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	HAL034084	A. BUILDING: _____ B. WING _____	08/12/2016

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FORSYTH VILLAGE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(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 Forsyth County Department of Social Services conducted an Annual Survey on August 10, 2016 to August 12, 2016.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure storage areas which contained cleaning agents, bleaches and other substances which may be hazardous if ingested, inhaled, or handled were locked and not accessible to residents. The findings are: Observation on 08/10/16 at 4:29 pm revealed: -A housekeeper exiting a closet which stored chemicals and had a sign on the door labeled "Employees Only." -The housekeeper attempted to close the door to the chemical closet and the door did not latch. -The housekeeper looked down at the door knob	D 056		

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and went down the hall without closing the door.
-Seven residents were within view of the chemical storage closet.
-Chemicals were stored on a shelving unit on the right side of the closet, which was in view of the open door.
-Chemicals and cleaning agents stored in the closet included:
-One 28 fluid ounces container of mariatic acid (A highly corrosive, strong mineral acid with many industrial uses) with no lid and brown and yellow stained/streaks on 3/4 of the sides of the bottle.
-Two full quart-size spray bottles of mildew destroyer with bleach.
-Two unmarked 32 ounce spray bottles with a clear liquid (one was 1/2 full and one was 3/4 full)
-One full gallon of matte finish sealer for clay pavers.
-One full gallon of heavy duty floor stripper concentrate with no lid.
-One unlabeled quart bottle 1/3 full with clear liquid and no lid.
-One gallon with approximately of high traffic floor polish with no lid.
-One gallon of window and multi-surface cleaner 3/4 full.
-On container of bleach (121 ounces).
-One quart spray bottle marked "bleach and water" 1/3 full.
-Bedbug and flea killer (spray).

Observation on 08/10/16 at 4:34 pm revealed someone reached into the closet, locked the door, closed the door, and turned the light off with the surveyor in the closet.

Interview on 08/10/16 at 4:45 with the housekeeper revealed:
-There were two chemical storage closets.
-One closet contained cleaning supplies that he

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used daily.
-The door had a lock, but the lock was broken.
-"People (staff) can jiggle it open."
-Third shift needed to use cleaning supplies and did not have a key to the chemical closet.
-He reported the problem with the door being able to be opened to the Administrator-In-Charge.
-He could not recall when he reported it to the Administrator-In-Charge.
-The Administrator-In-Charge told him to leave the door unlocked at night so the night shift staff could get to the cleaning supplies.
-He was unaware of any residents having obtained chemicals or cleaning supplies from the closet.

Observation on 08/10/16 at 5:30 pm revealed:
-The Administrator-In-Charge tried to open the locked chemical closet by rapidly moving the doorknob, without success.
-The Administrator hit the door with her hip and the door came open easily.

Interview with the Administrator-In-Charge on 08/10/16 at 5:32 pm revealed:
-She was unaware the locked door to the chemical closet could be opened without using a key.
-She had instructed staff to keep the doors to the chemical storage closets locked.

Observation on 08/11/16 at 6:30 am revealed the door to the chemical closet was closed and locked.

Interview on 08/11/16 at 6:38 am with a Personal Care Aide (PCA) revealed:
-She routinely worked the night shift.
-Staff "usually" had a key for the closet where the chemicals were stored.

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-The key was on the Medication Aide's (MA's) key ring.
-No residents had ever gotten into the chemicals or the chemical closet.

Interview on 08/11/16 at 6:49 am with a Medication Aide (MA) revealed:
-She routinely worked the night shift.
-The door to the closet where the chemicals were stored was supposed to be locked at all times.
-She had never known the door to be unlocked.
-She had a key to the closet door.
-She routinely checked all doors every night to ensure all outside doors and all storage doors were locked.
-No residents had ever gotten into the chemicals or into the chemical closet.

Interview on 08/10/16 at 5:25 pm with the Administrator-In-Charge revealed:
-The facility's policy was for chemicals to be locked when not in use.
-The facility bought some cleaning chemicals in large containers.
-The housekeeping staff would transfer the chemicals into plastic bottles for use.
-The plastic bottles were to be labeled with the name of the product or chemical at the time the chemical was transferred to the plastic bottle.
-The door to both chemical closets were to be locked at all times.
-She was not aware of any instances the chemical storage closet had been opened without a key.
-Third shift MAs had a key to both chemical closets which was kept on the medication cart.
-The acid in the unlocked closet was left by a previous maintenance employee.
-She did not know the acid was in the housekeeping closet.

