Division of	of Health Service Regu	lation			FORIVI AFFROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013007	B. WING		10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE	
CAREMO	OR RETIREMENT CENTE	-R	REMOOR PLACE POLIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
		sure Section and the partment of Social Services Survey on October 6 - 7,			
D 137	10A NCAC 13F .0407 Qualifications	7(a)(5) Other Staff	D 137		
	<ul><li>(a) Each staff person shall:</li><li>(5) have no substant</li></ul>	7 Other Staff Qualifications a at an adult care home iated findings listed on the a Care Personnel Registry IE-256;			
	facility failed to ensur A, C, and D) had no s the North Carolina He	and record reviews, the e 3 of 4 sampled staff (Staff substantial findings listed on			
	The findings are:				
	Care Aide (PCA)Documentation of a castaff A's personnel rewith no substantial fire-Staff A's daily responsersonal care to the response of the substantial fire-staff A's daily response of the response of the substantial fire-staff A's daily response of the response of the substantial fire-staff A's daily response of the substan	09/01/15 as a Personal completed HCPR check in cord was dated 09/29/15 adings. asibilities included providing residents.			
	Interview with Staff A 11:45 am revealed: -She was hired on 09	on 10/07/15 at 10/07/15 at /01/15 as a PCA.			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		HAL013007	B. WING		10	/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	•	
048540	00 DETIDEMENT OF UT	-S 4876 CAF	REMOOR PLACE			
CAREMO	OR RETIREMENT CENTE	KANNAP	OLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 137	Continued From page -She began training a	e 1 as a Medication Aide (MA) on	D 137			
	to her hire at this facil -Her current job dutie personal care to resid dressing, transfers, fe -She did not know if t HCPR check prior to	s included providing dents, including bathing, eeding, and activities. he facility had completed a her hiring.				
		h the Administrator on				
	Staff D's personnel re with no substantial fir -Staff D's current pos -Staff D's daily respon	10/28/09. completed HCPR check in cord was dated 11/10/09 idings.				
	Refer to interview with on 10/08/15 at 12:00	n the Director of Operations pm.				
	Refer to interview with 10/08/15 at 4:30 pm.	h the Administrator on				
	Staff C's personnel re with no substantial fir	06/22/15 as a PCA. completed HCPR check in ecord was dated 07/19/15				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	n Health Service Regu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1	<del></del>	
			B WING		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		HAL013007	B. WING		10/07/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
	-		REMOOR PLACE		
CAREMO	OR RETIREMENT CENTE	R	OLIS, NC 28081		
		KANNAP	OLIS, NC 2000		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	( - )
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	
IAG			IAG	DEFICIENCY)	
D 137	Continued From page	2	D 137		
	nersonal care to the r	esidents when she was			
	hired.	Coluctito Wilett offer was			
		y responsibilities included			
	_				
	providing personal ca	ire to residents.			
	Interview with Staff C	on 10/07/15 at 4:45 pm			
	revealed:	on 10/07/15 at 4.45 pm			
		and and the Alban alternation			
	-Upon hire, Staff C wo				
	department as a dieta	-			
		two days following her			
	hiring, she was transf	erred to nursing care			
	services.				
		ound as a Certified Nursing			
	Assistant, but her cer	tification expired in 2013.			
	-Staff C was provided	I "on-the-job training" by the			
	Manager and a Medic	cation Aide.			
	-Staff C provided care	e of residents with another			
	Nurse Aide (NA) help	ing her during her first one			
	to two weeks of worki	-			
		3			
	Refer to interview with	h the Director of Operations			
	on 10/08/15 at 12:00	•			
	Refer to interview with	h the Administrator on			
	10/08/15 at 4:30 pm.				
	Interview with the Dire	ector of Operations on			
	10/08/15 at 12:00 pm				
	·	for checking the HCPR for			
	new employees prior				
		rienced high volumes of			
	staff turnover recently				
		ot checked the HCPR prior			
		eginning work, but checked			
	them "as soon as she	e coula".			
	1.6	10/00/17			
		ministrator on 10/08/15 at			
		as the facility's policy that			
	HCPR checks were to	be completed prior to hire.			

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	n riealtii Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		HAL013007	B. WING		10/07/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE LIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 139	Continued From page 3		D 139		
D 139	39 10A NCAC 13F .0407(a)(7) Other Staff Qualifications		D 139		
	(a) Each staff person (7) have a criminal ba	Other Staff Qualifications at an adult care home shall: ackground check in 114-19.10 and 131D-40;			
	This Rule is not met TYPE B VIOLATION	as evidenced by:			
	failed to assure a Crir	ew and interview, the facility minal Background check to hire on 3 of 4 sampled C).			
	The findings are:				
	Care Aide (PCA)Documentation of a control background check in dated 10/7/15.	09/01/15 as a Personal completed criminal Staff A's personnel record			
	revealed: -She began training a 10/05/15Her current job duties personal care to resid dressing, transfers, fe -She signed a crimina	lents, including bathing, eding, and activities.			
	Refer to interview with	n the Director of Operations			

