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A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation on 09/10/19 to 09/11/19. The complaint investigations were initiated by the Alexander County Department of Social Services on 07/29/19.	{D 000}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review, and interviews, the facility failed to assure the facility was free of hazards as evidenced by a resident smoking with oxygen in use creating an opportunity for an ignition of a combustible exposing all occupants of the facility to danger of a fire or explosion. The findings are: Observation during initial tour of the facility on 09/10/19 at 9:15am revealed: -Resident #2 was sitting on the porch in a chair	D 079		

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with an oxygen nasal cannula in her nose smoking a cigarette.
-The oxygen nasal cannula was connected to a portable oxygen tank.
-A housekeeper was present at the end of the side walk cleaning a throw rug with a broom.
-The housekeeper did not approach Resident #2.
-The housekeeper walked past Resident #2 and entered the building.
-When the housekeeper was walking into the building a medication aide (MA) approached the entrance to the building.
-The MA remained in the building and did not approach Resident #2 on the porch outside of the building.
-After prompting the MA returned to the porch approached Resident #2 to remove the oxygen from Resident #2.

Review of the facility's policy for use of tobacco dated 12/10/14 revealed:
-"1. Residents who smoke must use designated smoking areas."
-"2. No smoking is allowed in residents' bedrooms."
-"3. Staff will supervise residents who smoke as needed."

Interview with the Resident #2 on 09/10/19 at 9:30am revealed:
-She used oxygen continuously because with exertion she had become short of breath.
-She sat on the porch with her oxygen in her nose and smoked when she had cigarettes to smoke.
-No one had told her not to do this.
-She turned the oxygen off and left the nasal cannula in her nose connected to the oxygen tank.
-She did not know that if she left the nasal cannula in her nose when she was smoking the

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residual amount of oxygen in the tubing could ignite causing a fire or explosion.

Interview with the housekeeper on 09/10/19 at 9:49am revealed:
-He knew Resident #2 was sitting on the porch smoking with an oxygen nasal cannula connected to a portable oxygen tank.
-He did not approach Resident #2 because she was a very sensitive resident that became emotional easily.
-He did not immediately go and tell a MA that Resident #2 was smoking with an oxygen nasal cannula in her nose.
-He did not want to upset Resident #2.

Interview with the MA on 09/10/19 at 9:54am revealed:
-Resident #2 had attempted to smoke while wearing her oxygen several times.
-She had told Resident #2 to remove her oxygen and leave it in the building when this happened.
-This was the first time she had caught her smoking while wearing her oxygen.
-She had not told the Administrator about the incidents.

Interview with another resident on 09/10/19 at 1:50pm revealed:
-She had witnessed Resident #2 sitting on the porch smoking with oxygen in her nose numerous times.
-She had never said anything to Resident #2.
-She never told any of the staff that she saw Resident #2 smoking while wearing her oxygen.
-She did not know it was dangerous for Resident #2 to wear oxygen while she was wearing her oxygen.

Interview with a personal care aide (PCA) on

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D 079	Continued From page 3 09/10/19 at 2:12pm revealed: -She saw Resident #2 sitting on the porch almost daily smoking while she was wearing her oxygen over the past couple of months. -She did not tell Resident #2 not to smoke while she was wearing her oxygen. -She did not tell anyone she saw Resident #2 smoking while she was wearing her oxygen. -She did not know that the oxygen could ignite causing a fire or an explosion until today. Telephone interview with a Respiratory Therapist from the facility's oxygen supply company on 09/10/19 at 2:51pm revealed: -When oxygen was delivered to the facility the staff and residents were educated on the hazards of oxygen. -The oxygen should never be worn when a person was smoking. -The oxygen was a non-flammable and supports combustion. -The oxygen should remain away from ignition sources like smoking a cigarette. -The oxygen when turned off on a portable oxygen tank remains in the tubing and nasal cannula and can ignite. Interview with the Owner of the facility on 09/10/19 at 3:08pm revealed: -She had never observed Resident #2 smoking while wearing her oxygen. -She expected the staff to approach Resident #2 when she was smoking while wearing her oxygen. -The staff should have asked Resident #2 to stop smoking and remove her oxygen. -The staff had not told her there was a problem with Resident #2 smoking while using oxygen. -She knew oxygen could ignite and cause a fire or an explosion.	D 079		

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D 079	Continued From page 4 -When the oxygen supply company had delivered the oxygen, they had educated the staff and residents about the hazards of oxygen use. -There was warning signs posted in the facility to alert staff and residents about the hazard of oxygen. -The staff and Resident #2 had failed to comply with the facility's policy for use of tobacco. Interview with the Administrator on 09/11/19 at 11:00am revealed: -She was told Resident #2 had been smoking while using oxygen yesterday (09/10/19). -She had never seen Resident #2 smoking while using oxygen. -The use of oxygen while smoking was hazardous to everyone in the building. -The staff and Resident #2 had failed to comply with the facility's policy for use of tobacco. _____ The facility failed to ensure a resident was not smoking while wearing oxygen. The facility's failure resulted in detrimental risk of serious injury or death to the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2019.	D 079		
D 124	10A NCAC 13F .0402 Qualifications Of Administrator-In-Charge 10A NCAC 13F .0402 Qualifications Of	D 124		

