Received via email 10/14/2016 HRD

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FORM APPROVED

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
	HAL076032	A. BUILDING: _____ B. WING _____	09/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 September 1-2, 2016 and September 6-7, 2016.	D 000		
D 014	10A NCAC 13F .0206 Capacity 10A NCAC 13F .0206 Capacity (a) The licensed capacity of adult care homes licensed pursuant to this Subchapter is seven or more residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A facility shall be licensed for no more beds than the number for which the required physical space and other required facilities in the building are available. (d) The bed capacity and services shall be in compliance with G.S. 131E, Article 9, regarding the certificate of need. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility exceeded the licensed capacity of 56 residents (20 beds of the 56 designated for a Special Care Unit and 36 beds designated for Assisted Living Unit) by providing medications administration and assistance with activities of daily living for 4 residents assigned to 4 Independent Living beds. The findings are: Review of the facility's 2016 license revealed: -The facility was licensed for a total of 56 beds with 20 of the 56 beds designated for Special Care Unit (SCU) beds. -The facility had 36 beds designated for the	D 014	See attached POC dated 10/11/2016 dg	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Karen Burns — Regional Director — 10/11/16

STATE FORM 6899 — 1N2211 — If continuation sheet 1 of 55

Reviewed and accepted
10-18-16
AHR for SP

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D 014	Continued From page 1 Assisted Living Unit (ALU). Observation during the entrance tour on 09/01/16 from 9:00 am to 11:30 pm revealed: -The census for the SCU was 18 residents (with one resident in hospital and one bed vacant). -The census for the ALU was 33 residents (with one resident in a rehabilitation center and 2 vacant beds.) -The facility had 4 Suites located at the end of one the ALU halls with a glassed foyer area and exit/entrance door (Suites E, F, G, and H). -Suites E, F, G, and H had single occupants. -The facility had 4 Suites located at the end of another one of the ALU halls. (Suites A, B, C, and D). Review of the Resident Roster and room number list revealed: -The SCU had 19 residents listed with one resident identified as being in the hospital. -The ALU had 34 residents listed with one resident identified as being in a rehabilitation center. -Suites E, F, G, and H were identified as "Independent Living Suites" and the residents' names were blacked out. -Suites A, B, C, and D were identified as included in the ALU census. Interviews on 09/01/16 at 11:00 am and on 09/02/16 at 10:12 am with the Executive Director (ED) revealed: -She had been working at the facility as the Executive Director since June 2016. -She had not worked at a facility that had Independent Living residents before coming to the facility and was not familiar with all the rules and regulations for Independent Living Suites. -The Resident Roster and room number list	D 014	DOL Attached POC dated 10/11/16 eg	

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D 014	Continued From page 2 included all the residents that were currently residing in the building. -The facility had 4 Suites that had been designated and approved for Independent Living and those residents had been blacked out on the list and were not counted on the census for the license. -The facility provided limited services for the Independent Living residents which included: housekeeping services, laundry services for clothes and bed linens, meals, and some assistance with medications. -The ED was aware of at least one resident that was a patient of the Nurse Practitioner (NP) that came to the facility to see ALU residents. -The residents in Suites E, F, G, and H were admitted before she came to the facility. Interview with a Medication Aide/Supervisor on 09/02/16 at 9:50 am revealed: -Medications for the 4 residents (#9, #10, #11, and #12) of the Independent Living Suites (E, F, G, and H) were kept separately on the medication cart in a separate lower left drawer of the medication cart. -MA staff administered medication to the 4 residents in the Independent Living Suites along with the other residents in the ALU. Review of the facility's "Independent Living Residency Agreement" revealed services included: -Routine housekeeping, including weekly changing of bed linens and daily touch-up cleaning as needed. -Food services with snacks. -Assistance with self-medication administration. Observation on 09/02/16 at 9:50 am of the medication cart for residents on the back hall	D 014	See attached POC dated 10/11/2016 lg	

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D 014	Continued From page 3 revealed the medications for the 4 (Independent Living)residents in Suites E, F, G, and H (Residents #9, #10, #11, and #12) were stored in a lower left drawer of the cart. A separate Medication Administration Record (MAR) binder for the 4 Independent Living residents was on the top of the cart. Observation on 09/02/16 at 9:50 am revealed the facility had record binders for Residents #9, #10, #11, and #12 located in a separate section in the medication room. Interview on 09/06/16 at 11:50 am with the facility's NP revealed: -She was not aware of any residents in the facility that were considered "Independent Living" residents. -She had no idea which residents were "Independent Living" residents. -She routinely saw Resident #9, Resident #10, Resident #11, and Resident #12 (Residents in Suites E, F, G, and H). She considered all the residents as either ALU or SCU residents. -Resident #10 needed extra care due to his mental status. -She considered Resident #11 as the most able to live independently. Interview with a MA Supervisor on 09/05/16 at 5:35 pm revealed: -She had been a MA Supervisor on second shift for 4 months. -She worked from 2:00 pm to 10:00 pm. -She was responsible for administering medications to residents who resided in the "suites", including Residents #9, #10, #11, and #12. Interview with the Regional Director (RD) on	D 014	DEL attached POC dated 10/11/16 eg	

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D 014	Continued From page 4 09/07/16 at 3:45 pm revealed: -She had recently been assigned oversight of the facility . -There had not been an admission to an Independent Living bed since she had been Resident Director for the facility. -Residents who resided in the Independent Living Suites were supposed to be completely independent. -Residents' families assisted them to doctor appointments. -The facility staff were not supposed to be performing medical tasks for the Independent Living residents. -She had never had oversight of a facility that had Independent Living beds before this facility. -She knew that the residents residing in the Independent Living suites were not included in the census for the ALU. -She would need to discuss with the Administrator to learn more about the Independent Living beds. Interview with the Executive Director (ED) on 09/07/16 at 3:50 pm revealed: -She had been the ED at the facility since June 2016. -There had not been an admission to an Independent Living bed since she had been the ED. -She did not know if all the residents occupying the Independent Living Suites had signed contracts for Independent Living. -She had not audited resident records for the contracts for ALU or Independent Living. -She knew they did not have to provide 24 hour supervision in Independent Living and did not have to do 2 hour checks on the residents. -The Resident Care Coordinator (RCC) or the ED would utilize a screening tool prior to admitting a resident to an Independent Living bed. (Residents	D 014	See attached POC dated 10/11/16 09	

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D 014	Continued From page 5 #9, #10, #11, and #12 had documentation of a pre-admission screening.) -The facility provided linen service, housekeeping, and meals and snacks for the Independent Living residents. -The Independent Living residents were invited to participate in the activities for the ALU residents. A. Review of the facility's records for Residents #9, Resident #10, Resident #11, and Resident #12 residing in the 4 suites designated for Independent Living Suites revealed: 1. Review of Resident #9's record revealed: -The resident's admission date was 05/06/14. -The resident had an "Independent Living Residency Agreement" signed 05/06/14. -There was a current FL-2 dated 05/09/16 with diagnoses including hyponatremia, congestive heart failure, hypertension, dementia Alzheimer, gastroesophageal reflux disease, cerebrovascular accident, hiatal hernia, and carotid artery stenosis. -Domiciliary was the recommended level of care on the current FL-2, with intermittently disoriented documented. -There was a Care Plan dated 06/01/15 with activities of daily living (ADL) needs listed as limited assistance with eating, dressing, grooming/personal care, and extensive assistance with bathing, including staff wash back and lower extremities. -The resident was receiving Quarterly Medication Reviews from the contract pharmacy with the last review date of 07/12/16. Review of Resident #9's current FL-2 dated 05/09/16 and Medication Administration Record (MAR) for August 2016 and September 2016 revealed medications listed on the MAR as	D 014	See attached POC dated 10/11/16. cg	

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D 014	Continued From page 6 ordered, and staff had initialed medication administration for medications as follows: Antacid fast acting suspension (for acid indigestion), clopidogrel 75 mg (for circulation), hydralazine 100 mg (for high blood pressure), MAPAP (acetaminophen) 325 mg (for pain), natural fiber powder (for bowel regulation), spironolactone 25 mg (for fluid retention), Zantac 150 mg (for acid reduction), lorazepam 0.5 mg (for anxiety), metoprolol tartrate 25 mg (for blood pressure and heart rate), sodium chloride 1 gram (to replace sodium in the body), docusate sodium 100 mg (for constipation), simvastatin 5 mg (for elevated cholesterol), acetaminophen PM as needed (for insomnia), meclizine 25 mg as needed (for dizziness), and a health shake (nutritional supplement). Observation on 09/07/16 of the medications on hand for administration in the medication cart drawer for Resident #9 revealed Antacid fast acting suspension, clopidogrel 75 mg, hydralazine 100 mg, MAPAP (acetaminophen) 325 mg, natural fiber powder, spironolactone 25 mg, Zantac 150 mg, lorazepam 0.5 mg, metoprolol tartrate 25 mg, sodium chloride 1 gram, docusate sodium 100 mg, simvastatin 5 mg, acetaminophen PM, and meclizine 25 mg were all available for administration. 2. Review of Resident #10's record revealed: -The resident's admission date was 08/22/15. -The resident did not have documentation for an "Independent Living Residency Agreement". -The resident had a "Home Contract for [Name of Facility] Admissions and Service Agreement" signed 09/21/15. (The same contract signed by ALU residents.) -There was a current FL-2 dated 09/15/15 with diagnoses including malaise and fatigue,	D 014	See attached POC dated 10/11/2016. lg	

