

Division of Health Service Regulation

PRINTED: 08/07/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 000	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted an annual survey on 08/17/17.	C 000			
C 007	10A NCAC 13G .0208 Capacity 10A NCAC 13G .0208 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any	C 007	See Attachment C007- Addendum per telephone with Ms. Gina Stavredes on 11/8/17: The Administrator monitors at least weekly to assure fire watches are being done and documented on the flow sheets. The correction date of 10/1/17 was extended to 11/6/17. Refer to Attached Letter from ACLS dated 10/26/17. W. Williams 11/16/17		

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

STATE FORM

TITLE

(X6) DATE

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* The plan of correction with addendum was approved on 11/16/17. Refer to addendum on pages 1, 16, 20, and 23 of this Statement of Deficiencies.

W. Williams
11/16/17

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C 007	Continued From page 1 possible changes that may be required to the building. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 4 of 5 residents (#1, #2, #3, #4) residing in the facility who had cognitive and/or physical impairments which would prevent the residents from independently evacuating the facility. The findings are: Review of the facility's 2017 license revealed: -The facility was licensed for a capacity of 6 residents. -The facility was licensed for all ambulatory residents 1. Review of Resident #1's current FL-2 dated 03/15/17 revealed: -The resident's diagnoses included dementia and fracture of the right femur. -The resident was constantly disoriented. -The resident was semi-ambulatory and required physical assistance from staff. -The resident was incontinent of bowel and bladder. Review of the Resident Register revealed Resident #1 was admitted to the facility on 08/15/11.	C 007	<i>See Attachment</i>	

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C 007	Continued From page 2 Review of Resident #1's current assessment and care plan dated 03/15/17 revealed: -The resident had limited ability with ambulation due to unsteady gait. -The resident required limited physical assistance from staff. -The resident was oriented but was forgetful and needed reminders. -The resident was totally dependent for all activities of daily living including eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Observation of Resident #1 on 08/17/17 at 10:14 a.m. revealed: -The resident was lying in a fetal position in a hospital bed with both side rails up. -The resident was sleeping and made a low groaning noise when spoken to but she did not open her eyes. -There was a pillow between the resident's knees and a wedge cushion between the resident and the side rail on the right side of the bed. Observation of Resident #1 on 08/17/17 at 12:11 p.m. revealed: -The resident was being physically assisted by one staff from her bedroom to the dining room. -Staff were holding on to the resident by her left arm. -The resident required physical assistance the entire way from her bedroom area to the living room chair. -The staff person physically assisted the resident to transfer, ambulate, and sit down. -The resident was leaning to one side once physically assisted to a seated position. -The resident would not reply when spoken to. Interview with the Supervisor-in-Charge (SIC) on	C 007	<i>See Attachment</i>		

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C 007	Continued From page 3 08/17/17 at 11:05 a.m. revealed: -Resident #1 required staff assistance in all areas to include transfers and ambulation. -Resident #1 could not evacuate on her own due to her unsteadiness. -One staff person would be needed to transfer and evacuate Resident #1 because she had a very unsteady gait. Interview with a second SIC on 08/17/17 at 12:40 p.m. revealed: -Resident #1 needed the physical assistance of a staff person daily to help her ambulate and transfer safely because she was so unsteady -In the event of a fire drill or an evacuation, Resident #1 would require staff assistance Interview with the Administrator on 8/17/17 at 1:12 p.m. revealed: -Resident #1 verbalized but was unable to respond to requests. -Resident #1 required limited assistance from a staff person during all areas of daily living. -Resident #1 could not get out of bed on her own -She instructed all staff to physically assist the residents to help ensure their safety and to avoid potential injuries. -Resident #1 required at least one person to transfer her into different seating systems. -Resident #1 could not participate in fire drills or evacuate without assistance in the case of a fire. -Resident #1's status had declined within the past couple of years. -She had not notified anyone at the Division of Health Service Regulation (DHSR) that the capabilities of Resident #1 did not match the capability listed on the facility's license. Refer to interview with the Administrator on 08/17/17 at 10:25 a.m.	C 007	See Attachment		

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C 007	Continued From page 4 Refer to interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:10 p.m. Refer to interview with the Administrator on 08/17/17 at 3:50 p.m. 2. Review of Resident #3's current FL-2 dated 10/01/16 revealed: -The resident's diagnoses included dementia, osteoporosis, coronary artery disease, macular degeneration, fall risk, and gait disturbance. -The resident was intermittently disoriented. -The resident was semi-ambulatory with a walker. -The resident was continent of bowel and bladder. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on 10/05/15. -The resident required assistance with dressing, bathing, toileting and ambulation. -The resident used walker, hearing aid, wheelchair and eyeglasses. Review of Resident #3's current assessment and care plan dated 10/01/16 revealed: -The resident was ambulatory with device. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident was incontinent of bowel and bladder. -The resident required limited assistance with toileting, bathing, dressing, and grooming. -The resident was independent with eating, ambulation and transfer. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 07/14/17	C 007	<i>See Attachment</i>		

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C 007	Continued From page 5 revealed: -The resident was checked off for 2 personal care tasks, ambulation using assistive devices that required physical assistance and transferring semi-ambulatory -The nurse documented the resident was "mobile via 2 wheel walker with staff hands on assist" and "transfer assist with 1 staff required." Review of Resident #3's primary care provider (PCP) order dated 07/25/17 revealed there was an order for Physical Therapy (PT). Review of Resident #3's PT note dated 08/01/17 revealed: -The resident started gait training with focus on posture awareness. - "Minimal/moderate assistance with sitting to standing." - "Maximum ups (or hand placement to prevent pulling on assistive device)." Observation of Resident #3 on 08/17/17 at 11:00 a.m. revealed: -The resident was sitting in a chair on the porch with a family member and a case manager. -The resident's 2 wheeled walker was next to her. -The resident was wearing a hearing aide in her right ear. Interview with Resident #3's care manager (CM) on 08/17/17 at 11:00 a.m. revealed: -She was hired by the resident's family to provide transportation to medical appointments and be the extra set of eyes and ears for them. -She visited the resident once or twice a week. -The resident required 1-person assistance with bathing -The resident was continent with incontinence briefs and "just needed verbal instruction" from	C 007	See Attachment		

