

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2019
NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 6, 2019 and September 9, 2019.	D 000		
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 record reviews and interviews, the facility failed to assure health care referral and follow-up with the resident's psychiatric and/or medical Nurse Practitioner (NP) for 1 of 4 sampled residents (#4) who exhibited repeated behaviors of touching, moving and removing another resident's belongings. The findings are: Review of Resident #4's current FL-2 dated 07/30/19 revealed: -Diagnosis included Alzheimer's. -Resident #4 was intermittently disoriented. -Resident #4 had wandering behaviors. Based on observations, record reviews, and interviews, Resident #4 was not interviewable.	D 273		

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

TITLE

(X6) DATE

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D 273	Continued From page 1 Interview with Resident #4's roommate on 09/09/19 at 11:14 am revealed: -She has had belongings touched, moved and she thought stolen by Resident #4. -She took visitors to her room during visits and Resident #4 talked when she tried to have private conversations with her visitors. -She wished Resident #4 left the room when she had visitors. -When she confronted Resident #4 about her belongings, she "fussed and cussed at her". -She thought staff were aware of Resident #4's behavior because staff would obtain her belongings back from Resident #4's side of the room. Interview with Resident Care Coordinator (RCC) on 09/09/19 at 11:54 am revealed: -She knew about Resident #4's behaviors of touching, moving, and removing other resident's belongings. -Resident #4 wandered and went into other residents' rooms. -She had spoken with Resident #4 about touching, moving, and removing other resident belongings, but she became "upset and cussed." -Resident #4 had dementia and she exhibited the same behavior before coming to the facility per Resident #4's son. -She had spoken with the former psychiatric Nurse Practitioner (NP) about Resident #4's behavior and Resident #4's medication was adjusted. -She told staff to try to keep Resident #4 out of her room to decrease her behavior of touching and moving her roommate's belongings. -She had not discussed resident #4's behavior with the medical NP. -There was a new Psychiatrist but she had not called to discuss the Resident #4's behaviors.	D 273		

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D 273	Continued From page 2 -She had not discussed Resident #4's behaviors with the Administrator. Interview with the Senior Manager (SM) on 09/09/19 at 1:30 pm revealed: -There were weekly meetings with the RCCs but he did not know about the behaviors exhibited by Resident #4. -He expected the RCCs to discuss with him any resident concerns. -RCCs and medication aides were responsible for communicating concerns about residents to the physician. Interview with the Administrator on 09/09/19 at 1:50 pm revealed: -She was not aware of Resident #4's behaviors. -She expected the RCCs and medication aides (MAs) to contact the providers, family members, and for the RCCs to discuss resident concerns at weekly administrative meetings. Telephone interview with Resident #4's medical NP on 09/09/19 at 4:20 pm revealed: -Staff reported to her when Resident #4 was first admitted in April 2019 that she wandered and wanted to go home. -She told the former psychiatric NP about Resident #4's behaviors and the former psychiatric NP would always follow-up with the resident. -She was contacted on 09/09/19 by the RCC to discuss Resident #4's behaviors, but that was the first time the facility had called her about Resident #4. -The former psychiatric NP saw Resident #4 on 05/08/19 and documented in the computerized medical record that "Resident #4 needed to be transferred to a memory care with wander guards because she was a high risk for elopement".	D 273			

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D 273	Continued From page 3 -Resident #4 was started on seroquel 12.5 mg (used to treat schizophrenia) and ativan was discontinued. -There was no documentation concerning touching and moving items on 05/08/09. -The former psychiatric NP last saw Resident #4 on 06/19/19 and adjusted one medication, trazodone (used for insomnia), but there was no documentation about behaviors related to touching and moving other resident's belongings.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure physician orders were implemented for 2 of 3 sampled residents (#2, #3) with orders for weekly blood pressures and weights. The findings are:	D 276		

