Division of Health Service Regulation

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

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 2/3/16 and 2/4/16.	D 000	Staff shall provide supervision of residents in accordance w each resident's assessed needs, care plan & current symptoms. QA meetings will be held every 2 weeks & as needed to review personal care issues such as falls, skin issues, weight, care plan changes, significant changes, physician order changes, behaviors & other issues. Interventions will be identified & incorporated as needed. RCC/ SM coordinator will be responsible for implementing interventions. Administrator will follow-up to make sure interventions implemented including in-services. QA meeting will also follow-up on previously identified →	Immediate/ 2-24-16
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to ensure supervision was provided in accordance with each resident's assessed need, multiple falls resulting knee injuries for 1 of 5 sampled (#4) residents. The findings are: Review of Resident #4's current FL2 dated 2/20/15 revealed: -Diagnoses included dementia secondary to Parkinson's disease, depression, and neuropathy. -Resident was constantly disoriented and semi ambulatory. Review of the Resident Register for Resident #4 revealed she was admitted to the facility on 2/20/15. Review of the special care unit Resident Profile and Care plan dated 3/15/15 for Resident #4, supervision was needed for ambulation. Review of the Licensed Health Professional Support (LHPS) assessment for Resident #4	D 270		

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

owner/administrator — 2/25/16

acknowledged

Plan of correction plus attachments.

2/25/16

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D 270	Continued From page 1 dated 1/10/16 revealed: -Staff supervision was required for her ambulation with a walker. -Staff supervision was required for transfers. -The LHPS Nurse recommended staff continue with current plan of care. Resident had potential for falls/ injury. Observation of Resident #4 on 2/3/16 at 11:20am revealed: -She was ambulating in her room on the special care unit, without the use of a walker. -She was wearing a black knee brace on her right knee. Interview with a patient care assistant (PCA) on 2/3/15 at 11:15am revealed: -Resident #4 was on falls precautions because she "falls a lot". -Staff try to sit with her and walk with her to prevent her from falling. -The staff monitor Resident #4 ever 30 minutes. Review of the facility's Incident and Accident Reports and Progress Notes revealed resident #4 has fallen 29 times in the last 6 months. Review of Resident #4's incident and accident reports revealed: -She had fallen 29 times between 9/10/15 and 2/2/15. -On 9/10/15 at 7:30pm, a resident reported to the supervisor in charge supervisor, Resident #4 was on the floor. When the SIC entered the room Resident #4's roommate was helping her get into a recliner. Resident #4 said she fell, but was not hurt. The resident care coordinator (RCC) was notified, and a message was left for the power of attorney (POA). -On 9/13/15 at 2:30pm, she was walking down	D 270	interventions to insure implementation and outcome c residents needs be met.	

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

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D 310	Continued From page 13 review the facility failed to assure therapeutic diets were served as ordered for 2 of 5 resident's (#1,#6) with physician's orders for a reduced concentrated sweets diet (RCS) and a low fat and low cholesterol diet (LFLC). The findings are: Observation of the kitchen on 2/3/2016 at 10:45 AM revealed: -Vitamin D whole milk was the only milk seen in the refrigerator. -There was sugar-free syrup. -There were individual packaged flavored jellies that were not sugar-free. -There were large jars of grape jelly that were not sugar free. -There were no sugar-free or low-sugar snacks found. 1.Review of Resident #1's FL-2 dated 2/19/2015 revealed: -Diagnoses included chest pain-resolved, gastroparesis, atrial fibrillation, diabetes mellitus type 2 and benign essential tremor. -There was a physician's order for a 2000 calorie diet. Review of Resident #1's Resident Register revealed an admission date of 5/9/2008. Review of subsequent physician's order dated 5/8/2015 revealed an order for a RCS diet. Review of the diet list posted (no date) revealed Resident #1 was on a RCS diet. Review of the posted menu for 2/4/2016 revealed breakfast would be juice, cereal, eggs, sausage, french toast with syrup and margarine, beverage of choice and milk.	D 310	in-service dietary staff on menus, therapeutic diets + recipes and snacks. Dietary Manager and Administrator will monitor meals to insure diets served as ordered. cna's in-serviced Feb 8-10, 2016 on appropriate snacks provided per diet + therapeutic diets. SIC's will monitor snacks (what cna's offer per diet). RCC Administrator will follow-up.	