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C 007	Continued From page 6 staff. -The resident was independent with eating and grooming. -The resident could ambulate but because of her hunched back posture, it could be scary to see her do it alone -The resident could evacuate if an emergency happened but would need some direction to the door. Interview with Resident #3's family member on 08/17/17 at 11:10 a.m. revealed: -She lived out of state so she visited whenever she came in town. -The resident could walk with a walker but she would need some assistance. Observation of Resident #3 on 08/17/17 at 12:50 p.m. revealed -The resident's family member assisted the resident to ambulate from the dining room to the hallway bathroom. -The family member held on to one arm of the resident; once the resident was inside the bathroom, the family member stepped out of the bathroom. -The family member had her hand on the resident's back as they were walking back to the dining room and the staff held the resident's left arm when the resident was sitting Observation of Resident #3 on 08/17/17 at 6:20 p.m. revealed the family member had a hand on the resident's back and the staff was walking alongside the resident Interview with Resident #3's PCP on 08/17/17 at 5:30 p.m. revealed the resident was ambulatory with a walker and required minimal assistance however she would not be able to evacuate	C 007	See Attachment		



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C 007	Continued From page 7 independently in emergency situations. Refer to interview with the Administrator on 08/17/17 at 10:25 a.m. Refer to interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:10 p.m. Refer to interview with the Administrator on 08/17/17 at 3:50 p.m. 3. Review of Resident #2's current FL-2 dated 05/05/17 revealed: -The resident's diagnoses included dementia, acute encephalopathy, atrial fibrillation, essential hypertension, aortic stenosis - moderate; and urinary retention with incomplete bladder emptying. -The resident was constantly disoriented to place and time and intermittently disoriented to person. -The resident was totally dependent for ambulation, transferring, toileting, bathing, and dressing. -The resident required extensive assistance with eating -The resident was incontinent of bowel and bladder -The resident's hearing was impaired. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 11/02/16 -The resident was forgetful and needed reminders. -The resident required assistance with dressing, bathing, ambulation, toileting, positioning and turning, getting in and out of bed, grooming, nail care, skin care, mouth care, feeding, and orientation to time and place.	C 007	<i>See Attachment</i>		

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C 007	Continued From page 8 -The resident had a walker and a wheelchair for long distances. Review of Resident #2's current assessment and care plan dated 11/02/16 revealed: -The resident was ambulatory with aide or device. -The resident required extensive assistance with bathing. -The resident required limited assistance with eating, toileting, ambulation, dressing, and grooming. -The resident required supervision with transferring. -The resident was sometimes disoriented, forgetful, and needed reminders. Review of a hospital discharge summary dated 05/05/17 for Resident #2 revealed: -The resident was admitted to the hospital on 04/28/17 with altered mental status in addition to baseline dementia. -The resident's diagnoses included acute encephalopathy, urinary tract infection, weakness, and pleural effusion. -The resident was discharged on hospice services on 05/05/17. Review of a licensed health professional support (LHPS) review dated 07/14/17 for Resident #2 revealed: -The resident was lying on her hospital bed sleeping. -The resident was wearing oxygen at 3 liters per minute via nasal cannula. -The resident required assistance by 2 staff for transfers. -Staff turn and reposition the resident every 2 hours. -The resident received hospice services.	C 007	See Attachment		

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C 007	Continued From page 9 Observation of Resident #2 on 08/17/17 at 10:42 a.m. revealed: -The resident was lying in a recliner in the living room. -The resident was asleep and covered with a blanket. Observation of Resident #2 on 08/17/17 at 3:45 p.m. revealed: -The Administrator physically assisted Resident #2 transfer from sitting in the recliner chair to a standing position and walking across the living room to a sofa. -The Administrator physically held onto the resident during transferring and ambulation and verbally instructed the resident. Based on observations, interviews, and record reviews, Resident #2 was not interviewable due to diagnoses of dementia. Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 10:05 a.m.: -Resident #2 required assistance with ambulation and transferring. -Resident #2 would need physical assistance to evacuate the facility. -Resident #2 would also need assistance to be led out of the facility in the case of a fire because she would not understand what was going on. Interview with Resident #2's family member on 08/17/17 at 1:20 p.m. revealed: -The resident had lived at the facility a little less than a year. -The resident was currently receiving hospice services. -The resident had a fall in April 2017 and broke her hip. -The resident could not currently sit up or stand.	C 007	<i>See Attachment</i>		

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C 007	Continued From page 10 without assistance. -The resident would "absolutely" need physical assistance to evacuate the facility due to the resident's physical and mental incapacities. Telephone interview with Resident #2's hospice nurse on 08/17/17 at 3:30 p.m. revealed: -Resident #2 started hospice services the first time in January 2017 then came off their services and restarted on 05/05/17. -Resident #2 required two person assistance with transferring. -Resident #2 could not evacuate the facility in case of a fire either physically or mentally without assistance. Refer to interview with the Administrator on 08/17/17 at 10:25 a.m. Refer to interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:10 p.m. Refer to interview with the Administrator on 08/17/17 at 3:50 p.m. 4. Review of Resident #4's current FL-2 dated 02/09/17 revealed: -The resident's diagnoses included dementia, hypertension, and clostridium difficile colitis. -The resident was intermittently disoriented. -The resident was semi-ambulatory. -The resident was incontinent of bowel and bladder. Review of Resident #4's Resident Register revealed: -The resident was admitted to the facility on 08/25/16. -The resident required assistance with dressing, bathing, ambulation with walker, toileting.	C 007	See Attachment		

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C 007	Continued From page 11 grooming, nail care, mouth care, skin care, and orientation to time and place. -The resident had significant memory loss and must be redirected. -The resident was forgetful and needed reminders. Review of Resident #4's current assessment and care plan dated 08/26/16 revealed: -The resident was ambulatory with aide or device and required verbal cues -The resident required limited assistance with toileting, bathing, dressing, and grooming. -The resident required supervision with eating, ambulation, and transferring. -The resident was sometimes disoriented, forgetful, and needed reminders Observation of Resident #4 on 08/17/17 at 12:19 p.m. revealed: -An SIC physically assisted Resident #4 transfer from sitting on the couch to a standing position with a walker -The SIC physically held onto Resident #4's upper left arm while she assisted the resident in walking from the living room to the dining room. -The Administrator verbally instructed Resident #4 telling the resident to put her heels down when walking -The SIC physically assisted Resident #4 to a sitting position in a chair at the dining room table. Observation of Resident #4 on 08/17/17 at 12:36 p.m. revealed: -The resident was unable to feed herself. -The resident was fed and prompted by staff during the lunch meal. Based on observations, interviews, and record reviews, Resident #4 was not interviewable due	C 007	SEE Attachment		

