STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077012	A. BUILDING: _____ B. WING _____	05/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

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D 000	Initial Comments The Adult Care Licensure Section and the Richmond County Department of Social Servies conducted an annual survey on May 23, 24, and 25, 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, interviews and record reviews, the facility failed to maintain ceilings and walls in good repair resulting in holes in the walls from broken toilet paper and paper towel holders in 10 bathrooms on the Special Care Unit, and one bathroom in the Assisted Living section of the facility; holes in walls, wet marks, peeling paint on walls and ceilings in five rooms and two bathrooms on the Special Care Unit, and one community bathroom in the Assited Living section of the facility. The findings are: Observations of the "Moore Community" on the Special Care Unit (SCU) on 5/10/17 from 11:31am until 12:45pm revealed: -In the bathroom of room # 44 there was no toilet paper holder revealing two holes in the wall next to the toilet and the toilet paper holder with screws approximately two inches in length still	D 074		

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

Jaylus Rogers | Administrator | 6/29/17

Reviewed and accepted 6/30/2017 - HF

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D 074	Continued From page 1 attached, was on top of the paper towel holder. -In room #48 there was a plastered, but unpainted hole in the wall behind the head of the bed by the window. -In the bathroom of room #48 the toilet paper holder was loose and ajar from the wall. -In room #50 there was a basketball size wet mark in the ceiling above the entryway with peeling "popcorn" paint that had fallen on the floor. -In the bathroom of room #51 there was a broken double roll toilet paper holder hanging from one side on the wall revealing two large holes where the other side of the toilet paper holder had been secured to the wall. -In the bathroom of room #54 the toilet paper holder was loose and ajar from the wall revealing a gap of approximately two inches between the toilet paper holder and the wall. -In the bathroom of room #54 there was a cracked baseboard tile with loose pieces of tile under the bathroom sink. Interview with a Personal Care Aide (PCA) on 5/23/17 at 12:37pm revealed: -She was assigned to room #44, but had not noticed the broken toilet paper holder with screw attached on top of the paper towel holder. -It was not there on 5/22/17, so she had not reported it to anyone. Observations of the "Richmond Community" on the Special Care Unit (SCU) on 5/10/17 from 3:48pm until 4:45pm revealed: -The common bathroom across from the nurse's station had wet marks and peeling paint around the vents on the ceiling and wet marks on the ceiling above the first shower. -There was chipped, warped and missing paint on the wall around the sink in the common bathroom	D 074		

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D 074	Continued From page 2 across from the nurse's station. -There was a doorknob sized hole in the wall behind the door in the common bathroom across from the nurse's station. -In the common bathroom across from the yellow room there was no toilet paper holder revealing two holes in the wall next to the toilet. -In the yellow room there was a wet mark on the ceiling approximately the diameter of a basketball and a doorknob sized hole in the wall behind the door with large amounts of dried plaster around the hole. -In the bathroom of room #61 there was a broken double roll toilet paper holder hanging from one side on the wall revealing two large holes where the other side of the toilet paper holder had been secured to the wall. -In the bathroom of room #62 the towel rack was missing leaving the bracket/mount on the wall. -In the bathroom of room #67 the paper towel holder was missing leaving three holes in the wall and a screw protruding approximately one inch from the wall next to the shower. -In the bathroom of room #69 the toilet paper holder was loose and ajar from the wall. -In room #72 there was a doorknob sized hole in the wall with a large area of dried plaster around the hole. Interview with a second PCA on 5/23/17 at 12:04pm revealed: -The Maintenance Staff and SCU Coordinator (SCUC) had it written down already where all the holes in the walls were, peeling paint on the ceiling and broken toilet paper holders. -The Housekeeping Supervisor goes around and checks to see what needs to be done as far as repairs and reports to the Maintenance Staff. -If she saw something that needed to be repaired, she would report it to the SCUC.	D 074		