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D 276	Continued From page 4 1. Review of Resident #2's current FL-2 dated 09/03/19 revealed: -Diagnoses included adult onset diabetes mellitus, chronic myelopathy, osteoporosis, hyperlipidemia, hypertension, chronic pleuritis, aortic atherosclerosis and depression. -There was an order for weekly blood pressures (BP). -There was an order for weekly weights. a. Review of Resident #2's six-month physician orders dated 02/26/19 revealed there were orders for weekly BPs. Review of Resident #2's July 2019 medication administration record (MAR) revealed: -There was a printed entry check BP every Thursday, scheduled for 8:00 am and dates that fell on Thursdays were shaded lighter than the other dates. -There were three of four BP readings documented for July 2019 on 07/04/19, 07/11/19, and 07/18/19. Review of Resident #1's August 2019 MAR revealed: -There was a printed entry for weekly BPs, scheduled for 10:00 am. -There was documented of two of five BPs for August 2019 on 08/15/19 and 08/22/19. Review of facility vital sign book revealed: -There was documentation of four of four BPs for July 2019. -There was documentation of two of five BPs for August 2019; there was no documentation for 08/01/19, 08/08/19, 08/22/19, and 08/29/19. Interview with Resident #2 on 09/06/19 at 9:40	D 276		

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D 276	Continued From page 5 am revealed: -Staff took her blood pressure but she did not recall the last time. -She had high blood pressure and diabetes. Telephone interview with Resident #2's Nurse Practitioner (NP) on 09/09/19 at 4:20 pm revealed: -She ordered the blood pressures because Resident #2 asked her to discontinue Lasix (used to treat hypertension). -She also ordered the blood pressures because of Resident #2's leg edema which had improved. Interview with the Resident Care Coordinator (RCC) on 09/09/19 at 11:54 am revealed: -BPs and weights were done weekly since she began working at the facility years ago. -The first and second shift were responsible for obtaining the BPs and weights. -She did not know the blood pressures and weights were not done as ordered for July 2019 and August 2019; preferred staff document the readings on the MAR instead of the vital sign book. -She had not reviewed the blood pressures and weights for August 2019 because she has had many appointments to attend. -She did not have first shift staff at this time, and the former first shift staff was not completing all required job tasks. Interview with the Administrator on 09/09/19 at 1:50 pm revealed she did not know blood pressures were not obtained as ordered for Resident #2. Refer to attempted interview with a personal care aide (PCA) on 09/09/19 at 1:31 pm.	D 276		

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D 276	Continued From page 6 Refer to interview with the Administrator on 09/09/19 at 1:50 pm. b. Review of Resident #2's six-month physician orders dated 02/26/19 revealed there were orders for weekly weights.. Review of Resident #2's July 2019 medication administration record (MAR) revealed: -There was a handwritten entry for check weight every Thursday and document, scheduled for 3-8 without a scheduled time of day. -There were two of four weights documented for July 2019 on 07/04/19, and 07/11/19. Review of Resident #1's August 2019 MAR revealed: -There was a printed entry for weekly weights, record and contact physician if weight was less than 105 pounds, scheduled for 4:00 pm. -There was documentation of one of four weights. for August 2019 on 08/15/19. Review of facility vital sign book revealed: -There was documentation of three of four weights for July 2019; there was no documentation for 07/18/19. -There was documentation of one of five weights for August 2019; there was no documentation for 08/01/19, 08/08/19, 08/22/19, and 08/29/19. Interview with Resident #2 on 09/06/19 at 9:40 am revealed she did not recall the last day she was weighed. Telephone interview with Resident #2's Nurse Practitioner (NP) on 09/09/19 at 4:20 pm revealed she ordered the weights because Resident #2 asked her to discontinue Lasix and she had diagnosis of congestive heart failure (CHF).	D 276		