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C 007	Continued From page 12 to diagnoses of dementia. Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 10:05 a.m.: -Resident #4 required assistance with ambulation and transferring. -Resident #4 would need physical assistance and she would have to be led out of the facility in the case of a fire because she would not understand what was going on. Refer to interview with the Administrator on 08/17/17 at 10:25 a.m. Refer to interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:10 p.m. Refer to interview with the Administrator on 08/17/17 at 3:50 p.m. Interview with the Administrator on 08/17/17 at 10:25 a.m. revealed: -The county Adult Home Specialist made a monitoring visit to the facility in July 2017 and there were concerns about two hospice residents that were unable to evacuate the facility independently in case of a fire. -One of the two hospice residents passed away after the monitoring visit. -The Division of Health Service Regulation (DHSR) Construction Section made a visit on 08/02/17 and she was told to replace the residents' bedroom doors with solid wood doors and to make sure two staff were on duty at all times. -She purchased new wooden doors on 08/04/17 and installed the doors on the residents' bedrooms on 08/07/17. -There were two staff on duty at all times.	C 007	See Attachment	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 13 Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:10 p.m. revealed: -At the last fire rehearsal (before 07/04/17), the residents evacuated to the car port area. -The staff would need to assist 4 of 5 residents (#1, #2, #3, #4) to evacuate. -Four of 5 residents had dementia so they would not be able to follow verbal directions. -Four of 5 residents would not know where to go if there was an emergency. -Four of 5 residents could ambulate with some assistance to evacuate. Interview with the Administrator on 08/17/17 at 3:50 p.m. revealed: -Four of the 5 residents currently residing in the facility would need verbal and physical assistance to evacuate. -She had not notified DHSR Adult Care Licensure Section or the Construction Section about the resident's being unable to evacuate independently. -She was aware her license capacity was for all ambulatory residents. -Most of the residents had been at the facility for a while and had declined mentally and physically over time. -She did not think about notifying DHSR when the residents' ambulatory status changed. -After the visit by DHSR Construction Section, she also added a second smoke detector in each residents' bedroom and to the hallway. -She was currently getting estimates to install a sprinkler system so she could meet the requirements to change her license capacity to non-ambulatory. -DHSR Construction Section was scheduled to come back to the facility next week to check the doors that were installed.	C 007	See Attachment	

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C 007	Continued From page 14 The facility exceeded it licensed capacity by having 4 of 5 residents that were unable to evacuate the facility independently due to cognitive and physical limitations. In the event of an emergency, such as a fire, the facility staff would be unable to evacuate residents in a timely manner. The failure of the facility to assure that residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's license was detrimental to the safety and welfare of the residents and constitutes a Type B Violation. Review of the facility's plan of protection dated 08/17/17 revealed: -There are two staff persons on each shift at all times -Extra fire alarms were added to each resident room, the den, and along the hallway. -The facility's fire alarm system is monitored by a security/fire alarm company and the system was upgraded. -The Administrator replaced all bedroom doors with solid wood doors -The Administrator will continue to work on exiting/evacuating with residents. -The facility staff will do fire watches every hour upstairs and downstairs -The Administrator will develop a form to document the fire watches -The Administrator will monitor the fire watch manual to ensure fire watch checks are being done. -The Administrator had the dryer vents and outside vents cleaned every 3 months -The Administrator will continue to get price quotes for sprinkler systems and do whatever is	C 007	See Attachment	

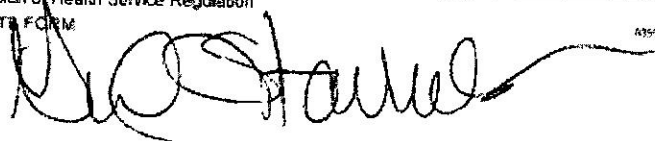
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/17/2017
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C 007	Continued From page 15 asked to keep the residents safe. -The Administrator will follow any directives given by the DHSR Construction Section for the safety of the residents. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2017	C 007	See Attachment C 059 Addendum per telephone with Ms. Gina Stavredes on 11/8/17: The staff on duty are responsible to assure cleaning supplies are locked at all times. The Administrator will monitor at least weekly during visits to the facility including review of log sheet. W. Williams 11/16/17		
C 059	10A NCAC 13G .0310 (b) Storage Areas 10A NCAC 13G .0310 Storage Areas (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure bleaches and cleaning solutions were stored in separate locked areas and were secure and not accessible to 5 of 5 residents living in the facility who were diagnosed with dementia. The findings are: Observation of the kitchen/dining room areas on 08/17/17 at 9:45 a.m. revealed: -There were a variety of cleaning supplies under the kitchen sink unsecured approximately one foot away from the dining room table where 4 residents were eating breakfast -The two doors of the cabinet under the kitchen	C 059			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE: 10918 RAVEN ROCK DRIVE RALEIGH, NC 27614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 059	Continued From page 16 sink were not lockable and were slightly ajar with various spray bottles filled with cleaning solution and cleaning supplies stored in the cabinet. -There were bottles filled with clorox bleach solution, all purpose cleaning solution, and exterior vinyl mold remover/cleaner. Observation of the laundry closet located in the dining room area on 08/17/17 at 9:50 a.m. revealed: -There were a variety of cleaning supplies including one gallon of bleach and spray bottles filled with cleaning solutions on a metal shelf above the washer and dryer. -There were a variety of spray bottles filled with cleaning solutions and a gallon of detergent on a small metal wheeled cart located between the washer and dryer. -The laundry closet doors were unlocked and slightly ajar. -The laundry closet area was less than one foot away from the dining room where 4 residents were eating breakfast. -There were bottles filled with clorox bleach solution, a gallon of bleach opened and laundry liquid solution and laundry powder opened. Observation of a residents' bathroom on 08/17/17 at 10:00 a.m. revealed: -There were a variety of cleaning supplies stored in a light brown medium sized box. -The cabinet doors were not secured or lockable. -The cabinet doors were slightly ajar -There were bottles filled with all purpose cleaning solution and clorox bleach solution. Review of the facility's 5 residents' records revealed 5 of the 5 residents had diagnoses of dementia.	C 059	See Attachment		



