Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096031	A. BUILDING: ______ B. WING ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDSBORO ASSISTED LIVING & ALZHEIMER'S CAI	2201 ROYALE AVENUE GOLDSBORO, NC 27534

(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 conducted an annual survey on 2/3/16 and 2/4/16.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to ensure supervision was provided in accordance with each resident's assessed need, multiple falls resulting knee injuries for 1 of 5 sampled (#4) residents. The findings are: Review of Resident #4's current FL2 dated 2/20/15 revealed: -Diagnoses included dementia secondary to Parkinson's disease, depression, and neuropathy. -Resident was constantly disoriented and semi ambulatory. Review of the Resident Register for Resident #4 revealed she was admitted to the facility on 2/20/15. Review of the special care unit Resident Profile and Care plan dated 3/15/15 for Resident #4, supervision was needed for ambulation. Review of the Licensed Health Professional Support (LHPS) assessment for Resident #4	D 270		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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dated 1/10/16 revealed:
-Staff supervision was required for her ambulation with a walker.
-Staff supervision was required for transfers.
-The LHPS Nurse recommended staff continue with current plan of care. Resident had potential for falls/ injury.

Observation of Resident #4 on 2/3/16 at 11:20am revealed:
-She was ambulating in her room on the special care unit, without the use of a walker.
-She was wearing a black knee brace on her right knee.

Interview with a patient care assistant (PCA) on 2/3/15 at 11:15am revealed:
-Resident #4 was on falls precautions because she "falls a lot".
-Staff try to sit with her and walk with her to prevent her from falling.
-The staff monitor Resident #4 ever 30 minutes.

Review of the facility's Incident and Accident Reports and Progress Notes revealed resident #4 has fallen 29 times in the last 6 months.

Review of Resident #4's incident and accident reports revealed:
-She had fallen 29 times between 9/10/15 and 2/2/15.
-On 9/10/15 at 7:30pm, a resident reported to the supervisor in charge supervisor, Resident #4 was on the floor. When the SIC entered the room Resident #4's roommate was helping her get into a recliner. Resident #4 said she fell, but was not hurt. The resident care coordinator (RCC) was notified, and a message was left for the power of attorney (POA).
-On 9/13/15 at 2:30pm, she was walking down

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D 270	Continued From page 2 the hall without her walker and fell to her knees. -There was no complaints of pain and no new injuries were noted. There were old healing bruises to her knees. Resident #4 was encouraged to use her walker. The resident's POA was notified. -On 9/13/15 at 3:40pm, Resident #4 was walking down the hallway using her walker and lost her balance. Resident #4 got herself up off of the floor before the supervisor could check on her. There were no visual signs of injury. The POA was notified. -On 9/13/15 at 9:50pm, a personal care aide (PCA) reported Resident #4 fell in the hallway and hit her head on another Resident's knee. Resident #4 had slurred words right after the fall. She was rechecked in 10 minutes and she was back to normal. The RCC was notified and a message was left for the POA. -On 9/14/15 at 1:00pm, a PCA reported Resident #4 was walking down the hall, lost her balance and fell down to the floor. The RCC was notified and the POA was notified. -On 10/10/15 at 5:00pm, Resident #4 was walking down the hallway without her walker and fell to the floor. She was pushed by another resident. -She had "red around the knee caps" and skinned her right knee. The RCC was notified and a message was left for her POA. -On 10-12/15 at 1:45pm, Resident #4 was walking down the hall, lost her balance and fell down to her knees. No injuries were noted, the RCC was notified and a message was left for her POA. -On 11/2/15 at 12:40pm, a PCA reported Resident #4 was found on the floor in her bedroom. The sore on her left knee was reopened, the area was cleaned and bandaged. The RCC and POA was notified.	D 270		