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D 276	Continued From page 7 Interview with the Resident Care Coordinator (RCC) on 09/09/19 at 11:54 am revealed: -BPs and weights were done weekly since she began working at the facility years ago. -The first and second shift were responsible for obtaining the BPs and weights. -She did not know the blood pressures and weights were not done as ordered for July 2019 and August 2019; preferred staff document the readings on the MAR instead of the vital sign book. -She had not reviewed the blood pressures and weights for August 2019 because she has had many appointments to attend. -She did not have first shift staff at this time, and the former first shift staff was not completing all required job tasks. Interview with the Administrator on 09/09/19 at 1:50 pm revealed she did not know weights were not obtained as ordered for Resident #2. Refer to attempted interview with a personal care aide (PCA) on 09/09/19 at 1:31 pm. Refer to interview with the Administrator on 09/09/19 at 1:50 pm. 2. Review of Resident 3's current FL-2 dated 10/09/18 revealed: -Diagnoses included cerebrovascular accident, chronic kidney disease, hyperlipidemia, peripheral vascular disease, ataxia, dysphagia, and schizophrenia. -There was an order for weekly blood pressures. Review of Resident #3's August 2019 medication administration record (MAR) revealed: -There was a printed entry for weekly blood	D 276		

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D 276	Continued From page 8 pressure checks, scheduled for 10:00 am. -There was documentation of two of five blood pressures for August 2019. Review of facility vital sign book revealed resident #3 had a vital sign sheet with documentation of two of five blood pressures for August 2019. Interview with Resident #3 on 09/09/19 at 9:50 am revealed: -Staff obtained blood sugar checks, blood pressure checks and weighed her. -She did not recall the last date staff took her blood pressure. Telephone interview with Resident #3's Nurse Practitioner (NP) on 09/09/19 at 4:20 pm revealed: -She began caring for Resident #3 in March 2019 and she did not change anything already ordered for her. -The order for weekly blood pressures was already ordered by the previous provider and she looked at the blood pressures when she saw Resident #3 but did not recall her diagnoses because she did not have Resident #3's record with her. Interview with the Resident Care Coordinator (RCC) on 09/09/19 at 11:54 am revealed: -BPs and weights were done weekly since she began working at the facility years ago. -The first and second shift were responsible for obtaining the BPs and weights. -She did not know the blood pressures and weights were not done as ordered for July 2019 and August 2019; preferred staff document the readings on the MAR instead of the vital sign book. -She had not reviewed the blood pressures and	D 276		

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D 276	Continued From page 9 weights for August 2019 because she has had many appointments to attend. -She did not have first shift staff at this time, and the former first shift staff was not completing all required job tasks. Interview with the Administrator on 09/09/19 at 1:50 pm revealed she did not know blood pressures were not obtained as ordered for Resident #3. Refer to attempted interview with a personal care aide (PCA) on 09/09/19 at 1:31 pm. Refer to interview with the Administrator on 09/09/19 at 1:50 pm. _____ Attempted interview with a personal care aide (PCA) on 09/09/19 at 1:31 pm was unsuccessful. Interview with the Administrator on 09/09/19 at 1:50 pm revealed: -The RCC and MAs were responsible for ensuring physician orders were followed. -There was a recent staff change at the facility because the person was not performing job tasks as required.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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D 282	Continued From page 10 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to the dry goods storage shelves, coffee makers, stove top drip pans and stove hood, oven, and lower kitchen cabinets. The findings are: Review of the current county Food Establishment Inspection Report revealed the food service area received an inspection score of "A" on 01/08/19. Review of the facility daily task schedule revealed: -The tasks were divided by shifts and day of the week. -The third shift staff was responsible for cleaning different items or areas depending upon the day of the week. -The third staff were to clean the stove/oven on Sunday. -On Tuesday, the third shift staff wiped down the drawers and cabinets, and cleaned the pantry. -There was no documentation for cleaning the coffee maker. Observation on 09/06/19 at 10:20 am of the dry goods storage shelves revealed: -There were resident snack baskets, bread, potatoes, onions, and snack items stored on the wooden shelves. -There was food debris, crumbs on the fourth shelf and onion skins on the fifth shelf. Observation on 09/06/19 at 10:21 am of the stove top drip pans revealed: -There were four cooking aisles on the electrical stove top.	D 282		