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C 059	Continued From page 17 Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 11:05 a.m. revealed. -Chemicals were kept locked in the outside storage closet area. -All chemicals/cleaning supplies were kept locked in the laundry closet or in the outside storage areas. -The laundry closet doors locked when they were closed hard. -Cleaning supplies were left out because someone forgot to put them away in a locked area -She had not seen any resident touch the cleaning supplies. Interview with a second SIC on 08/17/17 at 12:40 p.m. revealed -All chemicals were to be locked in one of the two secure areas. -Cleaning supplies were kept in the laundry closet or in the outside storage closet of the facility. -The cleaning supplies may have been left out by mistake by staff using them. -All staff were asked to keep all cleaning supplies in one of the two locked areas. Observation of the lockable laundry closet by the dining room on 08/17/17 at 12:50 p.m. revealed the closet was unlocked and contained various cleaning supplies such as a gallon of opened bleach, all purpose cleaning solution, and liquid laundry detergent. Observation of the residents' bathrooms and the kitchen cabinet area under the sink on 08/17/17 at 12:50 p.m. revealed the cleaning supplies had been removed. Interview with the Administrator on 08/17/17 at 1:15 p.m. revealed:	C 059	<i>See Attachment</i>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
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C 059	Continued From page 18 -Staff were to keep all cleaning supplies in the locked laundry closet or in the locked storage closet outside on the carport of the facility. -The laundry closet should have been locked but the latch on the laundry doors needed repair. -She was unaware the laundry doors would not stay locked if the doors were not closed hard. -She would have the locks on the laundry doors repaired as soon as possible. -Staff would be asked to keep all cleaning supplies in the locked closet area located on the carport of the facility until the laundry door locks were repaired/replaced. -The cabinet area under the kitchen sink was not lockable storage. -Cleaning supplies should not have been left under the kitchen sink. -Sometimes staff would forget to lock up the cleaning supplies in one of the two areas. -She was not aware of any of the residents ever touching the cleaning supplies. -Cleaning supplies should never be kept within the residents' reach. -She would immediately inform all staff to ensure that cleaning supplies were locked up in one of the two identified areas of the facility when not in use. Observation of the Administrator on 08/17/17 at 1:30 p.m. revealed she had removed the cleaning solution supplies and placed them in the locked storage closet are of the carport. The failure of the facility to assure cleaning supplies including bleach, liquid and powder laundry detergents, all purpose cleaning solutions, and exterior vinyl mold remover/cleaner were stored in locked areas and secured away from 5 of 5 residents living in the facility who were	C 059	See Attachment		

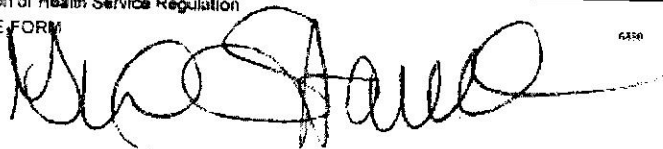
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
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C 059	Continued From page 19 diagnosed with dementia was detrimental to the health and safety of the residents. This constitutes a Type B Violation. Review of the facility's plan of protection dated 08/17/17 revealed: -All cleaning products have been moved to locked areas -The Administrator will repair the lock on the washroom door immediately. -The washroom is to remain locked at all times -Cleaning supplies in the hall closet will remain locked at all times. -The doors of the storage areas need to be checked often to ensure the safety of all residents -Each shift when arriving and leaving, staff will check all areas to ensure there are no cleaning items left out. -Staff will also check to make sure the washroom and hall closet are locked and secure. -The Administrator will monitor a log book for checking cleaning supplies. -The Administrator will do unannounced spot checks to ensure all cleaning supplies are locked or if cleaning supplies are being used, they are attended at all times. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2017.	C 059	See Attachment C202 Addendum per telephone with Ms. Gina Starnedes on 11/8/17: All current residents have required TB skin tests on file. The Administrator is responsible for assuring TB skin tests are done as required upon admission. The Administrator will monitor personnel files at least monthly. The correction date is 8/23/17. W. Williams		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each	C 202			

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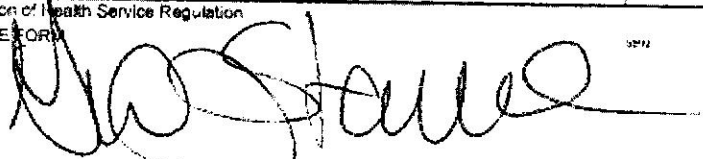
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
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C 202	Continued From page 20 resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 residents sampled (#3) was tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services The findings are: Review of Resident #3's current FL-2 dated 10/01/16 revealed the resident's diagnoses included dementia, osteoporosis, coronary artery disease, macular degeneration, fall risk, and gait disturbance. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/05/15. Review of Resident #3's previous facility's "Vaccination and Tuberculosis (TB) Screening Record" form, under "TB Screening" section, revealed: -There was a TB skin test placed on 01/29/15 and read as 0 mm (negative) with no date read documented. -There was a second TB skin test placed on 02/11/15 and read as 0 mm (negative) with no date read documented.	C 202	See Attachment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/17/2017
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C 202	Continued From page 21 -There was a handwritten note beside the 01/29/15 and 02/11/15 entries that read, "See Addendum to FL-2 form" -There was a third TB skin test placed on 07/31/15 and read as 0 mm (negative) on 08/03/15. - There were no documentation of dates read for the TB skin tests placed on 01/29/15 and 02/11/15. - Review of Resident #3's previous facility's "Addendum to FL-2" form, under "TB skin test" revealed: -There was a TB skin test dated 01/29/15 and the result was 0 mm (negative). -There was a TB skin test dated 02/11/15 and the result was 0 mm (negative). -There was no documentation on the Addendum form of the dates either of these TB skin tests were read. - Interview with the Administrator on 08/17/17 at 3:00 p.m. revealed: -She was not aware Resident #3's TB skin tests were incomplete. -Resident #3 came straight from another facility in 2015 when she was admitted. -She accepted the TB tests from the previous facility -She did not notice the TB skin tests did not have the dates read when the resident was admitted. -She was contacting the previous facility to attempt to obtain "read" dates for the TB skin tests on 01/29/15 and 02/11/15.	C 202	See Attachment		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily	C 367			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2017
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C 367	Continued From page 22 retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a record of the receipt and administration of controlled substances was maintained, accurate and reconciled for 2 of 2 residents sampled (#2, #3) who were prescribed controlled substances including Lorazepam topical gel (#3) and Lorazepam tablets and liquid Morphine (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 05/05/17 revealed the resident's diagnoses included dementia, acute encephalopathy, atrial fibrillation, essential hypertension, moderate aortic stenosis, and urinary retention with incomplete bladder emptying. Review of a hospice patient information form for Resident #2 revealed the resident was admitted to hospice on 01/05/17. Review of a hospital discharge summary dated 05/05/17 for Resident #2 revealed: -The resident was admitted to the hospital on 04/28/17 with altered mental status in addition to baseline dementia. -The resident's diagnoses included acute encephalopathy, urinary tract infection, weakness, and pleural effusion. -The resident was discharged on hospice on 05/05/17	C 367	See Attachment C367 Addendum per telephone with Ms. Gina Stawredas on 11/8/17: All controlled substances including hospice kits have accurate and up-to-date CS logs that reflect the current amount on hand. The Administrator monitors at least weekly by checking CS logs, MARs, and meds on hand. The correction date is 8/21/17. W. Williams 11/16/17	