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D 270	Continued From page 3 -On 11/3/15 at 9:30pm a personal care aide found Resident #4 on the floor, the resident fell going to the bathroom. The wound on her right knee reopened. The wound was cleaned, the RCC was notified and a message was left for her POA. -On 11/9/15 at 2:50pm, a PCA reported Resident #4 was walking down the hall, lost her balance and fell down on her left knee. No injury was noted. The RCC and was notified and a message was left for her POA. -On 11/18/15 at 10:15am a PCA reported Resident #4 was walking down the hall, lost her balance and fell to the floor. The RCC was notified and a message was left for her POA. -On 12/1/15 at 8:45am, Resident #4 was found on the floor in her bedroom, no injuries were noted. The RCC was notified and a message was left for her POA. -On 12/2/15 at 1:00pm a PCA reported Resident #4 was walking down the hall, lost her balance and fell to the floor. No injuries were noted. The RCC was noted and a message was left for the POA. -On 12/6/15 at 6:35pm Resident #4 was found on the floor in her room, not using her walker. The resident reopened the sores on her kneecaps. The RCC was notified and a message was left for her POA. -On 12/15/15 at 2:30pm, a PCA reported Resident #4 was walking down the hall, lost her balance and fell to the floor. No injury was noted. The RCC was notified and a message was left for her POA. -On 12/16/15 at 2:15pm, a PCA reported Resident #4 was found on the floor in her bedroom. The sore on her left knee was reopened, the area was cleaned and bandaged. The RCC was notified and a message was left for her POA. -On 12/21/15 at 2:30pm, Resident #4 was	D 270		

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walking down the hall, lost her balance and fell to the floor. The old sore on the resident's left knee was reopened. The wound was cleaned and bandaged. The RCC was notified and a message was left for her POA.
-On 12/25/15 at 10:30am Resident #4 fell onto her knee, got up from the floor by herself before someone could help her. The sore on her left knee was reopened, no other signs of injury were noted.
-The resident's knee was cleaned and bandaged and Resident #4 was encouraged to use her walker. A message was left for her POA.
-On 12/28/15 at 7:30am, staff reported Resident #4 was on the floor in her bedroom, the resident said she had fallen.
-There was an old healing abrasion to the resident's left knee, and 2 abrasions to the right knee that were previously reported with an area on the right knee, that was inflamed and hot to touch.
-The RCC and family was notified. The resident was sent to the hospital for evaluation.
-On 1/3/16 at 8:00am, staff reported Resident #4 fell to the floor on both knees and got herself up.
-The scab on the resident's left knee reopened, the wound was cleaned and a band aid was applied. A message was left for her POA.
-There were 3 falls documented on 1/11/16 on the same incident report.
-On 1/11/16 Resident #4 "fell down on her knees at 11:30am, also went down on knees again at 11:40am and 12:00pm".
-The sores on both knees were reopened, the right knee was draining blood and fluid. Both knees were bandaged. The RCC was notified and a message was left for her POA.
-Resident #4 was taken to the doctor's office for her knees to be evaluated later that day at 2:45pm.

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D 270	Continued From page 5 -On 1/17/16 at 5:45pm, a PCA reported Resident #4 fell in her room. -The wound on the resident's right knee was reopened, blood and fluid was coming out of the wound and it was "really warm and swollen". Resident was sent to the emergency room (ER). The RCC was notified and a message was left for her POA. -On 1/17/16 Resident #4 fell to her knees in the hallway, and got herself up off the floor. the resident was not using her walker when she fell. -The right knee was reopened and bloody fluid was noted. the resident's right knee was cleaned and a new bandage was applied. A message was left for her POA. -On 1/18/16 at 1:00pm, the PCA reported Resident #4 was found on the floor. -The resident's right knee was oozing bloody fluid, her right knee was cleaned and bandaged. The RCC was notified and a message was left for her POA. -On 1/31/16 at 11:10pm, she was in bed with another resident and Resident #4 rolled out of the other resident ' s bed. -There were no injury noted, Resident #4 was helped off of the floor, got up and laid down in the bed laughing. Resident's physician was made aware of her falls. -On 2/2/16 at 10/15am, Resident #4 was walking down the hall with her walker and fell to her knees, she got up before the supervisor could get her up. -The resident's right knee was oozing blood and fluid and was cleaned and bandaged. Her POA was aware. Review of physician notes for Resident #4 dated 1/11/16 revealed: -Resident #4 had fallen 3 times on that date. -The physician exam noted Resident #4's right	D 270		

