STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R-C 11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Wake County Human Services conducted a follow-up survey and complaint investigation on 11/15/16, 11/16/16 and 11/17/16. The complaint investigation was initiated by Wake County Human Services on 11/9/16.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls and floors were kept clean and in good repair in 9 resident rooms on 300 hall (309, 310, 314, 315, 317, 319, 324, 325, 331), 2 resident rooms on 100 hall (101, 102), the 300 hallway, and 3 television / dayrooms on 100 and 300 halls as related to torn and frayed duct tape placed over doorway transition strips, stained carpet and tiles, crumbs and dirt on floors, and stains, missing paint and holes on walls. The findings are: 1. Observation of the 300 hallway on 11/15/16 at 9:45 a.m. revealed: -There were multiple brown stained spots on the carpet up and down the hallway on 300 hall. -Some of the largest stains were at least one foot in diameter. Observation of resident Room 331 on 11/15/16 at	D 074	All attached POC date 1-12-17	

review 1/12/17

North Pointe of Garner
HAL-092-186
Plan of Correction
DHSR Survey 11/15/2016

10 NCAC 13F .0306(a)(1)-Housekeeping and Furnishings

(a) adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;

Plan of Correction

- Walls, ceilings, floors and floor coverings shall be cleaned. 11/15/2016 & ongoing
- Repairs will continue to be made to walls, ceilings and floors and floor coverings as remodeling of the community continues. 11/15/2016 & ongoing
- Thresh holds have been replaced and shall continue be replaced as needed. 11/27/2016 & ongoing
- Updated the daily, weekly and monthly housekeeping duty logs sheets to include routine scheduled cleaning of residents rooms, common areas with specific areas to be cleaned (ie, floors, walls, through cleanings, etc. 11/27/2016 & ongoing
- Update the maintenance log book for reporting of repairs, schedule of routine preventative duties/repairs. 11/27/2016 & ongoing
- Training with all staff on responsibilities of cleanliness of the facility, reporting of repairs and documentation of duties completed. Monthly training shall continue. 12/5/2016 & ongoing
- Facility added a new position of environmental director. 11/27/2016 & ongoing

Monitoring System

- Administrator/designee will perform daily walk through within the community to assure walls, ceilings, floors are in good repair. 11/27/2016 & ongoing

- Maintenance director/designee will monitor repair logs on a daily basis and document that follow up was completed. 11/27/2016 & ongoing

- Administrator/Designee shall randomly monitor housekeeping task sheets in comparison with duties performed to assure the facility is kept clean and in good repair.

  11/27/2016 & on going

- Any staff members found not following policy and procedures will receive additional training and/or disciplined up to and including termination. 11/27/2016 & on-going

10A NCAC 13F. .0306 (a) (2)Housekeeping and Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors;

Plan Of Correction

- All resident's rooms have been thoroughly cleaned and added to a routine through cleaning per the need of the residents. 12/1/2016 & ongoing

- Updated the daily, weekly and monthly housekeeping duty logs sheets to include routine scheduled cleaning of residents rooms, common areas with specific areas to be cleaned (ie, floors, walls, through cleanings, commode, urninals, soiled linen, etc)

  11/27/2016 & ongoing

- Training with all staff on responsibilities of cleanliness of the facility, reporting of urine smells and reasons for ongoing unpleasant odors and documentation of duties completed. Monthly training shall continue.
  12/5/2016 & ongoing

- Training with all staff on the proper way to dispose of soiled lines, disposable briefs, and cleaning, empting and storage of urinals/ bedside commodes. 12/5/2016 and ongoing

- Automatic air fresh dispensers were installed throughout areas that the potential for unpleasant odors. 12/1/2016 and ongoing

Monitoring System

- Administrator/designee will perform daily walk through within the community to assure facility is free of unpleasant odors. 11/27/2016 & ongoing

- Administrator/Designee shall randomly monitor housekeeping task sheets in comparison with duties performed to assure the facility is kept clean and free of unpleasant odors. 11/27/2016 & ongoing

- Corporate QA shall monitor facility monthly for unpleasant odors and shall audit documentation in comparison to cleaning. 11/27/2016 & ongoing

- Any staff members found not following cleaning and preventative procedures will receive additional training and/or disciplined up to and including termination. 11/27/2016 & ongoing

10A NCAC 13F. .0306 (a) (5)Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean, and orderly manner, free of obstructions and hazards.