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D 074	Continued From page 3 -She was going to report the peeling paint in room #50 to the SCUC and the Maintenance Staff. Observation of room #29 in the Assisted Living section of the facility on 05/23/2017 at 10:55am revealed: -There were three small holes in the wall over the commode. -There was one towel bar bracket affixed to the wall over the commode. Observations of the shower room across from room #27 in the Assisted Living section of the facility at on 05/23/2017 at 12:00pm revealed: -There was a large circular brownish colored stained area on the ceiling in the area of where the toilet was located. -There was a puddle of water under the sink next to the toilet after the faucet was turned on to check the water temperature at the shower room sink fixture. Interview with the Maintenance Staff on 05/23/2017 at 12:15pm revealed the sink fixture needed to be repaired and he would be replacing the piping to fix the faucet leak. Interview with the Maintenance Staff on 5/23/17 at 3:30pm revealed: -He had worked at the facility for four years and the last year and a half as Maintenance. -He was responsible for all the repairs in the building except painting and renovations like new flooring which were contracted out. -He was aware of the broken toilet paper holders, holes in the walls and wet marks with peeling paint on the ceilings. -The wet marks were from leaks in the roof when it rained.	D 074		

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D 074	Continued From page 4 -He had been working on a second leak in the roof on 5/23/17 which caused the peeling paint and wet mark in room #50. -He had fixed the toilet paper holders several times, but they kept getting broken because residents would use the toilet paper holder to push up off the toilet or new housekeeping staff would rip the toilet paper holders off the wall when putting new toilet paper rolls on. Interview with the Administrator on 05/23/2017 at 5:30am revealed: -The facility was in the process of painting and repairing walls and floors. -She did not know when the repairs would be completed. Further interview with the Maintenance Staff on 05/24/2017 at 9:20am revealed: -The holes in the wall in room #29 had come from the paper towel holder that was knocked down by a housekeeping staff. -He thought he had the paper towel holder in his office. -The holes in the wall had been there for about two months. -He had painted over the holes when he painted the bathroom about two months ago. -The towel bracket on the wall had been there for about three years. -He was the only person at the facility doing repairs. -He had not seen the brownish colored stain on the bathroom ceiling before. -The stain in the ceiling was "probably" coming from the rubber seal around the exhaust that may have come loose. Observation of the Maintenance Staff on 05/24/2017 at 9:25am revealed the area in the	D 074		

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D 074	Continued From page 5 ceiling was poked by the Maintenance Staff with his screwdriver. There was no spongy area observed and the area appeared to be dry. Interview with the Maintenance Staff on 5/24/17 at 2:40pm revealed: -He had started repairs on the SCU on 5/23/17. -Repairs at the facility were ongoing and constant, he was always busy. -The toilet paper holders in rooms #44, #61, #62 and #69 had been repaired. -He was not aware of all of the needed repairs on the SCU. -Staff used to write down repair concerns on a clipboard kept at the nurse's station that he would check every morning. -Staff had stopped using the form about six months ago and the clipboard was no longer hanging at the nurse's station. -He did not know why staff had stopped using the clipboard or what had happened to it. -Staff were going to start using the clipboard again. -He did walk through the SCU to check for needed repairs when he could and staff reported some repairs, but not all. -He had just started working on walls and ceilings and planned to get door stoppers to keep the doors from hitting the walls. Interview with the SCU Coordinator (SCUC) on 5/24/17 at 4:15pm revealed: -If she found things that needed to be repaired she reported to the Maintenance Staff. -There had been a clip board that staff used to write down things that needed to be repaired, but she did not know what happened to it. -Housekeeping staff and the Maintenance Staff checked routinely for needed repairs.	D 074		