Division of Health Service Regulation

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Division of Health Service Regulation

	or riealin Service Regu		1		<del></del>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL013007	B. WING		10/	07/2015
		1			1 10/	01/ <u>2</u> 010
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CAPEMO	OR RETIREMENT CENTE	4876 CA	REMOOR PLACE	≣		
OAILLIIO	OK KETIKEMENT GENTE	KANNAF	POLIS, NC 28081	l		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
				DEI IOIENOT)		
D 139	Continued From page	e 4	D 139			
	on 10/09/15 at 12:10 nm					
	on 10/08/15 at 12:10 pm.					
	Defer to intensious with	h the Administrator on				
	Refer to interview with the Administrator on 10/08/15 at 4:15 pm.					
	B. Review of Staff B'	s parsannal racards				
	revealed:	s personner records				
		06/01/15 as a PCA and then				
	transitioned to dietary					
	-Documentation of a					
	dated 06/24/15.	Staff B's personnel record				
		acibilities included providing				
		nsibilities included providing				
	•	residents when she was				
	hired.					
		y responsibilities included				
	preparation of resider	nts' meals, including				
	therapeutic diets.					
	Intomicus with Ctaff D	an 10/07/15 at 1:05 and				
		on 10/07/15 at 1:05 pm				
	revealed:	ale in diatame				
	-She worked as a coo					
		PCA, but moved to dietary				
	not long after she was					
	-She was responsible	•				
	including therapeutic	uiets, for residents.				
	Defer to interviewe	h the Director of Operations				
		h the Director of Operations				
	on 10/08/15 at 12:10	pm.				
	Defer to intension with	h the Administrator on				
		ii uie Auministiatui UN				
	10/08/15 at 4:15 pm.					
	C. Review of Staff C'	's nersonnel records				
	revealed:	a personner records				
	-Staff C was hired on	06/22/15 as a DCA				
	-Documentation of a					
		Staff C's personnel record				
	dated 07/13/15.					
	-Staff C's daily respor	nsibilities included providing				

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING.			
		HAL013007	B. WING		10/0	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CAREMO	OR RETIREMENT CENTE	ER .	REMOOR PLACI OLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 139	Continued From page	÷ 5	D 139			
	personal care to the residents.  Review of the nursing employee schedule revealed Staff C began duties on 06/22/15.					
	revealed: -Upon hire, Staff C widepartment as a dieta -Within approximately hiring, she was transf servicesStaff C had a backgr Assistant, but her cer-Staff C provided care Nurse Aide (NA) help to two weeks of working Refer to interview with on 10/08/15 at 12:10	ary aide.  If two days following her ferred to nursing care  ound as a Certified Nursing tification expired in 2013.  The of residents with another ting her during her first one ting in nursing care.  The the Director of Operations				
	10/08/15 at 12:10 pm -She was responsible background checks for hireThe facility had expestaff turnover recently -She knew she had no background check pri	e for obtaining criminal or new employees prior to crienced high volumes of				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013007	B. WING		10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CAREMO	OR RETIREMENT CENTE	≣R	REMOOR PLACE OLIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 139	Continued From page	e 6	D 139		
	10/08/15 as follows: -All new employees we checks completed pringerThe Director of Oper employee files to ensuche checks have been completed.	rations will review all current ure criminal background impleted. responsible for monitoring			
D 161	10A NCAC 13F .0504 For LHPS Tasks	4(a) Competency Validation	D 161		
	10A NCAC 13F .0504 Licensed Health Profi (a) An adult care hor non-licensed personn not practicing in their governed by their pra licensing laws are con demonstration for any specified in Subparag Rule .0903 of this Su performing the task a	nel and licensed personnel licensed capacity as lictice act and occupational mpetency validated by return ly personal care task graph (a)(1) through (28) of bchapter prior to staff lind that their ongoing lied through facility staff			
		nd record review, the facility I sampled staff (Staff A) was d for Licensed Health			

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Division	of Health Service Regu	lation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		
		HAL013007	B. WING		10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		4876 CA	REMOOR PLACE	· =	
CAREMO	OR RETIREMENT CENTE	R			
		KANNAF	OLIS, NC 28081		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	
TAG	REGOLATORT OR E	100 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	UAI
				·	
D 161	Continued From page	e 7	D 161		
		ersonnel record revealed:			
	-A hire date of 09/01/	15.			
	-Staff A was hired as	a Personal Care Aide			
	(PCA).				
	-There was no docum	nentation of the LHPS			
	competency validation	n.			
		cility Nurse completed an			
	LHPS competency evaluation for Staff A.				
	Interview with Staff A	on 10/07/15 revealed:			
	-She was hired as a F				
		PCA prior to her being			
		a FCA prior to her being			
	hired at this facility.	a included providing			
	-Her current job dutie	· · · · · · · · · · · · · · · · · · ·			
	l -	lents, including bathing,			
	_	om bed to wheelchairs,			
	,	ncluding therapeutic diets),			
	and activities.				
		tation training at the facility			
		he residents of the facility.			
	-The Facility Nurse w	as to do her competency			
	evaluation on 09/02/1	5, but was unable to return			
	to the facility to comp	lete it.			
	-The facility had a new	w nurse to complete her			
	LHPS competency ev	valuation on 10/06/15.			
	-She had provided re-				
	transfers from bed to				
		ours, incontinence care, and			
		ncluding therapeutic diets).			
	lecturing assistance (ii	icidaling therapeutic diets).			
	Observation on 10/06	5/15 from 12:00 pm to 12:55			
		7 10 HOIII 12.00 piii to 12.00			
	pm revealed:	ling againtance to C			
	-Staff A provided feed				
	residents in the dining				
	-All six residents were				
		six residents with feeding			
	assistance, including				
	nectar-thick and hone	ev-thick liquids.			