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D 124	Continued From page 5 Administrator-In-Charge The administrator-in-charge, who is responsible to the administrator for carrying out the program in an adult care home in the absence of the administrator, shall meet the following requirements: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program or have passed an alternative examination established by the Department; (3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional, licensed nursing home administrator or certified assisted living administrator; and (4) earn 12 hours a year of continuing education credits related to the management of adult care homes or care of aged and disabled persons. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure staff assigned as administrator in charge had completed 12 hours of continuing education annually related to management of adult care homes or care of aged and disabled persons, high school graduation, certificate under the G.E.D. program or passed an alternative examination established by the Department, and proof of 6 months of experience of management or supervision in long term care or health care setting, and licensed as an administrator or health care professional for 3 of 3 sampled staff (Staff A, B, and C). The findings are: 1. Review of the personnel record for Staff A	D 124		

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D 124	Continued From page 6 revealed: -Staff A was hired on 07/01/19 to work as a medication aide (MA). -There was no documentation of the required annual 12 hours of continuing education for AIC. -There was no documentation of a high school graduation, G.E.D., or alternative examination established by the Department. -There was no documentation of 6 months of experience of management or supervision in long term care, health care setting, or licensure as an administrator or health care professional. Interview with Staff A on 09/10/19 at 1:30pm revealed: -She was hired on as a MA a couple of months ago. -She had not completed any annual continuing education since she was hired. -She graduated with a high school diploma, but she had not provided a copy of it upon hire. -She worked in an assisted living facility in the past and had 6 months of experience as a supervisor. -She had not been asked to provide proof of her experience upon hire. -She did not know she was required to have any of these items completed and in her personnel record. -The Administrator maintained all personnel records and she did not have access to them. -She had been left alone in charge when the Administrator was not present. -She was the supervisor when the Administrator was absent. -She contacted the Administrator by telephone or text when she had issues with residents, staff, and scheduling. Refer to interview with the Administrator on	D 124		

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D 124	Continued From page 7 09/11/19 at 2:45pm. 2. Review of the personnel record for Staff B revealed: -Staff B was hired on 06/01/17 to work as a MA. -There was no documentation of the required annual 12 hours of continuing education for AIC. -There was no documentation of a high school graduation, G.E.D., or alternative examination established by the Department. -There was no documentation of 6 months of experience of management or supervision in long term care, health care setting, or licensure as an administrator or health care professional. Attempted telephone interview with Staff B on 09/11/19 at 1:40pm was unsuccessful. Refer to interview with the Administrator on 09/11/19 at 2:45pm. 3. Review of the personnel record for Staff C revealed: -Staff C was hired on 07/23/18 to work as a MA. -There was no documentation of the required annual 12 hours of continuing education for AIC. -There was no documentation of a high school graduation, G.E.D., or alternative examination established by the Department. -There was no documentation of 6 months of experience of management or supervision in long term care, health care setting, or licensure as an administrator or health care professional. Attempted telephone interview with Staff B on 09/11/19 at 1:50pm was unsuccessful. Refer to interview with the Administrator on 09/11/19 at 2:45pm.	D 124		

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D 124	Continued From page 8 Interview with the Administrator on 09/11/19 at 2:45pm revealed: -She had left the MAs in charge of the facility when she was absent. -She was present in the facility 3-5 days a week during first shift and stayed approximately 4-6 hours. -None of the current MAs left in charge when she was absent from the facility had the required credentials as AICs. -In the last three months the facility had to hire new MAs to replace the ones who had left employment. -She had attempted to schedule the current MAs for the required continuing education hours. -The last training was provided in January 2018 by the contracted agency to perform the continuing education hours. -She had not audited the MAs personnel records to ensure all their credentials were in place.	D 124		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities With A Capacity Or 10A NCAC 13F .0601 Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (b) At all times there shall be one administrator or administrator-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions in Paragraph (c) of this Rule, one of the following arrangements shall be used to manage a facility with a capacity or census of 7 to 30 residents: (1) The administrator is in the home or within	D 177		

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D 177	Continued From page 9 500 feet of the home with a means of two-way telecommunication with the home at all times; (2) An administrator-in-charge is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; or (3) When there is a cluster of licensed homes, each with a capacity of 7 to 12 residents, located adjacently on the same site, there shall be at least one staff member, either live-in or on a shift basis in each of these homes. In addition, there shall be at least one administrator or administrator-in-charge who is within 500 feet of each home with a means of two-way telecommunication with each home at all times and directly responsible for assuring that all required duties are carried out in each home. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure there was always one Administrator or administrator-in-charge (AIC) within 500 feet of the home with means of two-way telecommunication with the home. Observation on 09/10/19 from 9:15am to 12:45pm revealed: -There was not an Administrator or administrator-in-charge (AIC) present. -A medication aide (MA) contacted the Administrator by telephone. -The Administrator was absent. -The Owner was contacted by telephone by a medication aide (MA). -The Owner traveled from her home that was a 2-1/2 to 3-hour drive from the facility and arrived	D 177		