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D 074	Continued From page 6 Interview with the Administrator on 5/25/17 at 5:20pm revealed: -Staff were expected to fill out the maintenance form kept at the nurse's station for any needed repairs. -Sometimes staff would report needed repairs directly to the Administrator or the Maintenance Staff. -There was also a new Housekeeping Supervisor to help identify areas in need of repair.	D 074		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to report seven falls within three months to the Primary Care Provider, where one fall resulted in an emergency room visit for one resident (#4); and failed to schedule referral appointments for 2 of 7 sampled residents, (#4) for a nephrologist and (#1) for a dentist. The findings are: 1. Review of Resident #4's current FL-2 dated 4/19/17 revealed diagnoses included Elevated Brain Natriuretic Protein, Facial Edema, Elevated Troponin Level, Schizophrenia, Hypertension, Gout, Cardiomyopathy, History of Subdural Hematoma and Alzheimer's Dementia.	D 273		

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D 273	Continued From page 7 a. Observation on 5/23/17 at 12:49pm revealed: -Resident #4 was sitting in his wheelchair using his feet to move the chair forward. -The resident had a swollen lump approximately the size of a walnut on his right forehead, a deep purple bruise around his right eye and redness of his left eye. Interview with a Personal Care Aide (PCA) on 5/23/17 at 12:49pm revealed Resident #4 had fallen, but she did not know the details because she was not at work when the fall happened. Review of "Nurse's Notes" for Resident #4 revealed: -On 3/1/17 at 1:45am staff documented Resident #4 fell getting up. -There was no documentation included in the 3/1/17 staff note on whether or not the resident had any injury. -On 4/12/17 at 8:15pm staff documented Resident #4 fell trying to get up, there was no injury and the Administrator was notified. -On 4/25/17 at 2:15am staff documented that Resident #4 was found on the floor with no visible injuries and the family member and Supervisor were notified. -On 5/5/17 at 8:00pm staff documented Resident #4 fell trying to get up out of his wheelchair and denied hurting himself. -On 5/11/17 at 10:30pm staff documented Resident #4 was found on the floor in the hallway, he denied being hurt and there were no apparent injuries. -On 5/17/17 at 9:55am staff documented Resident #4 fell through the kitchen door hitting his head when a staff opened the door from the other side not knowing the resident was leaning into the door. -Staff documented the resident had a "big goose	D 273		

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D 273	Continued From page 8 egg" over his right eye, the resident's vital signs were taken, the resident was taken to the hospital by staff and the resident's family member was notified. -Staff documented Resident #4 returned from the hospital approximately three hours later on 5/17/17 with no new orders. -On 5/21/17 at 8:05pm staff documented Resident #4 was found on the floor with no injuries. -There was no documentation the resident's Primary Care Provider (PCP) had been notified of the falls between 3/1/17 and 5/21/17. Review of "Occurrence Reports" dated 3/1/17 through 5/21/17 for Resident #4 revealed: -Staff completed a report for falls on 3/1/17, 4/12/17, 4/25/17, 5/11/17, 5/17/17 and 5/21/17. -On the report dated 4/12/17 staff documented the name of a physician next to "Physician's name." -There was no documentation of dates and times Resident #4's PCP was notified of the falls. Review of Primary Care Provider (PCP) visit notes for Resident #4 revealed: -The resident was seen by the PCP on 1/11/17, 2/8/17, 3/9/17 and 4/17/17. -There was no documentation the PCP was made aware of the resident having frequent falls. Attempted interview with Resident #4's Primary Care Provider (PCP) on 5/25/17 at 2:38pm was unsuccessful. Based on observations, interviews and record reviews, Resident #4 was not interviewable due to diagnosis of Dementia. Telephone interview with Resident #4's family	D 273		