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D 014	Continued From page 7 abnormality of gait, failure to thrive-Adult, chronic ischemic heart disease, acute kidney failure, dementia negative of symptoms w/o (without) behavior disturbances, hyperlipidemia and hypertension. -Domiciliary was the recommended level of care documented on the current FL-2 dated 09/15/15. -There was a no Care Plan for the resident. -The resident was seen for medications and health care by the facility's Nurse Practitioner (NP). -The resident was receiving Quarterly Medication Reviews from the contract pharmacy with the last review date of 07/12/16. Review of Resident #10's current FL-2 dated 09/15/15, medication orders, and Medication Administration Record (MAR) for August 2016 and September 2016 revealed medications listed on the MAR as ordered, and staff had initialed medication administration for medications as follows: amlodipine 10 mg (for high blood pressure), clopidogrel 75 mg (for circulation), donepezil 10 mg (for dementia), levothyroxine 25 mg (for thyroid replacement), Lisinopril 40 mg (for blood pressure), Remeron 30 mg (for depression), sertraline 5 mg (for depression), simvastatin 10 mg (for high cholesterol), and ferrous sulfate 325 mg (for iron supplement). Observation on 09/07/16 of the medications on hand for administration in the medication cart drawer for Resident #10 revealed amlodipine 10 mg, clopidogrel 75 mg, donepezil 10 mg, levothyroxine 25 mg, Lisinopril 40 mg, Remeron 30 mg, sertraline 5 mg, simvastatin 10 mg, and ferrous sulfate 325 mg were available for administration. 3. Review of Resident #11's record revealed:	D 014	DLL attached POC dated 10/11/16. dg	

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D 014	Continued From page 8 -The resident's admission date was 03/07/16. -The resident did not have documentation for an "Independent Living Residency Agreement". -The resident had a "Home Contract for [Name of Facility] Admissions and Service Agreement" signed 03/07/16. (The same contract signed by ALU residents.) -There was a current FL-2 dated 02/19/16 with diagnoses including benign positional vertigo, coronary artery disease, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, neuropathy pain in legs, and mild anemia. -Domiciliary was the recommended level of care documented on the current FL-2 dated 02/19/16. -There was a Care Plan dated 03/11/16 with activities of daily living (ADL) needs listed as limited assistance with eating, and supervision for ambulation, bathing, dressing, and grooming. -The resident was seen for medications and health care by the facility's NP with an order for anti-thrombotic hose; on in the morning and off in the evening. -The resident was receiving Quarterly Medication Reviews from the contract pharmacy with the last review date of 07/12/16. Review of Resident #11's current FL-2 dated 02/19/16, medication orders, and MARs for August 2016 and September 2016 revealed medications listed on the MAR as ordered, and staff had initialed medication administration for medications as follows: albuterol sulfate 0.083% nebules (for breathing), Breo 100-25 inhaler (for breathing), clopidogrel 75 mg (for circulation), CO-Q-10 (for general health), Biotin (a vitamin supplement), ferrous sulfate 325 mg (for iron supplement), fish oil 1000 mg (for lowering triglycerides), hydrochlorothiazide 25 mg (for blood pressure), I-Caps (for vitamin supplement), isosorbide mononitrate extended release 30 mg	D 014	See attached POC dated 10/11/16. lg	

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D 014	Continued From page 9 (for angina), metoprolol tartrate 25 mg (for blood pressure/heart), Protonix 40 mg (for acid indigestion), Esther-C (for vitamin supplement), calcium with Vitamin D (for calcium supplement), albuterol nebules (for breathing), gabapentin 300 mg (for neuropathy pain), pravastatin 80 mg (for high cholesterol), meclizine 25 mg as needed (for dizziness), Nitrostat 0.4 mg as needed (for angina), and anti-thrombotic hose on am and off pm (for circulation). Observation on 09/07/16 of the medications on hand for administration in the medication cart drawer for Resident #11 revealed albuterol sulfate 0.083% nebules, Breo 100-25 inhaler, clopidogrel 75 mg, CO-Q-10, Biotin, ferrous sulfate 325 mg, fish oil 1000 mg, hydrochlorothiazide 25 mg, I-Caps, isosorbide mononitrate extended release 30 mg, metoprolol tartrate 25 mg, Protonix 40 mg, Esther-C, calcium with Vitamin D, albuterol nebules, gabapentin 300 mg, pravastatin 80 mg, meclizine 25 mg, and Nitrostat 0.4 mg were available for administration. 4. Review of Resident #12's record revealed: -The resident's admission date was 07/30/15. -The resident did not have documentation for an "Independent Living Residency Agreement". -The resident had a "Home Contract for [Name of Facility] Admissions and Service Agreement", signed 07/30/15, available for review. (The same contract signed by ALU residents.) -There was a current FL-2 dated 05/31/16 with diagnoses including pneumonia, sepsis, pressure ulcer of sacral region (stage 2), weakness, bacteremia, other malaise, and abnormality of gait. -Domiciliary was the recommended level of care on the current FL-2 dated 05/31/16. -There was a Care Plan dated 08/05/16 with	D 014	See attached POC dated 10/11/16. 99	

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D 014	Continued From page 10 activities of daily living (ADL) needs listed as limited assistance with eating, toileting, ambulation, grooming and transferring, and extensive assistance with bathing, and dressing. -The resident was seen for medications and health care by the facility's NP for monitoring warfarin therapy. -The resident was receiving Quarterly Medication Reviews from the contract pharmacy with the last review date of 07/12/16. Review of Resident #12's current FL-2 dated 05/31/16, medication orders, and MARs for August 2016 and September 2016 revealed medications listed on the MAR as ordered, and staff had initialed medication administration for medications as follows: Levemir Flexpen (for diabetes), Novolog insulin sliding scale (for diabetes), finger stick blood sugar checks before meals and at bedtime, metformin 1000 mg (for diabetes), lactulose liquid (for constipation), Tylenol 325 mg (for mild pain), gabapentin 300 mg (for neuropathy pain), Ativan 0.5 mg (for anxiety), Cerovite tablets (for vitamin supplement), ferrous sulfate 325 mg (for iron replacement), Proscar 5 mg (for prostate), Synthroid 50 mcg (for thyroid replacement), Procardia XL 60 mg (for blood pressure), Occuvite (vitamin supplement), Diovan HCT-220/12.5 (for blood pressure), Vitamin D3 1,000 units (for vitamin supplement), docusate sodium 100 mg (for constipation), Paxil 10 mg (for anxiety/depression), Torsemide 20 mg (for fluid retention), warfarin 4 mg (for blood thinner), potassium chloride 10 milli-equivalent (for potassium supplement), albuterol 0.83mg/ml nebules (for breathing), ibuprofen 800 mg (for mild pain), Zofran 4 mg as needed (for nausea), Dulcolax 10 mg suppository as needed (for constipation). (Anti-thrombotic hose application	D 014	DEI attached POC dated 10/11/16. lg	

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D 014	Continued From page 11 in the morning and removal at bedtime was documented on the August 2016 MAR). Observation on 09/07/16 of the medications on hand for administration in the medication cart drawer for Resident #12 revealed: Levemir Flexpen, Novolog insulin sliding scale, metformin 1000 mg, lactulose liquid, Tylenol 325 mg, gabapentin 300 mg, Ativan 0.5 mg, Cerovite tablets, ferrous sulfate 325 mg, Proscar 5 mg, Synthroid 50 mcg, Procardia XL 60 mg, Occuvite, Diovan HCT-220/12.5, Vitamin D3 1,000 units, docusate sodium 100 mg, Paxil 10 mg, Torsemide 20 mg, warfarin 4 mg, potassium chloride 10 milli-equivalent, albuterol 0.83mg/ml nebules, ibuprofen 800 mg, Zofran 4 mg, Dulcolax 10 mg suppository were available for administration. Finger stick blood sugar check supplies were in a plastic container on a shelf in the medication room. B. Observations and interviews at various times from 09/01/16 to 09/07/16 with Resident #9, Resident #10, Resident #11, and Resident #12, and facility staff revealed: 1. Interview with Resident #9 during the initial tour on 09/01/16 at 9:27 am revealed: -She had resided at the facility for a year. - "It is just like home." -She performed her own Activities of Daily Living (bathing, dressing, and toileting). -She ate in the Assisted Living dining room for her meals. -The facility had activities, but she preferred to stay in her room. -She used a rolling walker with a seat for ambulation. -The Medication Aides (MAs) administered her medications.	D 014	See attached POC dated 10/11/16. eg	

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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 014	Continued From page 12 Interview with a Personal Care Aide (PCA) on 09/07/16 at 2:49 pm revealed: -She had been assigned to provide personal care services to Resident #9 in the past. -Resident #9 had medications administered by the MAs. -Sometimes Resident #9 would request medications from the MAs because she had complaints about being nauseated. -She often complained of nausea on shower days. -She thought Resident #9 did her own bathing because "I have never noticed she had an odor." -The PCAs helped the resident with making her bed. 2. Observation with Resident #10 during the initial tour on 09/01/16 at 9:30am revealed: -Resident #10 lying on a couch in Suite F. -Resident was dressed in pants, shirt, socks and shoes. -Resident appeared to have not shaved recently as he had ½ inch facial hair on his face and neck. Interview with Resident #10 at 9:32 am revealed: -He liked living at the facility and enjoyed his room. -He was able to dress himself, bathe himself, and toilet independently. -Staff administered his medications. A second interview with Resident #10 on 09/07/16 at 2:40 pm revealed: -He thought he had lived at the facility for 2 or 3 months. -He thought he was admitted from his home. - "I take my own medicine." - "I don't keep my medicines in my room." -He knew he was taking "a blood thinner", and	D 014	See attached POC dated 10/11/16. dg	