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL013007	B. WING		10/0	7/2015
CAREMOOR RETIREMENT CENTER 4876 CAR		4876 CARE	RESS, CITY, STA Moor Place Lis, NC 28081	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 161	10/07/15 at 12:20 pm -She and the Manage ensuring an LHPS co completed for new hir a taskShe could not verify evaluation had been obecause the LHPS no 109/01/15 and was to recomplete the LHPS ewas unable to return the -She attempted to coron 10/06/15 and 10/0 reach herThe facility hired a new she completed the LH for Staff A on 10/06/15 Review of an LHPS costaff A revealed the experience of 10/06/15 by an RN.  Interview with the Adra 4:25 pm revealed it would be something the same and the	ector of Operations on revealed: r were responsible for mpetency evaluation was es prior to them performing  f an LHPS competency completed for Staff A urse came to the facility on return on 09/02/15 to valuation for Staff A, but o the facility on 9/2/15. Intact the nurse by telephone 7/15, but was unable to ew nurse on 10/06/15 and IPS competency evaluation for valuation was completed on ininistrator on 10/08/15 at as the facility's policy that	D 161			
D 309	Service  10A NCAC 13F .0904 (e) Therapeutic Diets (3) The facility shall r current listing of resid	(e)(3) Nutrition and Food  Nutrition and Food Service in Adult Care Homes: naintain an accurate and ents with physician-ordered uidance of food service	D 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL013007	B. WING		10	)/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CAREMO	OR RETIREMENT CENTI	4876 CA	REMOOR PLACE			
		KANNAF	OLIS, NC 28081			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 309	Continued From page	e 9	D 309			
	physician ordered the sampled residents pr	n, record review, and				
	The findings are:  Observation on 10/06/15 at 11:15 am in the kitchen revealed:  -A posted therapeutic diet list that included residents who must have egg whites, chopped meats, regular ground/mechanical soft diets.  Observation on 10/06/15 at 11:50 am in the kitchen revealed:  -23 color coded note cards that included the residents name, therapeutic diets, date of birth and admission date.  -Resident #4 was listed to have egg whites.					
	cards posted in the k	6/15 at 6:10 pm the diet note itchen revealed 28 color it included the resident's ets, date of birth and				
	08/18/15 revealed: -Diagnoses including history of falls, osteol urinary tract infection seizures, history of all hypertension, dyslipid aneurysm.	nt #4's current FL2 dated  dysphagia. dementia, porosis, weakness, history of , cardiovascular accident, bdominal aortic aneurysm, demia and history of cerebral anical soft diet, no table salt liquids.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013007	B. WING		10/07/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAREMOOR RETIREMENT CENTER			EMOOR PLACE			
	OLUMBA DV OT		DLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 309	Continued From page	e 10	D 309			
	order dated 8/21/15 for Ground, soft-mechan thickened liquids.  Review of the diet list revealed: -Resident #4 was listeresident #4 was not list to receive a "regulater." -There was no section included thickened lictoresident #4 did not livered with the other theraper.  Observation of the lune #4 on 10/06/15 from revealed: -The resident was see of tea and one 6 fluid were thickened to horous the example of the section of the section of the section of the lune #4 on 10/06/15 from revealed: -The resident was see of tea and one 6 fluid were thickened to horous the section of the section of the section of the section of the squash, one bite of the roll are	ed to have egg whites.  listed on the resident diet lar, ground, soft-mechanical on of this diet list that luids.  have a diet card available entic diet cards.  Inch meal served to Resident 12:42 pm to 1:10 pm  Inved one 6 fluid ounce glass ounce glass water both hey consistancy.  Inved 1 piece of grilled laces) which was ground.  Inuply, sweet potatoes (1/2 for dessert and 1 roll.  Inded 25% of the chicken,  Inded 75% of the pears.				
	Attempt to interview F unsuccessful.	Resident #4 was				
	Refer to interview with on 10/06/15 at 4:45 p	n the Kitchen Manager (KM) m.				
	Refer to interview with (RCC) on 10/07/15 at	n Resident Care Coordinator : 11:15 am.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,		is a transfer to the second and the	A. BUILDING: _		00 22.25	
		HAL013007	B. WING		10/07/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
CAREMO	OR RETIREMENT CENTI	≣R	EMOOR PLACE DLIS, NC 28081			
	CLIMMADY CT		<del></del>		ON	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLE	ETE
D 309	Continued From page	e 11	D 309			
	Refer to interview with the Dietary Aide (DA) serving lunch on 10/07/15 at 12:10 pm.  Refer to interview with the Administrator on 10/07/15 at 4:03 pm.  Refer to interview with the Dietary Manager (DM) on 10/07/14 at 4:45 pm.  B. Review of Resident #5's current FL2 dated 2/25/15 revealed:  -Diagnoses included history of pneumonia resolved, chronic edema, Alzheimer's Dementia, hypertension, osteoporosis, anxiety, depression, irritable bowel syndrome, history of chest pain.  -An order for a regular ground diet.					
	revealed a regular/so special instructions w	nt prefers no meat, but if				
	revealed:					
	note cards posted in -28 color coded note resident's name, ther and admission dateThe diet card for Res	cards that included the apeutic diets, date of birth sident #5 listed therapeutic ound mechanical soft. No				
	Interview with Reside	ent #5 on 10/07/15 at 10:58				