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D 273	Continued From page 9 member on 5/25/17 at 5:18pm revealed: -The facility did a great job with Resident #4; "he's in good hands as far I can see." -The staff contacted the family member regularly with any concerns. -He had been contacted last week (5/17/17) when the resident fell and went to the hospital. Interview with a second PCA on 5/24/17 at 11:58am revealed: -Resident #4 had had a few falls because he would get up from his wheelchair and walk. -That was how he fell and injured his face, he had gotten out of his wheelchair and walked in the dining room. -Staff rounded on residents every two hours and for some residents who liked to wander staff checked on where they were every 15 minutes. Interviews with a Medication Aides (MA) on 5/25/17 at 5:32pm and 6:20pm revealed: -When a resident fell she would check the resident for injuries and check the resident's vital signs. -If the resident was hurt they would be sent to the emergency room. -The MA would call the Administrator, write an incident report, call the resident's family, complete 24 hour charting and fax the incident report to the doctor. -She had completed the "occurrence report" dated 4/12/17 where the name of the physician was documented. -She had just documented the name of Resident #4's doctor, but did not fax the report to any doctor. Interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm revealed: -Staff were expected to check resident and get	D 273		

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D 273	Continued From page 10 help with any falls. -Usually if she was on duty staff would get her. -The Supervisor on duty was responsible for checking the resident for any injuries. -Most of the residents on the SCU were not really able to say if they were hurt or not, so if the fall was not witnessed she would send them to the emergency room. -Staff document the fall and notify the resident's family member. -Staff had not been notifying the Primary Care Provider (PCP). -Staff used to fax any hospital discharge paper work and the "occurrence report" to PCP's office, but they just stopped doing that. -The Administrator had been the person faxing the "occurrence report" to PCP's office because she had to sign off on the report first. -The PCP visited residents at the facility every month. -She used a "Doctor Visit Note" sheet to review any concerns with PCP during the visit. -The visit note sheet would have the resident's vital signs, weight and any major concerns. -She could not recall specifically discussing any of the falls for Resident #4 with the PCP. Interview with the Administrator on 5/25/17 at 5:20pm revealed: -When a resident fell staff were expected to get the Supervisor on duty who checked the resident for any injuries and if the resident needed to be sent to the emergency room. -Staff were expected to notify the facility on call person (Administrator, SCUC or Director of Resident Services) and the resident's family member. -The PCP was notified when a resident returned from the hospital. -Hospital discharge instructions were faxed to the	D 273		

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D 273	Continued From page 11 PCP. -Staff would communicate significant changes, hospital visits and any complications with residents to the PCP when she came to the facility each month. -Staff were expected to notify the PCP of frequent falls and falls with injuries when the PCP came to the facility each month. b. Review of "Nurse's Notes" for Resident #4 revealed: -On 4/17/17 at 6:00pm staff documented Resident #4 was sent to the hospital for his face and legs being swollen, and his family member was notified. -On 4/20/17 at 3:00pm staff documented Resident #4 returned from the hospital. Review of a hospital discharge summary for Resident #4 dated 4/20/17 revealed: -Resident #4 was admitted to the hospital on 4/19/17 for acute heart failure, elevated troponins and chronic kidney disease with facial swelling and decreased appetite. -There were instructions for the resident to have a follow up appointment with a nephrologist within one week. Interview with the Transporter on 5/25/17 at 2:32pm revealed: -She needed to send physician notes and lab results to the nephrologist's office before they would schedule an appointment for Resident #4. -Sometimes it took her a while to get appointments scheduled because she was also responsible for taking residents to their appointments, completed "PCA" sheets every two weeks, was responsible for submitting the daily midnight census for billing, and scheduled and coordinated personal care assessments for	D 273		

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D 273	Continued From page 12 residents. -She had not reported not being able to schedule an appointment with the nephrologist for Resident #4 to anyone. -If an emergency appointment came up such as resident needing to go to the hospital she would go to the office and get help if there was an appointment for another resident already scheduled. Attempted interview with Resident #4's Primary Care Provider (PCP) on 5/25/17 at 2:28pm was unsuccessful. Based on observations, interviews and record reviews, Resident #4 was not interviewable due to diagnosis of Dementia. Telephone interview with Resident #4's family member on 5/25/17 at 5:18pm revealed: -He felt staff kept up with Resident #4's appointments and did a great job with resident. -If the family member was available, he would take the resident to some of his appointments. Observation of Resident #4 on 5/25/17 at 5:05pm revealed the resident had swelling on the right side of his face, swelling to his right hand and no swelling to either lower extremity. Interview with a Medication Aide (MA) on 5/25/17 at 5:05pm revealed: -Resident #4 had swelling to his face because of the fall where he injured himself. -He had problems with Gout and swelling to his hands and had seen a doctor and was taking water pills. Interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm revealed:	D 273		