Plan Of Correction

- All resident's rooms have been thoroughly cleaned and added to a routine through cleaning per the need of the residents but no less than weekly thorough cleanings 12/1/2016 & ongoing

- Updated the daily, weekly and monthly housekeeping duty logs sheets to include routine scheduled cleaning of residents rooms, common areas with specific areas to be cleaned

(ie, floors, walls, through cleanings, commode, urninals, soiled linen, etc)
11/27/2016 & ongoing

- Training with all staff on responsibilities of cleanliness of the facility, reporting of problem areas, siting of roaches, bed bugs and ants, and documentation of duties completed. Monthly training shall continue.
  12/5/2016 and ongoing

- Training with all staff on the proper way to prevent ants/roaches/bedbugs and procedures for bed bug siting. 12/5/2016 and ongoing

- Residents reminded of the policy for storing food in containers in their rooms. Containers provided for residents. 12/1/2016 and ongoing

- Continued contract with the pesticide company for routine and urgent treatment.
  11/17/2016 & ongoing

Monitoring System

- Administrator/designee will perform daily walk through within the community to assure facility is free of clutter, clean and orderly and free of obstructions and hazards.
  11/27/2016 &
  ongoing

- Administrator/Designee shall randomly monitor housekeeping task sheets in comparison with duties performed to assure the facility is kept clean and free clutter.
  11/27/2016 & ongoing

- Corporate QA shall monitor facility monthly to assure the facility is free of clutter, clean and orderly, free of obstructions and hazards. 11/27/2016 & ongoing

- Any staff members found not following cleaning and preventative procedures will receive additional training and/or disciplined up to and including termination.
  11/27/2016 & ongoing

10A NCAC 13F. 0901(a)-Personal Care and Supervision-

Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend for themselves.

Plan of Correction

- Resident #3 and #4 are receiving services according to their plan of care and the other care needs they are unable to independently perform. 11/17/2016 & ongoing

- All Residents assessed by RN for care needs and care plans/pcs logs updated to reflect needs of the residents. 11/30/16-12/18/16

- All Resident records audited to assure documentation reflects the needs of the residents.
  11/21/16 –12/18/16

- All Resident Bath Schedules updated for all personal care aides per their assignment.
  12/5/2016

- RN conducted training with Personal Care Aides on personal care aide task to include, bathing, dressing and grooming and recognizing the care needs of the residents on a daily basis.
  11/30/2016 and ongoing

- Staff training on proper documentation of care provided.
  11/30/2016 and ongoing
- Residents interviewed to assure their needs are being attended to by staff.
  12/27/2016 and ongoing

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

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

Plan Of Correction

- Referral and follow up was immediately provided for residents identified in the SOD. 11/17/2016
- Audit of residents records to assure referral follow up of the health care needs of the residents. 11/17/2016- 12/17/2016
- Staff retrained on the identification and reporting of residents needs to assure appropriate referral and follow up. 11/16-11/18/2016 & on
- LPN was hired to oversee resident care services. 11/21/2016
- An additional Administrator with strong Resident Care Experience onsite for 4 weeks and then biweekly there after x 1 month to assist with the health care needs of the residents. 11/21/2016 & ongoing
- Implementation of daily order/referral notebook for LPN to review and discuss with SIC's daily to assure referral and follow up of resident health care needs. 11/21/2016 and ongoing
- Re-Implementation and training on referral and follow up appointment binder. LPN/Administrator shall review daily to assure all appointments are made and kept as ordered. 11/15/2016 and ongoing
- Ongoing staff guidance on referral and follow up. 11/21/2016

- Contracted Registered Nurse on site 4-6 times per month x 1 month then prn thereafter assisting with ongoing training and assessments of the resident's health care needs. This in addition to the consulting nurse through pharmacy that performs LHPS assessments.