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Division of Fleatin Service Regulation		1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			1			
			D WING			
		HAL013007	B. WING		10/0	7/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STA	TE ZIP CODE		
			, ,	•		
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE			
		KANNAPC	DLIS, NC 28081			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	KIAI E	DAIL
				,		
D 309	Continued From page	e 12	D 309			
	. •					
	am revealed:					
		meat because it was hard				
		ause of her missing teeth.				
	-She usually was not	served meat.				
	-When she was not se	erved meat there was not a				
	substitute served or o	ffered.				
	-When she was serve	ed meat it was not cut up,				
	but if she asked staff	they would cut it for her.				
	-She did not know wh	y she did not ask staff to cut				
	her meat at lunch yes					
	-Sometimes she did v	-				
	Refer to interview with	n the Kitchen Manager (KM)				
	on 10/06/15 at 4:45 p					
	on 10/00/10 at 1.10 p					
	Refer to interview with	n Resident Care Coordinator				
	(RCC) on 10/07/15 at					
	(NCC) on 10/07/15 at	. 11.15 am.				
	Defer to intensions with	the Dieton, Aide (DA)				
		n the Dietary Aide (DA)				
	serving lunch on 10/0	7/15 at 12.10 pm.				
	D ( ) : ( ) : ( )	(I) A 1 - 2 2 4 - 1 - 1				
		n the Administrator on				
	10/07/15 at 4:03 pm.					
	<b>D</b> ( )					
		n the Dietary Manager (DM)				
	on 10/07/14 at 4:45 p	m.				
		<del></del>				
		chen Manager (KM) on				
	10/06/15 at 4:45 pm r					
		r coded according to the diet				
	group the resident ha					
	-The groups included	mechanical soft, pureed,				
	cardiac and no conce	ntrated sweet diets.				
	-The description of the	e diets were posted above				
	each color section.	•				
		s responsible for updating				
	•	e nursing staff did this on a				
	weekly basis.	orang otan and unio on a				
		reviewed and undated last				

week.

Division of Health Service Regulation

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	or Regulation	1	0.00 1	CONCERNATION	J = :	OLIDA (EV	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
VIAD LEWIN (	O CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _			LLILD	
		HAL013007	B. WING		10.	/07/2015	
					,		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
CAREMO	OR RETIREMENT CENTE	ER	REMOOR PLACE				
		KANNAP	OLIS, NC 28081				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION		COMPLETE DATE	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	AFFROFRIATE	DATE.	
D 309	Continued From page	e 13	D 309				
	Interview with RCC o	n 10/07/15 at 11:15 am					
	revealed:	11 10/07/10 at 11:10 am					
		the dietary staff when there					
		dmitted and their diet before					
	the first meal was ser						
		ry staff verbally and in writing					
		ange in a resident or if					
	thickened liquids were						
		ietary staff that was working					
	at the time of the diet						
	admission.	ary oriange or non					
		ignated Dietary Manager					
	and they all worked to						
	and they all worked to						
	Interview with the Die	etary Aide (DA) serving lunch					
	on 10/07/15 at 12:10						
		ite to prepare next and what					
		because the DA did so					
		s next on the list (pointing to					
	the posted resident d	iet list).					
	•	and utilized as a quick					
	reference or "cheat sl	heet".					
	-She did not know wh	no created the list but the					
	nursing staff was goo	d about telling her about					
	changes.						
		d updated the DA last week					
		ng in the dining room and					
	<u> </u>	d in her personal notebook.					
		example of a therapeutic					
	diet change						
		ministrator on 10/07/15 at					
	4:03 pm revealed:						
		g the card system for years					
	and it had served the						
		nsible for notifying dietary					
	staff of changes in res						
	-There was a Dietary						
	responsible for the ov	verall process in the dining					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		HAL013007	B. WING		10	/07/2015
	ROVIDER OR SUPPLIER  OR RETIREMENT CENTE	4876 CA	DDRESS, CITY, STAREMOOR PLACE	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 309	food, drinks and other dietary.  Interview with the Die 10/07/14 at 4:45 pm r -The DM did not under cards were not presered. He checked all the diresidents' diets were redided get the diet in staff and the updates dietary staff by the RO-The DA was not away was not accurate.	manager ordered all the r necessary items for tary Manager (DM) on evealed: erstand why the dietary nt and posted on 10/06/15. iet cards last week all the posted and accurate. formation from the nursing were typically given to the CC. re that the resident diet list	D 309			
D 310	Service  10A NCAC 13F .0904 (e) Therapeutic Diets (4) All therapeutic die supplements and thic served as ordered by  This Rule is not met Based on observation interviews, the facility sampled residents (R physician's order for the	n, record review, and failed to assure 1 of 6 esident #5) with a	D 310			