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D 014	Continued From page 13 thought that was the only medicine he took, but he was not certain. -He thought staff administered his medications to him once a day. -He dressed himself, but at times had problems buttoning his shirts and he would ask for staff assistance with this. -He was able to put on his socks and shoes independently. -The facility staff did his laundry and cleaned his suite. -He did not recall seeing a doctor, but his family member would take him to the doctor if he needed to go. -He was able to get in and out of the bed independently. -He had not had any recent falls. -He used the wheelchair to get to the Assisted Living dining room for meals. -He took his showers without assistance from staff. -He did not need assistance with toileting and was not incontinent of bowel or bladder. -He could feed himself. Interview with a Personal Care Aide (PCA) on 09/07/16 at 2:45 pm revealed: -Resident #10 "sometimes had problems with balance and would look for a railing to steady himself." -He recently started using his wheelchair for ambulation. -The MAs administered medications to Resident #10. -Resident #10 did not need help with dressing. -She had provided assistance with his showers, including washing his back, hair, and shaving. -Resident #10 would dress himself while seated on the toilet and staff would monitor him. -She would make his bed, but "I think he can do	D 014	See attached POC dated 10/11/16. lg	

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D 014	Continued From page 14 it." 3. Interview on 09/07/16 at 3:35 pm with a MA revealed Resident #11 was out of the facility with a family member. Resident #11 was unavailable for interview on 09/01/16 at 9:30 am and 09/07/16 at 2:30 pm and 3:30 pm. Interview with a Personal Care Aide (PCA) on 09/07/16 at 2:55 pm revealed: -She had not been assigned to Resident #11, but knew staff assisted her with removing her TED hose each night. -First shift PCAs assisted Resident #11 with putting on her anti-thrombotic (TED) hose each morning. 4. Interview with Resident #12 during the initial tour on 09/01/16 at 9:20 am revealed: -He had resided at the facility for six months. -He resided in a suite room that included a kitchen area, a living area, and a private bathroom. -Staff administered his medications. -Staff provided supervision for him when he showered "because they don't want me to fall." -Staff washed his hair "even though I could do that myself." -He had not had any falls. -He was able to transfer himself from bed to wheelchair. -He usually ambulated with a walker, but used the wheelchair to go to the Assisted Living dining room. -He was a diabetic and the Medication Aide (MA) checked his blood sugars four times a day. Interview with a Personal Care Aide (PCA) on	D 014	See attached POC dated 10/11/16. eg	

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D 014	Continued From page 15 09/07/16 at 2:40 pm revealed: -She worked second shift, usually on the Special Care Unit, but had been assigned to Resident #12 in the past. -She obtained assignments from the PCA book each morning. -Staff divided the assignments and Residents #9, #10, #11, and #12 were included in the assignments. -She had provided personal care assistance for Resident #12 when assigned to him. -Resident #12 would "call for staff to help him in and out of the shower." -She would wash his hair and back and provide supervision during his shower to ensure he did not fall. -She would remove his TED hose at 8:00 pm "because he cannot do it himself." -Resident #12 was independent with dressing and toileting. -Resident #12 was able to go to the dining room independently. -He slept in a recliner instead of a bed. -He was able to ambulate with a walker or propel self in the wheelchair. -She had not observed Resident #12 having any confusion when she worked with him. -The MAs administered medications to Resident #12. C. Observations and interviews at various times on 09/07/16 with Resident #9, Resident #10, Resident #11, and Resident #12 and facility staff revealed: 1. Interview on 09/07/16 at 2:30 pm with Resident #9 revealed: -She had resided at the facility for 2 or 3 years. -She performed her own Activities of Daily Living (bathing, dressing, and toileting).	D 014	Del attached POC dated 10/11/16. dg	

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D 014	Continued From page 16 -She was independent with using her rolling walker with a seat for ambulation. -She had a hard time remembering the medications she was prescribed and when to take the medications. -She depended on facility staff to administer her medications. Interview with a Personal Care Aide (PCA) on 09/07/16 at 3:00 pm revealed: -She had been working at the facility for one year. -She had been assigned to provide services to Resident #9 in the past. -Resident #9 routinely took her shower during the second shift. -She helped Resident #9 with her showers. 2. Interview with a second shift Personal Care Aide (PCA) on 09/07/16 at 3:00 pm revealed she routinely made sure that Resident #10 was transported to the Assisted Living dining room, in his wheelchair, for dinner. 3. Interview on 09/07/16 at 3:00 pm with a second shift Personal Care Aide (PCA) regarding Resident #11 revealed: -She helped Resident #11 with her showers. -She helped Resident #11 remove her anti-thrombotic (TED) hose in the evening. 4. Interview on 09/07/16 at 2:20 pm with Resident #12 revealed: -He had resided at the facility for 2 to 3 months. -Staff assisted him with getting in and out of the shower, and standby to make sure he does not fall. -Staff applied his anti-thrombotic (TED) hose in the morning and removed them in the evening. -He used a walker to get around most of the time, but used a wheelchair wheel he was too tired.	D 014	Del attached POC dated 10/11/16. dg	

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D 014	Continued From page 17 -The Medication Aide (MA) checked his blood sugars four times a day. -MA staff administered his medications. Interview with a Personal Care Aide (PCA) on 09/07/16 at 3:05 pm revealed: -Resident #12 needed help by staff getting in and out of the shower. -She removed Resident #12's anti-thrombotic (TED) hose in the evening. Based on observations, record reviews, and interviews with staff and residents, the facility was providing medication administration to 4 of 4 residents living in the Independent Living suites, and assistance with Activities of Daily Living for 3 of 4 residents living in the Independent Living suites which resulted in the 4 residents not being included in the census of the Assisted Living Unit.	D 014	See attached POC dated 10/11/16. dg	
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: Based on observations, interviews, and record reviews, the facility failed to provide personal assistance and supervision during the serving and assistance with meals to 1 of 5 sampled residents (Resident #1). The findings are:	D 270		

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D 270	Continued From page 18 Review of Resident #1's current FL-2 dated 05/09/16 revealed: -Diagnoses included Alzheimer's Disease and Myastenia Gravis. -Resident #1 was disoriented constantly. Review of Resident #1's record revealed: -A physician's order on 06/30/16 to refer to Hospice with diagnosis of failure to thrive. -Resident #1's weights in July 2016 were 112 pounds (lbs) 07/03/16, 111 lbs 07/10/16, 111 lbs 07/17/16, 109 lbs 07/24/16, 110 lbs 07/27/16, and 109 lbs 07/30/16. -An order for weekly weights on 10/16/14. -The order for weekly weights was discontinued on 08/01/16. Review of Resident #1's current Care Plan dated 05/01/16 revealed: -Resident #1's ability to feed self was rated as a 2 (limited assistance) with encouragement needed. -Resident #1's ability to chew or swallow was rated as a 1 (supervision) with encouragement needed. Review of a Hospice Team Care Plan Assessment dated 07/02/16 revealed: -Resident #1 had a diagnosis of failure to thrive. -Resident #1 was on a mechanical soft diet with thin liquids. -Resident #1's appetite was fair and she needed assistance with feeding. -Resident #1 was 63 inches tall and weighed 101 lbs. Reveiw of the resident diet list, dated November 2015, and posted in the kitchen revealed Resident #1 was ordered a regular mechanical soft diet.	D 270	See attached POC dated 10/11/16. dg	

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D 270	Continued From page 19 Observation of the lunch meal service in the Special Care Unit (SCU) on 09/01/16 from 11:45 am to 12:45 pm revealed: -Resident #1 remained in her bed during the lunch meal. -Resident #1 did not receive a lunch tray or assistance with a meal. -The dietary staff removed the serving cart at 12:45 pm after asking a Personal Care Aide (PCA) if all of the residents had been served and they replied all residents had been served. Interview with a PCA on 09/01/16 at 11:50 am revealed: -Resident #1 received meals in her room because eating in the SCU made her nervous and agitated. -"We feed her in her room after we get finished with everyone else." Interview with a second PCA on 09/01/16 at 12:48 am revealed: -She had worked at the facility as a PCA for one month. -Resident #1 had been fed lunch by another PCA. -"I thought [PCA's name] said she had fed her." A second interview with the first PCA on 09/01/16 at 12:49 revealed: -She thought the second PCA had provided and fed lunch to Resident #1. -She would immediately notify dietary staff that a lunch meal was needed for Resident #1. Observation of the lunch meal on 09/01/16 at 1:00 pm revealed: -Resident #1 was served in her room at 1:00 pm by a Personal Care Aide (PCA). -The meal included a solid piece of fried steak,	D 270	See attached POC dated 10/11/16. dg	

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D 270	Continued From page 20 mashed potatoes, greenbeans, orange sorbet, 8 ounces of tea, and 8 ounces of water. -The PCA cut the fried steak into small 1/2 inch pieces with a fork for Resident #1. -Resident #1 fed herself with a fork and spoon. -The PCA remained at the bedside with Resident #1 during the meal and prompted as needed. -Resident #1 coughed at 1:09 pm after eating a piece of steak. -The resident did not cough again during the meal. -The resident ate 100% of the meal. A second interview with the first PCA on 09/01/16 at 1:15 pm revealed: -She would be observing Resident #1 during the lunch meal. -Resident #1 became anxious and agitated when going to the dining room, so family asked if she could be fed in her room. -Resident #1 did well feeding herself. -She did not think Resident #1 had a history of choking when eating or drinking. -The PCAs would cut up the meat for Resident #1 if needed. Interview with a cook on 09/01/16at 1:30 pm revealed: -She prepared plates for residents who were eating in the SCU dining room. -When all of the residents in the dining room had their plates, she left the food cart in the SCU kitchen area. -The PCAs would plate the food for residents who were not eating in the dining room or who were coming to the dining room late. -There were no resident names on the plates. -She was told by the PCAs that everyone had been served at lunch today, so she removed the food cart.	D 270	See attached POC dated 10/11/16. eg	