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knee had a horizontal laceration that occurred on 12/28/15, in which resident had been seen in the ER, with purulent drainage of the right knee a wound culture was obtained.
-On 12/28/15, an abrasion to the left knee sustained left knee injury in the first week of January 2016, no drainage and no X-rays were noted.
-Both knees were x-rayed and a right knee wound culture was obtained on 1/11/15.
-The diagnosis revealed bilateral knee injury after falls one week apart.
-An antibiotic was given in the clinic with a prescription of Septra Dx to be taken twice a day for 14 days.
-Physical therapy was to be held for now.
-An order was obtained, to wash bilateral knees twice a day with soap and water and apply band aid.

Review of Progress notes for Resident #4 revealed:
-On 9/29/15 at 1:00pm, a PCA reported Resident #4 was found on the floor, there were no signs or symptoms of injury. The RCC and family was notified.
-On 12/29/15 at 11:16pm, resident was very funny acting with her mood swings on 12/29/15, a PCA reported she choked another resident at approximately 8:45pm for no reason. Resident #4 was also very shaky that day.
-On 1/11/16, between 11:30 am and 12:30pm she fell 3 times, refusing to use her walker. She was taken to the doctor by a family member.
-On 1/26/16 per family, Resident #4 was given a brace by an orthopedic to wear on her right leg to keep her knee straight. The brace was to be worn at all times to keep the knee extended.

Interview with the RCC on 2/3/16 at 11:30am and

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D 270	Continued From page 7 12:10pm revealed: -Resident #4 falls on her knees a lot, sometimes daily, sometimes multiple times a day. -She has a place on her right knee that is split and when she falls it keeps getting busted open. -She had began taking physical therapy (PT) 12/14/15, due to her falls. -Her primary care physician stopped her PT on 1/11/16. -The staff have to encourage her to use her walker, but she is "hard-headed". -The fluid around the resident's knee is infected and her orthopedist is going to decide in the next few weeks whether or not he will do surgery on it. -She has a knee brace that she wears to keep her knee straight. -Staff documented 30 minute checks to monitor Resident #4. -Staff encourage her to use her walker or sit back down. -The resident does have a family member that is involved in her care. -Resident #4's family member takes her to doctor appointments. -The RCC ,has spoken with Resident #4's family member and with her primary care physician about her falls. -She has discussed with Resident #4's primary care physician whether or not she was "appropriate" for her current level of care. -Resident #4's family likes the facility and wants her to stay where she is. -Physical therapy was started in December 2015, but the physician stopped the PT last month. -Resident #4 has been to the orthopedic physician two times, they are talking about removing the sack around the knee, where the infection is. She will be going back at the end of the month or in March, to determine the next move.	D 270		

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-Resident #4 was "on her 3rd or 4th round of antibiotics now ".
-The facility does not know how to stop her from falling.
-She has a wheelchair locked up in the office.
-Her family asked her not use it because Resident #4 was more dangerous with the wheelchair.
-She would not ride in it and let staff push her, she would push it around the unit and it made her more subject to fall.

A copy of the facility's falls policy was requested and was not received.

Observation of Resident #4 on 2/4/2016 at 8:48 AM revealed:
-She was in her room sitting in her recliner.
-Resident #4's right knee was red and larger than her left.
-There was dried blood that had extended down the front of her leg, from her knee down to her ankle.
-The resident was wiping the blood off her knee with a napkin.

Based on observation, interview and record review, Resident #4 was not interviewable.

Interview with a medication aide on 2/4/16 at 10:25am revealed:
-Resident #4 has fallen quite a bit.
-She uses her walker sometimes and sometimes she will just walk off without it.
-Staff constantly remind her to use her walker.
-She has Parkinson's disease and it seems like she can't catch her footing when she is walking.
-Staff monitor her more frequently than the other residents and assist her when they see she needs it.