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D 310	Continued From page 18 -If the Dietary Manager had any questions, he could come to her or to the Administrator. -The Administrator would oversee any training the Dietary Manager may need. Interview with the Administrator on 2/4/2016 at 11:25 AM revealed: -She was not aware the kitchen staff was not following the menu. -She would ensure the Dietary Manager was made aware that they must follow the menu. -She would make sure sugar-free alternatives for the diabetic residents are ordered. -She would make sure the therapeutic diet menu are followed. Interview with the Dietary Cook on 2/4/2016 at 3:05 PM revealed: -She worked the dinner meal. -She followed the menu that was posted in the kitchen. -If the diet ordered was a RCS diet, she would give them unsweet tea. -If the diet ordered was a LFLC diet, she would make sure their food was not fried. -She could ask the Dietary Manager if she had any questions on how to prepare the menu items.	D 310		2/6/16
D 486	10A NCAC 13F .1501 (e) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:	D 486	Facility will insure documentation of restraints in use will be completed. A new restraint documentation form has been put in place along for documentation every 30 minutes.	

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D 486	Continued From page 19 (1) restraint alternatives that were provided and the resident's response; (2) type of restraint that was used; (3) medical symptoms warranting restraint use; (4) the time the restraint was applied and the duration of restraint use; (5) care that was provided to the resident during restraint use; and (6) behavior of the resident during restraint use. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure documentation of a restraint while it was in use for 1 of 1 resident sampled with restraints (#2). The findings are: 1.Review of Resident #2's current FL-2 dated 2/9/2015 revealed: -Diagnoses included dementia, hypertension-benign, urinary tract infection, metabolic encephalopathy and protein calorie malnutrition. -Resident #2 was semi-ambulatory with no assistive device listed. -Resident #2 was constantly disoriented. Review of Resident #2's Resident Register revealed an admission date of 1/27/2010. Review of the Facility's February 2016 restraint record revealed: -The record had blocks for a staff signature every 2 hours for the entire month. -There was no documentation on 2/1/2016 between 6:00 AM and 2:00 PM. -There was no documentation on 2/4/2016 between 8:00 AM and 11:45 AM when the record	D 486	Staff has been in-serviced on new form, how to monitor residents restraints (all shifts), turning & re-positioning, toileting & appropriate documentation. SIC's will monitor cna's & forms each shift. RCC & Administrator will monitor documentation throughout the week. Administrator will continue to in-service as needed.	

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D 486	Continued From page 22 took her back to her room. She then removed the seat belt and laid the resident in bed. -The RCC made the staff aware of all new resident orders.	D 486		2/24/16
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interview, observation, and record review the facility failed to assure residents were free from neglect as related to personal care and supervision. The findings are: Based on observation, interview and record review, the facility failed to ensure supervision was provided in accordance with each resident's assessed need, multiple falls resulting knee injuries for 1 of 5 sampled (#4) residents. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D914	Facility will assure residents are free of mental & physical abuse, neglect, exploitation. Administration, RCC will monitor resident care needs to ensure needs are met.	

FALLS POLICY

POLICY: Goldsboro Assisted Living provides a safe environment in order to minimize falls. When a fall happens, the staff will take immediate/appropriate action in order to maintain each resident's health and safety.

PROCEDURE:

When a resident has fallen, the SIC will be notified immediately.

If the resident is still down on the floor, the staff does not need to get the resident up until the SIC/supervisor has checked the resident for any obvious signs of injury such as bleeding, loss of consciousness, a broken bone, head injury, etc. The SIC/supervisor, after checking the resident thoroughly from head to toe, will assess the resident to determine if there are any injuries and if it is safe to move the resident.

If there is any indication of an injury such as severe bleeding, loss of consciousness, a broken bone or head injury, 911 will be called immediately. Staff will stay with the resident and attempt to keep them as comfortable as possible until rescue arrives. Another staff member will copy the necessary paperwork that will be transported with the resident.