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D 056	Continued From page 4 -She did not know there were chemical containers being stored without lids. -She was unaware of any instances when the closet had been forced open by residents or staff. -"With our resident population, this door needs to be locked." -The Maintenance Director and the housekeeper maintained the chemical storage closets. -She had not checked the chemical closet since the previous Maintenance Director was no longer employed. -She would immediately have the Maintenance Director to replace the door lock on the chemical closet. Review of the facility's Chemical Storage Policy (undated) revealed: -The purpose was to ensure the safety of residents by ensuring they were not able to access any dangerous products. -Potentially dangerous products would be inaccessible and kept under lock and key at all times. -All chemicals, first aid supplies, and cleaning agents are stored in their original labeled containers. -All chemicals, first aid supplies and cleaning agents are stored in their original labeled containers. A Plan of Protection was provided by the facility dated 08/10/16: -Fix the locks on the chemical closet doors. -Provide keys to all 3 shifts Medication Aides. -Label all spray bottles. -Remove all chemicals with no lids on them. -Check Housekeeping closet daily; Maintenance will check it throughout the day. -Any unlocked doors to chemical closets will be reported to the Administrator-In-Charge.	D 056		

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D 056	Continued From page 5 -The Administrator-In-Charge will have a meeting with all staff about keeping doors locked at all times. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 26, 2016.	D 056		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures at sink fixtures in 14 rooms occupied by residents on C hall were maintained between 100 and 116 degrees Fahrenheit. The findings are: Review of the facility census revealed: -There were 42 residents currently residing in the facility. -Of the 42 current residents, 14 residents lived on Hall C. Observations of hot water temperatures on Hall C	D 113		

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at various times on 08/10/16 and 08/11/16 revealed:
-On 08/10/16 at 10:15 am, hot water temperature in the bathroom sink for room 37 was 72 degrees Fahrenheit.
-On 08/10/16 at 10:20 am, hot water temperature in the bathroom sink for room 29 was 72 degrees Fahrenheit.
-On 08/10/16 at 10:29 am, hot water temperature in the bathroom sink for room 36 was 72 degrees Fahrenheit.
-On 08/11/16 at 6:59 am, hot water temperature in the bathroom sink for room 30 was 72 degrees Fahrenheit.
-On 08/11/16 at 7:05 am, hot water temperature in the bathroom sink for room 33 was 72 degrees Fahrenheit.

Interviews at various times on 08/10/16, 08/11/16, and 08/12/16 with seven residents who lived on Hall C revealed:
-There had been no hot water on Hall C for a period of time which varied by report from one week to two months.
-The residents had private bathrooms and private showers, but the water was cold in their rooms. They had to go up the hall to a shower room on another hall to take their showers.
-One resident stated she sometimes went somewhere else within the building to shower, but sometimes she "just washed up and prayed for the hot water to be fixed".
-One resident stated she had her own shower, but went to the shower room because she "don't like to wash in cold water".
-One resident stated she used the shower room on the other hall "every once in a while" but usually just used the shower in her room anyway. "It's cold, but it feels good. I don't mind."
-One resident stated the water used to be hot but

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since it has been cold, he takes showers in the shower room on another hall and stated he did not mind.
-One resident stated he took a sponge bath every day because the water was too cold to shower and he did not want to use the shower room on the other hall because there was no privacy.

Confidential interview with a staff member revealed:
-There had not been hot water on Hall C for a "couple of months".
-The staff member initially stated the reason for the hot water issue was unknown, then stated the reason was because the gas bill was not paid.
-The rest of the building had hot water because it was on a separate gas line than Hall C.
-All staff were aware of the problem with the water, but the staff member had not heard about any plans to fix the hot water.
-Residents complained "all the time" about not having hot water.

Interview on 08/11/16 at 6:49 am with a Medication Aide (MA) revealed:
-When she assisted residents with showers, she usually gave the showers in the shower room on the other hall because it was bigger.
-She had not heard any complaints from residents or staff about water being cold.
-She knew "they" were working on the hot water.
-She did not know who was working on the hot water because she came to work at 11:00 pm.

Interview on 08/11/16 at 11:18 am with the Administrator-In-Charge (AIC) revealed:
-She was not aware there was no hot water on Hall C until yesterday, 08/10/16.
-She called the gas company on 08/10/16 to come out and make sure the pilot light was not

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out. The pilot was not out and they said the hot water tank "might need to be serviced".
-On 08/10/16, the hot water temperature setting was adjusted up to see if the water was getting hot.
-She was calling today to get the hot water heater serviced.
-The Maintenance Director was supposed to check hot water temperatures every day and report to the AIC any temperatures that were outside the range of 100 to 116 degrees Fahrenheit.
-The Maintenance Director had not reported any hot water temperatures outside the range.
-Yesterday, 08/10/16, the Maintenance Director told the AIC he had been trying to turn up the temperature setting for the hot water to get it within range.

Interview on 08/11/16 at 11:56 am with the Maintenance Director revealed:
-He checked hot water temperatures "as often as I can", which was "probably twice a week" on each of the three halls.
-He noticed the water was cold on Hall C about four days ago.
-He thought hot water temperatures had to be between 90 and 115 degrees Fahrenheit.
-He contacted a plumber today to come fix the issue on Hall C.