11/30/2016 & ongoing

Monitoring System

- Regional Director/Administrator/RCC will perform random chart audits weekly x2 weeks then monthly x4 months, then randomly thereafter to insure compliance referral and follow up. 12/1/2016 & ongoing

- Daily stand- up meetings between the management team to follow up any health care needs of the residents to assure appropriate referral and follow up.

11/21/2016 & ongoing

- Corporate QA on site monthly to assure all procedures for referral and follow up are being carried out and that the health care needs of the residents are being met.

11/21/2016 & ongoing

- Any staff members found not following policy and procedures will receive additional training and/or disciplined up to and including termination. 11/21/2016 & ongoing

10A NCAC 13F. 1004(a)-Medication Administration

(b) 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 the section and the facility's policies and procedures.

Plan Of Correction

- LPN was hired to oversee resident care services including medication administration.

11/21/2016

- Facility shall assure medications are administered as ordered. resident's record
  11/17/2016 & ongoing

- Audit of residents records to assure medications are being given as ordered.

  11/17/2016- 12/17/2016

- RN retrained medication aides medication administration.

  12/12/2016, 12/19/2016 and
  12/21/2016 and monthly thereafter

- An additional Administrator with strong Resident Care Experience onsite for 4 weeks and then biweekly there after x 1 month to assist with the health care needs of the residents including medication administration. 11/21/2016 & ongoing

- Implementation of daily order/referral notebook for LPN to review and discuss with SIC's daily to assure referral and follow up of resident health care needs including medication administration. LPN/Administrator shall review daily to assure orders are carried out. 11/15/2016 and ongoing

Monitoring System

- Unannounced weekly medication passes conducted by LPN/Designee to assure staff are administering medications as ordered.

  1/2/2016 & ongoing

-

- Regional Director/Administrator/RCC will perform random chart audits weekly x2 weeks then monthly x4 months, then randomly thereafter to insure compliance with medication administration 11/21/2016 & ongoing

- Any staff members found not following policy and procedures will receive additional training and/or disciplined up to and including termination.

North Pointe of Garner
HAL-092-186
Plan of Correction
DHSR Survey 11/15/2016
11/21/2016 & ongoing

G.S. 131D -21(2)- Declaration of Residents' Rights

Every resident shall have the following rights: (2) To receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations.

- Staff training on Resident Rights. 11/15/2016 and ongoing
- Facility hired a community liaison whose duties include assisting with assuring residents rights are not violated. 12/5/2016
- Resident Satisfaction survey were conducted and shall be conducted quarterly to assure residents rights are being violated. 12/30/2016 & ongoing

Monitoring System

- Administrator/RCC/Designee will randomly monitor resident's needs based on MAR and chart documentation weekly x2 weeks, then monthly x4 months and randomly thereafter, to ensure resident rights are not being violated.

  11/21/2016 & on-going

- Administrator/RCC/Designee will conduct random interviews with resident's weekly x2 weeks, then monthly x4 months and randomly thereafter, to ensure resident rights are not being violated. 11/21/2016 & ongoing

- Any staff member found to be in violation of resident rights will receive additional training and/or disciplinary action, up to and including termination.

  11/21/2016 & ongoing

Karen Quinn, Admin

Signature / Executive Director

1.12.2017

Date

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D 074	Continued From page 1 Observation of resident Room 331 on 11/15/16 at 9:58 a.m. revealed: -There was a blue circular stain in the middle of the floor about 2 feet in diameter. Interview with a resident in Room 331 on 11/15/16 at 9:58 a.m. revealed: -The resident moved to Room 331 about 6 months ago. -The blue circular stain on the floor in her room was blue permanent magic marker that she got on the floor when she made a rug after she moved in the room. Observation of resident Room 324 on 11/15/16 at 10:50 a.m. revealed: -There were food crumbs and dirt scattered all over the floor from the doorway to the other side of the room. -There were two grapes on the floor in front of the mini refrigerator. Interview with the resident who resided in Room 324 on 11/15/16 at 10:50 a.m. revealed: -The resident complained about the crumbs on his floor. -The resident asked, "Why don't they clean my room?" -He did not know when his room was last cleaned. -The housekeepers only vacuum about every 6 months. -There was only one housekeeper currently for the entire facility. -There were two housekeepers at one time but now there was only one. Observation of resident Room 319 on 11/15/16 at 11:00 a.m. revealed: -There were multiple brown and black stains all	D 074		