If there is no injury requiring transport, staff will assist the resident to stand and escort them to an appropriate place (bed, chair, w/c etc.)

The SIC will provide any first aide needed such as treatment for skin tear, etc.

An incident report will be completed detailing what happened, description of injury if any, staff action and who was notified. RCC will complete follow-up on incident.

A 72- hour acute monitoring report will be put in place to follow up on resident's condition.

QA: If resident continues to have falls, staff will monitor resident and situation to determine if any type of intervention is needed to keep resident safe, including meeting with family members and communication with physician.

Goldsboro Assisted Living and Alzheimer's Care
2201 Royall Avenue
Goldsboro, NC 27534
P- (919) 735-7684
F- (919) 735-8552

DHHS in building for annual survey February 3-4, 2016. Surveyors had a concern regarding [redacted] and her falls. Plan of protection put in place on February 4 for resident. 1:1 sitter/aide was assigned to resident 24 hours/day.

February 5, 2016: Met with resident's husband and sister. Discussed concerns from the state surveyors and level of care for resident. I told the family that I did not feel we were able to meet the resident's needs at this time and that alternative placement needed to be found. Discussed level of care change with sister. She stated she would take a new FL-2 to resident's primary doctor and get it signed. Sister stated resident had a doctor's appointment the following Tuesday (February 9, 2016). If resident's knee was not any better he was going to schedule surgery at that time. Asked sister to discuss possibly admitting resident to hospital for surgery to make placement easier and to help resident with transition.

February 6, 2016: Husband called asking us to fax information to another facility because they thought they had found placement.

February 9, 2016: Met with sister after resident's doctor's appointment. Sister stated surgery was scheduled for Tuesday, February 16, 2016. I told the sister I would continue 1:1 with resident until her surgery. When I asked sister if she had talked to doctor about hospital admission, she never answered the question. RCC told her that she had attempted to call the doctor's office several times but never got a return call. Sister said she had taken the FL-2 to possible new facility but had not gotten it signed. Sister was reminded several times that we would not be able to take care of the resident after her surgery due to actual, surgery, mental status, Parkinson's and other diagnosis. I told the sister we could not keep her safe. We suggested skilled nursing for the resident's overall well-being and safety.

February 15, 2016: Sister called to say that they had not gotten an answer from the other facility. She was once again told that the resident could not

return to this facility for the reasons listed above. We once again asked about the FL-2 that was supposed to have been signed by the primary physician. The family has not gotten it signed. (The sister has been saying that she would rather get the FL-2 signed because she could get to the doctor sooner than we could). The sister did say she would get the FL-2 signed.
At that time we decided to see if we could find placement for the resident.

I contacted Ashley Dawson, AHS, DSS to let her know what was going on and to get her input. She suggested I call DHHS and talk to them about what I needed to do. (I did, they were closed). Ashley did tell us to do a discharge notice. We discussed the FL-2 for SNF and I told her we were working on finding placement.

We contacted Genesis in Mt. Olive. We exchanged the necessary information with them and they stated they had a bed and would take the resident Tuesday, February 16 after she had surgery. Family was on their way to Barbour Court in Smithfield to see if they would take resident. We contacted them and let them know that Mt. Olive had agreed to take the resident.

February 16, 2016: Family picked resident up at 7am to take resident to hospital for out-patient surgery on her knee. We contacted the family for an update. They said that Barbour Court had told them it would be easier to admit the resident if she was in the hospital. Family was unsure if they were going to take her. We once again told family that Genesis in Mt. Olive had agreed to take resident right after surgery. Family said that if the hospital would not help them they were going to take resident to ER. We are unsure as to why family will not go to Mt. Olive. Family states they still have not gotten FL-2 signed.

We have gotten a new skilled FL-2 on resident signed by her primary physician.

Family called. Resident came through surgery OK, but they are keeping her overnight.

Discharge notice has been done and will be mailed via certified mail to Jerry Grady, husband.

I have called [redacted], AHS, DSS to make sure she is up to date on what is going on.

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