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D 270	Continued From page 21 -She was unaware Resident #1 had not received a lunch meal until she was notified by the PCA on the SCU unit. Observation of the SCU dinner meal on 09/01/16 from 5:30 pm to 6:30 pm revealed: -A cook plated the food in the SCU kitchen area from a heated food cart for the PCAs to serve to residents. -At 6:07 pm, a PCA delivered a dinner meal to Resident #1 in her room. -At 6:09 pm, the PCA returned to the SCU dining room to assist with providing meals to the residents eating in the SCU dining room. -At 6:12 pm, Resident #1 was observed feeding herself a meal consisting of 4 ounces of turkey breast cut into bite size pieces, 1/2 cup of dressing, 1/2 cup of buttered green peas, 1/2 cup orange slices, and 8 ounces of cranberry juice. -At 6:16 pm, Resident #1 continued feeding herself without supervision or assistance from SCU staff. -At 6:25 pm, Resident #1 was no longer eating and had pushed the overbed tray away from her bed. -No SCU staff checked on Resident #1 during the meal. -The resident had no difficulties eating or drinking during the meal. -Resident #1 consumed 3/4 of the cranberry juice, none of the water, 1/2 of the green peas, and 3/4 of the turkey and dressing. Observation of the lunch meal service provided to Resident #1 on 09/02/16 from 11:35 am to 12:05 pm revealed: -Resident #1 was in bed with the head of bed elevated to a 70 degree angle. -Resident #1 was served a lunch meal at 11:35 pm by a PCA.	D 270	DLL attached POC dated 10/11/16. dey	

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D 270	Continued From page 22 -The lunch meal served included a whole chuck wagon steak patty, potatoes cut into 3/4 inch squares, mixed fruit in 1/2 inch squares, carrot slices 1 and 1/2 inch in diameter and 1/4 inch thick, one slice of white bread, and 12 ounces of tea. -The PCA was seated in a chair beside the resident for meal observation, but did not assist with eating or chopping, cuting, or altering the meat in any different size. -Resident #1 ate 100% of the steak patty by picking up the patty and eating it with her hands. -Resident #1 ate 100% of the meal. -Resident #1 had no coughing or choking during the meal. Interview with a fourth PCA on 09/02/16 at 11:35 am revealed: -She had worked at the facility as a PCA for 2 weeks. -She was instructed by another PCA to take the lunch meal to Resident #1 in her room. Based on observation and record review on 09/02/16, it was determined Resident #1 was not interviewable. Interview with the Executive Director on 09/02/16 at 8:53 am revealed: -Resident #1 was served in her room because she becomes agitated in the dining room with the noise and interactions with other residents. -Staff had been instructed by her that Resident #1 was not to be eating by herself in her room without staff supervising and assisting as needed, especially when eating meats. -Resident #1 was currently on Hospice and had recently been losing weight. -Resident #1 was requiring more assistance with personal care and was disoriented.	D 270	See attached POC dated 10/11/16. DG	

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D 270	Continued From page 23 -She was unaware the SCU staff was not providing supervision and assistance during all meals.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a Vitamin D laboratory test was obtained as ordered for 1 of 5 sampled residents (Resident #5). The findings are: Review of Resident #5's current FL2 dated 03/04/16 revealed: -Diagnoses included a cerebrovascular accident, hyperlipidemia, and dysphagia. -An order for Vitamin D2 50,000 units take 1 tablet once a week on Saturday only. Review of Resident #5's record revealed: -An order dated 04/04/16 stated "in 1 month do B12, CBC, and Vitamin D." -An order dated 06/27/16 for a CBC, B12, Lipid Panel and Liver Panel. -Results for a CBC, B12, Lipid Panel, Liver Panel were completed on 6/30/16 by an outside laboratory. -There were no results for a Vitamin D level. Review of Resident #5's most recent Vitamin D	D 273	See attached POC dated 10/11/16. eg	

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D 273	Continued From page 24 laboratory results dated 07/24/15 revealed: -Resident #5's Vitamin D level was 29.8 (Normal range is 30.0 -3000.0 mg/ml). -Resident #5's Vitamin D level was noted as low. Based on observation and record review, it was determined Resident #5 was not interviewable. Interview with Resident #5's Nurse Practitioner (NP) on 09/06/16 at 11:35 am revealed: -The facility did not have a laboratory company that came to the facility "routinely." -The facility had "gotten better" about obtaining lab tests ordered since they had obtained a transport person to "help take residents to the office or lab to get the tests done." -If she ordered a lab test to be done, her expectation was that the facility would arrange for it to be completed. -She was had initially ordered the Vitamin D lab test on 04/04/16 and when she found there were no results, she thought she had reordered it on 06/27/16. -There had been no negative outcomes for Resident #5 by not having the Vitamin D lab test completed; however, she did want current results. -She planned to re-order the Vitamin D test. Interview with the Resident Care Coordinator (RCC) on 9/6/16 at 11:05 am revealed: -She was not employed as the RCC at the time the order for Vitamin D was written. -She was unaware the Vitamin D lab ordered on 04/04/16 had not been completed. -She did not know why the Vitamin D lab had not been completed. -She called Resident #5's physician's office today and they did not have any results of the Vitamin D level being completed. -She maintained a "lab book" where she tracked	D 273	See attached POC dated 10/11/16. eg	

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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 273	Continued From page 25 orders for labs and checked them off when the results were received. -If she did not receive reports for ordered labs, she would review why the labwork had not been completed or why the facility had not received the results. -The RCC was responsible to follow-up as to why laboratory tests were not completed. -The facility would transport residents to either the physician's office or the local hospital laboratory to have labs drawn. Interview with the Executive Director (ED) on 9/6/16 at 11:20 am revealed: -She became ED for the facility in June 2016. -She was unaware the Vitamin D labs ordered on 04/04/16 had not been obtained for Resident #5. -The RCC was responsible for ensuring ordered lab tests were completed. -The ED developed a "lab book" for the RCC to utilize to track the completion of lab orders. -The facility recently hired a transportation staff person who transported residents to have labs drawn. -The RCC and the transportation staff person "work hand in hand" to get residents to the lab provider.	D 273	See attached POC dated 10/11/16. DG	
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on	D 287		

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	HAL076032	A. BUILDING: _____ B. WING _____	09/07/2016

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D 287	Continued From page 26 documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers for residents' meals on the Special Care Unit (SCU). The findings are: Interview with the Administrator on 09/01/16 at 9:30 am revealed the current census was 18 residents on the Special Care Unit. Observation of the lunch meal and evening meal served on the SCU on 09/01/16 revealed: -Silverware was provided by the dietary staff to the SCU. -Each set of tableware was wrapped in a paper napkin and included a fork and a spoon, with no knife. -Three Personal Care Aides (PCAs) were placing the wrapped silverware at each place setting. Observation of the lunch meal on 09/01/16 from 11:30 am to 12:15 pm revealed: -Seventeen residents ate in the SCU dining room in two separate seatings. -Residents were served country fried steak, mashed potatoes, green beans, one slice of white bread,and pudding. -Staff assisted some residents with cutting the fried steak. -No difficulties observed with residents eating the fried steak without a knife.	D 287	See attached POC dated 10/11/16. dg	

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D 287	Continued From page 27 Observation of a resident served lunch in her room on 09/01/16 at 1:00 pm revealed: -The resident received a set of table ware wrapped in a paper napkin and included a fork and a spoon, with no knife. -A PCA was at the bedside to assist the resident. -The resident was served fried steak, which the PCA cut up with a fork. -The resident was served 8 ounces of tea in a plastic disposable cup and 8 ounces of water in a plastic disposable cup. -The plates were non-disposable. -The resident was able to feed herself. Observation of the supper meal from 5:30 pm to 6:30 pm on 09/01/16 revealed: -No residents were provided a knife to use during the meal. -Residents were served a slice of turkey breast, dressing,green peas, cranberry sauce, and beverages of tea, water, and coffee. -The cook cut up each residents' turkey slice before it was served. -Three of 14 residents were served 8 ounces of water and 8 ounces of tea in disposable plastic cups. -The beverages were prepared by two PCAs and placed at the table setting for each resident. Based on observations and interviews on 09/01/16 at 1:00 pm and 5:30 pm, it was determined the residents were not interviewable. Interview with a PCA on 09/01/16 at 1:10 pm revealed: -She assisted the resident served in her room with cutting up her meat. -"The steak came whole, but I cut it up for her with a fork." -It was the facility's policy for the residents on the	D 287	See attached POC dated 10/11/16. dg	

