STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043019	A. BUILDING ______ B. WING ______	02/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRIMROSE VILLA RETIREMENT IV	431 JUNNY ROAD ANGIER, NC 27501

(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 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A VIOLATION WITH A DIRECTED PLAN OF CORRECTION. Based on observation and interviews of staff and residents, the facility failed to assure all exit doors accessible by residents were equipped with a sounding device which was audible to the staff through out the building when the door was opened. The findings are: Observation on 02/03/09 at 4:00pm of the facility's location revealed a two-lane road visible from the facility and a fence starting at the road and running along the property line behind the facility. The fence stopped behind the facility at a cedar tree. The bar-styled fence was approximately 6-feet tall. Additional observations on 02/04/09 at 5:25pm revealed beside the facility's property was a business with 18-wheel trucks docked and parked in the yard. A wooded area and a grassy	D 067		

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D 067	Continued From page 1 area separated the business and the facility's property. In the grassy area, a rocky ravine was observed running horizontally through the property of the business. Observation of the facility's front entrance door on 02/03/09 at 11:45am revealed no alarm/beeping sound was heard upon entering the facility. On 02/03/09 at 12:10pm a resident was observed walking out of the front door. No alarm/beeping sound was heard upon the resident exiting the facility. Interview with the Supervisor in Charge (SIC) on 02/03/09 at 2:15pm revealed the door alarm beeps in the SIC's room. Further interview revealed she could hear the alarm at the end of the hall where the kitchen is located if she was not talking or working. Further interview revealed it was very difficult to hear the alarms at times. Further interview revealed the Supervisor had informed her that there was another alarm, but he would have to show her how to set it. Interview with the Supervisor on 02/03/09 at 3:15pm revealed there was only one alarm system which was monitored every three months by the company who installed it. Further interview revealed he mainly worked in another building and since he did not have any wanderers he did not set the alarms. During the interview, the Supervisor revealed if a resident walked out of the door, the staff might not hear the alarm. The Supervisor stated the "beep" sound was from the alarm. Documentation provided by the Supervisor on 02/03/09 revealed service tickets from the alarm company for annual fire inspections which occurred on 04/12/02, 08/22/03, 04/01/04 and 04/20/05. No additional	D 067		

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D 067	Continued From page 2 documentation was provided by the facility of inspections by the alarm company since 2005. On 02/03/09, the alarms were checked on exit doors. Observation of the front entrance door at 3:45pm on 02/03/09 revealed when the front door was opened, two beeps were heard in the hallway near the entrance door. It was observed that the alarm keypad was located in the SIC's room and beeped in the SIC's room. Additional observation revealed the soft sound of two beeps were heard near the exit doors on the left and right sides. During the this time, there was no background noise present. Observation during this time revealed when the front exit door was not completely shut, the alarm/beeps would not sound upon opening the door. Additional observation of an exit door in the sunroom on 02/03/09 at 4:00pm revealed when the door was opened, no alarm/beep was heard. Observation of the facility revealed no staff response when the exit doors were opened throughout the survey on 02/03/09. Directed Plan of Correction for Type A Violation: 1. The facility is to assure assessment of all residents to identify residents deemed confused or at risk for wandering, or have a history of elopement. The facility is to then assure all exit doors have an alarming device in place to alert staff when these identified residents attempt to leave the building. This is to begin immediately. 2. The facility is to develop a monitoring system to ensure identified residents are supervised when the door alarms are disengaged. This is to begin immediately. 3. The facility is to assure physicians' orders and recommendations for 24-hour supervision or	D 067		

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D 067	Continued From page 3 one-on-one supervision of residents are implemented. This is to begin immediately. 4. The facility is to assure adequate staffing patterns are implemented to meet physicians' orders for supervision, as well as residents' assessed to need additional supervision due to a history of elopements. This is to begin immediately. 5. The facility is to assure all staff are knowledgeable of the above systems. 6. The facility is to identify staff deemed responsible for these systems. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 6, 2009.	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and staff who directly supervise the administration of medications shall have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule 10A NCAC 13F .0503 prior to the administration or supervision of the administration of medications. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.	D 125		