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D 273	Continued From page 13 -She was aware Resident #4 was referred to see a nephrologist because she reviewed the discharge paper work. -She was not aware the appointment to see the nephrologist had not been made for Resident #4. -The transporter was the only one who scheduled appointments because she knew all of the residents appointments that were already scheduled. -Usually she reviewed discharge instructions and PCP orders and if a resident needed a follow up appointment scheduled she wrote it on a card and gave the card to the Transporter. -The transporter would then schedule the appointment and take the resident to the appointment. -There was no system in place of checking to see that follow up appointments had been scheduled and if residents had gone to the appointment. -It had not been reported to her until 5/25/17, that Resident #4 did not have an appointment to see the nephrologist. -The transporter had come to her the morning of 5/25/17 and said the nephrologist office needed some paper work before they would schedule the appointment. -As of 5/25/17, Resident #4 did not have an appointment with the nephrologist. Interview with the Administrator on 5/25/17 at 5:20pm revealed: -The SCUC was responsible for auditing resident records every month to assure all documentation, including making sure residents went for any ordered follow up appointments. -She was not aware Resident #4 had not had a nephrologist appointment scheduled for more than one month after the referral. -She had previously talked with the transporter about not overbooking herself and to ask for help	D 273		

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	HAL077012	A. BUILDING: _____ B. WING _____	05/25/2017

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D 273	Continued From page 14 when needed. 2. Review of current FL-2 dated 08/10/2016 for Resident #1 revealed diagnoses included status post traumatic brain injury, cerebrovascular accident, bipolar, and non-ischemic chest pain. Review of the Resident Register for Resident #1 revealed the resident was admitted to the facility on 10/17/2005. Review of a physician's order dated 08/17/2016 for Resident #1 revealed there was an order for the facility to set up an appointment with the dentist for right sided gum pain and gum swelling for Resident #1. Review of record for Resident #1 revealed there was no documentation that Resident #1 had been seen by a dentist for right sided gum pain and gum swelling. Interview with Resident #1 on 05/23/2017 at 12:00pm revealed: -The resident had a sore throat. -The resident denied having any other pain. Interview with the Director of Resident Services (DRS) on 05/24/2017 at 12:25pm revealed: -The facility had missed scheduling the dental appointment for Resident #1. -The DRS scheduled the appointment for 06/01/2017 with a dentist when the missed appointment was brought to her attention. -She was not aware of Resident #1 having any more complaints of gum pain or swelling. Further interview with the DRS on 05/25/2017 at 10:50am revealed: -She had been the DRS since 05/01/2016.	D 273		

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D 273	Continued From page 15 -She was not aware of the physician's order dated 08/17/2016 for Resident #1 to be set up with the dentist for right sided gum pain and swelling. -The transportation person was responsible for scheduling medical appointments. -The facility was "in transition" of changing transportation staff when the physician wrote the order for Resident #1 to be seen by the dentist. -The previous transportation person was no longer working at the facility. -Resident #1 had complained to the physician about her gums bothering her back in August 2016. -No one had seen any gum swelling on Resident #1. -Resident #1 had not complained to staff since then about her gums. -Resident #1 had not been to the dentist. -Most residents went to the dentist yearly and the facility tried to schedule dental appointments when the residents asked. -She wrote medical appointments on her calendar. -She reviewed resident records every two months to ensure there were no missed orders. -She did not know how the order dated 08/17/2016 for Resident #1 to be seen by a dentist was missed. -When a resident was seen by a physician, the physician orders were given to her, she reviewed the order, made a copy of the order and gave it to the transportation person who scheduled the appointments. Interview with the current Transportation Staff on 05/25/2017 at 11:15am revealed: -She started in the position of transportation staff in mid-September 2016. -She was responsible for scheduling	D 273		