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D 270	Continued From page 9 -Sometimes when she is in the hallway and they see her falling and just cannot get to her fast enough before she falls. -When Resident #4 is in her room, they find her on the floor. Interview with a second medication aide on 2/4/16 at 1:40pm revealed: -Resident #4 falls a lot, but staff try to encourage her to use her walker. -Sometimes she will walk with the staff. -The staff try to encourage her to sit down a lot of times, to keep her from falling. -Staff monitor Resident #4 every 30 minutes and document on a sheet in the office. -Interview with the Supervisor/Memory Care Coordinator on 2/4/16 at 11:45am revealed, when she noticed the 30 minute blocks were not filled in on the observation sheets from 9:00am through 11:30am on 2/4/16 " let me fill those in now, I have been monitoring her, but have not had time to document it". Review of observations logs for Resident #4 revealed: -On the log dated 2/4/16 there was staff initials documented in each 30 minute block 12:00am through 9:00am. There was no documented monitoring from 9:30am though 11:30am. -There were four observation logs dated 2/1/16-2/4/16. -The logs were timed in 30 minute intervals which started at 12:00am and went through 11:30pm. -On the log dated 2/1/16 staff initialed 12:00am, 2:30am, ,5:00am, and 7:00am. There were arrows pointing downward for and each initialed block through the next initialed block. There were initials in each 30 minute block between 7:00am and 2:30pm. There was no documented	D 270		

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monitoring 3:00pm through 11:30pm.
-On the log dated 2/2/16 there was staff initials at 12:00am ,2:30am, 5:30am and 7:00am. There were arrows pointing downward for and each initialed block through the next initialed block. At 7:00am,10:00am, 12:30pm, and 2:30pm. There was no documented monitoring 3:00pm through 11:30pm.
-On the log dated 2/3/15 there were staff initials at 12:00am,2:30am, 5:00am, and different initial at 7:00am, 9:30am, 11:30am, 1:30pm and arrows through 2:30pm. There were arrows pointing downward for and each initialed block through the next initialed block. There was no documented monitoring from 3:00pm through 11:30pm.

Interview with the supervisor/memory care coordinator on 2/4/16 at 12:10pm revealed:
-Resident #4 has had "several" falls.
-The staff watch her and try to make sure she has a walker at all times.
-She has a wheelchair, but her family requested she not use it because she tries to push the wheelchair and she is more at risk for falls when she does that.
-Resident #4's wheelchair is kept in the office to keep her from using it.
-Staff is told to make sure they know where she is and that she has her walker with her.
-Resident #4 is up and down all day and in and out.
-Resident #4 gets upset because she thinks she can do everything on her own.

Documentation on family meetings and meeting with the primary care physician was requested and was not provided.

Interview with the Administrator on 2/4/16 at

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2:30pm regarding Resident #4 revealed:
-Resident #4 has Parkinson's disease and has some confusion.
-A lot of times she goes down on her knee or backside.
-The facility implemented 30 minute checks.
-Resident #4 will not stay in her chair or wheelchair. If you ask her to, she will get up.
-PT was working with her, but that has been suspended for now.
-Resident #4 is not someone you can restrain, she is going to get up and fall and keep falling.
-The Administrator has not had a discussion with Resident #4's family or physician about not being able to meet her needs.
-The physician has to decide in the near future.
-She has not met with Resident #4's family to discuss her fall issues.
-The RCC has spoken with the family, and physician, she has not.

A second interview with the Administrator regarding Resident #4 on 2/4/16 at 4:20pm revealed:
-A one to one sitter has been placed with Resident #4.
-She has set up a meeting with Resident #4's family, to discuss her falls and see what interventions they could come up with.

Telephone calls to Resident #4's Primary Care Physician and Orthopedic physician were not returned.
Telephone calls to Resident #4's POA were not returned.

Review of the plan of protection received from the facility on 2/4/16 revealed:
-A staff member will be assigned to Resident #4 for one to one monitoring 24 hours a day.