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D 287	Continued From page 28 SCU to not have knives available for meals. -She was unaware of any incidences when a resident had used a knife inappropriately. -She felt the facility had enough staff to assist residents on the SCU with cutting up their meat, if needed. Interview with a second PCA on 09/07/16 at 10:25 am revealed: -The dietary staff provided drinking cups for the SCU. -The unit did not have enough non-disposable cups on the unit to serve all of the residents the 8 ounce glasses. -She had requested, to dietary staff, additional glasses be delivered to the unit. -She made the request "several weeks ago." -She was unaware residents' beverages were to be served at meals in non-disposable beverage glasses. -Residents on the SCU had previously been served beverages in plastic disposable glasses if there were not enough non-disposable glasses available on the unit. Observation on 09/07/16 at 10:25 am revealed (15) 8 ounce non-disposable cups in the cabinet on the SCU for 18 current residents residing in the SCU. Observation on 09/01/16 at 1:35 pm revealed multiple non-disposable glasses (10 ounce and 8 ounce) stacked in the Assisted Living Dining room. Interview with a wait staff person on 09/02/16 at 1:30 pm revealed: -She prepared the silverware for residents to use during meals. -For the SCU, she only included a spoon and	D 287	All attached POC dated 10/11/16. dcg	

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D 267	Continued From page 29 fork. -She was asked by two former PCAs on the SCU to not put knives in the silverware packets. -She had not been including knives in the silverware packets for about 2 months. Interview with a cook on 09/01/16 at 1:30 pm revealed: -The wait staff in dietary put silverware wrapped in napkins on the cart to be delivered to the SCU. -The wait staff put beverages to be served on the cart and deliver it to the SCU. -The PCAs on the SCU pour and serve beverages to the residents and placed the silverware at the tables. -Sometimes the PCAs or cook would cut up residents' meat since they do not have a knife, especially if they were on a modified diet for consistency. Interview with the Dietary Manager on 09/01/16 at 1:05 pm revealed: -The wait staff prepared the silverware for the SCU. -The former Executive Director had told him it was a danger for the residents on the SCU to have knives, so he instructed staff not to include a knife to residents on the SCU. Interview with the Executive Director on 09/08/16 at 11:20 am revealed: -She had been the Executive Director since June 2016. -The facility did not have a policy stating there would be no knives available for residents in the SCU. -She had requested there be no knives in the SCU because residents in the SCU reaching into other's plates or silverware and was afraid a resident could become agitated and use the knife	D 267	All attached POC dated 10/11/16. dg	

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D 287	Continued From page 30 towards the other resident. -There had been no incidences involving knives, to her knowledge. -Staff were available on the unit during meal time to assist residents if they needed help with cutting up their food and also for supervision. -She was unaware some residents on the SCU had been served beverages in non-disposable glasses. -She would check with the Dietary Manager on the availability of non-disposable glassware for the SCU.	D 287	See attached POC dated 10/11/16. dg	
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: (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 observation and interview, the facility failed to serve eight ounces of pasteurized milk at least twice a day to residents in the Special Care Unit (SCU). The findings are: Review of the menu spreadsheet revealed: -Milk (8 ounces) was to be served at breakfast on	D 299		

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D 299	Continued From page 31 09/01/16 and 09/02/16. -Milk was not listed for lunch or supper on 09/01/16 and 09/02/16. Observation of the lunch meal served in the SCU on 09/01/16 from 11:30 am to 12:15 pm revealed: -Seventeen residents were served in the SCU dining room in 2 seatings. -Beverages were prepared, poured, and served by the Personal Care Aides (PCAs). -Beverages served included water, tea, fruit punch, cranberry juice, and coffee. -One resident was served 8 ounces of milk in a coffee cup. Observation of the supper meal served in the SCU on 09/01/16 from 5:30 pm to 6:30 pm revealed: -Seventeen residents were served in the SCU dining room in 2 seatings. -One resident was served in her room. -Beverages were prepared, poured, served by the PCAs. -No milk was offered or served to residents. -There was a gallon container of 2% milk that was 3/4 full in the refrigerator in the SCU kitchen. -None of the residents requested milk. Observation on 09/02/16 at 8:15 am revealed there were 8 full gallons of 2% milk in the refrigerator in the facility kitchen. Observation on 09/07/16 at 10:20 pm revealed snacks being served to residents in the SCU, including cookies and milk. Based on observations and interviews on 09/01/06 from 5:30 pm to 6:30 pm, it was determined the residents were not interviewable.	D 299	See attached POC dated 10/11/16. dg	

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D 299	Continued From page 32 Interview with a PCA on 09/01/16 at 6:30 pm revealed: -The dietary staff provided beverages for the unit. -The PCAs poured and served beverages to residents during meals. -Milk was usually served at breakfast and at snack time. -Sometimes they would serve milk at supper "for the ones who like milk." -There were currently only two residents she knew that liked milk. -She was not aware 8 ounces of milk was to be served at least twice a day at meals. Interview with the Dietary Manager on 09/06/16 at 1:10 pm revealed: -The facility had milk available for residents. -He was unaware residents were to be served 8 ounces of milk twice a day with meals. Interview with the Executive Director on 09/02/16 at 8:45 am revealed: -Milk was to be offered daily to all residents, both in the SCU and Assisted Living. -Some residents did not like to drink milk, so if it was served, it would be wasted. -She had instructed staff in the SCU to offer milk twice a day. -The facility had a contract with a food service company that provided milk.	D 299	See attached POC dated 10/11/16. cg	
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.	D 310		

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D 310	Continued From page 33	D 310	See attached POC dated 10/11/16. dg	

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets (mechanical soft) were served as ordered by the physician for 2 of 5 sampled residents (Residents #1 and #8) in the Special Care Unit (SCU).

The findings are:

Review of the Week 3 Day 5 Lunch mechanical soft diet menu revealed residents were to receive a #6 scoop of ground country fried steak, 1/2 cup of mashed potatoes, 1/2 cup of green beans, a wheat dinner roll, 1 packet of margarine, 1/2 cup of pudding parfait, and beverage of choice.

Review of the Week 3 Day 5 dinner mechanical soft diet menu revealed residents were to receive a #10 scoop of ground mesquite roasted turkey, 1/2 cup of sage dressing, 1/2 cup of buttered green peas, 1 wheat dinner roll, 1 packet of margarine, 1/2 cup of chilled pears, and beverage of choice.

A. Review of Resident #1's current FL-2 dated 05/09/16 revealed:
-Diagnoses included Alzheimer's Disease, Myastenia Gravis, low vitamin D, and hypocalcemia.
-There was no diet order on the FL-2 form.

Review of Resident #1's record revealed a physician's order dated 04/11/16 for a regular mechanical soft diet.

Review of the resident diet list dated November

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D 310	Continued From page 34 2015, and posted in the kitchen revealed Resident #1 was ordered a regular mechanical soft diet (meats choppped or ground mechanically). Review of the resident diet list, November 2015 and posted on an inside cabinet door in the SCU revealed: -Resident #1 was ordered a low fat, low cholesterol mechanical soft diet. -The resident diet list posted in the SCU had not been updated for SCU staff guidance. Observation of the lunch meal on 09/01/16 at 1:00 pm revealed: -Resident #1 was served in her room at 1:00 pm by a Personal Care Aide (PCA). -The meal included a solid piece of fried steak, mashed potatoes, green beans, orange sorbet, 8 ounces of tea, and 8 ounces of water. -The PCA cut the fried steak into small 1/2 inch pieces with a fork for Resident #1. -Resident #1 fed herself with a fork and spoon. -The PCA remained at the bedside with Resident #1 during the meal and prompted as needed. -Resident #1 coughed at 1:09 pm after eating a piece of steak. -The resident did not cough again during the meal. -The resident ate 100% of the meal. It was determined by observation and record review on 09/01/16 at 1:00 pm Resident #1 was not interviewable. Interview with a PCA on 09/01/16 at 1:15 pm revealed: -She would be observing Resident #1 during the lunch meal. -Resident #1 became anxious and agitated when	D 310	See attached POC dated 10/11/16 eg	

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D 310	Continued From page 35 going to the dining room, so family asked if she could be fed in her room. -Resident #1 did well feeding herself. -She did not think Resident #1 had a history of choking when eating or drinking. -The PCAs would cut up the meat for Resident #1 if needed. Review of the Week 3 Day 5 dinner mechanical soft diet menu revealed residents were to receive a #10 scoop of ground mesquite roasted turkey, 1/2 cup of sage dressing, 1/2 cup of buttered green peas, 1 wheat dinner roll, 1 packet of margarine, 1/2 cup of chilled pears, and beverage of choice. Observation of the dinner meal on 09/01/16 from 6:15 pm to 6:45 pm revealed: -Resident #1 was served in her room at 6:15 pm by a PCA. -The PCA did not remain with Resident #1 in her room. -The meal included 4 ounces of turkey breast cut into bite size pieces, 1/2 cup of dressing, 1/2 cup of buttered green peas, 1/2 cup orange slices, and 8 ounces of cranberry juice. -No bread was served to Resident #1 and the turkey breast was not prepared as mechanical soft by dietary staff. Interview with a cook on 09/01/16 at 5:50 pm revealed: -The turkey breast was prepared in slices, but "I cut them up as I serve them." -The turkey breast was not mechanically chopped in the kitchen. -She was aware some residents had a diet order for mechanically soft meats, but she chose to cut them up into small pieces with a fork and knife. -It was easier to cut the meats up as she served	D 310	See attached POC dated 10/11/16. jg	