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D 273	Continued From page 16 appointments after she received the physician's order from the DRS. -She was not aware that Resident #1 needed to be scheduled for an appointment with a dentist until she was contacted by the Administrator on 05/24/2017 about the appointment. -She told the Administrator on 05/24/2017 that she had no knowledge of the need for Resident #1 to have a dental appointment. -She had not scheduled the 06/01/2017 appointment for Resident #1, but did call on 05/25/2017 and reschedule the dental appointment to 06/19/2017. -She had to schedule public transportation for the 06/19/2017 appointment for Resident #1.	D 273		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S.	D 463		

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D 463	Continued From page 17 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 4 sampled residents (#4 and #5) admitted to the Special Care Unit had a pre-admission screening completed and documented in the resident record. The findings are: 1. Review of Resident #4's current FL-2 dated 4/19/17 revealed diagnoses included Elevated Brain Natriuretic Protein, Facial Edema, Elevated Troponin Level, Schizophrenia, Hypertension, Gout, Cardiomyopathy, History of Subdural Hematoma and Alzheimer's Dementia. Review of Resident #4's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 10/24/14. Review of Resident #4's record revealed there was no pre-admission screening completed on admission to SCU. Refer to interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm. Refer to interview with the Administrator on 5/25/17 at 5:20pm. 2. Review of Resident #5's current FL-2 dated 3/20/17 revealed diagnoses included Dementia, Cerebral Vascular Accident with Right Sided Weakness, Hypertension, Coronary Artery Disease and Urinary Tract Infection.	D 463		

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D 463	Continued From page 18 Review of Resident #5's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 3/1/17. Review of Resident #5's record revealed there was no pre-admission screening completed on admission to SCU. Refer to interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm. Refer to interview with the Administrator on 5/25/17 at 5:20pm. --- Interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm revealed: -She had worked as the Director of Resident Services before she became the SCUC. -She had been working as the SCUC for approximately one year and there was a lot of new tasks specific to the SCU that she was still learning. -She was aware residents needed a pre-admission screening completed on admission to the SCU. -She had not reviewed resident records for residents who were in the SCU when she became the SCUC to assure they had a pre-admission screening completed. -There were a few residents who had not had a pre-admission screening done because she had overlooked that task. -She was primarily focused on making sure the day to day needs and safety of the residents were met by helping on the floor. Interview with the Administrator on 5/25/17 at 5:20pm revealed: -She was responsible for completing the	D 463		

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D 463	Continued From page 19 screenings on all residents admitted to the facility. -The SCUC was responsible for auditing resident records every month to assure all documentation, including SCU pre-admission screening, had been completed.	D 463		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 3 of 4 sampled residents (#4, #5 and #11) admitted to the Special Care Unit had a resident profile completed within 30 days of admission and quarterly thereafter.	D 464		

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D 464	Continued From page 20 The findings are: 1. Review of Resident #4's current FL-2 dated 4/19/17 revealed diagnoses included Elevated Brain Natriuretic Protein, Facial Edema, Elevated Troponin Level, Schizophrenia, Hypertension, Gout, Cardiomyopathy, History of Subdural Hematoma and Alzheimer's Dementia. Review of Resident #4's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 10/24/14. Review of Resident #4's record revealed there was no resident profile completed within 30 days of admission to SCU and there were no quarterly profile assessments completed for Resident #4 since admission to the SCU. Refer to interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm. Refer to interview with the Administrator on 5/25/17 at 5:20pm. 2. Review of Resident #5's current FL-2 dated 3/20/17 revealed diagnoses included Dementia, Cerebral Vascular Accident with Right Sided Weakness, Hypertension, Coronary Artery Disease and Urinary Tract Infection. Review of Resident #5's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 3/1/17. Review of Resident #5's record revealed there was no resident profile documented since admission to SCU on 3/1/17.	D 464		