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DIVISION	n nealth Service Regu	ilation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1	<del></del>	
			D WING		
		HAL013007	B. WING		10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
IVAIVIL OI II	TOVIDER OR GOLT EIER		, ,		
CAREMO	OR RETIREMENT CENTE	≣R	REMOOR PLAC		
		KANNAF	OLIS, NC 2808		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
				BEI IOIENOT)	
D 310	Continued From page	e 15	D 310		
	Continuou i rom page				
	Observation on 10/06	6/15 at 11:15 am in the			
	kitchen revealed:				
	-A posted therapeutic	diet list that included			
		ave egg whites, chopped			
		d/mechanical soft diets.			
		ne therapeutic diet menus			
	which were approved				
		•			
	=	week-at-a-glance menu for			
	this week.				
		dinator (RCC) provided a list			
	•	peutic diets (not specified), a			
	list of residents that w	vere diagnosed as diabetic			
	and a list of residents	that required feeding			
	assistance.				
	Observation on 10/06	6/15 at 11:50 am in the			
	kitchen revealed:				
	-23 color coded note	cards that included the			
		apeutic diets, date of birth			
	and admission date.				
	and damicolon date.				
	Paviow of Pasidant #	5's current FL2 dated			
	2/25/15 revealed:	o s carrett i Lz dated			
	-Diagnoses included	history of pneumonic			
		ema, Alzheimer's Dementia,			
		orosis, anxiety, depression,			
		me, history of chest pain.			
	-An order for a regula	ar ground diet.			
		5's subsequent diet order			
	dated 8/05/15 revealed	ed:			
	-A regular/soft mecha	nical diet with special			
		the prescribing practitioner,			
		meat, but if given meat must			
	be chopped."	, 5 :			
		for a no added salt diet.			
	THEIC WAS NO GIVE	ioi a no added sait diet.			
	Review of the posted	diet liet noeted in the			
		diet iist posted iii tiie			
	kitchen revealed:		1		[

