator will communicate with staff during monthly staff meetings to discuss behaviors. Identified behaviors will be addressed through contact with the appropriate mental health or medical professional. Date Completed: 4/26/17	
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, interviews, and record reviews, the facility neglected to adequately supervise Resident #7 which led to the exploitation of two residents (Resident #6 and #8). The findings are: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision in accordance with assessed needs and current symptoms for 1 of 4 sampled residents (Resident #7). [Refer to tag 0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D914		