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D 177	Continued From page 10 at 12:45pm. Interview with a resident on 09/11/19 at 10:07am revealed: -The staff members were sleeping and sometimes playing games on their phones when the Administrator was absent during the day on weekends, and at night during the week. -There were times he had to go and find staff to attend to his roommate when he needed incontinent care. -The Administrator was in the facility approximately two days a week. -When the Administrator was in facility, she stayed a couple of hours and left the facility. -He did not know who was in charge when the Administrator was absent. Interview with another resident on 09/11/19 at 10:45am revealed: -He did not know which staff member to go to when the Administrator was absent. -The Administrator was not in the facility unless it was pay day for the residents. Interview with a first shift MA on 09/10/19 at 9:15am revealed: -She was scheduled to work first and second shift depending on the day of the week. -The Administrator was always available by telephone if she was needed. -The Administrator lived approximately 1-1/2 hours' drive from the facility. -No one was designated as an administrator-in-charge. -She had contacted the Administrator, but she was not available to come to the facility today (09/10/19). -The Owner had been contacted, and she would take approximately 2-1/2 to 3 hours to travel to	D 177		

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the facility.
-The Administrator was in the facility 2-3 days a week during first shift, but never during second shift when she was working.

Interview with a first shift MA on 09/11/19 at 2:18pm revealed:
-There was not a set schedule when the Administrator would be at the facility.
-The Administrator telephoned or sent her a text message if she was coming to the facility when she was on her way.
-The Administrator shows up and stayed during first shift and would leave after a couple of hours.
-She did not remember taking any training as an AIC.
-She was responsible for processing physician's orders, administering medications, scheduling resident's appointments, and any emergency medical situations.
-If something was to happen, she was told to call the police or emergency responders and call the Administrator.
-She had not had to call the police or emergency responders.
-She reported all issues concerning other staff members to the Administrator.

Interview with the Administrator on 09/11/19 at 2:45pm revealed:
-She was at the facility 3-5 days a week during first shift.
-She lived approximately 1-1/2 hours from the facility.
-The MAs were left in charge of the facility when she was absent.
-The MAs did not have the credentials under state guidelines as AICs.
-She was available by telephone if the MAs needed her for any reasons.

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D 177	Continued From page 12 -She had failed to ensure the MAs left in charge when she was not in the building were trained as AICs, because she lived greater than 500 feet from the facility.	D 177		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance to 2 of 3 sampled residents (#1 and #3) according to the care plans related to showering. The findings are: 1. Review of Resident #1's current FL2 dated 02/20/19 revealed: -Diagnoses included type 2 diabetes, mental retardation, and hyperlipidemia. -The resident required personal care assistance with bathing, feeding, and dressing.	D 269		

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D 269	Continued From page 13 Review of Resident #1's Care Plan dated 02/20/19 revealed: -The resident was sometimes disoriented and forgetful. -The resident was totally dependent for toileting, bathing, dressing, and grooming/personal hygiene. Observation of Resident #1 on 09/10/19 at 9:42am revealed: -The resident was standing in his room holding onto a walker and began to walk out of the room. -The resident smelled strongly of urine. -There were stains visible on the left upper leg of his light gray sweat pants. Interview with a resident on 09/11/19 at 10:07am revealed: -There were occasions when Resident #1 smelled like urine. -The resident would inform staff Resident #1 needed incontinent care. Review of the first shift shower list on 09/10/19 revealed Resident #1 was scheduled to receive a shower on Mondays, Wednesday, and Fridays. Review of Resident #1's July 2019 personal care record revealed: -The resident was documented to have received 4 showers, 27 sponge baths, and 175 toileting occurrences on first shift. -The resident was documented to have received 219 toileting occurrences on second shift. -The resident was documented to have received 9 showers, 17 sponge baths, and 55 toileting occurrences on third shift (there was no documentation toileting occurrences for third shift from 07/10/19 to 07/31/19). -There were 4 documented refusals to bathe on	D 269		