Review of the facility water temperature log revealed:
-In August (no date) 2016, hot water temperatures for Hall C were 133 degrees Fahrenheit in rooms 19 and 21, 100 degrees Fahrenheit in room 23, 116 degrees Fahrenheit in room 24, 68 degrees Fahrenheit in rooms 25 and 26, and 70 degrees Fahrenheit in room 27.
-In July (no date) 2016, hot water temperatures

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D 113	Continued From page 9 for Hall C ranged from 101 to 121 degrees Fahrenheit. In June (no date) 2016, hot water temperatures for Hall C ranged from 108 to 114 degrees Fahrenheit. Interview on 08/12/16 at 9:19 am with the AIC revealed: -The facility hot water was heated by two separate gas lines. -She contacted the gas company on 08/10/16 to check on the lower line, which serviced Hall C. -The gas company worker said the hot water tank needed service. -The AIC called a plumber yesterday, 08/11/16, who came and re-lit the pilot light. -The plumber said the hot water heater needed to be replaced, but the whole problem with the hot water at this time was the pilot light was out. -All the hot water temperatures on Hall C were now in compliance. Telephone interview on 08/12/16 at 8:37 am with a representative from the facility's gas company revealed: -The facility had two separate gas lines and accounts that serviced the facility. -No more information could be provided. Observations at various times on 08/12/16 of hot water temperatures throughout Hall C revealed hot water temperatures ranged from 112 to 114 degrees Fahrenheit.	D 113		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes:	D 299		

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D 299	Continued From page 10 (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve eight ounces of pasteurized milk at least twice a day to residents of the facility. The findings are: Review of the weekly menu spreadsheet revealed: -Two percent milk was to be served at breakfast and dinner on 08/10/16 and 08/11/16. -Milk was not listed to be served at lunch on 08/10/16 and 08/11/16. Observation of the lunch meal served on 08/10/16 from 12:50 pm to 1:10 pm revealed: -Thirty-seven residents were being served in the dining room. -Beverages had already been placed at each table setting. -Beverages served included water and pink lemonade. -No residents were offered or served milk at lunch. Observation of the kitchen area on 08/10/16 at 10:25 am revealed 2 full gallons of whole milk and 1.5 gallons of 2% milk stored in the refrigerator.	D 299		

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D 299	Continued From page 11 Review of the posted dinner menu for 08/10/16 revealed: -A handwritten list posted on the refrigerator that listed hot dogs, pork and beans, and peaches. -No beverages were listed. -The weekly menu spreadsheet was not posted in the kitchen. Observation of the dinner meal served on 08/10/16 from 5:35 pm to 6:05 pm revealed: -Thirty-five residents were being served in the dining room. -Beverages had already been placed at each table setting. -Beverages included water and pink lemonade. -Residents' plates were being served by dietary staff and Personal Care Aides (PCA). -No residents were offered or served milk at dinner. -There was no milk on the serving table where the beverages were prepared by the PCAs. Interview with a resident on 08/10/16 at 11:15 am revealed: -There was no milk or juice served to residents to drink at meals. -Residents were only served water with every meal. -The resident would like to have milk with meals. Interview with a second resident on 08/12/16 at 9:00 am revealed: -Milk was served each morning with cereal. -"You have to ask for milk if you want it." Interview with a third resident on 08/12/16 at 9:40 am revealed: -Milk was served each morning with cereal. -He did not drink milk, but "people have to ask for	D 299		

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milk if they want it."

Interview on 08/12/16 at 11:04 with a PCA revealed:
-The PCAs were responsible for preparing and serving beverages to residents during meals.
-The kitchen staff placed the milk containers in a large stainless steel bowl with ice to keep milk cold.
-The milk was located at the serving station and residents could request milk.
-She served breakfast and lunch when she worked first shift.
-Residents were served milk with their cereal each morning.
-Residents could request milk if they wanted it.
-Residents were served juice, water, and milk (if they wanted it at lunch).
-She did not know what was served at dinner.
-The facility had milk available and had not run out of milk when she was serving residents.

Interview with a cook on 08/12/16 at 9:05 am revealed:
-He had only been working at the facility since 08/08/16.
-Milk was purchased by the Dietary Manager.
-The Dietary Manager wrote down and posted what food was to be prepared for daily meals.
-Beverages were served in the dining room by the PCAs.
-Milk was available to be served to the residents by the PCAs.

Interview with the Administrator-In-Charge on 08/10/16 at 6:10 pm revealed:
-She was aware milk was to be served twice a day to residents.
-She did not know why milk was not served at dinner on 08/10/16.