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D 125	Continued From page 4 Based on review of personnel records, and interviews, the facility failed to have documentation of successful completion of the clinical skills validation portion of the competency evaluation prior to the administration of medications for 1 of 3 medication aides sampled (Staff A). The findings are: Review of personnel record on 02/03/09 revealed Staff A was hired on 01/06/09 as a Supervisor in Charge. The personnel record revealed no documentation that Staff A had been clinically validated to administer medications at this facility. Additional review of Staff A's personnel file revealed a Clinical Skills Validation checklist from a previous employer dated 08/15/08. Review of the Medication Administration Records (MARs) revealed Staff A administered medications from 01/06/09 to 01/30/09. Additional review of the MARs revealed Staff A was on duty 24 hours per day during this time period, and passed all medications in the facility for 8 of 8 resident. Review of the MARs revealed Staff A administered oral solid medications, liquid medications orally, administered eye drops, applied skin creams and medicated patches. Interview with Staff A on 02/03/09 at 2:20pm revealed she had "certification" in medication administration. Staff A stated she was qualified because she had attended a community college. Interview with the Administrator on 02/03/09 at 4:45pm revealed she was responsible for ensuring medication aides were validated before passing medications. The Administrator stated she thought Staff A was qualified to administer medications until she was informed by the county Adult Home Specialist on 01/30/09. The	D 125		

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D 125	Continued From page 5 Administrator stated Staff A was no longer administering medications. The Administrator stated the nurse was scheduled to be at the facility on 02/02/09, but she never arrived. The Administrator stated she would get the nurse to validate Staff A. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 20, 2009.	D 125		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION. Based on interview and record review, the facility failed to ensure a criminal background check was completed for 1 of 3 employees (Staff A) in accordance with G.S. 114-19.10 and 131D-40. The findings are: Review of personnel records on 02/03/09 revealed Staff A was hired on 1/6/09 as a Supervisor in Charge. Additional review revealed no documentation a county or state-wide criminal background check was completed. During an interview on 02/04/09 at 4:30pm, the Administrator stated she was responsible for obtaining the criminal background checks. The Administrator stated she allowed the new employees to obtain a county criminal	D 139		

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D 139	Continued From page 6 background check. She stated she was only doing county criminal checks and had stopped doing the state-wide checks. Further interview revealed she was aware a state check had not been done on Staff A as required. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 20, 2009.	D 139		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: THIS IS A TYPE A VIOLATION WITH A DIRECTED PLAN OF CORRECTION Based on record reviews and interviews, the facility failed to provide supervision for 1 of 4 residents sampled whose assessed needs and current symptoms included wandering behaviors (Resident #4). The findings are: Record review revealed Resident #4's current FL-2, signed by the physician on 11/25/08, listed the following diagnoses: Bipolar Affective Disorder, Hypertension, Psychotic Features, Inflammatory Bowel Disease, Iron Deficiency Anemia. The FL-2 documented the resident was intermittently disoriented and wandered intermittently. The Care Plan dated 11/25/08 revealed the resident was sometimes disoriented, forgetful and needed reminders. The Care Plan also documented the resident was independent	D 270		

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with ambulation. Record review revealed the following physician's orders:

On 11/28/08 an order for Trazodone 150mg at bedtime as needed for sleep;
On 01/06/09 an order for Vistaril 50mg at bedtime as needed for sleep and nerves.

Review of the January 2009 Medication Administration Record (MAR) revealed Resident #4 received Trazodone each night from 01/01/09-01/31/09 for sleep. The results documented were "ok" for each night.

Review of the February 2009 MAR revealed no documentation Trazodone nor Vistaril was administered on 02/01/09.

Record review revealed a hospital visit on 10/08/08 which stated the resident was "very demented" and confused. Review of the hospital's flow sheets revealed the resident required a sitter while in the emergency department due to confusion. The note stated "the sitter is a staff member. The pt [patient] is under constant surveillance by the sitter". An additional note documented on the flow sheet stated, "Pt [patient] crawling out of bed several times and assisted back to bed and placed back on monitor. Pt is confused, found pt standing in doorway with gown off. Pt assisted back into gown".