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D 464	Continued From page 21 Refer to interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm. Refer to interview with the Administrator on 5/25/17 at 5:20pm. 3. Review of Resident #11's current FL-2 dated 11/4/16 revealed: -Diagnoses included Dementia. -The resident was admitted to the Special Care Unit (SCU) on 11/12/14. Review of Resident #11's record revealed: -A resident profile and service plan was completed 11/12/15 for Resident #11. -There was no documentation of a quarterly profile assessment after 11/12/15 for Resident #11. Refer to interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm. Refer to interview with the Administrator on 5/25/17 at 5:20pm. --- Interview with the SCU Coordinator (SCUC) on 5/25/17 at 3:25pm revealed: -She had worked as the Resident Services Director before she became the SCUC. -She had been working as the SCUC for approximately one year and there was a lot of new tasks specific to the SCU that she was still learning. -She did not know about completing the resident profile and care plan quarterly. -She thought once the resident was approved for personal care hours that, that was their care plan and nothing else needed to be done.	D 464		

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D 464	Continued From page 22 Interview with the Administrator on 5/25/17 at 5:20pm revealed the SCUC was responsible for auditing resident records every month to assure all documentation, including resident quarterly profiles and care plans, had been completed.	D 464		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform 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: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: 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. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication	D935		

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D935	Continued From page 23 administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 medication aides (Staff C) hired after October 2013, who administered medications, had passed the written Medication Aide test within 60 days of completion of the medication clinical skills checklist. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired on 06/28/2016 as a Personal Care Aide. -Staff C was promoted to a Medication Aide/Supervisor (MAS) on 11/16/2016. -There was documentation of a Medication Clinical Skills Checklist completed 11/16/2016. -There was documentation for 5-hour medication training on 11/11/2014. -There was documentation for 10-hour medication training on 01/02/2015. -There was documentation for diabetic care training on 02/05/2017. -There was no documentation Staff C had passed the written Medication Aide Exam. Review of February 2017 Medication	D935		

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D935	Continued From page 26 facility "about 1-2 months ago". Interview with the Business Office Manager (BOM) on 05/25/2017 at 5:35pm revealed: -She was responsible for completing new hire paperwork which included certifications and verification that staff had passed the medication exam. -Staff C was already in the position of MA when she (BOM) was hired in the position of BOM. -She had never asked Staff C for a copy of her medication aide exam certificate. -She was responsible for reviewing personnel files to make sure all documentation required was present. -It had been "a couple months" since she had reviewed personnel files. -She had started reviewing personnel files but had not gotten through everybody's file. -She had not reviewed Staff C's personnel file.	D935		

- RULE 10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS

THE FACILITY WILL ENSURE RULE IS MET FROM THIS DAY FORWARD; HOUSEKEEPING SUPERVISOR WILL MONITOR ROOMS WEEKLY COMPLETE CHECK OFF LIST AND TURNING IT IN MAINTENANCE SUPERVISOR WEEKLY, AND ADMINISTRATOR FOR REPAIRS WEEKLY. MAINTENANCE WILL START REPAIRS ASAP.

ADMINISTRATOR WILL MONITOR MONTHLY TO ENSURE REPAIRS ARE BEING COMPLETED. FACILITY ARE CURRENTLY REPAINTING THE WHOLE FACILITY AS YOU SEEN DURING YOUR VISIST, PROJECTED FINISH DATE IS ABOUT LATE JULY.