Gina Stawredas

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUREAU _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2017
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C 367	Continued From page 23 Review of a hospice physician's orders/plan of care form dated 05/05/17 revealed: -There was an order for Lorazepam 0.5mg 1 tablet every 6 hours as needed for anxiety and agitation (Lorazepam is a controlled substance used to symptoms of anxiety.) -There was an order for Morphine Concentrate 100mg/5ml take 0.25ml (5mg) every 3 hours as needed for pain or shortness of breath (Morphine is a controlled substance used to treat pain) Observation of medications on hand for Resident #2 on 08/17/17 revealed: -There was a supply of 10 Lorazepam 0.5mg tablets dispensed on 01/05/17. -All 10 of the Lorazepam 0.5mg tablets remained on hand and had not been administered. -There was a second supply of Lorazepam 0.5mg tablets dispensed on 01/06/17. -Fourteen of the 15 tablets dispensed on 01/06/17 remained on hand -There was a third supply of Lorazepam 0.5mg tablets dispensed on 05/08/17. -Four of 10 tablets dispensed on 05/08/17 remained on hand. -A total of 35 Lorazepam 0.5mg tablets were dispensed by the hospice pharmacy from 01/06/17 to 05/08/17. -Seven Lorazepam 0.5mg tablets had been used from the total supply of 35 tablets. Review of the controlled substance (CS) logs for Resident #2's Lorazepam revealed: -There was one CS log for Lorazepam 0.5mg and the information was handwritten. -The instructions were to take 1 tablet every 6 hours as needed for anxiety or agitation. -The quantity received was 10 tablets but there	C 367	See Attachment	



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C 367	Continued From page 24 was no date received documented. -The words, "hospice kit", were documented at the top of the page -The first dose was documented as administered on 06/08/17 at 1:30 p.m. -A second dose was documented as administered on 07/05/17 at 8:00 a.m. -A third dose was documented as administered on 07/06/17 at 7:00 a.m. -The amount remaining was documented as 7 tablets. -There was no other CS logs for the two other supplies of Lorazepam on hand at the facility -The CS log on hand only accounted for 3 of the 7 tablets that had been used. Review of the January 2017 - August 2017 medication administration records (MARs) for Resident #2 revealed: -There were 3 doses of Lorazepam 0.5mg documented as administered from January 2017 - August 2017 -The 3 doses were documented on 06/08/17, 07/05/17, and 07/06/17. -There was only documentation for 3 of the 7 tablets used from the supply of Lorazepam dispensed. Observation of medications on hand for Resident #2 on 08/17/17 revealed: -There was a 30ml bottle of Morphine Concentrate 100mg/5ml dispensed on 01/06/17. -The remaining liquid in the bottle was just above the increment for 20ml. -There was a 15ml bottle of Morphine Concentrate dispensed on 01/06/17. -The remaining liquid in the bottle was slightly below the increment for 15ml. -There was a 15ml bottle of Morphine Concentrate dispensed on 05/08/17.	C 367	See Attachment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 367	Continued From page 25 -The seal on the 15ml bottle dispensed on 05/08/17 had not been broken. -A total of 60ml of Morphine Concentrate was dispensed by the hospice pharmacy from 01/06/17 to 05/08/17 Review of the controlled substance (CS) logs for Resident #2's Morphine Concentrate revealed: -There was one CS log for Morphine Concentrate 100mg/5ml and the information was handwritten. -The instructions were to take 0.25ml (5mg) every 3 hours as needed for moderate to severe pain or shortness of breath. -The quantity received and date received were not documented. -The quantity of 30 was circled and dated 05/22/17 at 4:20 p.m. and marked through with the word, "error" -The back page of the CS log (for documenting liquids) for Morphine Concentrate had 7 entries for the administration of the liquid Morphine -The quantity of 120ml was circled and the first dose was documented as administered on 05/22/17 at 4:00 p.m. (30ml of Morphine at 0.25ml per dose would equal 120 doses of the medication.) -The CS log counted down in increments of 5ml only and would have been inaccurate to use for doses of 0.25ml. -One dose each was documented on 06/08/17 at 1:30 p.m., 06/09/17 at 5:00 a.m., 06/16/17 at 10:00 a.m., 07/05/17 at 9:00 a.m., and 07/06/17 at 7:00 a.m. -The last dose was documented as administered on 07/12/17 at 12:10 p.m. -A total of 7 doses were documented which would equal 1.75ml of Morphine being used. -The amount remaining was documented as 85ml. -There was no other CS logs for the two other	C 367	See Attachment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 367	Continued From page 26 supplies of Morphine Concentrate on hand at the facility. -The CS log on hand only accounted for the administration of 1.75ml of the 60ml of Morphine Concentrate that was dispensed. Review of the January 2017 - August 2017 medication administration records (MARs) for Resident #2 revealed: -There were 6 doses of Morphine Concentrate documented as administered from January 2017 - August 2017. -One dose each was documented on 06/08/17, 06/09/17, 06/22/17 (not on CS log), 07/05/17, 07/06/17, and 07/12/17. -There was only documentation for 6 doses of Morphine Concentrate or 1.5ml. Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 2:40 p.m. revealed: -Resident #2 was receiving hospice services. -The Lorazepam and the Morphine came in the resident's hospice kits. -The resident occasionally needed the Lorazepam and Morphine as "prn" (as needed) medications. -They started documentation for the liquid Morphine on the line for 120 because that was what a hospice nurse told them to do. -They were supposed to document the administration of the controlled substances on the MARs and on the CS logs. -They may sometimes forget to document in both places. -She did not know why some of the supplies of Lorazepam and Morphine did not have CS logs. Interview with the Administrator on 08/17/17 at 2:58 p.m. revealed. -Resident #2 had been on hospice previously and	C 367	See Attachment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 367	Continued From page 27 it was stopped then it restarted in May 2017. -The resident's medications came in hospice kits and some were supplied during her first admission to hospice. -The hospice pharmacy did not send CS logs with the medications like the primary pharmacy did. -Staff would have to make their own CS logs for the medications from hospice. -Staff were supposed to document the administration of controlled substances on the MARs and on the CS logs. -She did not realize some of the hospice medication supplies did not have CS logs to account for the medications. -She would contact the hospice nurse about sending some of the overstock back to hospice. -She would make sure they had updated and current CS logs for all controlled substances. Telephone interview with the hospice nurse for Resident #2 on 08/17/17 at 3:30 p.m. revealed: -Resident #2 had received hospice services from 01/05/17 - 04/05/17 and then it started again on 05/05/17. -The resident's hospice medications were sent in hospice kits by the hospice mail order pharmacy to the facility. -The resident received medications from hospice in January 2017 and May 2017. -She did not recall helping the facility fill out any CS logs for Resident #2 but another hospice nurse may have helped. -She had tried to help them with CS logs with a different resident in the past but it had been a while. Based on observations, interviews, and record review, the resident was not interviewable due to diagnoses of dementia.	C 367	See Attachment		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 367	Continued From page 28 Attempts to contact the hospice pharmacy on 08/17/17 were unsuccessful. 2. Review of Resident #3's current FL-2 dated 10/01/16 revealed: -The resident's diagnoses included dementia, osteoporosis, coronary artery disease, macular degeneration, fall risk, and gait disturbance. -There was a medication order for Lorazepam 0.5mg/0.5ml gel, apply 1ml topically 3 times a day as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety disorders). Observation of medications on hand on 08/17/17 revealed there was a total of 58 prefilled syringes of Lorazepam 0.5mg/0.5ml gel on hand. Review of Resident #3's October 2016 - August 2017 medication administration records (MARs) revealed: -There was a handwritten entry for Lorazepam 0.5 mg/0.5 ml gel, apply 1ml topically 3 times a day as needed for agitation. -Lorazepam was documented as administered beginning 10/03/16 and last on 08/16/17. -There were 3 doses administered on 10/03/16 (8 am), 10/04/16 (8 am), and 10/05/16 (8 am). -There were 3 doses administered on 12/09/16 (8 am), 12/12/16 (8 am), and 12/13/16 (8 am). -There was 1 dose administered on 01/10/17 (9 am). -There was 1 dose administered on 03/18/17 (10 pm). -There was 1 dose administered on 04/14/17 (8 pm). -There were 3 doses administered on 05/09/17 (9 am), 05/10/17 (8 am), and 05/11/17 (7 pm). -There was 1 dose administered on 06/7/17 (9 am).	C 367	SEE Attachment		