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D 310	Continued From page 36 the plates. -She did not serve bread with the meal "because they already were getting dressing and that is a starch." Observation of the lunch meal service provided to Resident #1 on 09/02/16 from 11:35 am to 12:05 pm revealed: -Resident #1 was in bed with the head of bed elevated to a 70 degree angle. -Resident #1 was served a lunch meal at 11:35 pm by a PCA. -The lunch meal served included a whole chuck wagon steak patty, potatoes cut into 3/4 inch squares, mixed fruit in 1/2 inch squares, carrot slices 1 1/2 inch in diameter and 1/4 inch thick, one slice of white bread, and 12 ounces of tea. -The chuck wagon steak patty was not prepared as mechanical soft by dietary staff utilizing -The PCA was seated in a chair beside the resident for meal observation, but did not assist with eating or chopping, cuting, or altering the meat in any different size. -Resident #1 ate 100% of the steak patty by picking up the patty and eating it with her hands. -Resident #1 ate 100% of the meal. -Resident #1 had no coughing or choking during the meal. Interview with a PCA on 09/02/16 at 11:35 am revealed: -She had worked at the facility as a PCA for 2 weeks. -She was instructed by another PCA to take the lunch meal to Resident #1 in her room. Interview with a second PCA on 09/02/16 at 12:08 pm revealed: -The Resident Diet List was not posted today in	D 310	All attached POC dated 10/11/16. JG	

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D 310	Continued From page 37 the SCU kitchen. -She knew there were a few residents who received mechanical soft diets, but Resident #1 was not one of them. Interview with a cook on 09/02/16 at 12:10 pm revealed: -There was a posted list in the kitchen of resident's on therapeutic diets, including texture modified diets. -He did not prepare a mechanical soft diet today for Resident #1. Interview with the Executive Director (ED) on 09/02/16 at 8:55 am revealed: -Resident #1 had recently been admitted for Hospice care. -Hospice had requested the medical provider to make Resident #1's diet less restrictive due to her failure to thrive diagnosis. -The medical provider ordered for Resident #1's diet to be changed to the regular mechanical soft diet. Refer to interview with a cook on 09/01/16 at 12:35 pm. Refer to interview with a PCA on 09/01/16 at 6:30 pm. Refer to interview with a second cook on 09/01/16 at 5:50 pm. Refer to a second interview with the second cook on 09/01/16 at 6:33 pm. Refer to interview with the Executive Director on 09/02/16 at 8:45 am. B. Review of Resident #8's current FL-2 dated	D 310	See attached POC dated 10/11/16 dg	

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D 310	Continued From page 38 12/12/15 revealed: -Diagnoses included major neurocognitive disorder, frontal varient, schizophrenia, constipation, Vitamin D deficiency, tardive dyskinesia, hiatal hernia. -There was no diet order on the FL-2 form. Review of Resident #8's record revealed a physician's order dated 04/11/16 for a regular mechanical soft diet. Review of the resident diet list, dated November 2015, and posted on the board in the kitchen revealed Resident #8 was ordered a low fat, low cholesterol mechanical soft diet. Review of the resident diet list, November 2015, and posted on an inside cabinet door in the SCU revealed Resident #8 was ordered a low fat, low cholesterol mechanical soft diet. Observation of the lunch meal on 09/01/16 at 1:00 pm revealed: -Resident #8 was served a solid piece of fried steak, mashed potatoes, green beans, orange sorbet, 8 ounces of cranberry juice, 1 slice of white break, vanilla pudding, 8 ounces of water, and coffee with creamer and sugar. -The PCA cut the fried steak into small 1/2 inch pieces with a fork for Resident #8. -Resident #8 fed herself with a fork and spoon. -Resident #8 ate 100% of the food and drank 3/4 of the liquids. -Resident #8 had no difficulties with eating or drinking during the meal. Observation of the dinner meal on 09/01/16 from 6:15 pm to 6:45 pm revealed: -Resident #8 was served in the dining room during the second serving.	D 310	All attached POC dated 10/11/16. 09	

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D 310	Continued From page 39 -The cook served the plates from a heated serving cart. -The cook cut the turkey slices into bite-size pieces for the residents before the plate was served. -The meal included 4 ounces of turkey breast cut into bite size pieces, 1/2 cup of dressing, 1/2 cup of buttered green peas, 1/2 cup orange slices, and 8 ounces of cranberry juice. -No bread was served to Resident #1 and the turkey breast was not prepared as mechanical soft. It was determined by observation and record review on 09/01/16, from at 1:00 pm and from 6:15 pm to 6:45 pm, Resident #8 was not interviewable. Refer to interview with a cook on 09/01/16 at 12:35 pm. Refer to interview with a PCA on 09/01/16 at 6:30 pm. Refer to interview with a second cook on 09/01/16 at 5:50 pm. Refer to a second interview with the second cook on 09/01/16 at 6:33 pm. Refer to interview with the Executive Director on 09/02/16 at 8:45 am. Interview with a cook on 09/01/16 at 12:35 pm revealed: -She had been working at the facility as a cook for two weeks. -The Dietary Manager (DM) was out of facility this week. -She had worked as a cook in other facilities.	D 310	See attached POC dated 10/11/16 dg	

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D 310	Continued From page 40 -She utilized the posted resident diet list in the kitchen so she would know what diet was ordered for residents. -She thought there was a notebook with the therapeutic menus in the kitchen for guidance, but she did not know where the book was kept. -She knew how to prepare mechanically soft diets because she had worked in other facilities as a cook. -She asked the DM when she was hired about preparing special diets and was told by the DM they served the same food to residents on special diets, but changed how it was prepared if the resident was on a special diet. -She had not used a therapeutic diet spreadsheet at this facility -She thought residents who were diabetic should have a different meu. Interview with a second cook on 09/01/16 at 5:50 pm revealed: -The turkey breast was prepared in slices, but "I cut them up as I serve them." -The turkey breast was not mechanically chopped in the kitchen. -She was aware some residents had a diet order for mechanically soft meats, but she chose to cut them up into small pieces with a fork and knife. -It was easier to cut the meats up as she served the plates. -She did not serve bread with the meal "because they already were getting dressing and that is a starch." Interview with a PCA on 09/01/16 at 6:30 pm revealed: -Residents on the SCU were served from a serving cart brought to the unit for each meal by dietary staff. -The cook was responsible for plating the food for	D 310	See attached POC dated 10/11/16. eg	

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D 310	Continued From page 41 residents. -There was a Resident Diet List posted in the cabinet near the serving station for reference. -She thought the cook was responsible for updating the Resident Diet List in the SCU. -The current diet list posted "needed to be updated." -Sometimes SCU staff would check the list to see what type of snack a resident could have. Further interview with the second cook on 09/01/16 at 6:33 pm revealed: -She used serving spoons, but did not know if they were the serving size for listed on the therapeutic diet menu. -She used the week-at-a-glance menu and sometimes used the therapeutic diet spreadsheet. -She had worked at the facility for a long time and knew what diets residents were to be served. Interview with the Executive Director (ED) on 09/02/16 at 8:50 am revealed: -The contracted food company provided the therapeutic diet menus. -The DM was responsible for training the cooks to follow the therapeutic diet menus when cooking and serving residents with therapeutic diets. -She was unaware the cooks were not utilizing the therapeutic diet sheet when preparing meals for residents on special diets. -When a resident had a new order or diet order change for a therapeutic diet, the Resident Care Coordinator made a copy of the order for the dietary staff. -The RCC was responsible for updating the posted Resident Diet List when there were new dietary orders. -She was not aware there was an outdated Resident Diet List posted in the SCU kitchen.	D 310	See attached POC dated 10/11/16. JG	

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D 310	Continued From page 42 -She did not think there needed to be a Resident Diet List posted in the SCU kitchen because the dietary staff was responsible for preparing the meals for residents on the SCU. -She removed the Resident Diet List from the SCU kitchen on 09/01/16 after the dinner meal. -The ED would create a diet order notebook for dietary staff reference to ensure dietary staff had the most current diet orders.	D 310	See attached POC dated 10/11/16-9a	
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, record reviews and interviews, the facility failed to assure medications were administered as ordered for 2 of 5 sampled residents (Resident #6 and #5) with physician orders for Prednisone (Resident #6), and Vitamin D (Resident #5). The findings are: A. Review of Resident #6's current FL2 dated 04/04/16 revealed: -Diagnoses included chronic pyelonephritis, urinary tract infection, dysphagia, hypertension, hyperlipidemia, debility, and Myasthenia Gravis. -Physicians' orders for Prednisone 50 mg (a	D 358		

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D 358	Continued From page 43 medication that treats inflammation) every other day. Review of Resident #6's Resident Register revealed an admission date of 02/24/15. Review of Resident #6's record on 09/02/16 revealed: -There was no order to give the Prednisone 40 mg every day. - A subsequent physician's order dated 07/12/16 for Prednisone 40 mg every other day. Review of Resident #6's July 2016 Medication Administration Record (MAR) revealed: -An entry for Prednisone 40 mg every other day and scheduled for administration at 8:00 am. -Documentation of administration of the above medication as ordered 07/13/16 - 07/31/16. -Documentation of the specific days for medication to be given were marked on the MAR. Review of Resident #6's August 2016 MAR revealed: -An entry for Prednisone 40 mg every other day and scheduled for administration a 8:00 am. -Documentation of administration of the above medication as ordered 08/02/16 - 08/30/16. -Documentation of the specific days for medication to be given were marked on the MAR. Review of Resident #6's September 2016 MAR revealed: -An entry for Prednisone 40 mg every other day and scheduled for administration a 8:00 am. -Documentation of administration of the above medication given (on 2 consecutive days) on 09/01/16 and 09/02/16. -Documentation of the specific days for medication to be given were marked on the MAR.	D 358	All attached POC dated 10/11/16. DG	