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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 270	Continued From page 12 -Meetings will be held beginning 2/4/16 with each shift [PCA and supervisor] to discuss monitoring of residents at risk for falls (including documentation, what to look for when monitoring residents and how often. -The supervisor on each shift will monitor documentation and PCAs at least hourly to make sure the PCAs are fulfilling their duty as needed. -The RCC will monitor the supervisor reports and PCA documentation to ensure compliance. -The RCC will report to the Administrator daily regarding the above. -The Administrator will monitor supervisor reports, PCA documentation and PCAs daily. -The Administrator will meet with families of residents at risk for falls to discuss interventions. -The Administrator will speak also speak with the physician regarding interventions and level of care. -The Administrator will review the falls policy and make changes as necessary. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 5, 2016.	D 270		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record	D 310		

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review the facility failed to assure therapeutic diets were served as ordered for 2 of 5 resident's (#1,#6) with physician's orders for a reduced concentrated sweets diet (RCS) and a low fat and low cholesterol diet (LFLC). The findings are:

Observation of the kitchen on 2/3/2016 at 10:45 AM revealed:
-Vitamin D whole milk was the only milk seen in the refrigerator.
-There was sugar-free syrup.
-There were individual packaged flavored jellies that were not sugar-free.
-There were large jars of grape jelly that were not sugar free.
-There were no sugar-free or low-sugar snacks found.

1.Review of Resident #1's FL-2 dated 2/19/2015 revealed:
-Diagnoses included chest pain-resolved, gastroparesis, atrial fibrillation, diabetes mellitus type 2 and benign essential tremor.
-There was a physician's order for a 2000 calorie diet.

Review of Resident #1's Resident Register revealed an admission date of 5/9/2008.

Review of subsequent physician's order dated 5/8/2015 revealed an order for a RCS diet.

Review of the diet list posted (no date) revealed Resident #1 was on a RCS diet.

Review of the posted menu for 2/4/2016 revealed breakfast would be juice, cereal, eggs, sausage, french toast with syrup and margarine, beverage of choice and milk.

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Review of the RCS therapeutic diet menu for week 5 day 33 revealed residents ordered a RCS diet were to be served: ½ cup of juice of choice, ½ cup of cereal of choice, 1 ounce egg of choice, 1 slice of toast, 1 package of margarine, 1 package of diet jelly, 1 cup of coffee or tea and 1 cup of milk.

Observation of Resident #1 during the breakfast meal on 2/4/2016 at 7:15 AM revealed:
-The resident was served 1 slice of toast, 2- 8 ounce cartons of vitamin D whole milk, 1 cup of water, 1 scrambled egg, 2 small sausage links, 1 cup of chocolate milk and 1 margarine packet.
-The resident consumed 100% of food and beverages.

Interview with Resident #1 on 2/4/2016 at 8:10 AM revealed he preferred milk rather than coffee so he usually gets 2 cartons of milk.

Refer to interview with the Dietary Manager on 2/4/2016 at 8:10 AM

Refer to interview with the Administrator on 2/4/2016 at 8:45 AM

Refer to interview with the Resident Care Coordinator (RCC) on 2/4/2016 at 9:00 AM

Refer to interview with the Administrator on 2/4/2016 at 11:25 AM

Refer to interview with the Dietary Cook on 2/4/2016 at 3:05 PM

2. Review of Resident #6's FL-2 dated 4/3/2015 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, rhinitis, schizophrenia and nicotine

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dependence.
-There was a physican's order for a no added salt (NAS)/RCS/Low fat, Low Cholesterol (LFLC) diet.

Review of Resident #6's Resident Register revealed an admission date of 11/1/2000.

Review of the diet list posted (no date) revealed Resident #6 was on a NAS/RCS/LFLC diet.

Review of the posted menu for 2/4/2016 revealed breakfast would be juice, cereal, eggs, sausage, french toast with syrup and margarine, beverage of choice and milk.

Review of the therapeutic diet menu for week 5 day 33 breakfast meal revealed residents ordered a NAS/RCS/LFLC diet were to be served: ½ cup of juice of choice, ½ cup of cereal of choice, ¼ cup egg substitute, 1 slice of toast, 1 package of margarine, 1 package of diet jelly, 1 cup of coffee or tea and 1 cup of skim milk.