According to interviews with the Activity Staff, SIC and Medication Aide/SIC on 02/03/09 and 02/04/09, Resident #4 required supervision because she liked to "walk" throughout the night. Record review revealed no documented history of elopement; however, interviews on 02/03/09 and 02/04/09 revealed Resident #4 had left the facility

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D 270	Continued From page 8 "several times". During an interview with the Administrator on 02/03/09 at 1:30pm, she revealed Resident #4 was independent when the resident was admitted. Further interview revealed the resident was also competent to go uptown unsupervised when she first was admitted. Continued interview revealed Resident #4's behavior had changed approximately two years ago when she became depressed. According to the Administrator the resident had started packing her clothes and coming to the door wanting to leave. When this behavior started Resident #4's family member moved her to another facility but the resident was still not happy and the resident was readmitted to a sister-facility. The Administrator said she had moved her to this facility so she could be with other females her age with hopes it would help calm the resident. Continued interview revealed Resident #4's behaviors did not improve. Further interview revealed the physician was contacted and informed of the resident's condition. The Administrator revealed they had changed physicians and the current physician was aware the resident was a wanderer. Further interview revealed the resident had been referred to a psychiatrist approximately a year ago due to dementia. The Administrator stated during the interview they had no written policies on supervision of residents but had verbally informed the Supervisors in Charge to keep their eyes on the resident and keep her with them. The Administrator stated they tried to keep the resident busy. During the interview, the Administrator stated the resident was not a wanderer because "we watched her". According to the Administrator, Resident #4 had left the	D 270		

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D 270	Continued From page 9 facility last year. The Administrator stated they saw her behind the building and watched her until she started going towards the gate. The Administrator stated they went to get her, but the resident could walk very fast. According to the Administrator the resident had gotten about a mile away from the facility before staff caught her. Further interview with the Administrator revealed the SIC had contacted her on 02/02/09 around 7:30am and informed her she went to check on the resident again at 7:00am to 7:15am, but the resident was no longer in the facility. The Administrator instructed the staff to call the police. Interview revealed the SIC had last observed the resident in her bed at 5:30am. The Administrator stated by the time she arrived at the facility the police were there. Further interview revealed she had contacted the resident's responsible party as soon as she got to the facility at around 8:15am. When asked about the facility schedule, the Administrator stated the Activity Staff provides showers to residents in the facility on Mondays, Wednesdays and Fridays. The Administrator stated the SIC's responsibilities were to prepare meals, administer medications and watch the residents. The Administrator stated breakfast preparation should take no longer than 1 hour. The residents should be eating breakfast by 8:00am. The Administrator stated the Supervisor administers medications in the facility between 7:30am and 8:00am. During the interview the Administrator stated the facility did not have a written policy for wanderers. The Administrator stated she and the Supervisor verbally informed new employees of their duties and how to supervise the residents according to	D 270		

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D 270	Continued From page 10 their needs. Interview with the SIC on 02/03/09 at 2:15pm revealed she checked on the resident at 5:00 am; then the SIC took a shower. The interview revealed the SIC had checked on Resident #4 at 5:30am and found her sleeping in her bed. The SIC stated the resident walks at night so she sleeps in the morning. According to the SIC another staff (the Activity Staff) who was suppose to be at work at 7:00am on 02/02/09 was running late. The SIC stated she had been busy preparing breakfast. The SIC said she normally kept Resident #4 with her in the kitchen or office when the resident was awake. Further interview revealed she went to check on Resident #4 at 7:50am and discovered the resident was not in bed. The SIC said she checked the facility to see if Resident #4 was in the facility since she had found the resident in a closet at one time. Further interview revealed when she could not locate the resident she called the Supervisor who was in a sister facility which was on the premises. The SIC (Staff A) stated she called the Supervisor (Staff C) three times, but when she could not reach him, she called the Administrator. Continued interview revealed the Administrator told her to go find the Supervisor and to call the police. Further interview revealed after the Supervisor was located he started searching the grounds for Resident #4 but was unable to find her. The SIC stated it was after 8:00am when the police were called. The SIC revealed it was very difficult to hear the alarms at times. The SIC revealed she is dependent on the other staff who arrives at 7:00am to watch the residents while she is preparing breakfast. The SIC revealed she was the only staff in the facility during that time to supervised the residents and prepare breakfast.	D 270		

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Interview with the Supervisor on 02/03/09 at 3:15 pm revealed the Administrator called him after 7:00am after the SIC called her on 02/02/09 regarding Resident #4. The Supervisor revealed as soon as he was contacted about Resident #4 not being in the facility, he and two other employees started searching the facility grounds and surrounding area for the resident. Further interview revealed he could not remember how long they searched but said "for a good little bit". The Supervisor stated they searched more than 30 minutes. The Supervisor said the SIC had called the police, and the police arrived while they were looking for Resident #4. Further interview revealed the Supervisor could not give a time when the police arrived. Continued interview revealed the Administrator had called the resident's family member as soon as she arrived at the facility.