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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
D 269	Continued From page 14 third shift (07/05/19, 07/26/19, 07/29/19, 07/31/19). Review of Resident #1's August 2019 personal care record revealed: -The resident was documented to have received 2 showers, 29 sponge baths, and 181 toileting occurrences on first shift. -The resident was documented to have received 220 toileting occurrences on second shift. -The resident was documented to have received 3 showers, 21 sponge baths, and 182 toileting occurrences on third shift. -There were 7 documented refusals to bathe on third shift (08/05/19, 08/09/19, 08/14/19, 08/19/19, 08/21/19, 08/24/19, 08/26/19). Review of Resident #1's September 2019 personal care record from 09/01/19 to 09/09/19 revealed: -The resident was documented to have received 1 shower, 7 sponge baths, and 57 toileting occurrences on first shift. -There was 1 documented refusal to bath on first shift on 09/04/19. -The resident was documented to have received 63 toileting occurrences on second shift. -The resident was documented to have received 0 showers and 9 sponge baths on third shift. Review of Resident #1's shower record dated 08/19/19 revealed: -Resident #1 was documented as having refused a shower three times. -The document was signed by the PCA and the Supervisor. -Resident #1's Physician Assistant (PA) acknowledged the refusal on 08/21/19. Review of Resident #1's record revealed there	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 15 were no other shower records documenting shower refusals and acknowledgment from the resident's primary care provider. Interview with a personal care aide (PCA) on 09/10/19 at 11:40am revealed: -There was a showering schedule for first and third shift (staff worked 12 hour shifts). -Resident #1 was scheduled to receive showers on Monday, Wednesday, and Friday. -Resident #1 "refuses showers a lot." -"But we sponge him off and change his clothes." -If a resident refused a shower, the PCA would "wait a little bit then ask again two more times." -If a resident refused three times, "we can't do anything." -They usually had a different staff member approach the resident to assist with shower on the second attempt. Telephone interview with Resident #1's home health service representative on 09/10/19 at 1:45pm revealed: -Resident #1 had recently been treated for skin breakdown on the "buttock." -They had been seeing Resident #1 twice a week for wound care to the buttock. -The last wound care visit was 08/29/19. -The wound was now "closed" and "healed." -The resident had no other skin breakdown. -Resident #1 was ambulatory with a walker which helped with "pressure relief." -Resident #1 had "some incontinence." Interview with a PCA on 09/11/19 at 8:45am revealed: -Resident #1 "likes a shower." -"He loves it." -"He's no problem." -"I shave him too."	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 16 -The resident received sponge baths "between toileting." -Resident #1 had been changed "last week" to receive his showers on days, because they were having difficulty with him taking a shower when he was on the evening shower schedule. Interview with Resident #1's PA on 09/11/19 at 9:03am revealed: -One had to be "careful" if a resident said no "not to force them." -When resident's felt as if they were made to do something they did not want to do, they had a tendency to react physically with staff. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with the Administrator on 09/11/19 at 2:30pm. 2. Review of Resident #3's current FL2 dated 09/04/19 revealed: -Diagnoses included paranoid schizophrenia, corneal transplant, hypertension, edema loser extremity, and dyslipidemia. -The resident was semi-ambulatory and constantly disoriented. -The resident was incontinent of bladder and bowel. Review of Resident #3's Care Plan dated 08/29/19 revealed: -The resident was completely dependent on staff for assistance with bathing. -The resident required extensive assistance with ambulation, dressing, grooming, and transfers. -The resident required limited assistance with toileting.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 269	Continued From page 17 Observation of Resident #3 on 09/10/19 at 9:28am revealed: -The resident was lying in bed with his entire body covered with the bed linens except his head. -The resident had beard stubble on his face. -The resident stuck his left arm out from under the bed linens. -From the forearm to the knuckles of the all five fingers on the resident's hand there were large patches of thick loose white skin. -The visible skin under the loose white patches of skin on the forearm to the hand was reddened. -There were two 1/4 inch irregular bordered thick brown crusts at the bottom of the resident's third and fourth fingers. -There were two small circular reddened areas at the bottom of the index finger. Review of the third shift shower list on 09/10/19 revealed Resident #3 was scheduled to receive a shower on Mondays, Wednesday, and Fridays. Review of Resident #3's July 2019 personal care record revealed: -The resident was documented to have received 31 sponge baths on first shift. -The resident was documented to have received 1 shower (07/10/19) and 15 sponge baths on third shift. -There were 15 documented refusals to bathe on third shift (07/01/19, 07/03/19, 07/05/19, 07/08/19, 07/11/19, 07/12/19, 07/14/19, 07/15/19, 07/17/19, 07/19/19, 07/22/19, 07/24/19, 07/26/19, 07/29/19, 07/31/19). Review of Resident #3's August 2019 personal care record revealed: -The resident was documented to have received 31 sponge baths on first shift.	D 269		

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D 269	Continued From page 18 -The resident was documented to have received 1 shower (08/02/19) and 18 sponge baths on third shift. -There were 12 documented refusals to bathe on third shift (08/05/19, 08/07/19, 08/09/19, 08/12/19, 08/14/19, 08/16/19, 08/19/19, 08/21/19, 08/23/19, 08/26/19, 08/28/19, 08/30/19). Review of Resident #3's September 2019 personal care record from 09/01/19 to 09/09/19 revealed: -The resident was documented to have received 9 sponge baths on first shift. -The resident was documented to have received 0 showers and 6 sponge baths on third shift. -There were 3 documented refusals to bathe on third shift (09/03/19, 09/04/19, 09/09/19). Review of Resident #3's record revealed there were no shower records documenting shower refusals and acknowledgment from the resident's primary care provider. Interview with a personal care aide (PCA) on 09/10/19 at 11:40am revealed: -There was a showering schedule for first and third shift (staff worked 12 hour shifts). -If a resident refused a shower, the PCA would "wait a little bit then ask again two more times." -If a resident refused three times, "we can't do anything." -They usually had a different staff member approach the resident to assist with shower on the second attempt. Interview with a PCA on 09/11/19 at 8:45am revealed: -Resident #3 refused showers "a lot." -"He's a night shower." -"I shave him though on the days he wants to be	D 269		