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D 299	Continued From page 13 -The Dietary Manager was responsible for purchasing milk. -The facility's policy was for milk to be served twice a day to residents.	D 299		
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 observations, interviews, and record reviews, the facility failed to utilize a therapeutic diet menu to ensure meals were served as ordered by the resident's physician for 2 of 3 sampled residents (Residents #6 and #8), including double portions and no concentrated sweets. The findings are: Observation on 08/10/16 at 3:30 pm revealed: -There were no posted therapeutic menus in the kitchen area for staff guidance. -There were no therapeutic menus being utilized by kitchen staff for meal preparation for therapeutic diets. -There was a therapeutic menu spreadsheet, signed by a dietician, located beneath the daily menu kept in a notebook in the Dietary Manager's office. A. Review of Resident #8's current FL-2 dated	D 310		

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D 310	Continued From page 14 03/03/16 revealed: -Diagnoses included non-insulin dependent diabetes mellitus, hypertension, hyperlipidemia, and schizophrenia. -An order for a No Concentrated Sweets (NCS) diet. -An order to weigh Resident #8 every week and notify the physician for a loss of five pounds or more. Review of Resident #8's record revealed: -A physician's order dated 04/19/16 for NCS diet. -A physician's order dated 07/14/16 that "Resident may receive double portions of each meal three times a day for weight loss." -Results of a chest x-ray dated 05/19/16 with clinical indication being "weight loss". -Results were "no new active cardiopulmonary disease appreciable." Review of Resident #8's May 2016 MAR revealed: -On 05/04/16, weight was documented at 145.8 pounds. -On 05/11/16, weight was documented as 147.4 pounds. -On 05/18/16, weight was documented as 150.4 pounds. -On 05/25/16, weight was documented as 152.4 pounds. Review of Resident #8's "Vital sign and weight flow sheet" revealed, on 05/06/16, weight was documented as 147.6 pounds. Review of Resident #8's June 2016 MAR revealed: -On 06/01/16, weight was documented as 154.0 pounds. -On 06/08/16, weight was documented as 153.6	D 310		

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pounds.
-On 06/15/16, weight was documented as 155.4 pounds.
-On 06/22/16, weight was documented as 158.6 pounds.
-On 06/29/16, weight was documented as 160.4 pounds.

Review of Resident #8's "Vital sign and weight flow sheet" revealed, on 06/07/16, weight was documented as 145.4 pounds.

Review of Resident #8's July 2016 MAR revealed:
-On 07/06/16, weight was documented as 162.4 pounds.
-On 07/13/16, weight was documented as 166.8 pounds.
-On 07/20/16, weight was documented as 167.8 pounds.
-On 07/27/16, weight was documented as 166.8 pounds.

Review of Resident #8's "Vital sign and weight flow sheet" revealed:
-On 07/05/16, weight was documented as 146.8 pounds.
-On 07/29/16, weight was documented as 147 pounds.

Review of Resident #8's August 2016 MAR revealed, on 08/03/16, weight was documented as 167.4 pounds.

Observation of weight obtained on 08/11/16 revealed Resident #8 weighed 141.8 pounds.

Observation of the breakfast meal served to Resident #8 on 08/11/16 from 7:45 am to 8:15 am revealed:
-Resident #8 was served 1 piece of buttered

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white toast, dried oat cereal (8 ounces) with 2% milk, scrambled eggs (6 ounces), and water (8 ounces).
-Resident #8's serving sizes for the food were the same as other residents being served.
-Resident #8 requested an additional bowl of cereal and more water.
-The Dietary Manager provided the cereal and water to him, but told him "You know you have to wait until everyone comes in for breakfast before we give seconds so everyone can eat."
-Resident #8 was provided a second bowl of oat cereal and a second glass of water.
-Resident #8 ate all of the meal, including the second bowl of oat cereal and the second glass of water.
-There was no therapeutic menu posted for staff reference for serving sizes or alternates for residents' on a No Concentrated Sweets diet.

Observation of the lunch meal served to Resident #8 on 08/11/16 from 12:40 pm to 1:10 pm revealed:
-Resident #8 was served 1/2 piece of buttered garlic bread, 1 pear with cottage cheese, 6 ounces of green beans, and 6 ounces of baked spaghetti with mozzarella cheese.
-The portion sizes served to Resident #8 were the same as the serving sizes of the other residents.
-Resident #8 immediately requested a peanut butter and jelly sandwich "because I don't eat spaghetti".
-Upon prompting from the Dietary Manager, he ate all of the green beans and the pear.
-He was provided with 2 peanut butter and jelly sandwiches and ate both of them.
-There was no posted therapeutic menu for staff guidance for serving sizes or alternates for residents on a No Concentrated Sweets diet.