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D 074	Continued From page 2	D 074		

over the carpet throughout the room.
-There was an area about 6 x 12 inches with missing paint and small circular holes on the wall beside a closet door.
-There was an area of stripped off wood about 1 x 6 inches on a closet door near the knob.
-There was multiple dried brown stains running down the wall near the light switch that appeared to be liquid spills.

Interview with a resident in Room 319 on 11/15/16 at 11:00 a.m. revealed:
-The facility staff used to shampoo the carpet but the facility was short staffed right now and had not done it recently.
-He could not recall when the carpet was last shampooed but stated the stains had been there "a while".
-One housekeeper had to clean the whole facility so she only had time to empty the trash in the residents' rooms and maybe sweep.
-The housekeeper did not sweep or dust.

Interview with the housekeeper on 11/15/16 at 11:12 a.m. revealed:
-She was currently the only housekeeper for the entire facility.
-It was impossible to clean the facility by herself because it was too large and too much for one person to do.
-She cleaned the bathrooms daily by mopping and wiping them down.
-Some days she could sometimes clean about 18 to 20 residents' rooms depending on how dirty the rooms were but some of the rooms were "too messy".

Observation of resident Room 324 on 11/15/16 at 4:23 p.m. revealed the crumbs and grapes were still on the floor.

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D 074	Continued From page 3 Interview with the Maintenance Director on 11/15/16 at 4:30 p.m. revealed: -The stains on the carpet in the 300 hallway were caused by the carpet company spilling glue down the hallway when they installed carpet in a resident's room about a month ago. -He thought the carpet company would come back and remove the stains but they did not. -The facility had a small non-commercial carpet shampoo machine but it was too small and it would not remove the stains caused by the glue. -He usually tried to shampoo the carpet at least weekly but it had been over a month since he last had time to shampoo the carpet. -He had been helping transport residents to appointments for the last 2 to 3 weeks and had not had time to shampoo the carpet. -They would need a commercial shampoo machine capable of heat steaming the carpet to get the glue stain to release from the carpet. Interview with the Interim Administrator on 11/15/16 at 4:55 p.m. revealed: -He had been helping at this facility for about two weeks. -He usually worked as an Administrator at a sister facility. -A Regional Director for the corporation was currently working as the Administrator for this facility but she was not available today. -He and the Administrator had discussed the stains on the carpet last week and were in the process of looking for a resolution to the problem. -There was a facility protocol for cleaning. -He did not know the specific protocol but the Administrator would be able to answer with specific details when she returned to the facility. Interview with an Administrator from a sister	D 074		

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D 074	Continued From page 4 facility on 11/15/16 at 5:07 p.m. revealed: -She was at the facility today to provide support and assistance to the Interim Administrator. -Housekeeping staff should vacuum carpeted areas daily. Interview with the Administrator on 11/17/16 at 6:30 p.m. revealed: -Housekeepers were responsible for day to day cleaning in residents' rooms including mopping, dusting, and vacuuming. -She assumed the carpet company responsible for staining the carpet would come back and get it out. -She was not sure if the carpet company planned to come back but she would check on it. -The facility usually had two housekeepers working from 7am - 3pm from Monday - Saturday. -One of the housekeepers was injured about a month ago and had not returned to work yet. -The Maintenance Director and the aides on the floor were helping out by doing things like emptying the garbage. -They were currently in the process of hiring another housekeeper and she was supposed to start next Wednesday, 11/23/16. 2. Observation of the floors on the 300 hall throughout the survey from 11/15/16 - 11/17/16 revealed: -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the tile of resident room 309. -A transition piece was missing on the floor entrance, joining the hallway carpet to the carpet of resident room 310. -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the carpet of resident room 314.	D 074		