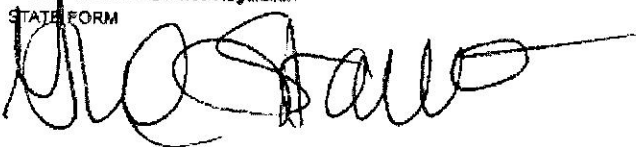
Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 29 -There were 6 doses administered on 07/24/17 (8 am), 07/25/17 (10 am), 07/27/17 (7 pm), 07/28/17 (8 am), 07/31/17 (8 am), and 07/31/17 (7:15 pm). -There were 3 doses administered on 08/01/17 (8 am), 08/15/17 (7:45 pm), and 08/16/17 (6:30 pm). Review of Resident #3's controlled substance (CS) log for Lorazepam gel revealed: -There was one CS log for Lorazepam gel. -The pharmacy label on the CS log indicated this supply of Lorazepam gel (90 gm) was dispensed on 10/05/16. -The first documented dose from this supply was on 10/05/16 at 8:00 a.m. and the first documentation started on the row of "Doses Present" for 90. -The last documented dose from this supply was 08/16/17 at 6:00 p.m. -There were 25 doses of Lorazepam gel (1ml prefilled syringes) documented as administered from 10/05/16 - 08/16/17. -There was 1 dose administered on 10/05/16 at 8 a.m. -There were 4 doses administered on 12/08/16 (7 pm), 12/09/16 (8 am), 12/12/16 (8 am), and 12/13/16 (8 am). -There were 4 doses administered on 01/10/17 (9 am), 01/11/17 (10 am), 01/12/17 (8 am), and 01/13/17 (8 am). -There was 1 dose administered on 03/18/17 (10 pm) -There was 1 dose administered on 04/20/17 (7 pm). -There were 3 doses administered on 05/04/17 (7 pm), 05/09/17 (8 pm), and 05/10/17 (8 am). -There were 2 doses administered on 06/07/17 (9 am) and 06/22/17 (7:30). -There were 6 doses administered on 07/24/17 (8 am), 07/25/17 (10 am), 07/27/17 (7 pm), 07/28/17 (8 am), 07/31/17 (8 am), and 07/31/17 (7:15 pm).	C 367	See Attachment	

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Division of Health Service Regulation

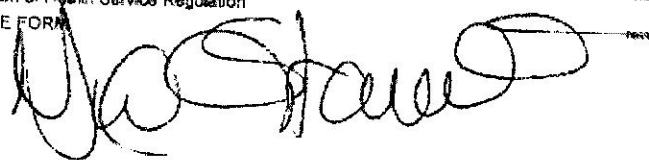
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
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C 367	Continued From page 30 -There were 3 doses administered on 08/01/17 (8 am), 08/15/17 (7:45 pm), and 08/16/17 (6 pm). -The CS log indicated 66 prefilled syringes of Lorazepam 0.5mg/0.5ml gel was the amount remaining. Review of Resident #3's CS log and MARs from 10/2016 - 08/2017 revealed: -There were 25 doses of Lorazepam gel documented as administered on the CS log. -There were 22 doses of Lorazepam gel documented as administered on the MARs. -There was inaccurate documentation of Lorazepam gel on the CS log and MARs. -There were 4 doses of Lorazepam gel (10/03/16, 10/04/16, 04/14/17, 05/11/17) not documented on the CS log but documented on the MARs. -There should have been 29 doses documented on the CS log. -There were 3 doses of Lorazepam gel that could not be accounted for. Based on observations, interviews, and record review, Resident #3 was not interviewable due to diagnosis of dementia. Interview with a Supervisor-in-Charge (SIC) on 08/17/17 at 3:45 p.m. revealed: -She always counted the controlled drugs and documented the number of drugs remaining. -She counted Resident #3's Lorazepam gel after she last administered (08/01/17) the gel to the resident. -She was not aware that the total number of Lorazepam gel on hand did not match the CS log. Interview with the Administrator on 08/17/17 at 4:30 p.m. revealed: -She was aware that the total number controlled drugs on hand and the countdown sheet must	C 367	See Attachment		