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL013007	B. WING		10	)/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CAREMO	OR RETIREMENT CENTE	ER	REMOOR PLACE			
		KANNAI	POLIS, NC 28081			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 16	D 310			
	Ground Mechanical S	t #5 was listed as "Regular Soft" . ote card posted for Resident				
	served for the mechan revealed: -Resident was to be subeverage. -Resident was to be suchicken breast, 1/2 cu	served a 4 fluid ounce served 1 ground, grilled up of sweet potatoes, 1/2 up of blushing pears, 1 white bread.				
	#5 on 10/06/15 from revealed: -The resident was se of tea and one 6 fluid -The resident was se chicken breast (4 our ground, yellow squas (1/2 cup), pears (1/2 -The resident indeper the chicken with salt tableThe resident was ob cutting the chicken ar -The resident did not -The resident consum of the roll and 75% of -The resident consum	rved one 6 fluid ounce glass ounce glass of water. rved 1 piece of grilled nees) which was not cut or h (1/2 cup), sweet potatoes cup) for dessert and 1 roll. Indently cut and lightly salted that was available at the served having difficulty and chewing the chicken. have difficulty swallowing. The chicken hed 55% of the chicken. The sweet potato. The chicken hed 75% of the pears.				
	cards posted in the ki	/15 at 6:10 pm the diet note itchen revealed: cards that included the apeutic diets, date of birth				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		HAL013007	B. WING		10	0/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE			
	T		OLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 17	D 310			
	meal for the mechanic revealed: -The resident was to l beverage. -Chef's Entree of Cho 1/2 cup of Chef's Veg	be served 4 fluid ounces of soice, 1/2 cup of rice or pasta, etable of Choice, 1/2 of of white/wheat bread with				
	#5 on 10/07/15 from revealed: -The resident was ser of tea and one 6 fluid -The resident was ser (each approximately broccoli (1/2 cup), wh-Resident #5 cut up h with a forkResident #5 consum and rice, 50% of the brollResident #5 did not he	rved one 6 fluid ounce glass ounce glass of water. rved 5 uncut meatballs 18.1/2 inch in diameter), ite rice (1/2 cup) and 1 roll. er meatballs independently ed 75% of the meatballs proccoli and ate 100% of her mave any difficulty cutting up I not have difficulty chewing				
	am revealed: -Resident #5 did not of was hard for her to chimpaired dentition.	teeth in the bottom front and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL013007	B. WING		10	)/07/2015
	ROVIDER OR SUPPLIER OR RETIREMENT CENTI	4876 CAF	DDRESS, CITY, STATE REMOOR PLACE OLIS, NC 28081	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 310	-Resident #5 was goi resolved in the future -Resident #5 was usu -When Resident #5 was not a substitute substi	ang to get these dental issues  ally not served meat.  as not served meat there served or offered.  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff if they would cut it  as served meat it was not ed staff (DA) serving the term of the meal.  as each resident because elist (pointing to the resident the mechanical soft, pureed, entrated sweet diets.  as diets were posted above  are responsible for updating entrated sweet diet or updating entrated sweet diet or updating entrated sweet diet or updating entrated staff when there was a dietary staff verbally and in writing enge in a resident or if	D 310			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		HAL013007	B. WING		10/07/2015
	ROVIDER OR SUPPLIER  OR RETIREMENT CENTE	4876 CAI	DDRESS, CITY, STATE REMOOR PLACE OLIS, NC 28081	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 310	at the time of the dieta admission.  -She was not aware the was not cut as ordered. There was not a designation of the dieta admission.  -There was not a designation of the control of th	etary staff that was working ary change or new  ne meat for Resident #5 d. gnated Dietary Manager.  ninistrator on 10/07/15 at I the card system for years m well. nsible for notifying dietary sident diets.  tary Manager (DM) on evealed: d why the dietary cards posted on 10/06/15. esident #5 was served uncut diet cards last week all the posted and accurate. at the current diet card 5 was inaccurate. formation from the nursing were typically given to the	D 310		
D 358	(a) An adult care hon preparation and admi prescription and non-by staff are in accorda	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments	D 358		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL013007	B. WING	<del></del>	10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE		
	Т		DLIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 358	Continued From page	20	D 358		
		in the resident's record; and on and the facility's policies as evidenced by:			
	Based on observation review, the facility fail Prozac 20mg, was ad the licensed prescribi	n, interview and record ed to assure a medication, iministered as ordered by ang practitioner and in			
	accordance with the f procedures for 1 of 6 observed during med	residents (Resident #3)			
	The findings are:				
	on 10/07/15 at 7:23 a -The contract pharma medications in single -The Medication Aide Administration Record medications in the bu prior to administering -The MA administerior medications which ind Levothyroxine 75 mod chloride 20MEQ and 160/4.5 mcg inhalant -The MA documented 8:00 am medications	cy packaged the dose bubble packs. (MA) used the Medication d (MAR) to compare the bble pack and the MAR the medications. d Resident #3's 8:00 am cluded: Prozac 10 mg, g, aspirin 81 mg, potassium two puffs of Symbicort			
	mellitus type 2, chron disease, primary puln hypothyroidism. -A physician's order fo	3's current FL2 dated sion, hip fracture, diabetes ic obstructive pulmonary nonary hypertension and or Prozac 20mg one capsule to treat is used to treat			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		HAL013007	B. WING		10	/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
CAREMO	OR RETIREMENT CENTE	-R 4876 CA	REMOOR PLACE			
OAKLINO	OR RETIREMENT GENTE	KANNA	POLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 21	D 358			
	depression.)					
	Review of Resident # revealed an admissio	3's Resident Register on date of 2/12/15.				
		discharge summary dated #3 revealed an order for osule daily.				
	revealed:	3's October 2015 MAR				
	take one capsule one -Administration of Prodocumented from 10/	ozac 10mg daily was				
	Review of Resident #	3's September 2015 MAR				
	one capsule once dai					
	-Administration of Prodocumented from 9/0	• ,				
	Review of Resident # revealed:	3's August 2015 MAR				
	. •	ed entry for Prozac 10 mg 1 and-written 20 over the				
	mg to 20 mg.	the original entry from 10				
	-Administration of Producumented from 8/0					
	-An entry for Prozac 2 -A computer generate capsule daily with a "	3's July 2015 MAR revealed: 20 mg 1 capsule once daily. ed entry for Prozac 10 mg 1 hand-written 20" over the the original entry from 10				
		1/15 to 7/31/15 except for				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
VIAD I TWIN (	J. JOHNLOHON	IDEITH IOAHON NOWIDER.	A. BUILDING: _		JOINI LETED
		HAL013007	B. WING		10/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CAREMO	CAREMOOR RETIREMENT CENTER 4876 CAR			<b></b>	
		KANNAPO	OLIS, NC 28081		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 22	D 358		
	7/06/15, 7/07/15 and hospital on those day	7/08/15 (resident was in the s).			
	the contract pharmace -The order they had of Prozac 10mg 1 capsus -They did not supply but they did re-packar #3 and the Prozac war mail order pharmacy -The pharmacy gener residents at the facility -The pharmacy gener based on the medical them by the facility or order for Prozac 10m -They did not have ar increase the Prozac f	Resident #3 with her Prozac, ge the Prozac for Resident as supplied by Resident #3's rated the MARs for all of the y. rated Resident #3's MARs tion list that was supplied to a 2/13/15 which did have an g once daily. The subsequent orders to from 10mg to 20mg. Resident #3's Prozac and			
	Observation of the medication on hand for administration for Resident #3 on 10/07/15 revealed:  -The contract pharmacy repackaged Resident #3's Prozac 10mg in bubble packs.				
	-There was one pack from the 60 that were -There was a second	with 42 capsules remaining re-packaged on 8/31/15 pack with 30 capsules 0 that were re-packaged on			
	-Both packs were lab Prozac) 10mg take 1	eled Fluoxetine (generic capsule every day.			
	the mail order pharma -They had shipped 90 on 8/25/15.	on 10/07/15 at 1:06 pm with acy representative revealed: 0 capsules of Prozac 10mg 0 capsules of Prozac 10mg on			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL013007	B. WING		10/07/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE			
		KANNAPO	LIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	23	D 358			
	4/28/15.					
		n order for Prozac 20mg one				
	Interview with a Medion 10/07/15 at 10:30 am					
	-	bottles of medication from				
		acy and the facility sent the				
	bottles to their contra- re-packaged in the bu					
		the Prozac 10mg tablets				
	and they were sent for					
		IARs for accuracy and made				
	the next months MAR	changes were present on				
	-She and another MA					
	_	order for Resident #3's				
	•	when the resident returned				
	from the hospital in Ju-She did produce an i	•				
		as provided to the facility				
		ischarge that did have				
	Prozac 10 mg daily of					
	orders because they	s not considered medication				
		a signed medication list that				
	included Prozac 10 m					
	Interview on 10/07/15 #3 revealed:	at 10:45 am with Resident				
		aware of the names of the				
		medications provided and				
	they came on time ev	ery day.				
	-Resident #3 denied a	any symptoms of				
	depression.					
	Interview on 10/07/15					