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D 269	Continued From page 19 shaved." Interview with Resident #3's Physician Assistant (PA) on 09/11/19 at 9:03am revealed: -Resident #3 was very "paranoid." -One had to be "careful" if a resident said no "not to force them." -When resident's felt as if they were made to do something they did not want to do, they had a tendency to react physically with staff. Interview with Resident #3's psychiatric Physician's Assistant (PA) on 09/11/19 at 10:05am revealed: -Resident #3 was "difficult, aggressive with staff, and resistant to care." -Resident #3 was "very resistant with his refusal" of psychiatric services. -Resident #3 was his own responsible person. -She felt the resident was capable of making decisions about showering. Interview with Resident #3 on 09/11/19 at 9:14am revealed: -"I get a bath everyday." -"I get a bath just about every morning." Refer to the interview with the Administrator on 09/11/19 at 2:30pm. _____ Interview with the Administrator on 09/11/19 at 2:30pm revealed: -When a resident refused a shower, it was documented on the personal care services sheet and was put in a folder for the PA to see and she signs off on it. -Shower refusals had not been going to psychiatric providers for their review. -When a resident refused to shower, "we at least	D 269		

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D 269	Continued From page 20 offer the sponge bath to help get them clean." -"We try to meet the resident where they are. To work with them." -"I'd rather them have a sponge bath then not get clean at all."	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure referral and physician notification for 2 of 3 sampled residents (Resident #1 and Resident #3) regarding a thyroid stimulating hormone lab, a testosterone lab, and physician notification of resident refusals to shower. The findings are: 1. Review of Resident #1's current FL2 dated 02/20/19 revealed diagnoses included type 2 diabetes, mental retardation, and hyperlipidemia. a. Review of Resident #1's current FL2 dated 02/20/19 revealed: -Diagnoses included type 2 diabetes, mental	D 273		

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retardation, and hyperlipidemia.
-There was an order for levothyroxine (used to treat hypothyroidism 150mcg 1 tablet daily except Sunday.

Review of Resident #1's Physician Assistant's (PA) order dated 06/19/19 revealed thyroid stimulating hormone (TSH) to be drawn at next available lab draw.

Review of Resident #1's PA's order dated 06/20/19 revealed TSH to be obtained by home health skilled nursing every 2 months.

Review of Resident #1's thyroid stimulating hormone lab dated 06/20/19 revealed the result was 0.700 with a lab reference range of 0.358-3.74 uIU/mL.

Review of Resident #1's record revealed there were no other TSH results.

Interview with a medication aide on 09/10/19 at 12:20pm revealed Resident #1 had not had a TSH drawn since one was completed on 06/20/19.

Telephone interview with Resident #1's home health service representative on 09/10/19 at 1:45pm revealed:
-They had received the order to draw a TSH on 06/20/19 and every 2 months.
-Their previous clinical manager had not added the TSH to be drawn every 2 months so it had not been done.
-She was sending a nurse over "today or tomorrow" to draw the TSH which was ordered for 08/20/19.
-"Typically" a TSH was only drawn every 6 months to a year.

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D 273	Continued From page 22 Interview with a medication aide on 09/11/19 at 8:25am revealed: -The home health service had called the facility on 09/10/19 and notified them they had received the TSH order written 06/20/19, but had failed to do the one ordered for every two months. -The home health service had drawn the TSH that had been due on 08/20/19 on Resident #1 on the afternoon of 09/10/19. -The medication aides were supposed to keep track of lab orders by using the log entitled "Bloodwork Ordered by Physician" which was kept on the inside of the medication room door. Review of the Bloodwork Ordered by Physician log on 09/11/19 at 8:28am revealed there was an entry for Resident #1 TSH next draw date 08/20/19. Interview with Resident #1's PA on 09/11/19 at 8:58am revealed: -She had ordered the TSH for Resident #1 to be drawn every 2 months so home health would be able to come out to the facility to collect the blood for the tests. -The PA was not concerned that the lab was delayed. b. Observation of Resident #1 on 09/10/19 at 9:42am revealed: -The resident was standing in his room holding onto a walker and began to walk out of the room. -The resident smelled strongly of urine. -There were stains visible on the left upper leg of his light gray sweat pants. Interview with a resident on 09/11/19 at 10:07am revealed: -There were occasions when Resident #1	D 273		