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D 358	Continued From page 44 Observation on 09/02/16 at 8:14 am with MA, of medications on hand revealed that the Prednisone was available for administration. Interview on 09/02/16 at 10:25 am with MA revealed: -The Prednisone was ordered every other day and the last time she gave the medication was on 09/01/16. -She was aware at that point that Prednisone had been given two days in a row instead of every other day. -The Resident Care Coordinator (RCC) was responsible for marking the MAR for medications that were to be given on specific days. Interview on 09/02/16 at 10:40 am with Resident Care Coordinator (RCC) revealed: -The MARs came in from the pharmacy and were checked along with the MAR from the previous month. -The new MAR was checked for accuracy and new orders were verified and for orders that were left off. -If there was a clarification/discrepancy noted then the medication order was written on the MAR. -There was a second check done by the 3rd shift MA. -If there were any other clarifications needed then the doctor would be called. -She was not aware that the Prednisone had been given on 09/01/16 and 09/02/16. -She marked the MAR for all medications that were to be given on specific days. Interview on 09/02/16 at 11:00 am with Executive Director revealed: -She was not aware that the MAR had not been	D 358	See attached POC dated 10/11/16. dg	

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D 358	Continued From page 45 pre marked for Prednisone to be given every other day as ordered. -It is usual practice for the RCC to mark all of the MAR's for the medications that are to be given every other day. Interview on 09/06/16 at 12:35 with the Nurse Practioner (NP) revealed: -She was notified on 09/02/16 at 8:30 am about the extra dose of Prednisone given. -A telephone order was given to the MA to hold Saturday's dose of Prednisone and resume Prednisone on Sunday every other day. Based on observation and interview on 09/06/16 at 1:15 pm, it was determined that Resident #6 were not interviewable. B. Review of Resident #5's current FL2 dated 03/04/16 revealed: -Diagnoses included a cerebrovascular accident, hyperlipidemia, and dysphagia. -An order for Vitamin D2 50,000 units take 1 tablet once a week on Saturday only. Review of Resident #5's most recent Vitamin D laboratory results dated 07/24/15 revealed: -Resident #5's Vitamin D level was 29.8 (Normal range is 30.0 -3000.0 mg/ml). -Resident #5's Vitamin D level was noted as low. Review of Resident #5's July 2016 Medication Administration Record (MAR) revealed: -An entry for Vitamin D2 50,000 units 1 tablet and documentation of administration on 07/02/16, 07/09/16 and 07/16/16. -There was no documentation of Vitamin D2 50,000 units 1 tablet initialed as administered on the highlighted Saturdays dated 07/23/16 and 07/30/16.	D 358	All attached POC dated 10/11/16. dg	

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D 358	Continued From page 46 -There was a computer generated note of Vitamin D Deficiency on the medication entry on the MAR. Review of Resident #5s August 2016 MAR revealed: -An entry for Vitamin D2 50,000 units 1 tablet and documentation of administration on 08/13/16 and 08/27/16. -There was no documentation of Vitamin D2 50,000 units 1 tablet initialed as administered on the highlighted Saturdays dated 08/06/16 and 08/20/16. Observation of Resident #5's medications on hand on 09/02/16 at 3:27 pm revealed: -A bubble pack with a label identifying Vitamin D capsules 50,000 units dispensed with 6 caplets by the pharmacy on 07/20/16. -Two of 6 caplets remained in the bubble pack filled on 07/20/16. -A bubble pack with a label identifying Vitamin D capsules 50,000 units dispensed with 6 caplets on 08/20/16. -Six of 6 caplets remained in the bubble pack filled on 07/20/16. Interview with a Medication Aide (MA) on 09/06/16 at 11:00 am revealed: -Resident #6 was supposed to receive Vitamin D every Saturday. -Resident #6 received Vitamin D on 09/03/16 when she administered it to him. -She was unaware he had not received it every Saturday. -There were several MAs who worked on Saturdays and they were responsible for administering the Vitamin D to Resident #6 when they were dispensing medications. Interview on 09/02/16 at 10:40 am with Resident	D 358	See attached POC dated 10/11/16. gel	

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D 358	Continued From page 47 Care Coordinator (RCC) revealed she marked the MARs for all medications that were to be given on specific days. A second interview with the RCC on 09/06/16 at 11:07 am revealed: -The MA assigned to Resident #6 on Saturdays should have adminstered the Vitamin D as ordered by the physician. -The RCC was unaware Resident #6 had not received his Vitamin D weekly on Saturdays as ordered. -The RCC and the third shift MA reviewed MARs at the end of each month to "look for holes" in the documentation or administration of medications. -The RCC was not sure which one of them reviewed Resident #6's July 2016 and August 2016 MARs. Interview on 09/02/16 at 11:40 am with Resident #6's Nurse Practitioner (NP) revealed: -Resident # 6 had a low Vitamin D level and this was why she had ordered him to receive a Vitamin D supplement weekly. -She was not aware Resident #6 had not received the Vitamin D 50,000 units 1 tablet weekly as ordered. -Resident #6 had not experienced a negative outcome from not receiving the missed doseages of Vitamin D 50,000 weekly.	D 358	See attached POC dated 10/11/16. dg	
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 48 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of 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 record review, and interviews, the facility failed to assure accurate documentation of medications administered as needed (prn) on the Medication Administration Records (MARs), for 1 of 5 sampled residents (Resident #4) with a physician's order for Ambien. The findings are: A. Review of Resident #4's current FL2 dated 09/21/15 revealed: -Diagnoses included diabetes mellitus 2, uncontrolled hyperlipidemia, mental disorder, legally blind, hypertension, osteoarthritis, abnormal glucose levels. -A physician's order for Ambien 5 mg every night as needed (prn). (Ambien is a medication used for insomnia.) Review of Resident #4's Controlled Substance Sheet (CSS) revealed:	D 367	See attached POC dated 10/11/16. DG	

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D 367	Continued From page 49 -A CSS dated 06/16/16 for 15 Ambien 10 mg tablets (30 doses) dispensed on 06/16/16. -Fourteen doses were documented as administered from 06/17/16 to 06/30/16 at 8 pm. -Sixteen doses were documented as administered from 07/1/16 to 07/16/16 at 8:00 pm. -A second CSS dated 06/14/16 for 30 Ambien 5 mg tablets to be administered, and dispensed on 06/14/16. -Fourteen doses Ambien (5 mg) were documented as administered from 07/18/16 at 8:00 pm to 07/31/16 at 8:00 pm. -A total of 30 doses of Ambien were documented on the CSS dated 06/14/16 and 06/16/16. Review of Resident #4's July 2016 Medication Administration Record (MAR) revealed 11 doses of Ambien 5 mg were documented as administered from 07/01/16 to 07/31/16 at 8:00 pm. Comparison of Resident #4's CSS for 06/16/16 and 06/14/16 to Resident #4's July 2016 MAR revealed: -Eleven doses were documented as administered on the July 2016 MAR from 07/01/16 to 07/31/16 at 8:00 pm. -Ten of the eleven entries documented as given included time, reason or effectiveness of medication. (One occasion did not include the reason for administration and the outcome/effectiveness.) -Documentation of Ambien 5mg on the MAR was blank for 19 of 30 occasions from 07/01/16 to 07/31/16, including administration, the reason the medication was administered, and the outcome/effectiveness of the medication. Examples of administration logged on Resident	D 367	See attached POC dated 10/11/2016. lg	

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D 367	Continued From page 50 #4's CSS but not documented on the July 2016 MAR were as follows: -On 07/01/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/04/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/05/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. -On 07/06/16, CSS had a dose signed out at 8:00 pm with no dose documented as administered on the MAR. Continued review of Resident #4's CSS sheet dated 06/14/16 revealed: -The second CSS dated 06/14/16 for 30 Ambien 5 mg tablets, dispensed on 06/14/16, documented 16 doses signed out for Resident #4 from 08/01/16 to 08/16/16. -A CSS dated 08/11/16 documented 30 tablets of Ambien 5 mg dispensed on 08/11/16 with 15 tablets sign out for Resident #4 from 0/8/17/16 at 8:00 pm to 08/31/16 at 8:00 pm. Review of Resident #4's August 2016 MAR revealed: -Fifteen tablets were documented as administered on the MAR from 08/01/16 to 08/31/16 at 8:00 pm. -All 15 doses documented as administered included time, and reason or effectiveness of medication. Comparison of Resident #4's CSS for 06/14/16 and 8/11/16 to Resident #4's August 2016 MAR revealed: -Ambien 5 mg was documented as administered on the CSSs for the 31 occasions.	D 367	See attached POC dated 10/11/2016. 09	