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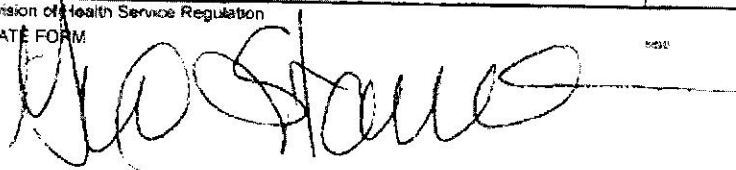
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/17/2017
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C 367	Continued From page 31 match. -She was not aware that Resident #3's Lorazepam gel did not match. -She did not suspect there was drug diversion going at the facility but the staff forgetting to document on both the MAR and CS log. -She administered Lorazepam gel to Resident #3 on 08/15/17 and 08/16/17 and documented on the MAR but she forgot to document on the CS log.	C 367	See Attachment	
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to capacity and storage areas. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation that residents' evacuation capabilities were different from the evacuation capability listed on the home's license for 4 of 5 residents (#1, #2, #3, #4) residing in the facility who had cognitive and/or physical impairments which would prevent the residents	C 912		

Division of Health Service Regulation
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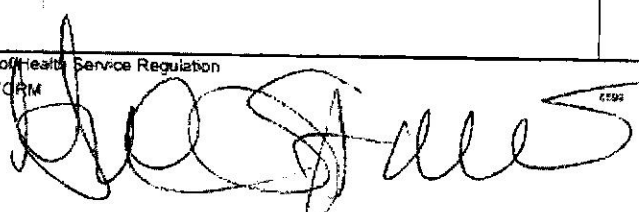
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/17/2017
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614			
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C 912	Continued From page 32 from independently evacuating the facility [Refer to Tag C007 10A NCAC 13G .0206 Capacity (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure bleaches and cleaning solutions were stored in separate locked areas and were secure and not accessible to 5 of 5 residents living in the facility who were diagnosed with dementia. [Refer to Tag C059 10A NCAC 13G .0310(b) Storage Areas (Type B Violation).]	C 912	See Attachment		



**Elsie's Place Family Care Home
10916 Raven Rock Drive
Raleigh, N.C 27614
Gina Stavredes, Administrator
License number: FCL-092-102**

Plan of Protection

9-17-2017

Dear Wendy,

I am faxing you my Plan of Protection on the following areas:

- 10A NCAC 13G. 1008 (a) Controlled Substance
- 10A NCAC 13G. 0206 Capacity
- 10A NCAC 13G. 0310 (b) Storage Areas
- 2 step TB test (sorry don't know the code for this)
- Request for Extension for Fire Sprinkler System

The reason I went ahead and did the 2 step TB test I never heard from [REDACTED] so I felt I needed to get something in place to ensure it will happen again.

I am also faxing you the forms I have developed to ensure these areas will not have any other issues arise. As well as our schedule of 2 staff per shift until Fire Sprinkler System is completely installed and approved by DHSR Construction Section.

As of 8/31/2017 I have a contract with [REDACTED], A [REDACTED] Company, contingent on estimate from [REDACTED] estimate for Fire Panel [REDACTED] with [REDACTED] is coming on 9/5/2017 to look at Elsie's Place for Fire Panel

Thank you so much for your assistance with this and for all your support!

Gina Stavredes

**Elsie's Place Family Care Home
N.C DHSR Adult Care Licensure
Request for Extension
Rule Violation Cited: 10A NCAC 13G.0206
Capacity**

I am requesting an extension on the installation of our Fire Sprinkler System. After speaking with several companies regarding my Fire Sprinkler Systems I received 2 quotes for installation.

1. [REDACTED] 919-[REDACTED] with [REDACTED] 8-22-2017
2. [REDACTED] 919-[REDACTED] with [REDACTED] and [REDACTED] 8-29-2017

I accepted [REDACTED] quote contingent on quote I would be receiving from [REDACTED] with [REDACTED] who would be installing the Fire Panel [REDACTED] only installs Sprinkler Systems and tanks).

I received quote from [REDACTED] on 9-20-2017 which I have accepted. I spoke with [REDACTED] on 9-21-2017 regarding a completion date, he estimates middle to end of December 2017. I ask why it would take so long his reply

- Getting plans drawn up 2-3 weeks
- [REDACTED] will forward his plans to [REDACTED] with [REDACTED]
- [REDACTED] will then submit the plans to his department to draw his plans to be drawn up (1-2 weeks)
- I will submit both drawings to [REDACTED] and [REDACTED] County for approval
- Getting approval from [REDACTED] County minimal 6 weeks (from his passed history)
- If any adjustments in plans need to be made and returned to [REDACTED] County for approval?
- Because I am on Well System this requires installation of 2 large tanks and pump system which requires installation of 230 volt plug and installation of reduced pressure backflow preventer (this will have to be installed by electrician and plumber). Which require permits from [REDACTED] County which also takes time 1-2 weeks.
- Once approved it will take 2 weeks for installation of system
- Will then contact DHHS Construction Section and [REDACTED] County for inspections, which after speaking with [REDACTED] this process with take up to 6 weeks

If everything goes without issue I am expecting this process to be complete by 3-1-2018.

I apologize for the length it is taking but I am at the mercy of all my contractors and inspectors and will continue 2 staff members per shift and fire rounds until the completion of installation of our Fire Sprinkler Systems.