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D 273	Continued From page 23 smelled like urine. -The resident would inform staff Resident #1 needed incontinent care. Review of the first shift shower list on 09/10/19 revealed Resident #1 was scheduled to receive a shower on Mondays, Wednesday, and Fridays. Review of Resident #1's July 2019 personal care record revealed: -The resident was documented to have received 4 showers, 27 sponge baths, and 175 toileting occurrences on first shift. -The resident was documented to have received 219 toileting occurrences on second shift. -The resident was documented to have received 9 showers, 17 sponge baths, and 55 toileting occurrences on third shift (there was no documentation toileting occurrences for third shift from 07/10/19 to 07/31/19). -There were 4 documented refusals to bathe on third shift (07/05/19, 07/26/19, 07/29/19, 07/31/19). Review of Resident #1's August 2019 personal care record revealed: -The resident was documented to have received 2 showers, 29 sponge baths, and 181 toileting occurrences on first shift. -The resident was documented to have received 220 toileting occurrences on second shift. -The resident was documented to have received 3 showers, 21 sponge baths, and 182 toileting occurrences on third shift. -There were 7 documented refusals to bathe on third shift (08/05/19, 08/09/19, 08/14/19, 08/19/19, 08/21/19, 08/24/19, 08/26/19). Review of Resident #1's September 2019 personal care record from 09/01/19 to 09/09/19	D 273		

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D 273	Continued From page 24 revealed: -The resident was documented to have received 1 shower, 7 sponge baths, and 57 toileting occurrences on first shift. -There was 1 documented refusal to bath on first shift on 09/04/19. -The resident was documented to have received 63 toileting occurrences on second shift. -The resident was documented to have received 0 showers and 9 sponge baths on third shift. Review of Resident #1's shower record dated 08/19/19 revealed: -Resident #1 was documented as having refused a shower three times. -The document was signed by the PCA and the Supervisor. -Resident #1's Physician Assistant (PA) acknowledged the refusal on 08/21/19. Interview with a personal care aide (PCA) on 09/10/19 at 11:40am revealed: -There was a showering schedule for first and third shift (staff worked 12 hour shifts). -Resident #1 was scheduled to receive showers on Monday, Wednesday, and Friday. -Resident #1 "refuses showers a lot." -"But we sponge him off and change his clothes." -If a resident refused a shower, the PCA would "wait a little bit then ask again two more times." -If a resident refused three times, "we can't do anything." -They usually had a different staff member approach the resident to assist with shower on the second attempt. Telephone interview with Resident #1's home health service representative on 09/10/19 at 1:45pm revealed: -Resident #1 had recently been treated for skin	D 273		

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breakdown on the "buttock."
-They had been seeing Resident #1 twice a week for wound care to the buttock.
-The last wound care visit was 08/29/19.
-The wound was now "closed" and "healed."
-The resident had no other skin breakdown.
-Resident #1 was ambulatory with a walker which helped with "pressure relief."
-Resident #1 had "some incontinence."

Interview with a PCA on 09/11/19 at 8:45am revealed:
-Resident #1 "likes a shower."
-"He loves it."
-"He's no problem."
-"I shave him too."
-The resident received sponge baths "between toileting."
-Resident #1 had been changed "last week" to receive his showers on days, because they were having difficulty with him taking a shower when he was on the evening shower schedule.

Interview with Resident #1's PA on 09/11/19 at 9:03am revealed:
-She had not been notified of every shower refusal.
-She did not expect staff to notify her of every shower refusal.
-One had to be "careful" if a resident said no "not to force them."
-When resident's felt as if they were made to do something they did not want to do, they had a tendency to react physically with staff.

Interview with the Administrator on 09/11/19 at 2:30pm revealed:
-When a resident refused a shower, it was documented on the personal care services sheet and is put in a folder for the PA to see and she

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signs off on it.
-Shower refusals had not been going to psychiatric providers for their review.
-When a resident refused to shower, "we at least offer the sponge bath to help get them clean."
-"We try to meet the resident where they are. To work with them."
-"I'd rather them have a sponge bath then not get clean at all."

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

2. Review of Resident #3's current FL2 dated 09/04/19 revealed diagnoses included paranoid schizophrenia, corneal transplant, hypertension, edema loser extremity, and dyslipidemia.

a. Review of Resident #3's Physician Assistant's (PA) order dated 08/14/19 revealed thyroid stimulating hormone (TSH) (used to determine the amount of thyroid stimulating hormone in the blood).and testosterone (measures the amount of testosterone that bound to proteins in the blood) blood level.

Review of Resident #3's record revealed:
-The TSH lab was collected on 08/19/19 and resulted on 08/21/19.
-The TSH lab was documented reviewed by the PA on 08/29/19.
-There was no testosterone result.