Observation of Resident #6 during the breakfast meal on 2/4/2016 at 7:15 AM revealed:
-The resident was served 1 cup of coffee, 4 ounces of orange juice, 1 cup of water, 1 slice of French toast, 2 small sausage links, 1 scrambled egg, ½ cup of sweetened corn cereal, 1 carton of vitamin D whole milk and 1 container of sugar-free syrup.
-The resident consumed 100% of the french toast with the sugar-free syrup, 100 % of the egg, 1 of the sausage links, 100% of the cereal, 100% of the milk, 50% of the water, none of her coffee or orange juice.

Observation of Resident #6 on 2/4/2016 at 7:35 AM revealed:
-She was sitting at the dining room table with her

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D 310	Continued From page 16 head down where her chin was towards her chest. -A walker was beside her chair. Interview with Resident #6 on 2/4/2016 at 8:05 AM revealed: -She had gotten enough to eat and was finished eating. -She would not converse further to answer questions. Refer to interview with the Dietary Manager on 2/4/2016 at 8:10 AM Refer to interview with the Administrator on 2/4/2016 at 8:45 AM Refer to interview with the Resident Care Coordinator (RCC) on 2/4/2016 at 9:00 AM Refer to interview with the Administrator on 2/4/2016 at 11:25 AM Refer to interview with the Dietary Cook on 2/4/2016 at 3:05 PM ________________________________ Interview with the Dietary Manager on 2/4/2016 at 8:10 AM revealed: -He was in charge of the kitchen and the kitchen staff. -He was responsible for all the ordering. -They had menus that they used to prepare the meals. -Every resident was served French toast except 2 residents that did not like it. -All the eggs were prepared scrambled. -He did not have an egg substitute, and had never ordered it. -He did not have any sugar-free jelly, only regular. -He could order the egg substitute and the	D 310		

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sugar-free jelly from the food supplier.
-Everyone was given the same milk.
-They occasionally give out chocolate milk in addition to the meal for any resident that wanted it.
-He ordered a variety of cereals and snacks and rotated them daily.
-Residents with an RCS diet would get fresh fruit for snacks, yogurt or one of the prepackaged crackers like party mix or baked cheese crackers.
-They did not have any low-sugar or sugar-free cookies.
-He would check with the food supplier to see if some sugar-free options could be ordered.

Interview with the Administrator on 2/4/2016 at 8:45 AM revealed:
-The Dietary Manager was responsible for ordering the food and beverages for the kitchen.
-The Dietary Manager was in charge of the menus.
-The resident's that had an order for a RCS diet would be given ½ the portion of dessert, would not be given "sweet snacks", would be given fresh fruit, yogurt, pretzels or baked cheese crackers.
-The kitchen provided sugar-free syrup and jelly.
-The resident's that had an order for a LFLC diet would be given margarine and their food would be prepared with less butter or oil.

Interview with the Resident Care Coordinator (RCC) on 2/4/2016 at 9:00 AM revealed:
-She went to the Alzheimer's Unit during meal times to help serve.
-The Administrator would oversee the meals on the assisted living side.
-She was not familiar with the menu.
-She was responsible for clarifying any diet orders from the physician.

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D 310	Continued From page 18 -If the Dietary Manager had any questions, he could come to her or to the Administrator. -The Administrator would oversee any training the Dietary Manager may need. Interview with the Administrator on 2/4/2016 at 11:25 AM revealed: -She was not aware the kitchen staff was not following the menu. -She would ensure the Dietary Manager was made aware that they must follow the menu. -She would make sure sugar-free alternatives for the diabetic residents are ordered. -She would make sure the therapeutic diet menu are followed. Interview with the Dietary Cook on 2/4/2016 at 3:05 PM revealed: -She worked the dinner meal. -She followed the menu that was posted in the kitchen. -If the diet ordered was a RCS diet, she would give them unsweet tea. -If the diet ordered was a LFLC diet, she would make sure their food was not fried. -She could ask the Dietary Manager if she had any questions on how to prepare the menu items.	D 310		
D 486	10A NCAC 13F .1501 (e) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:	D 486		

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(1) restraint alternatives that were provided and the resident's response;
(2) type of restraint that was used;
(3) medical symptoms warranting restraint use;
(4) the time the restraint was applied and the duration of restraint use;
(5) care that was provided to the resident during restraint use; and
(6) behavior of the resident during restraint use.