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D 310	Continued From page 17 Interview on 08/11/16 at 8:15 am with Resident #8 revealed: -He asked for seconds every day because he was still hungry. -"I ask for them everyday. I usually get them, but it depends on the size of the crowd." Interview with a cook on 08/11/16 at 12:53 pm revealed: -Resident #8 was served 2 peanut butter and jelly sandwiches made with 100% whole wheat bread. -He used regular grape jelly on the sandwich because "we are out of sugar free jelly". -The Dietary Manager told him today that he would get sugar free jelly when he went to the store. Interview with a second cook on 08/12/16 at 9:05 am revealed: -A regular size portion for meats was 3 ounces and a regular size portion for vegetables was 4 ounces. -He was aware Resident #8 was to receive double portions at each meal. -He only doubled the amount of the vegetables "because a lot of these people like vegetables." -He only doubled meat portions if the resident asked for another serving of meat. Interview with a Personal Care Aide (PCA) on 08/12/16 at 11:08 am revealed: -The dietary staff was responsible for plating food for residents. -The PCAs notified kitchen staff if a resident requested additional food. -She was not sure if Resident #8 received double portions. -The kitchen staff "makes sure all residents are fed before they give seconds to residents." -Resident #8 did request seconds at times.	D 310		

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D 310	Continued From page 18 Interview with the Dietary Manager on 08/11/16 at 8:30 am revealed: -He was aware Resident #8 had a physician's order to be served double portions. -He and the staff had not utilized a therapeutic diet spreadsheet to determine the initial portion size and what the doubled portion size would be. -He was told to give seconds once all of the residents were fed if there was food remaining. Interview with the Resident Care Coordinator (RCC) on 08/11/16 at 10:10 am revealed: -She was aware Resident #8 had an order to receive double portions. -The physician wrote the order because Resident #8's appetite had decreased and he had become "more picky" about what he was eating. -When there was a physician's order for double portions, the food was to be served in one serving instead of waiting to see if they ask for seconds. -She would discuss the need to provide the double portion servings with the Dietary Manager. Refer to interview with a cook on 08/10/16 at 4:15 pm. Refer to interview with a second cook on 08/11/16 at 12:53 pm. Refer to interview with the Dietary Manager on 08/11/16 at 8:30 am. Refer to interview with the Administrator-In-Charge on 08/11/16 at 8:45 am. B. Review of Resident #6's current FL-2 dated 04/18/16 revealed: -Diagnoses included end-stage renal disease, insulin-dependant diabetes mellitus, pancreatitis,	D 310		

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and anemia.
-A physician's order for a No Concentrated Sweets/No Added Salt diet.
-No order for double portions for Resident #6.

Observation of the breakfast meal served to Resident #6 on 08/11/16 from 7:45 am to 8:15 am revealed:
-Resident #6 was served 1 piece of buttered white toast, dried cereal (8 ounces) with 2% milk, scrambled eggs (6 ounces), coffee, apple juice (6 ounces), and water (6 ounces).
-Resident # 6 ate 100% of the meal.

Observation of the lunch meal served to Resident #6 on 08/11/16 from 12:40 pm to 1:10 pm revealed:
-Resident #6 was served 1/2 piece of buttered garlic bread, 1 pear with cottage cheese, 6 ounces of green beans, and 6 ounces of baked spaghetti with cheese sauce instead of tomato sauce.
-Resident #6 requested, and received, a second serving of 6 ounces of baked spaghetti.
-Resident #6 ate 2 servings of baked spaghetti, 1 and 1/2 slices of buttered garlic bread, no green beans, and no pears.

Interview with Resident #6 on 08/12/16 at 9:40 am revealed:
-He had been on dialysis for 4 years.
-His physician changed his insulin dosage on 08/11/16 because "the [blood sugars] have been going crazy - sometimes they are up and sometimes they are down."
-The facility did not give him anything with sugar.
-"I keep sweets in my bag in case my blood sugar bottoms out at dialysis."
-He drank coffee, lemonade (unsweetened), and hot chocolate every morning.

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-"I am on double portions. You have to ask for double portions if you want them."
-When dietary served the meals, he saw what they had and would ask for double of what he wanted.
-Dietary employees know what I can't eat - leafy greens, salad, tomatoes, orange juice, potatoes, and potato chips.
-The facility had sugar-free wafers and cookies for snacks.

Interview with the Dietary Manager on 08/10/16 at 8:35 am revealed:
-Resident #6 was on the list of residents who were diabetic.
-Resident #6 was not on a renal diet.
-The facility did not offer a renal diet.
-Resident #6 received double protein and could not have tomatoes, tomato sauce, leafy vegetables, and orange juice.
-The cook prepared a bagged lunch for Resident #6 on the days he attended dialysis.
-Resident #6 was provided for lunch today a banana, a bologna and cheese sandwich, and a fruit cup.
-Resident #6 always took a "soda" with him to dialysis.

Interview with a Medication Aide (MA) on 08/11/16 at 10:05 am revealed:
-Resident #6 was on a No Concentrated Sweets diet.
-Resident #6 was non-compliant with his diet and she encouraged him to be compliant with his diet.
-Resident #6 had fingerstick blood sugars checked four times daily.
-Resident #6 would go to the store and buy food that was not on his diet.