Telephone interview with Resident #3's home health agency representative on 09/11/19 at 10:35am revealed:
-They had received an order dated 08/14/19 for Resident #3 for a TSH and testosterone lab.
-Blood samples had been collected on 08/19/19

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D 273	Continued From page 27 for the TSH and testosterone levels. -The testosterone level had not been run by the lab even though it had been included on the order to the lab. -The facility staff had called the home health agency to get the result on 09/10/19 and that's when it was discovered the testosterone level had not been completed. -They had collected a blood sample that morning (09/11/19) for the testosterone level and should have a result by 09/12/19. Interview with the facility Owner on 09/11/19 at 11:20am revealed: -When they had received the TSH result for Resident #3, it should have prompted our medication aides to question when the testosterone level would be resulting. -The PA visited the facility every Wednesday. -The PA should have been prompted to ask about the testosterone level when they saw the TSH result on 08/29/19. -They were going to have to look at what they could do to help prevent this from happening. b. Observation of Resident #3 on 09/10/19 at 9:28am revealed: -The resident was lying in bed with his entire body covered with the bed linens except his head. -The resident had beard stubble on his face. -The resident stuck his left arm out from under the bed linens. -From the forearm to the knuckles of the all five fingers on the resident's hand there were large patches of thick loose white skin. -The visible skin under the loose white patches of skin on the forearm to the hand was reddened. -There were two 1/4 inch irregular bordered thick brown crusts at the bottom of the resident's third and fourth fingers.	D 273		

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	HAL002007	A. BUILDING: _____ B. WING _____	R 09/11/2019

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D 273	Continued From page 28 -There were two small circular reddened areas at the bottom of the index finger. Review of Resident #3's Care Plan dated 08/29/19 revealed: -The resident was completely dependent on staff for assistance with bathing. -The resident required extensive assistance with ambulation, dressing, grooming, and transfers. -The resident required limited assistance with toileting. Review of the third shift shower list on 09/10/19 revealed Resident #3 was scheduled to receive a shower on Mondays, Wednesday, and Fridays. Review of Resident #3's July 2019 personal care record revealed: -The resident was documented to have received 31 sponge baths on first shift. -The resident was documented to have received 1 shower (07/10/19) and 15 sponge baths on third shift. -There were 15 documented refusals to bathe on third shift (07/01/19, 07/03/19, 07/05/19, 07/08/19, 07/11/19, 07/12/19, 07/14/19, 07/15/19, 07/17/19, 07/19/19, 07/22/19, 07/24/19, 07/26/19, 07/29/19, 07/31/19). Review of Resident #3's August 2019 personal care record revealed: -The resident was documented to have received 31 sponge baths on first shift. -The resident was documented to have received 1 shower (08/02/19) and 18 sponge baths on third shift. -There were 12 documented refusals to bathe on third shift (08/05/19, 08/07/19, 08/09/19, 08/12/19, 08/14/19, 08/16/19, 08/19/19, 08/21/19, 08/23/19, 08/26/19, 08/28/19, 08/30/19).	D 273		

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D 273	Continued From page 29 Review of Resident #3's September 2019 personal care record from 09/01/19 to 09/09/19 revealed: -The resident was documented to have received 9 sponge baths on first shift. -The resident was documented to have received 0 showers and 6 sponge baths on third shift. -There were 3 documented refusals to bathe on third shift (09/03/19, 09/04/19, 09/09/19). Review of Resident #3's record revealed there were no shower records documenting shower refusals and acknowledgment from the resident's primary care provider. Interview with a personal care aide (PCA) on 09/10/19 at 11:40am revealed: -There was a showering schedule for first and third shift (staff worked 12 hour shifts). -If a resident refused a shower, the PCA would "wait a little bit then ask again two more times." -If a resident refused three times, "we can't do anything." -They usually had a different staff member approach the resident to assist with shower on the second attempt. Interview with a PCA on 09/11/19 at 8:45am revealed: -Resident #3 refused showers "a lot." -"He's a night shower." -"I shave him though on the days he wants to be shaved." Interview with Resident #3's Physician Assistant (PA) on 09/11/19 at 9:03am revealed: -She had not been notified of every shower refusal. -She did not expect staff to notify her of every	D 273		

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D 273	Continued From page 30	D 273		

shower refusal.
-Resident #3 was very "paranoid."
-One had to be "careful" if a resident said no "not to force them."
-When resident's felt as if they were made to do something they did not want to do, they had a tendency to react physically with staff.

Interview with Resident #3's psychiatric Physician's Assistant (PA) on 09/11/19 at 10:05am revealed:
-Resident #3 was "difficult, aggressive with staff, and resistant to care."
-Resident #3 was "very resistant with his refusal" of psychiatric services.
-Resident #3 was his own responsible person.
-She felt the resident was capable of making decisions about showering.

Interview with Resident #3 on 09/11/19 at 9:14am revealed:
-"I get a bath everyday."
-"I get a bath just about every morning."