Thank you in advance for your understanding with this matter,

COO? - Refer to addendum on page 1 of the Statement
of Deficiencies. W. Williams
11/16/17

Elsie's Place
New Policy regarding Fire Watch
8/18/2017

Following our State Inspection we have been instructed to begin Fire Watch rounds. What this includes is one staff member to make rounds around the entire upstairs and downstairs. What this involves is looking for potential fire hazards, smelling smoke, clogged vent etc. These are to be done once an hour by one staff member, staff members can alternate. Once the round is complete who ever completed the flow sheet needs to be completed and signed, this sheet needs to be completed after every round.

If you have any questions please feel free to contact me.

Thank you!

Gina

C007 -

* Refer to addendum on page 1 of the Statement of Deficiencies.

W. Williams
11/16/17

Elsie's Place License # FCL-092-102
N.C DHSR Adult Care Licensure Section
Plan of Protection
Rule Violation Cited: 10ANACAC 13G.0310 (6)
Storage Areas
8-17-2017

All cleaning supplies will be locked up at all times in washroom located in kitchen and in hall closet across from bathroom. This was completed while survey inspectors where at Elsie's Place on 8-17-2017.

These areas need to be monitored on each shift to ensure they remained locked at all times, if cleaning supplies are being used they are to be in the hands of staff at all times to ensure residents do not have contact with any cleaning supplies, administrator will also ensure all locks are secure and working properly.

Administrator will have a in service with all staff reviewing the above safety areas regarding cleaning supplies and have a in service on dementia and toxic chemicals to ensure they understand the dangers of cleaning supplies.

Administrator will develop a log sheet to be filled out at the beginning and end of each shift to sign off and by signing this form they are stating all cleaning supplies are in locked areas.

Administrator will make unannounced visits to ensure all staff are following these instructions at all times. If any cleaning supplies are not locked up or being used and not being monitored by staff using them they will be written up after 3 write ups they will be taken off schedule for a time determined by administrator.

All cleaning supplies will be locked up in appropriate areas: **Completion Date 8-17-2017**

Log sheet will be available to begin documenting on: **Completion Date 8-18-2017**

Gina Stavredes, Administrator

Signature: _____ **Date:** _____

C-059 * Refer to addendum on page 16 of the
Statement of Deficiencies.

W. Williams
11/16/17

Elsie's Place
New Policy 8/18/2017
Cleaning Product Storage Policy

All cleaning/chemical storage is to be locked are located in the laundry room and hall closet across from bathroom. If at any time cleaning/chemicals are being used by staff they need to be monitored at all times and locked back up in proper areas.

We have a new flow sheet for monitoring cleaning products, when arriving at work one of the 2 staff members need to make rounds and use flow sheet to check off what they observed. The 2 staff members need to communicate to ensure rounds are completed and documented. I will be monitoring the flow sheets and if they are not complete both staff members will be responsible.

If you have any questions please feel free to contact me.

Thank you,

Gina

Elsie's Place
NC DHSR Adult Licensure
Plan of Protection
8/17/2017
2 Step TB test and Results

Prior to admitting a resident to Elsie's Place will have all forms and immunization records on hand and will check dates of immunizations and results. If resident has not had TB skin test done will advise family to 1st TB skin test done and read prior to being admitting to Elsie's Place. At the time of admission will schedule for home health agency to give 2nd TB skin test as well as return date to read results.

This will be a standard practice at Elsie's Place going forward to ensure Elsie's Place is in compliance with NC DHSR Adult Licensure Regulations.

* C202 - Refer to addendum on page 20 of the Statement of Deficiencies.

W. Williams
11/16/17

ELSIE'S PLACE PRIOR TO ADMISSION

- Give FL-2: Review instructions
- Give Bill of Right's & Resident registration
- Family must pay community fee and 1st Month's rent/prorated amount prior to admission.
- Request Medicare/Insurance cards (need copy for chart)
- Lost Resident Form
- Funeral Information Form
- Administrative Information Sheet
- Signed Resident Contract
- Initial and date each page of contract, check in, etc... at bottom right.
- Request 2 step TB test (if it has not been done you must have 1st one read before moving in.)
- Resident Functional Activity Care Plan filled out by a physician
- Information on POA and code status (DNR ?)
- All emergency information
- Sign and date all forms, initial and date the bottom right corner of all pages

ALL FORMS MUST BE UP TO DATE AND PHYSICIAN'S SIGNATURE ON ALL FORMS THAT REQUIRE A SIGNATURE

THESE FORMS NEED TO BE IN AND COMPLETED ALONG WITH COMMUNITY FEE AND MONTHLY FEE NO LATER THAN TWO DAYS PRIOR TO MOVING IN. THIS WILL ALLOW US TIME TO REVIEW ALL FORMS TO INSURE THEY ARE COMPLETE AND ANSWER ANY QUESTIONS YOU MAY HAVE.

THANK YOU FOR YOUR HELP IN MAKING THIS A SMOOTH TRANSITION.

If you have any questions please feel free to contact me at the numbers listed below.
I'm looking forward to caring for your loved one and welcoming all of you into Elsie's Family...

Sincerely,

Gina Stavredes, Administrator
Cell 539-0397; Home; 844-0054

Initial / Date

Elsie's Place
NC DHSR Adult Licensure
Plan of Protection
8/17/2017
Rule Violation Cited: 10ANCAC 13G. 1008 (a)
Controlled Substances

Will have accurate narcotic sheet for all medications in building to ensure Elsie's will be doing weekly monitoring of all medications including non-narcotics monitoring not only MAR's narcotic sheets as well as medications on hand. All medications will be counted and will document date and time received. Will develop a flow sheet to assist in monitoring medications, review will be administered by Administrator/Supervisor and both will address any issue that occur.

Regarding Comfort Kits: Will work closely with hospice nurses to ensure all medications on hand in Comfort Kit will be listed on MAR and when appropriate have narcotic sheet with exact count when arriving at Elsie's Place. Will have hospice nurse present when documenting to ensure accuracy.
Hospice has already completed a in service to all Medication Tech at Elsie's on 8/18/2017

Pharmacy: Regarding resident reviews I contacted [REDACTED] with pharmacy on 8/18/2017 and discussed resident medication reviews and the need for reviews to be more detailed as well as focusing more on narcotics and MAR's. I have also asked for pharmacist to schedule an in service focusing on documentation on MAR's and narcotic sheets.

Completion: 8/18-2017 In service by Hospice 8/18/2017
8/21/2017 Flow sheet developed and reviews started
Will continue to contact [REDACTED] with pharmacy until he gets in service completed

* C367 - Refer to addendum on page 23 of the Statement of Deficiencies.

W. Williams
11/16/17