Interview on 08/11/16 at with Resident #6's Nurse

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D 310	Continued From page 21 Practitioner revealed: -He was aware Resident #6 was not on an ordered renal diet. -The facility did not offer a renal diet. -The NP was monitoring Resident #6's renal status with routine labs "Potassium levels and other levels" to make sure he was not going into kidney failure. -Resident #6 was non-compliant with his diet related to his diabetes and renal failure. Refer to interview with a cook on 08/10/16 at 4:15 pm. Refer to interview with a second cook on 08/11/16 at 12:53 pm. Refer to interview with the Dietary Manager on 08/11/16 at 8:30 am. Refer to interview with the Administrator-In-Charge on 08/11/16 at 8:45 am. _____ Interview with a cook on 08/10/16 at 4:15 pm revealed: -He had worked for the facility as a cook since 7/11/16. -He received training from the Dietary Manager about portion sizes to serve. -"I think it is 2 ounces of meat and 3 ounces for vegetables." -He did not have a menu to reference for portion sizes to be served for therapeutic diets. -"I think the Dietary Manager is working on this." -He had no concerns with having enough food to cook and there was enough food to give seconds if a resident asked for it. -There was a list of residents who were diabetics posted in the Dietary Manager's office. -The Dietary Manager posted a menu on the	D 310		

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refrigerator listing what was to be served for each meal, but it did not have portion sizes or what was to be served for special diets.
-The posted menu did not have what was to be served for residents who were on a therapeutic diet.
-He had not received any complaints from residents regarding the food served.

Interview with a second cook on 08/11/16 at 12:53 pm revealed:
-He had only been working at the facility as a cook since 08/08/16.
-He prepared the garlic bread for lunch on 08/11/16.
-He put butter on all of the garlic bread, including residents with a NCS diet order.
-He had not used a therapeutic diet spreadsheet for meal preparations since working as a cook at the facility.

Interview with the Dietary Manager on 08/11/16 at 8:30 am revealed:
-He was hired in July 2016 as the Dietary Manager.
-Administration provided him daily menus, prepared by a dietician, when he was hired.
-He thought he had only received the daily menus.
-He was unaware, until 08/10/16, there was a therapeutic menu spreadsheet for preparation of special diets located beneath the daily menu in a notebook kept at his desk.
-He and the cooks had not been utilizing the therapeutic menu spreadsheet since he was employed by the facility.
-The daily menu did not have portion sizes for guidance of kitchen staff.
-"We basically serve everyone the same thing, except we do not give diabetics things that have

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D 310	Continued From page 23 sugar in them and we substitute or cut back on how much we give starches." Interview with the Administrator-In-Charge on 08/11/16 at 8:45 am revealed: -She had provided the therapeutic diet spread sheet to the Dietary Manager when he was hired. -She was not aware the Dietary Manager and kitchen staff were not using the therapeutic diet spread sheet for guidance for meal preparation. `	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative	D 317		

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expression, increased knowledge and learning of new skills for the census of 48 residents currently living in the facility.

The findings are:

Review of the August 2016 Activity Calendar revealed:
-The week of August 1, 2016 through August 6, 2016 listed 12.5 hours of activities.
-The week of August 7, 2016 through August 13, 2016 listed 15.5 hours of activities.
-The week of August 14, 2016 through August 20, 2016 listed 15 hours of activities.
-The week of August 21, 2016 through August 27, 2016 listed 15.5 hours of activities.
-The week of August 28, 2016 through August 31, 2016 listed 8.5 hours of activities.

Review of the August 2016 Activity Calendar for the week of 8/7/2016 through 8/13/2016 revealed:
08/07/16
-10:00 am to 10:30 am Snack-N-Chat
-9:00 am to 12:00 pm Church Service
08/08/16
-9:00 am to 9:30 am One on One
-10:00 am to 10:30 am Snack-N-Chat
-1:00 pm to 2:00 pm Arts and Crafts
08/09/16
-9:00 am to 10:00 am Manicures
-10:00 am to 10:30 am Snack-N-Chat
-1:00 pm to 2:00 pm Outside Activities
08/10/16
-9:00 am to 10:00 am Pay Out
-12:30 pm to 1:30 pm Cheeseburger Wednesday with Ice Cream
-1:00 pm to 2:00 pm Play Dough
08/11/16
-10:00 am to 10:30 am Snack-N-Chat