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D 282	Continued From page 11 -Each drip pan was splattered with brownish stains and a greasy residue. -The edges of each drip pan had brownish stains. Observation on 09/06/19 at 10:21 am of the stove hood area revealed: -There was a yellowed coating on the stove hood that was tacky to the touch. -Underneath the stove hood, there were several brownish spots and stains splattered around the vent filter. Observation on 09/06/19 at 10:22 am of the oven revealed: -There were black and brown stains splattered on the inner over door glass. -There was a yellowish coating of greasy residue on the front outer surface of the stove directly above the oven door. -There were black stains splattered on the sides of the oven. -There were black stains at the edge of the bottom of the oven near the oven door. -There were crumbs and food debris in the lower oven drawer. Observation on 09/06/19 at 10:22 am of the two coffee makers revealed there were brownish stains on the lids for two coffee maker carafes. There was a build-up of white and black greasy substances on the front panel and control buttons of the coffee maker. Observation on 09/06/19 at 10:23 am of the lower kitchen cabinets revealed: -There were brownish drip stains throughout on each outer cabinet door. -There were drawers above the cabinet doors that had brownish drip stains scattered over the outer surface.	D 282		

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D 282	Continued From page 12 -There were four drawers near the kitchen doorway with brownish drip stains scattered over the outer surface. Interview with a Personal Care Aide (PCA) on 09/06/19 at 10:47 am revealed: -She did the following tasks daily: took out the trash, wiped down the countertops, cleaned coffee pots, organized and wiped down the shelves in the refrigerator, cleaned the microwave, cleaned the dining room tables, rinsed and placed dishes into the dishwasher, and swept and mopped the kitchen floors. -Third shift was responsible for cleaning many items in the kitchen such as the stove, oven, pantry, and cabinets. -There was a daily cleaning schedule kept in the medication room/office. -All the deep cleaning was done on third shift. -On Wednesdays, the facility did grocery shopping and the pantry shelves were cleaned and old food removed. -There were two coffee pots because the residents drank a lot of coffee in the morning. -The coffee pots were cleaned daily with dish detergent and water, but she was not able to get the brown stains off of the carafe lids. -The stove hood and the front of the stove were sticky to the touch, and she used a paper towel and a green colored cleanser to clean the stove. -She thought third shift cleaned the oven two weeks ago with oven cleaner. -She used the green colored cleanser when she spilled food on the cabinet doors or drawers. -She had not cleaned the cabinets in a while. Interview on 09/09/19 at 9:30 am with the third shift Supervisor/Medication Aide (MA) revealed: -She was responsible for cleaning the kitchen according to the daily cleaning schedule for the	D 282		

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D 282	Continued From page 13 third shift. -She cooked lunch and dinner the day before for the day shift staff to warm and serve. -Her daily cleaning tasks were rinsing the dinner dishes and placing them in the dishwasher, cleaning and sanitizing the countertops, stove top, microwave, and sweeping and mopping the floor. -Deep cleaning was done once a month; and the Resident Care Coordinator (RCC) told staff which day deep cleaning would be done. -She had not cleaned stove hood, wiped the stove drip pans daily with a dish cloth, dish detergent and water. -She had not requested or told the RCC about the condition of the drip pans. -She had not cleaned the cabinet outer doors or drawers recently and noticed that these areas had dripped food and spillage from food on them. -She used a dish cloth, dish detergent and water to clean the cabinets. -She was told the Personal Care Aide (PCA) cleaned the cabinets on 09/06/19. -She cleaned the oven three weeks ago with oven cleaner and the stains and spots were from recent cooking. -She cleaned the oven monthly. -She cleaned the coffee pot carafes and lids in the dishwasher and the brown stains had been there for a while, but she could not recall how long. -The facility had purchased new coffee makers over the years she worked at the facility but she did not know when the current coffee makers were purchased. -She cleaned out the pantry shelves once a month and the last time was August 2019. -She did not know there were crumbs and food debris on the shelves.	D 282		