COMPLETE DATE: 8/04/17

- RULE 10A NCAC 13F .0902(B) HEALTH CARE

FACILITY WILL ASSURE RULE IS BEING MET WHEN DRS/SCUC GETS ORDER FROM PCP/ER VISIT, THEY WILL PASS ORDERS TO TRANSPORTER SO APPOINTMENT CAN BE MADE, WITHIN 2 DAYS OF ORDER TRANSPORTER IS TO REPORT BACK TO DRS/SCUC WITH APPOINTMENT DATE AND TIME. AT THIS POIUNT DRS/SCUC WILL INFORM ADMINISTRATOR OF APPOINTMENT. ADMINISTRATOR WILL MONITOR APPOINTMENTS WEEKLY AT MANGEMENT MEETINGS TO ENSURE FOLLOW UP/REFERRAL ARE BE CARRY OUT. MANAGEMENT MEETING WILL BE WITH THE FOLLOW, ADMINISTRATOR, DRS, SCUC, TRANSPORTER, AND FLOOR SUPERVISORS. WE WILL MEET ONCE A WEEK TO DISCUSS ALL CONCERNS, FALLS, DR. APPOINMENTS, FOLLOW-UPS, REFERRALS, OR ANY CONERNS ABOUT TAKING CARE OF RESIDENT. SUPERVISORS WILL CONTINUE TO DO OCCURRENCE REPORTS AND FAX TO PCP AT THE TIME OF FALL, NOTIFY FAMILY, 24 HOUR DOCUMENTATION, SEND TO ER IF NEEDED, AND THEN PASS OCCURRENCE REPORT TO ADMINISTARTOR. DRS/SCUC WILL MONITOR DAILY. ADMINISTRATOR WILL MONITOR WEEKLY TO ENSURE ALL HAS BEEN COMPLETED

COMPLETED DATE: 7/14/17

- RULE 10A NCAC 13F .1306 ADMISSION TO THE SPECIAL CARE UNIT

FACILITY WILL ASSURE RULE HAS BEEN MET BY: BEFORE PLACEMENT TO UNIT AT INITIAL SCREENING ADMINISTRATOR/SCUC WILL DO PRE-SCREENING AND THEN AT ADMISSION ADMINISTRATOR WILL MADE SURE FORM IS IN CHART. SCUC WILL KEEP IN CHART UNTIL RESIDENT IS DISCHARGED FROM FACILITY. SCUC/ADM. WILL AUDIT CHART MONTHLY TO ENSURE RECORDS ARE COMPLETED AND IN FILE.

COMPLETED DATE: 7/14/17

- RULE 10A NCAC 13F .1307 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN.

FACILITY WILL ASSURE RULE BEEN MET AFTER ADMISSION BEFORE 30 DAYS ARE UP SCUC WILL DO QUARTELY REUIRED ASSESTMENTS. ADMINISTRATOR WILL MONTIOR THIS DURING AUDIT OF CHARTS MONTHLY AND DISCUSS DURING MANAGER MEETING TO ENSURE WE ARE COMPLETEING THEM. FACILITY HAS MONITOR TOOL IN PLACE TO HELP WITH THIS.

COMPLETED DATE: 7/14/2017

Daylis Rogers, Administrator 6/30/17 adjustment

- G.S.131D-4.5B ADULT CARE HOME MEDICATION AIDES; TRAINING AND COMPETENCY EVALUATION REQUIERMENT

FACILITY WILL ASSURE RULE IS MET BY AT THE TIME OF INTERVIEW CHECK FOR CREDENTIALS AND GET COPIES THEN. AT HIRE (BOM) WILL MAKE SURE COPIES ARE IN FILE. THERE WILL BE CHECK OFF IN PLACE TO COMPLETE EACH WEEK TO MAKE SURE AS THINGS ARE NEEDED THEY ARE ADDED TO EMPLOYEES CHART. ADMINISTRATOR WILL MONITOR MONTHLY.

COMPLETED DATE: 6/29/17

Angie Rogers, Administrator 6/30/17 adjustment