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D 074	Continued From page 5 -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the carpet of resident room 315. -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the tile of resident room 317. -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the tile of resident room 325. -A corner end of transition piece, at the entrance of the TV room (between double/fire doors, between room 312 and 314), was peeling about 4 inches and sticking up about 1 inch above the floor. Observation of the floors on the 100 hall throughout the survey from 11/15/16 - 11/17/16 revealed: -A strip of black duct tape was on floor entrance and joined the hallway carpet to the tile of resident room 101. -A strip of black duct tape was on floor entrance and joined the hallway carpet to the tile of resident room 102. -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the tiles of TV room/day room. -A strip of black duct tape was on the floor entrance and joined the hallway carpet to the carpet of TV room. Interview with the Administrator on 11/17/16 at 6:30 p.m. revealed: -Some of the duct tape in the door way thresholds had been removed and the stripping repaired since the last survey. -They were still working on completing all of the needed repairs. Interview with the Maintenance Director on	D 074		

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D 074	Continued From page 6 11/15/16 at 4:30 p.m. revealed: -The duct tape was used across some of the doorway thresholds because some of the strips were popping up and the tape was used to hold the strips down and prevent a tripping hazard. -The duct tape was torn and frayed in several areas and needed to be replaced or removed.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that residents' rooms (211, 214, 217, 225, 309, 310, 312, 324), residents' common bathrooms (300 hall), and the 300 hallway in the facility had no chronic unpleasant odors as related to strong and foul odors of urine and feces. The findings are: Observations on the 200 hall during the facility tour on 11/15/16 from 10:00 a.m. - 10:30 a.m. revealed: -There was a strong foul odor in resident room 211. -There was a urine odor in resident room 214. -There was a strong urine odor in resident room 217. -There was a strong urine odor in resident room	D 075		

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D 075	Continued From page 7 225. Confidential interview with a resident revealed: -The 300 hall and 200 hall of the facility had a chronic urine and feces smell. -The odors were coming from the common bathrooms on those halls. -It usually smelled like urine early in the morning and the smell lingered in the halls most of the day. -The resident's family member would not visit often because of the odors in the facility. Confidential interview with a second resident revealed: -There were chronic odors of urine and feces in the facility all the time especially on the 300 hall near the men's bathrooms and coming from some of the residents' rooms on 300 hall. -The resident usually smelled the odors all day long every day. Observation of the 300 hall throughout the day on 11/15/16 from initial tour at 9:50 a.m. - 4:30 p.m. revealed: -There was a strong urine and feces odor in the hallway starting at Room 301 and going down the hall just past the men's common bathrooms and down to Room 318 on the 300 hall. -The odors were strong throughout the day, including morning and afternoon. Observation of Room 324 on 11/15/16 at 10:50 a.m. revealed: -There were 2 urinals sitting on the floor under a table beside the bed. -One of the urinals was about half full of urine. -There was a strong urine odor in the room. Interview with the resident who resided in Room	D 075		

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D 075	Continued From page 8 324 on 11/15/16 at 10:50 a.m. revealed: -He usually emptied the urinals himself because staff did not empty them. -The urinals smelled foul and needed cleaning. Interview with the housekeeper on 11/15/16 at 11:12 a.m. revealed: -She was currently the only housekeeper for the entire facility. -It was impossible to clean the facility by herself because it was too large and too much for one person to do. -She did not have time to deep clean. -There were chronic urine and feces odors on the 300 hall every day. -The odors usually started around Room 309 and went down the hall past the common bathrooms on 300 hall. Observation of the men's common bathroom across from Room 315 on 11/15/16 at 11:18 a.m. revealed: -There were two white towels with multiple brown stains in the bath tub. -There were brown liquid stains on the toilet seat. -There was a strong odor of feces in the bathroom. Interview with the housekeeper on 11/15/16 at 11:20 a.m. revealed: -She had mopped the floor in the bathroom a few minutes ago. -She saw the dirty towels in the bath tub. -The personal care aides (PCAs) throw dirty towels on the floor or in the tub. -The PCAs have to take the soiled towels and linens to the laundry room. -She did not clean the tub because the PCAs had not removed the dirty towels. -She left the bathroom and did not offer to	D 075		