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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D 367	Continued From page 51 -Documentation for Ambien 5mg was blank for administration, reason the medication was administered, and the outcome/effectiveness of the medication for 16 of 31 occasions on the MAR. Examples of administration logged on Resident #4's CSS 06/14/16 and 08/11/16 but not documented on the August 2016 MAR were as follows: -On 08/02/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/04/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/06/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/09/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/10/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 08/11//16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. Review of Resident #4's CSS sheet dated 08/11/16 for 30 tablets dispensed on 8/11/16 revealed 5 tablets were documented as administered from 09/01/16 at 8:00 pm to 09/05/16 at 8:00 pm. Review of Resident #4's September 2016 MAR revealed 2 tablets were documented as administered on the MAR from 09/01/16 to 09/05/16 at 8:00 pm including time, reason and effectiveness.	D 367	See attached POC dated 10/11/16-04	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	09/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 367	Continued From page 52 Comparison of Resident #4's CSS for 08/11/16 to Resident #4's September 2016 MAR revealed: -The medication was documented as administered on the CSS for the 5 occasions. -Documentation for Ambien 5mg on the MAR was blank on 3 of 5 occasions. -The reason the medication was administered, and the outcome/effectiveness of the medication was not documented for the 5 occasions. Examples of administration logged on Resident #4's CSS but not documented on the September 2016 MAR were as follows: -On 09/03/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 09/04/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. -On 09/05/16, 1 dose was signed out at 8:00 pm with no dose documented as administered on the MAR. Interview with Resident #4 on 09/07/16 at 11:25 am revealed when she needed medicine at night to help her sleep, and asked for it she felt the Medication Aids (MAs) gave it to her every time. Interview with a 2nd shift MA on 09/07/16/at 2:10 pm revealed: -All "prn" medications were supposed to be documented on the front of the MAR, and on the back of the MAR for reason administered. MA staff should come back later and document on the back of the MAR if the medication was effective. -The MA staff documented removal of controlled substance from the locked drawer on the corresponding CSS.	D 367	All attached POC dated 10/11/16. LG	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	09/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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D 367	Continued From page 53 -She used the CSS to determine if the proper time had passed before administering another dose of the medication. -Sometimes MAs may be interrupted during the documentation of the "prn" and overlook documenting on the MAR. -The Resident Care Coordinator (RCC) was responsible for making sure the MAR and the CSS were accurate. -The RCC would be responsible for auditing for accuracy of the MARs compared to the CSS documentation. -She did not know if the RCC was conducting routine audits of the "prn" controlled substances. -She noticied that the Ambien had been given every night instead of just as needed and will call the doctor for an order to give the Ambien as a scheduled medication. Interview with RCC on 09/07/16 at 3:40 pm revealed: -MAs were supposed to initial the front on the MAR that the medication had been given, and sign the back with notation of why the medication was given and also was to come back and write a response to the medication. -MAs were supposed to sign out the "prn" medication on the CSS sheet along with a date and time. -She had not been checking the MAR against the CSS for accuracy. -She was responsible for hand writing the order for a medication that she received from an outside pharmacy onto the new CSS. -She was responsible for making sure the MARs were accurate with all new orders and all medications continued from the previous month. -She was responsible for making sure any medications that had a time limit were accurately marked on the MAR to be given only during those	D 367	See attached POC dated 10/11/16 eg	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	09/07/2016

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D 367	Continued From page 54 times.	D 367	See attached POC dated 10/11/16. dg	

North Pointe of Archdale
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13F. 0206 Capacity

(a) The Licensed capacity of adult care homes licensed pursuant to this Subchapter is seven or more residents.
(b) The total number of residents shall not exceed the number shown on the license.
(c) A facility shall be licensed for no more beds than the number for which the required physical space and other required facilities in the building are available
(d) The bed capacity and services shall be in compliance with G.S. 131E, Article 9, regarding the certificate of need.

Plan of Correction

- The facility shall assure that the total number of residents cared for shall not exceed the licensed capacity. 11/9/2016 & ongoing
- Personal care services shall be provided for residents residing in independent suites by home care agency staff. 11/9/2016 & ongoing
- Executive Director trained on staffing of independent suites. 10/11/2016 & ongoing

Monitoring System

- Regional Director/QA staff shall randomly monitor census to assure the facility is operating at licensed capacity. 10/11/2016 & ongoing

10 NCAC 13F .0901(b) Personal Care and Supervision

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

Plan of Correction

- Immediate Dietary Training on proper preparation and serving of meals as ordered. 9/01/2016, 9/08/2016 & 9/15/2016 and monthly thereafter
- Personal Care Aide training on proper assistance with meals per the resident's plan of care and ordered diet. 9/29/2016 & monthly thereafter
- Implementation of resident meal checklist for residents who eat in their rooms to assure PCA's know that all residents have received their meal as ordered by the physician and receive the level of assistance needed per their plan of care. 9/29/2016 & monthly thereafter

Monitoring System

- Executive Director/ QA Staff/ designee will perform random meal observation to assure residents are receiving diets as ordered and resident is receiving level of assistance per their care plan weekly x 1 monthly then bi weekly. 9/26/2016 & on-going
- Regional Director/QA Staff/designee will perform random audits to assure that meal observations are being performed. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

10 NCAC 13F. .0902(b) Health Care

(b) The facility shall assure referral and follow up to meet the routine and acuter health care needs of the residents.

Plan Of Correction

- Consultation with resident's physician to report the missed Vitamin D Lab. Lab order to be obtained week of 9/26/2016.
- Lab Referral and Follow Up Notebook was implemented on 6/01/2016 and will continue to be used to assure that labs are completed as ordered. 6/01/2016 & ongoing

Monitoring System

- Executive director/ QA staff will continue to perform monthly audits to assure lab notebook is being utilized and that labs are completed as ordered. 9/01/2016 & ongoing
- Regional Director/QA staff shall randomly audit to assure monthly audits of the lab notebooks are being used. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

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10A NCAC 13F. .0904(b) (2) Nutrition and Food Service

(b) Food Preparation and Service in Adult Care Homes:
(2) Table service shall include a napkin and non-disposable place setting consisting of a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.

Plan Of Correction

- Knives were immediately added to the place settings on the SCU. 9/01/2016 & ongoing
- Non-Disposable glasses were available and staff were counseled on using them. 9/01/2016 & ongoing.
- Staff training on proper table service and place settings. 9/08/2016

Monitoring System

- Executive Director/ QA Staff/ designee will perform random meal observation to assure proper table service and place settings are provided weekly x 1 month then bi-weekly thereafter. 9/26/2016 & ongoing
- Regional Director/QA Staff/designee will perform random audits to assure that meal observations are being performed monthly. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

10A NCAC 13F. .0904(d) (3) (A) Nutrition and Food Service

(d) Food Requirements in adult care homes daily menus shall include the following:

(3) Daily menus for regular diets shall include the following; (A) Homogenized whole milk, low fat milk, skim milk, or buttermilk: One cup (8oz) of pasteurized milk at least twice daily. Reconstituted dry milk or diluted evaporated milk may be used for cooking only and not for

drinking purposes due to the risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.

Plan of Correction

- Staff immediately trained on offering 8oz of milk at all meals and monthly thereafter. 9/01/2016 & ongoing

Monitoring System

- Executive Director/ QA Staff/ designee will perform random meal observation to 8oz of milk is offered twice daily weekly x 1 month and then bi-weekly thereafter. 9/26/2016 & ongoing
- Regional Director/QA Staff/designee will perform random audits to assure that meal observations are being performed monthly. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

10A NCAC 13F. .0904 (e) (4)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.

Plan of Correction

- Staff training on proper preparation of meals per the residents diet ordered using the therapeutic diet spreadsheet and therapeutic diet menu. 9/82016 & 9/15/2016
- Re-implementation of dietary staff orientation training sheet to include therapeutic diet menus. 10/1/2016 & ongoing
- Updated Diet Order Spreadsheet. 9/12/2016
- Diet Notebook set up for the SCU for cooks to use when serving meals(Notebook includes therapeutic menu with servings size and dietary spreadsheet that list diets ordered for each resident. Week of 9/26/2016

Monitoring System

- Executive Director/ QA Staff/ designee will perform random meal observation to assure meals are served as ordered per therapeutic diet order weekly x 1 month and then bi-weekly thereafter.
  9/26/2016 & ongoing
- Executive Director/QAstaff/designee will perform random audits to assure dietary spreadsheet is updated per diets ordered. 10/01/2016 & onoging
- Regional Director/QA Staff/designee will perform random audits to assure that meal observations are being performed monthly. 10/01/2016 & ongoing
- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

10NCAC 13F .1004 (a) 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 residents record; and (2) rules in this section and the facility's policies and procedures.

Plan of Correction

- MAR was corrected to reflect dates that resident was to receive the Prednisone.
  9/02/2016
- Notification of Physician of Medication Error for prednisone and Vitamin D.
  9/02/2016
- Staff training on facility policy to assure they are following and administering orders as transcribed to the MAR and Medication Label. 9/20/2016 & monthly thereafter
- Staff training on the facility policy to assure they are documenting medications as given.
  9/20/2016 & monthly thereafter
- MAR's reviewed to assure medications are being given and documented correctly.
  9/20/2016

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Monitoring System

- RCC/QA staff/ED shall randomly audit MAR's weekly x 1 month then monthly thereafter to assure that staff are administering and documenting medications as ordered and transcribed. 9/2/2016 & ongoing

- QA Staff/ Regional Director shall monthly follow up to assure that medication audits are being completed and areas found out of compliance are addressed. 10/1/2016 & ongoing

- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

10NCAC F .1004(j)
The residents medication administration record(MAR) shall be accurate and include the following (1) Residents name:(2) Name of the medication or treatment order;(3) strength and dosage or quantity of medication administration;(4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed(PRN) and documenting the resulting effect on the resident:; (6) date and time of administration;(7) documentation of any omission of 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).

Plan of Correction

- Staff training on facility policy of proper as needed medication administration. 9/21/2016 and monthly thereafter
- MAR's reviewed to assure medications are being given and documented correctly. 9/20/2016

Monitoring System

- RCC/QA staff/ED shall randomly audit MAR's weekly x 1 month then monthly thereafter to assure that staff are administering and documenting as needed medications per policy. 9/2/2016 & ongoing

- QA Staff/ Regional Director shall monthly follow up to assure that medication audits are being completed and areas found out of compliance are addressed. 10/1/2016 & ongoing

- Any staff found not following proper procedures shall receive additional training and/or disciplinary action. 9/01/2016 & ongoing

Jaken Quinn, Regional Director — October 11, 2016

Signature / Executive Director — Date