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NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	Continued From page 14 Interview with the Resident Care Coordinator (RCC) on 09/06/19 at 12:58 pm revealed: -Staff had a daily cleaning schedule and the third shift staff was responsible for cleaning many areas of the kitchen. -The oven was cleaned two weeks ago with oven cleaner by third shift staff. -The cabinets were cleaned with a cleaner that was causing them to be discolored, lightening the color. -Staff was expected to clean the cabinets when food dripped or spilled on them. -The dry goods storage or pantry was on the cleaning schedule but she did not think it was being cleaned weekly according to the schedule. -She made rounds in the kitchen two weeks ago and deep cleaning was done. -She had not had a chance to do a recent round due to staff changes and attending appointments. -She and the third shift staff were responsible for the kitchen cleaning. Interview with the Senior Manager (SM) on 09/09/19 at 1:00 pm revealed: -Staff were expected to follow the cleaning schedule as documented. -Staff did not tell him about the coffee pots' stains and the inability to remove the stains. -The stove, hood, and oven were all listed on the cleaning schedule and he expected those items to be cleaned weekly. Interview with the Administrator on 09/09/19 at 1:50 pm revealed: -Staff had a cleaning schedule to follow and she expected the cleaning schedule to be completed as indicated. -The night shift was responsible for a large portion of the cleaning in the kitchen. -She had spoken with staff recently within the	D 282		

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D 282	Continued From page 15 past two weeks about maintaining the cleanliness of the facility.	D 282		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there were matching therapeutic diet menus for 1 of 3 sampled residents (#1) with an order for a cardiac diet. The findings are: Review of Resident 1's current FL-2 dated revealed: -Diagnoses included abdominal hernia with obstruction, fatty liver, type 2 diabetes mellitus -There was an order for a cardiac diet. Review of the facility diet roster in the kitchen revealed there was documentation Resident #1 was to be served a cardiac diet. Review of the facility's menus revealed there was not a menu available for use by the staff for a cardiac diet. Observation of the lunch meal service on 09/06/19 at 12:20 pm revealed:	D 296		

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D 296	Continued From page 16 -Resident #1 was served a hot dog on a bun with coleslaw, potato salad, baked beans, a small bowl of sugar free ice cream and a diet soda. -Resident #1 ate all of the meal and drank all of the diet soda. Interview with Resident #1 on 09/09/19 at 11:44 am revealed: -Her physician placed her on a strict diet, but she did not know the name of the diet. -She did not recall what she was allowed to eat and what foods were restricted. -She had heart and breathing problems and that was the reason for the strict diet. Interview with a personal care aide (PCA) on 09/06/19 at 10:47 am revealed: -She thought Resident #1 was on a regular diet. -She knew what to serve a cardiac diet because she used the regular menu posted in the kitchen. -A cardiac diet meant nothing greasy, seasoning was minimized, and bland foods were served to the resident. -There was a book she referred to as "the recipe book" in the kitchen that contained the therapeutic menus. -She used the book sometimes and had not used the recipe book daily since she first started in October 2018. -She also talked with the residents on different therapeutic diets and asked them what they preferred to eat. -She was not able to locate a cardiac menu in the recipe book. -Resident #1 was sent to the hospital once and she came back with instructions, but she did not know if the instructions changed her diet. Interview with the Supervisor/medication aide (MA) on 09/09/19 at 9:27 am revealed:	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2019
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D 296	Continued From page 17 -Resident #1 was served a regular diet because that was her diet order. -She did not know Resident #1's diet order was cardiac. -She cooked the lunch and dinner meals the same for all residents. -She did not add any sugar or salt when she cooked the food and she followed the regular menu posted in the kitchen. -The Resident Care Coordinator (RCC) reviewed the FL-2s and informed her of residents' diet order changes. -She did not have a cardiac modified menu in the modified diet book in the kitchen. -She did not call Resident #1's physician to clarify the diet order because she thought Resident #1 was on a regular diet. -She did not know what to serve Resident #1 for a cardiac diet. -She served Resident #1 a regular diet. Telephone interview with Resident #1's Nurse Practitioner (NP) on 09/09/19 at 4:20 pm revealed Resident #1 was ordered a cardiac diet because of her history of hypertension. Interview with the Resident Care Coordinator (RCC) on 09/06/19 at 12:58 pm revealed: -There was a modified diet book with therapeutic menus. -When she saw Resident #1 was on a cardiac diet she used the computer to read what food items were allowed on a cardiac diet. -A cardiac diet meant no sugars, no greasy foods, and little salt as possible. -She did not print what she viewed on the computer for a cardiac diet and verbally relayed to staff what she had read which was to serve Resident #1 no sugar, low cholesterol and low grease.	D 296		