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-The MAs did check the MARs month to month to

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL013007	B. WING		10/07/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
	10115211 011 001 1 21211		MOOR PLACE	,		
CAREMO	OR RETIREMENT CENTE	R	LIS, NC 28081			
0/10/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	J 0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
D 358	Continued From page	24	D 358			
	verify accuracy.	owed family members to				
	Interview with Resident #3's psychiatrist on 10/07/15 at 2:13 pm revealed: -He had increased Prozac 20mg daily for Resident #3 March 26, 2015The decrease to Prozac 10 mg may have occurred because the primary care physician wanted her on the least amount of medication that was effective and if this was the case he would be fine with the decreaseSince the primary care doctor did not change the dose, he was going to fax the facility an order for Prozac 20mg to clarify what dose Resident #3 should be takingHe wanted Resident #3 to take the higher dose because she had been going through a lot and her presentation was considered to be "fair".					
D 367	10A NCAC 13F .1004 Administration	(j) Medication  Medication Administration	D 367			
	(j) The resident's me	dication administration e accurate and include the				
	<ul> <li>(2) name of the medic</li> <li>(3) strength and dosal</li> <li>(3) administered;</li> <li>(4) instructions for ad or treatment;</li> <li>(5) reason or justifical medications or treatment</li> </ul>					