Interview with the Administrator on 09/11/19 at 2:30pm revealed:
-Resident #3 had "a long history of refusing showers."
-When a resident refused a shower, it was documented on the personal care services sheet and is put in a folder for the PA to see and she signs off on it.
-Shower refusals had not been going to psychiatric providers for their review.
-When a resident refused to shower, "we at least offer the sponge bath to help get them clean."
-"We try to meet the resident where they are. To work with them."
-"I'd rather them have a sponge bath then not get clean at all."

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 4 sampled residents (Resident #1) related to a medication to treat a thyroid condition. The findings are: Review of Resident #1's current FL2 dated 02/20/19 revealed: -Diagnoses included type 2 diabetes, mental retardation, and hyperlipidemia. -There was an order for levothyroxine (used to treat hypothyroidism) 150mcg 1 tablet daily except Sunday.	D 358		

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D 358	Continued From page 32 Review of Resident #1's thyroid stimulating hormone lab dated 06/20/19 revealed the result was 0.700 with a lab reference range of 0.358-3.74 uIU/mL. Review of a subsequent order for Resident #1 dated 08/21/19 revealed levothyroxine 150mcg 1 tablet daily except Sunday. Review of Resident #1's July and August 2019 electronic Medication Administration Records (eMARs) revealed: -There were entries for levothyroxine 150mcg 1 tablet every day except Sunday scheduled at 8:00am. -From 07/01/19 to 07/31/19, the levothyroxine was documented as not administered for 4 occurrences out of 27 opportunities (the medication was not administered on the following Saturdays 07/06/19, 07/13/19, 07/20/19, and 07/27/19.) -From 08/01/19 to 08/31/19, the levothyroxine was documented as not administered for 5 occurrences out of 27 opportunities (the medication was not administered on the following Saturdays 08/03/19, 08/10/19, 08/17/19, 08/24/19, and 08/31/19.) Review of Resident #1's September 2019 eMAR from 09/01/19 to 09/10/19 revealed: -There was an entry for levothyroxine 150mcg 1 tablet every day except Sunday scheduled at 8:00am. -From 09/01/19 to 09/10/19, the levothyroxine was documented as not administered for 1 occurrence out of 8 opportunities (the medication was not administered on Saturday 09/07/19.) Observation of Resident #1's medications on hand on 09/10/19 at 12:06pm revealed:	D 358		

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D 358	Continued From page 33 -There was one bubble pack of levothyroxine 150mcg tablets available with 9 doses remaining. -The dispense date was 07/02/19. -There were 31 total tablets dispensed. Interview with a medication aide on 09/10/19 at 12:08pm revealed: -The levothyroxine was ordered for Resident #1 to be administered daily except for Sundays. -Resident #1 should get the levothyroxine on Saturdays. -She did not know why the eMAR would be blocked out for administration on Saturdays and Sundays. -Saturday and Sunday were unchecked in the eMAR system and thus would not prompt staff to administer the medication on Saturdays or Sundays. Telephone interview with the contracted facility pharmacy on 09/10/19 at 2:00pm revealed: -Resident #1's order was for levothyroxine 150mcg 1 tablet every day except Sunday dated 02/20/19. -They dispensed 31 tablets of levothyroxine 150mcg on 07/02/19. -They dispensed 30 tablets of levothyroxine 150mcg on 08/01/19. -A new monthly supply of 31 tablets would be delivered to the facility on 09/12/19. -The facility faxed new orders to the pharmacy. -When the pharmacy received the order, they would enter it into the eMAR system. -A pharmacist then checked the new order in the eMAR system. -The facility also verified the order was entered correctly in the eMAR system. -The order had been entered incorrectly in the eMAR system. -The entry had been corrected in the eMAR	D 358		

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D 358	Continued From page 34 system now and the medication will now show up to be administered daily Monday through Saturday. Interview with a medication aide on 09/11/19 at 8:25am revealed: -The Administrator was the only one who had the privileges in the eMAR to approve orders. -They made the Administrator copies of all the orders, so she knew about all the new orders that were written. Interview with Resident #1's Physician's Assistant (PA) on 09/11/19 at 8:58am revealed: -The levothyroxine was ordered to be given every day except Sundays. -She did not feel the resident having missed doses of the medication on Saturdays during the months of July, August, and September were of concern. -She would expect the facility to fix the issue in the eMAR system and administer the medication correctly going forward. Interview with the Administrator on 09/11/19 at 2:30pm revealed: -She had no idea how the incorrect eMAR entry for the levothyroxine was missed. -She was responsible for checking the eMARs against the orders monthly for errors. -She had checked Resident #1's eMAR for completion, but "did not pick up on" the medication was not being administered on Saturdays and Sundays Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 358		

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{D912}	Continued From page 35	{D912}		
{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 observations, interviews and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to housekeeping and furnishings. The findings are: Based on observations, record review, and interviews, the facility failed to assure the facility was free of hazards as evidenced by a resident smoking with oxygen in use creating an opportunity for an ignition of a combustible exposing all occupants of the facility to danger of a fire or explosion.[Refer to Tag D079 10A NCAC 13F .0306(5) Housekeeping and Furnishings (Type B Violation)].	{D912}		