Further interview with the Supervisor revealed the facility did not have any wanderers. The Supervisor stated if the facility "accepted wanderers they would be in trouble because wanderers should be in a locked unit".

In an interview with the Activity Staff, on 02/04/09 at 11:35am, she revealed she works Monday through Friday from 7:00am to 1:00pm. The interview with the Activity Staff revealed on 02/02/09, she arrived at 7:00am and was told that Resident #4 was missing "before she got out of the car". The staff stated she re-checked the facility, then got back in her car and checked housing developments. She stated she searched for about 20 to 25 minutes. When she returned to the facility the police were already there.

During the interview, the Activity Staff recalled an incident when the Administrator had to go and get

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the resident because the resident had left the facility. The Activity Staff stated when she arrived at the facility in the mornings she would get the resident up if she was not already up. The Activity Staff stated they supervised Resident #4 by keeping her "right beside" the staff or in the kitchen with them so they would not have to go after her. The Activity Staff stated they also gave the resident books to read.

In a confidential interview with staff, it was revealed Resident #4 left the facility several times. It was revealed Resident #4 was the resident that staff "really had to watch".

An interview with the SIC on 02/03/09 at 2:15pm revealed she told the Supervisor about the resident not sleeping. The SIC stated she was responsible for preparing meals, assisting residents with personal hygiene and making sure the residents are "happy". When asked about supervising residents, the SIC stated it depended on the resident as to how much she watched them. The SIC stated she always kept Resident #4 near her.

Based on an interview on 02/13/09 at 9:45am with a police official, on 02/02/09 at 7:49am, the local police department was dispatched to the facility to search for Resident #4 who was missing. Emergency Services call details revealed at 12:24pm, Resident #4 was located. According to a statement provided by Emergency Services dated 02/02/09, Resident #4 was found laying down in the ravine and did not respond when touched and had no pulse. Review of the Medical Examiner's Certificate of Death stated the resident's time of death was 6:00am on 02/02/09 from a closed head injury due to falling in a ditch.

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D 270	Continued From page 13 Interview with Resident #4's family member on 02/10/09 at 9:10am revealed the Administrator called her cell phone at 10:00am and 11:30am on 02/02/09. Further interview revealed the Administrator had left a message saying Resident #4 was missing. Interview with the Administrator on 2/3/09 at 1:30pm revealed residents are supervised according to their needs. Interview with the SIC on 2/3/09 at 2:15 pm revealed the resident had been checked at 5:30 am and was in bed asleep. The SIC stated she went to the kitchen to prepare breakfast. When the SIC returned to check on the resident at 7:50 am, Resident # 4 was not there. The facility's staffing pattern did not prevent other duties from interfering with immediate response to and supervision of residents. Directed Plan of Correction for Type A Violation: 1. The facility is to assure assessment of all residents to identify residents deemed confused or at risk for wandering, or have a history of elopement. The facility is to then assure all exit doors have an alarming device in place to alert staff when these identified residents attempt to leave the building. This is to begin immediately. 2. The facility is to develop a monitoring system to ensure identified residents are supervised when the door alarms are disengaged. This is to begin immediately. 3. The facility is to assure physicians' orders and recommendations for 24-hour supervision or one-on-one supervision of residents are implemented. This is to begin immediately. 4. The facility is to assure adequate staffing patterns are implemented to meet physicians' orders for supervision, as well as residents'	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043019	A. BUILDING ______ B. WING ______	02/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 14 assessed to need additional supervision due to a history of elopements. This is to begin immediately. 5. The facility is to assure all staff are knowledgeable of the above systems. 6. The facility is to identify staff deemed responsible for these systems. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 6, 2009.	D 270		
D 448	10A NCAC 13F .1211 Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following: (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications; (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse; (3) accident, fire safety and emergency procedures; (4) infection control; (5) refunds; (6) missing resident; (7) identification and supervision of wandering residents;	D 448		