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D 317	Continued From page 25 -11:00 am to 12:00 pm Resident Choice -1:00 pm to 2:00 pm RCM -3:00 pm to 3:30 pm Badminton 08/12/16 -10:00 am to 10:30 am Snack-N-Chat -11:00 am to 12:00 pm Manicures -1:30 pm to 2:30 pm Shopping 08/13/16 -10:00 am to 10:30 am Snack-N-Chat -11:00 am to 11:30 am Residents Choice Observation on 8/10/16 at 8:45 am revealed an activity calendar with words that were too small to read. Observation on 8/10/16 at 9:30 am revealed the residents were in line to receive their pay as an Activity. Observation on 8/10/16 at 12:50 pm revealed the residents were served cheese burgers and fries as an activity. Observation on 8/11/16 at 10:15 am revealed there were snacks, but no chatting or conversation among residents or a group facilitator. Confidential interviews with 5 residents revealed the following comments or concerns: -"Someone stole the Bingo Board." -"We have no outings to the Park or Ball park." -"Everyone is bored." -"I have been at the facility for a year and there are no outings except trips to the doctor's office." -"We get the opportunity to paint about once a week and the ladies get their nails done." -"We have no activities." -"We do not have many activities." -"We are bored and it should be something that	D 317		

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D 317	Continued From page 26 we can do besides stay at the facility all day everyday." Interview with the Activities Director on 8/10/16 at 3:30 pm revealed: -She made the activities calendar; however, it was approved by the Administrator-In-Charge (AIC) before it was posted. -"Residents Choice" was "anything the Resident wants to do." -Residents participated in Snack-N-Chat by discussing the news, weather, or current events with each other during snack time. Interview with the AIC on 8/11/16 at 2:30 pm revealed: -The Activities Director was responsible for the activity calendar with the AIC's approval. -"Snack-N-Chat" meant the residents discussed current events "one on one." -"Residents Choice" meant the residents got the opportunity to choose a special meal at the Residents Council meeting. -The residents were given a date a month in advance to go out on an outing. They were asked to save their money in order to pay for their activities, but only one of the residents saved his money, so the outing was cancelled and some residents claimed that if they had to pay for it they did not want to go.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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	HAL034084	A. BUILDING: _____ B. WING _____	08/12/2016

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D 338	Continued From page 27 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide residents with a reasonable response to his or her requests regarding requests for second servings of food. The findings are: Observation of the food supply on 08/10/16 at 9:50 am revealed there was a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the regular menu. Observation of the breakfast meal served to Resident #8 on 08/11/16 from 7:45 am to 8:45 am revealed residents were served 1 slice of buttered white toast, dried oat cereal (8 ounces) with 2% milk, scrambled eggs (6 ounces), juice (6 ounces), and water (8 ounces). -Some residents were served coffee, if requested. Observation of the breakfast meal on 08/11/16 at 8:15 am revealed: -A resident requested additional eggs. -The Dietary Manager told the resident he would have to wait until everyone was served so everyone who wanted eggs, received them. -The resident who requested additional eggs did not receive them. -There were 7 dozen eggs in the refrigerator in the kitchen. Interview with a resident on 08/11/16 at 10:45 pm revealed: -He had requested additional eggs at breakfast on 08/11/16. -He had not received the requested additional	D 338		

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eggs because the dietary staff "did not have enough" eggs to serve him a second portion.
-He usually received second portions when he requested them, but sometimes he did not because "they don't have enough" food prepared for second portions.
-He had not had any recent weight loss.

Interview on 08/11/16 at 8:15 am with a resident revealed:
-He asked for seconds every day because he was still hungry.
-"I ask for them everyday. I usually get them, but it depends on the size of the crowd."

Interview with a resident on 08/10/16 at 9:00 am revealed:
-There was not enough food to eat and residents were only given water to drink.
-There was no milk or juice to drink.

Interviews with nine residents at various times on 8/10/16 revealed:
-The food truck stopped delivering food to the facility about 2 months ago, and ever since then, there was not enough food served to the residents.
-The facility had "cut back" on food since "they stopped the truck from coming".
-There's not enough to eat. The residents "do not get to eat like we used to since they stopped the food truck 2 months ago."
-Sometimes the residents got enough to eat and sometimes they did not get enough.
-"They don't give enough food".
-The meals were "just too small portions".
-The staff did not offer second helpings to residents.
-Sometimes there was enough food for second helpings, but usually not.

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-Snacks were served in the morning, afternoon, and evening.
-Four residents stated they got enough to eat.

Confidential interview with a staff member revealed:
-The facility did not pay their bills, so various services had been discontinued.
-The food delivery truck discontinued service because the bill had not been paid, "so when these people say they hungry, believe them".
-There was currently food in the facility because the health inspector had just come, so the cook went out and bought food while the inspector was present.

Interview with the Dietary Manager on 08/11/16 at 8:30 am revealed:
-He could not provide extra eggs to the resident that requested them at breakfast this morning because "some residents get up late and I had to save the eggs for them."
-Another resident came in after the first resident requested additional eggs.
-If he had given the first resident the additional serving of eggs, "I would not have had any for [resident's name]."
-He and the staff had not utilized a diet spreadsheet to determine the portion sizes to be served during meals to residents.
-He was told to give seconds once all of the residents were fed if there was food remaining.
-This was how he was told to handle requests for seconds.
-He did grocery shopping for the facility.
-The facility previously had food delivered by a food company, but administration cancelled the service several months prior.