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D 296	Continued From page 18 -Staff followed the No Added Salt, low cholesterol/low fat menu for the cardiac diet. -She had not discussed Resident #1's cardiac diet with the NP. -She had seen the NP and forgot to mention Resident #1's cardiac diet. Interview with the Administrator on 09/09/19 at 1:50 pm revealed: -The RCC and MAs were responsible for ensuring the correct diet was served to residents. -She did not know Resident #1 had a cardiac diet ordered. -There should be a menu for each diet in the kitchen modified diet book.	D 296		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to assure 1 of 3 sampled residents (Resident #1) was protected from harm and kept safe from the behaviors exhibited by a resident sharing the same room. The findings are: Review of Resident 1's current FL-2 dated 07/30/19 revealed: -Diagnoses included abdominal hernia with obstruction, fatty liver, type 2 diabetes mellitus.	D 338		

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D 338	Continued From page 19 -Resident #1 was semi-ambulatory and used a walker. -She needed assistance with bathing, dressing and feeding. Review of Resident #1's Resident Register revealed an admission date of 07/29/19. Interview with Resident #1 on 09/06/19 at 10:03am revealed: -Her roommate went through her personal items several times and stole jewelry and clothing. -A Personal Care Aide (PCA) went into her roommate's drawer last week and found one of the missing items; she could not remember the PCA's name. -Her family member planned to come to the facility on 09/06/19 to talk with staff about the stolen items. Second interview with Resident #1 on 09/06/19 at 4:48 pm revealed: -She was not currently missing any items at the time of the interview. -She informed her family member, the Resident Care Coordinator (RCC), and a Dietary Aide (DA) about her roommate stealing her items. -Her family member talked with the DA 2-3 weeks ago. -The DA told her family member he needed to come in person to talk about this matter with management. -On 09/03/19, her roommate was rummaging around in Resident #1's dresser. -She told her roommate to stop and the roommate pushed her. -Resident #4 reported this to the PCA. -The PCA said she would speak with her roommate. -Her roommate was "sick and would not change."	D 338		

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D 338	Continued From page 20 -Emergency Medical Services (EMS) was called last weekend because she was so upset over this situation. -She refused to go to the hospital because she did not want to go without her family member being present. -Her healthcare provider ordered anxiety medication for her. Telephone interview with Resident #1's family member on 09/09/19 at 10:00am revealed: -He was aware of problems between Resident #1 and her roommate. -The roommate had taken items belonging to Resident #1. -The missing items were rings, a telephone, and clothes; the rings had been returned. -He was concerned that Resident #1 was not aware of other items that may be missing. -Management did not call him about this matter. -Staff did not do anything about this matter. -Staff told Resident #1 to keep her stuff put away so her roommate would not take her items. -Two weeks ago, a former PCA (name unknown) told him to speak with management about this situation. -The PCA said she had documented about this situation in his family member's file. -Two weeks ago, the roommate put her own items in his Resident #1's closet and then accused Resident #1 of stealing the items from her. -The roommate told Resident #1 she was going to "beat her [expletive]." -The PCA did not think the threat was credible. -The PCA said the roommate would be moved to another room. -He planned to speak with management in person on 09/09/19.	D 338		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2019
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D 338	Continued From page 21 Attempted interview with the PCA on 09/09/19 at 1:32 pm was unsuccessful. A second interview with Resident #1 on 09/09/19 at 11:16 am revealed: -Her roommate had a pushed her right forearm a week or more ago, when she witnessed the roommate placing her belongings into her (Resident #1's) closet. -The PCA responded when her roommate was rummaging through her dresser and spoke with her roommate. -Her roommate had been touching, moving, and removing her belongings since she was admitted. -Whenever she confronted her roommate about touching, moving, and stealing her belongings, her roommate "fussed and cussed" at her. -She did not like being spoken to in that manner by her roommate. -When her roommate pushed her, she was told her roommate by staff that her roommate was sick and the RCC spoke with her and the roommate. -Her right forearm was not hurt, but staff called EMS because she had shortness of breath and her heart rate was fast. -She did not go to the hospital when EMS came to the facility because she began to feel better. -She did not feel the staff had done all they could do concerning addressing her roommate moving and touching and taking her belongings. -There was a former staff that would always retrieve her belongings back from her roommate. -She felt angry when dealing with the situation and was told by her family member to keep her temper down. -She did not feel safe considering she did not know when her roommate may speak to her inappropriately or move her belongings. -She had spoken with a former staff, the RCC,	D 338		