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D 448	Continued From page 15 (8) management of physical aggression or assault by a resident; (9) handling of resident grievances; (10) visitation in the facility by guests; and (11) smoking and alcohol use. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop written policies and procedures for missing residents and for identification and supervision of wandering residents. The findings are: Record review revealed Resident #4's current FL-2, signed by the physician on 11/25/08, which included diagnoses of Bipolar Affective Disorder and Psychotic Features. The FL-2 documented the resident was intermittently disoriented and wandered intermittently. The Care Plan dated 11/25/08 revealed the resident was sometimes disoriented, forgetful and needed reminders. Record review revealed a hospital visit on 10/08/08 which stated the resident was "very demented" and confused. Review of the hospital's flow sheets revealed the resident required a sitter while in the emergency department due to confusion and remained under constant surveillance by the sitter. The note stated the sitter is a staff member. Review of call transcripts provided by Emergency Services revealed on 02/02/09 at 8:53am a call was received in reference to a missing person. On 02/02/09 at 9:12am, Emergency Services was at the facility. According to a statement provided by Emergency Services dated 02/02/09, Resident	D 448		

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D 448	Continued From page 16	D 448		

#4 was found laying down in the ravine and did not respond when touched. The resident did not have a pulse. Review of the Medical Examiner's Certificate of Death stated the resident's time of death was 6:00am on 02/02/09 from a closed head injury due to falling in a ditch.

Interview with the Administrator on 02/03/09 at 1:30 pm revealed the residents are supervised according to their needs. The Administrator revealed the facility did not have written policies but she and the Supervisor would walk around with the new employees and verbally tell them what their duties were and how to supervise the residents according to their needs. Further interview revealed they tried not to accept wanderers but if the resident had a history of wandering, staff were to keep the resident with them and keep the resident busy unless there was another staff person in the facility who was responsible for the resident's supervision. The Administrator revealed they had no written policies on supervision of residents but had verbally informed the Supervisors in Charge to keep their eyes on the resident and keep Resident #4 with them. The Administrator stated they tried to keep the resident busy. During the interview, the Administrator stated the resident was not a wanderer because "we watched her".

Interview with the Supervisor in Charge (SIC) on 02/03/09 at 2:15pm revealed she had started working at the facility on 01/06/09 and was verbally informed how to supervise residents. Further interview revealed she had been instructed to keep Resident #4 close to her and busy. The SIC stated supervision depended on the residents as to how much she watched them.

Interview with the Supervisor on 02/03/09 at

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D 448	Continued From page 17 3:15pm revealed the facility did not have written policies on the supervision of residents. Further interview revealed the staff were told verbally how to supervise residents according to their needs. Interview revealed there were no wanderers in the facility. Further interview revealed the facility did not "accept wanderers and they would be in trouble if they did because wanderers should be in a locked unit".	D 448		
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: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to physical environment, qualifications of medication staff, other staff qualifications, and personal care and supervision. The findings are: 1. Based on observation and interviews of staff and residents, the facility failed to assure all exit doors accessible by residents were equipped with a sounding device which was audible to the staff through out the facility when the door was opened. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type A Violation)]. 2. Based on review of personnel records, and interviews, the facility failed to have	D912		

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D912	Continued From page 18 documentation of successful completion of the clinical skills validation portion of the competency evaluation prior to the administration of medications for 1 of 3 medication aides sampled (Staff A). [Refer to Tag 0125, 10A NCAC 13F .0403 Qualifications Of Medication Staff (Type B Violation)]. 3. Based on interview and record review, the facility failed to ensure criminal background checks were completed for 1 of 3 employees (Staff A) in accordance with G.S. 114-19.10 and 131D-40. [Refer to Tag 0139, 10A NCAC 13F .0407 Other Staff Qualifications (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to provide supervision for 1 of 4 residents sampled whose assessed needs and current symptoms included wandering behaviors (Resident #4). [Refer to Tag D270, 10A NCAC 13F .0901 Personal Care and Supervision (Type A Violation)].	D912		