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
CAREMOOR RETIREMENT CENTER  4876 CAREMOOR PLACE KANNAPOLIS, NC 28081  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 367  Continued From page 25  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, interviews and record			HAL013007	B. WING		10	/07/2015	
CAREMOOR RETIREMENT CENTER  KANNAPOLIS, NC 28081    X4   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   D 367   D 367      D 367   Continued From page 25   D 367   D 367      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, interviews and record   D 367   D 367	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE			
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    D 367   Continued From page 25   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, interviews and record   ID PROVIDER'S PLAN OF CORRECTION (X5 COMPL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION OF CORRECTION (X5 COMPL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION OF CORRECTION (X5 COMPL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION OF CORRECTION (X5 COMPL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION OF COMPL DATION OF COMPLETE DATION OF	CAREMO	OR RETIREMENT CENTE	ER					
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, interviews and record	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETE DATE	
the Medication Administration Record (MAR) according to the facility's policies and procedures for 1 of 6 sampled residents (#3).  The findings are:  Review of Resident #3's current FL2 dated 4/20/15 revealed: -Diagnoses of depression, hip fracture, diabetes mellitus type 2, chronic obstructive pulmonary disease, primary pulmonary hypertension and hypothyroidismAn order for Prozac 20 mg.  Review of the Resident Register revealed the date for admission to the facility was 2/12/15.  Review of Resident #3's October 2015 MAR revealed: -An entry for Prozac 10 mg - take one capsule once dailyAdministration of Prozac 10mg daily was documented from 10/01/15 to 10/07/15.  Review of Resident #3's September 2015 MAR revealed: -An entry for Prozac 10mg - take one capsule once dailyAdministration of Prozac 10mg - take one capsule once dailyAdministration of Prozac 10mg daily was	D 367	medications or treatmonission, including re (8) name or initials of the medication or treasignature equivalent to documented and main administration record.  This Rule is not met Based on observation reviews, the facility fathe Medication Admin according to the facility for 1 of 6 sampled rest.  The findings are:  Review of Resident #4/20/15 revealed: -Diagnoses of depresmellitus type 2, chron disease, primary puln hypothyroidismAn order for Prozac and Review of the Resided date for admission to.  Review of Resident #revealed: -An entry for Prozac and coumented from 10/4  Review of Resident #revealed: -An entry for Prozac and coumented from 10/4  Review of Resident #revealed: -An entry for Prozac and coumented from 10/4  Review of Resident #revealed: -An entry for Prozac and counce daily.	nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be intained with the medication (MAR).  as evidenced by: as, interviews and record ailed to assure accuracy of inistration Record (MAR) ty's policies and procedures sidents (#3).  Bis current FL2 dated assion, hip fracture, diabetes ic obstructive pulmonary monary hypertension and and according to the facility was 2/12/15.  Bis October 2015 MAR  and mg - take one capsule object to 10/07/15.  Bis September 2015 MAR	D 367				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL013007	B. WING		10/07/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDR			RESS, CITY, STA	TE, ZIP CODE	
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE LIS, NC 28081		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 367	Continued From page	26	D 367		
	documented from 9/0	1/15 to 9/30/15.			
	revealed: -An entry for Prozac 2 once dailyThe "2" in the numb the original, computer number 10Administration of Prodocumented from 8/0 Review of Resident # -An entry for Prozac 2 once dailyThe "2" in the numb the original, computer number 10Administration of Prodocumented from 7/0	1/15 to 8/31/15.  3's July 2015 MAR revealed: 20 mg - take one capsule  per 20 was hand written over r generated "1" in the  per 20mg daily was 1/15 to 7/31/15 except for 7/08/15 because resident			
	electronically signed I	3's record revealed an Discharge Summary from a /08/15 with an order for			
	#3's Prozac 10mg in I -There was one pack from the 60 that were -There was a second remaining from the 30 8/27/15.	icy repackaged Resident bubble packs. with 42 capsules remaining repackaged on 8/31/15 pack with 30 capsules 0 that were repackaged eled Fluoxetine (generic			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			7 56.25 ter			
		HAL013007	B. WING		10	)/07/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
CAREMO	OR RETIREMENT CENT	4876 CAI	REMOOR PLACE			
CAREIVIO	OR RETIREMENT CENT	KANNAP	OLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	Continued From pag	e 27	D 367			
	sure new orders and the next months MAI-She and another MAI-She thought that the Prozac was reduced returned from the ho-She produced an urlist that was provided #3's discharge that con the list.  -She knew that this I medication orders be-She did not produce included Prozac 10 r Interview on 10/07/1 #3 revealed: -Resident #3 was no medicationsResident #3 took that they came on time e-Resident #3 denied Interview on 10/07/1 Administrator revealed the MARs mo accuracy.  Interview with Residual 10/07/15 at 2:13 pm-He had increased President #3 March 2	n revealed:  IARs for accuracy and made changes were present on R.  A did this monthly. Forder for Resident #3's to 10mg when Resident #3 spital in July 2015. Insigned hospital medication of to the facility upon Resident lid have Prozac 10 mg daily ist was not considered ecause they were unsigned. For at 10:45 am with Resident was a signed medication list that mg.  To at 10:45 am with Resident was a to the names of the emedications provided and very day. For at 4:03 pm with the end the medication aides did not not not not to verify  The side of the name is the end the medication aides did not				
	occurred because th wanted her on the le	e primary care physician ast amount of medication d if this was the case he				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		HAL013007	B. WING		10	/07/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT			
CAREMO	OR RETIREMENT CENTE	R	EMOOR PLACE DLIS, NC 28081			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 367	dose, he was going to Prozac 20mg to clarif should be taking. -He wanted Resident because she had bee		D 367			
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate	laration of Residents' Rights ration of Residents' Rights have the following rights: and services which are and in compliance with state laws and rules and	D912			
	reviews, the facility fareceived care and set appropriate, and in confederal and state laws regarding criminal bachires.  The findings are: Basinterview, the facility findings are sampled staff (Staff A.)	as evidenced by: as, interviews, and record iled to ensure residents rvices which were adequate, and rules and regulations ckground checks for new  sed on record review and failed to assure a Criminal as completed on 1 of 4 .). [Refer to Tag 139 10A 7) Other Staff Qualifications				

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