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D 338	Continued From page 22 and her family member about the situation. -She had seen the Senior Manager (SM) but she did not talk with him about her concerns with her roommate. -Staff had not done anything to help her with preventing her roommate from touching, moving and taking her belongings other than suggest she not leave her belongings out and try to secure them from her roommate. -She wanted something done but she did not know what could be done. -She had made good friends at the facility, but she did not feel comfortable with her roommate. Review of the local county emergency medical services (EMS) records for Resident #1 revealed: -EMS responded to Resident #1 on 08/30/19 at 4:20 pm at the facility for complaints of chest pain/pressure after eating. -Resident #1 was not transported. Observation of Resident #1 on 09/09/19 at 11:30 am revealed she did not have any marks or bruises on her right forearm. Interview with Supervisor/Medication Aide (MA) on 09/09/19 at 9:34 am revealed: -Residents got along with each other well. -When there were arguments between residents, she intervened and spoke with each resident involved. -The facility did not have a problem with residents not getting along with one another. Interview with the RCC on 09/09/19 at 12:20 pm revealed: -She knew Resident #1's roommate was "hiding" her belongings in her chest of drawers or closet. -She was told by staff that Resident #1 reported a week or more ago that her roommate had pushed	D 338		

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D 338	Continued From page 23 her. -The staff reported that there was no physical altercation between the residents only verbal altercation. -She spoke with both residents separately and the roommate denied pushing Resident #1. -Resident #1 told her the roommate pushed her but she did not have any injuries. -Resident #1's roommate had dementia and she thought the roommate was just cleaning and tidying up the room. -She had spoken with the roommate's family member and he reported that the roommate exhibited the same behaviors in his home of taking his belongings out of his room and moving them. -If staff saw the roommate with an item in her hand that did not belong to her she would deny it and became upset when confronted. -She told staff to try to keep the roommate out of the room because Resident #1 liked to stay in the room. -Also, she told staff to talk with the residents as well. -She thought the other residents antagonized the situation between Resident #1 and her roommate. -No staff had seen the roommate become physical with regard to her behaviors. -Resident #1 did not tell her how she felt about having her belongings touched, moved and removed from her side of the room. -She did not tell the medical Nurse Practitioner (NP) about the recent interaction between Resident #1 and her roommate. -She had not discussed the situation with the Administrator. -She had just tried to keep Resident #1 and her roommate apart as much as possible.	D 338		

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D 338	Continued From page 24 Telephone interview with Resident #1's NP on 09/09/19 at 4:20 pm revealed: -Resident #1 had discussed with her one week ago about her roommate touching, moving and removing her belongings. -Resident #1 had never told her she was pushed by her roommate, but Resident #1 expressed she was annoyed by her roommate's behavior. -She was not contacted until 09/09/19 by the staff about Resident #1's roommate's behaviors. Interview with the Administrator on 09/09/19 at 1:50 pm revealed: -She did not know about Resident #1's concerns with her roommate, until 09/09/19. -Staff did not witness any physical altercation between Resident #1 and her roommate, but that did not mean it did not happen. -She expected staff to contact the provider (medical and psychiatric), the family members, and get all parties involved in obtaining the best solution for both residents. -She expected the residents to be cared for, supported and provided with a safe environment. _____ The facility failed to assure and provide Resident #1 with a safe environment which resulted in Resident #1 being pushed by her roommate and her belongings were repeatedly touched, moved and hidden by her roommate, resulting in Resident #1 not feeling safe. This failure was detrimental to the safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 24,	D 338		

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D 338	Continued From page 25 2019	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration	D 367		