This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to assure documentation of a restraint while it was in use for 1 of 1 resident sampled with restraints (#2). The findings are:

1.Review of Resident #2's current FL-2 dated 2/9/2015 revealed:
-Diagnoses included dementia, hypertension-benign, urinary tract infection, metabolic encephalopathy and protein calorie malnutrition.
-Resident #2 was semi-ambulatory with no assistive device listed.
-Resident #2 was constantly disoriented.

Review of Resident #2's Resident Register revealed an admission date of 1/27/2010.

Review of the Facility's February 2016 restraint record revealed:
-The record had blocks for a staff signature every 2 hours for the entire month.
-There was no documentation on 2/1/2016 between 6:00 AM and 2:00 PM.
-There was no documentation on 2/4/2016 between 8:00 AM and 11:45 AM when the record

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D 486	Continued From page 20 was checked and a copy was made. Review of the physician's restraint order for Resident #2 dated 12/10/2015 revealed: -There was an order for a seat belt. -The reason for the restraint was due to Alzheimer's and resident's inability to self-correct position. -The seat belt was to be used when the resident was in the wheelchair. -The restraint was to be checked every 15 minutes, loosened every 2 hours and as needed and removed when not in wheelchair. Review of Resident #2's restraint use disclosure statement revealed: -The power of attorney signed consent for restraint usage on 1/4/2013. -There was no other consent present. Review of Resident #2's restraint assessment revealed: -The assessment was performed by the registered nurse from hospice. -Medical symptoms that warranted the use of the restraint included: Alzheimers related dementia, unable to sit up and hold up head without leaning forward. -Medical symptoms which affected the resident included disease process with decline. Leaning forward in wheelchair and unable to reposition self. -Medical symptoms occurred daily. -Previous alternatives included every 2 hours and as needed checks, frequent repositioning and redirecting. -The resident was unable to follow commands used as alternatives. Observation of Resident #2 on 2/4/2016 at 11:50	D 486		

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AM revealed the resident was in her wheelchair by the dinning room with the seat belt in place and secured.

Interview with the Resident Care Coordinator (RCC) on 2/4/2016 at 2:00 PM revealed:
-The nursing assistants document the restraint checks and releases on a restraint flow record.
-The sheet had a place for the nursing assistants to sign every 2 hours.
-They should sign the sheet every 2 hours and use appropriate code listed at the bottom to allow reader to know if Resident #2 was up in the wheelchair with the seat belt or in bed.
-The missing signatures on the sheet should be signed and should would speak to staff regarding that.
-There was nowhere for staff to document they were checking on the resident every 15 minutes per the physician's order.
-She would formulate a new sheet and instruct staff on frequency of checks for Resident #2.

Interview with the Nursing Assistant on 2/4/2016 at 3:00 pm revealed:
-She had been trained on the use of restraints.
-She checked on Resident #2 every 2 hours and released the seat belt, toileted and repositioned her.
-She checked on Resident #2 more frequently than every 2 hours as she performed her other duties.
-She was not aware she was supposed to check on Resident #2 every 15 minutes while the seat belt was in use.
-She documented the restraint usage on a sheet in the resident's flow book at the nurse's station.
-She had not had time to document every 2 hours.
-She had fed Resident #2 breakfast and then

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D 486	Continued From page 22 took her back to her room. She then removed the seat belt and laid the resident in bed. -The RCC made the staff aware of all new resident orders.	D 486		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interview, observation, and record review the facility failed to assure residents were free from neglect as related to personal care and supervision. The findings are: Based on observation, interview and record review, the facility failed to ensure supervision was provided in accordance with each resident's assessed need, multiple falls resulting knee injuries for 1 of 5 sampled (#4) residents. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914		