Interview with a cook on 08/10/16 at 4:15 pm

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D 338	Continued From page 30 revealed: -The Dietary Manager purchased food for the facility. -He had no concerns with food supply. -There was enough food to give residents seconds. -He had not received complaints from residents about not receiving enough food. -The cook provided the snacks that were served three times a day. -Examples of snacks included cookies, crackers, fig newtons, vanilla bars.	D 338		
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 ensure medications (Renvela, Atropine eye drops, Vigamox eye drop) were administered as ordered by a licensed prescribing practitioner for 1 of 2 residents (Resident #6) observed during a medication pass. The findings are: A. Review of Resident #6's current FL-2 dated 04/18/16 revealed: -Diagnoses included end-stage renal disease and	D 358		

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glaucoma.
-A physician's order for Renvela 800 mg, three tablets (2400 mg) three times daily with meals. (Renvela binds with phosphate from food in the digestive tract and is used to help control phosphate and calcium levels in people with kidney disease.)

Review of the August 2016 Medication Administration Record (MAR) revealed the morning dose of Renvela 2400 mg was scheduled for administration at 7:00 am daily with instructions to administer with meals.

Observation on 08/11/16 of the 8:00 am medication pass revealed:
-Staff A, Medication Aide (MA)/Supervisor, prepared the resident's morning medications, including three Renvela 800 mg tablets.
-Staff A administered the resident's oral medications at 7:39 am and documented administration immediately thereafter.
-Staff A did not administer the medication with food.

Observation of the morning breakfast meal service on 08/11/16 revealed Resident #6 was served the breakfast meal at 7:48 am and began eating at 7:49 am.

Interview on 08/11/16 at 10:46 am with Staff A revealed:
-When a medication was ordered to be administered with meals, she routinely gave it "right when (the resident) was entering the dining room" for a meal.
-She thought as long as the resident ate right after taking the medications, it was okay.

Interview on 08/11/16 at 10:58 am with the

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Resident Care Coordinator (RCC) revealed:
-She provided all training for MAs and was responsible for oversight of the MAs.
-It was her expectation that medications ordered to be administered with food be given "with food", meaning let the resident get a few bites of food before taking the medications, then finish his meal afterwards.

Interview on 08/11/16 at 8:19 am with Resident #6 revealed he "always" took his morning medications prior to the breakfast meal.

B. Review of Resident #6's record revealed:
-A physician's order dated 08/02/16 for Atropine 1%, one drop in the left eye daily. (Atropine drops are used to dilate the eye and treat certain inflammatory conditions of the eye.)
-A physician's order dated 08/02/16 for Vigamox 0.5%, one drop in the left eye four times daily. (Vigamox is an antibiotic used to treat eye infections.)
-A physican's order dated 08/09/16 for Prednisolone 1%, one drop in the left eye three times daily. (Prednisolone is a corticosteroid used to treat inflammation in the eye.)

Observation on 08/11/16 of the 8:00 am medication pass revealed:
-Staff A, Medication Aide (MA)/Supervisor, administered three different eye preparations into the left eye without waiting the recommended 5 minutes between different eye medications. (It is recommended to wait at least 5 minutes between different eye medications to keep the first medication from being washed out by the second before it has had time to be absorbed.)
-Staff A administered one drop of Atropine 1% into the left eye 1 minute and 10 seconds after administering Prednisolone one drop into the

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D 358	Continued From page 33 same eye. -Staff A administered one drop of Vigamox into the left eye 1 minute and 35 seconds after administering Atropine into the same eye. -Staff A documented administration of the three eye medications. Interview on 08/11/16 at 10:46 am with Staff A revealed: -Different eye medications should be administered 3-5 minutes apart. -She did not wait 3-5 minutes this morning because the resident was "impatient". -She did not usually administer the resident's eye medications with his oral medications prior to breakfast, but usually gave them after the resident finished breakfast. -She administered the eye drops this morning prior to the breakfast meal because she thought the surveyor wanted to see all the resident's medications administered. Interview on 08/11/16 at 8:19 am with Resident #6 revealed: -He "always" took his morning medications before the breakfast meal. -His eye drops were administered this morning the same way they were administered every day. -Staff "always" waits "3-5 minutes" between the different eye medications.	D 358		
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.	D912		

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D912	Continued From page 34 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to safe storage of chemicals. The findings are: Based on observation and interview, the facility failed to assure storage areas which contained cleaning agents, bleaches and other substances which may be hazardous if ingested, inhaled, or handled were locked and not accessible to residents. [Refer to Tag 0056, 10A NCAC 13F .0305(f)(4) (Type B Violation).]	D912		