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D 367	Continued From page 26 Records for 1 of 3 sampled residents (Resident #2) related to the documentation of administration of a sedative. The findings are: Review of Resident #2's current FL2 dated 09/03/19 revealed: -Diagnoses included adult onset diabetes mellitus, chronic myelopathy, osteoporosis, hyperlipidemia, hypertension, chronic pleuritis, aortic atherosclerosis and depression. -There was an order for mirtazapine 15 mg at bedtime. Review of Resident #2's previous physician orders revealed there was a medication order for mirtazapine 7.5 mg written on 05/03/19. Review of Resident #2's Medication Administration Record (MAR) for September 2019 revealed: -There was an entry for mirtazapine 15 mg take ½ tablet (7.5 mg) daily at bedtime for insomnia, scheduled for 8:00 pm. -There was documentation mirtazapine 15 mg ½ tablet (7.5 mg) was administered from 09/01/19 to 09/05/19 at 8:00 pm. Observation of Resident #2's medications on hand on 09/09/19 at 9:00 am revealed there was one bubble pack of mirtazapine 15 mg 30 whole tablets dispensed on 9/5/19. Based on observations, record reviews, and interviews, there were no subsequent orders that changed the dose of mirtazapine. Telephone interview with Resident #2's Nurse Practitioner (NP) on 09/09/19 at 4:32 pm	D 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2019
NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 27 revealed: -Resident #2's last visit date was 09/03/19. -Resident #2 was discharged from the hospital on 09/02/19. -She completed a new FI-2 for Resident #2 on 09/03/19 and she did not have Resident #2's records for reference for the mirtazapine dose. -The order for mirtazapine 15 mg on Resident #2's FL-2 was accurate. Interview with the Resident Care Coordinator (RCC) on 09/09/19 at 12:20 pm revealed: -She transcribed new orders onto the MARs. -She was responsible for ensuring the information on the MARs was accurate. -She reviewed the next month's MARs when they arrived from the pharmacy at the end of the month. -She also tried to check the MARs once a week to catch discrepancies. -The first shift Medication Aide (MA) was the staff who checked the MARs after she reviewed them to ensure the MARs were accurate. -She no longer had a first shift MA and was in the process of finding a new MA for first shift. -She knew Resident #2 was to be administered mirtazapine 15 mg because she placed a change of instructions sticker on the previous pack dispensed by pharmacy. -She did not realize she had not documented on Resident #2's new Mirtazapine 15 mg order on the September MAR, she may have skipped over the order. Telephone interview with the facility's contracted pharmacy on 09/09/19 at 10:53 am revealed: -The pharmacy provided MARs to the facility with the current medication orders printed on the MARs. -If there were any mid-month medication order	D 367		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
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D 367	Continued From page 28 changes or medication orders after the new MARs were sent, the pharmacy did not place them on the MARs until the following month. -Resident #2 had a new order for mirtazapine sent on 09/03/19 for 15 mg and the older order was for mirtazapine 7.5 mg. -Mirtazapine 7.5 mg was dispensed on 08/30/19 for 15 whole tabs that were split by the pharmacy and was a 30-day supply. -Mirtazapine 15 mg was dispensed on 09/05/19, which was the facility's cycle fill day, 30 whole tablets were dispensed. Interview with the Administrator on 09/09/19 at 1:55 pm revealed: -The RCC/MAs were responsible for ensuring the MARs had the correct medication and dosage as ordered documented. -She expected the RCC to ensure the MARs were reviewed for accuracy. -The facility would start using electronic MARs on 10/01/19 and she hoped that it would help prevent any inaccurate information on the MARs.	D 367		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	D912		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL001029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/09/2019
NAME OF PROVIDER OR SUPPLIER SPRINGVIEW - STEWART BUILDING		STREET ADDRESS, CITY, STATE, ZIP CODE 611 W WHITSETT STREET GRAHAM, NC 27253		
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D912	Continued From page 29 Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to resident rights. The findings are: Based on observations, record reviews and interviews the facility failed to assure 1 of 3 sampled residents (Resident #1) was protected from harm and kept safe from the behaviors exhibited by a resident sharing the same room.	D912		