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D 075	Continued From page 9 remove the dirty towels or clean the tub. Observation of resident Room 324 on 11/15/16 at 4:23 p.m. revealed: -One of the urinals under the bedside table was about 3/4ths full of urine. -There was still a strong odor of urine in the room. Interview with the Maintenance Director on 11/15/16 at 4:30 p.m. revealed: -There were chronic urine odors in the hallway on 300 hall and some of the residents' rooms. -There was a very strong urine odor in Room 309 and he thought the tile needed to be removed and replaced in order to get rid of the odor. -There was a very strong urine odor in Room 312 and he thought the odor was coming from urine in the carpet and the urine needed to be removed to get rid of the odor. -He usually tried to shampoo the carpet at least weekly but it had been over a month since he last had time to shampoo the carpet. -He had been helping transport residents to appointments for the last 2 to 3 weeks and had not had time to shampoo the carpet. Interview with the Interim Administrator on 11/15/16 at 4:55 p.m. revealed: -He had been helping at this facility for about two weeks. -He usually worked as an Administrator at a sister facility. -A Regional Director for the corporation was currently working as the Administrator for this facility but she was not available today. -He was aware of the chronic odors in the facility. -He and the Administrator had discussed the chronic odors last week and were in the process of looking for a resolution to the problem.	D 075		

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D 075	Continued From page 10 Interview with an Administrator from a sister facility on 11/15/16 at 5:07 p.m. revealed: -She was at the facility today to provide support and assistance to the Interim Administrator. -The PCAs should keep the urinals in the residents' rooms emptied. Observation of the 300 hall on 11/16/16 at 9:11 a.m., 10:25 a.m. and 12:55 p.m. revealed: -There continued to be urine and feces odors throughout the hallway on the 300 hall. -The odors were as strong as the previous day, 11/15/16. Observation of Room 309 and 312 on 11/16/16 at 10:25 a.m. revealed there was a very strong odor of urine in both rooms. Interview with the Resident Care Coordinator (RCC) on 11/16/16 at 10:25 a.m. revealed: -There was always a chronic odor of urine and feces in the facility. -The worst odor was always on the 300 hall and it smelled like urine and feces. Observation of the 300 hall on 11/17/16 throughout the day revealed: -There continued to be urine and feces odors throughout the hallway on the 300 hall. -The odors were as strong as the previous two days, 11/15/16 and 11/16/16. Observation of Room 310 on 11/17/16 at 10:45 a.m. revealed the room smelled like urine. Interview with a resident in Room 310 on 11/17/16 at 10:45 a.m. revealed: -The room smelled the way it always smelled. -The resident did not complain about the odor.	D 075		

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D 075	Continued From page 11 Observation of Room 312 on 11/17/16 at 10:48 a.m. revealed: -There was a very strong odor of urine in the room. -There was one resident residing in the room and he was lying in a hospital bed. -The resident had a catheter bag handing on the side of the hospital bed. -The resident did not speak when spoken to. Observation of Room 309 on 11/17/16 at 10:50 a.m. revealed: -There was a very strong odor of urine and feces in the room. -There was one resident resting in bed with a urinal that was about 3/4th full of urine hanging on the bed rail. Interview with a resident in Room 309 on 11/17/16 at 10:50 a.m. revealed: -The room always smelled like urine and feces. -Staff usually emptied the urinal for the resident. Interview with the Administrator on 11/17/16 at 6:30 p.m. revealed: -Housekeepers were responsible for day to day cleaning in residents' rooms including mopping, dusting, and vacuuming. -Housekeepers were responsible for daily cleaning of all bathrooms including cleaning the tubs, toilets, showers, and floors. -She was aware of the chronic odors in the facility. -She had recently discussed with other management staff about trying to shampoo the carpet more to try to help with the odors. -They had ordered a different chemical to clean the floors with this week and would start using it to see if it would help with the odors.	D 075		

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D 075	Continued From page 12 -The facility usually had two housekeepers working from 7am - 3pm from Monday - Saturday. -One of the housekeepers was injured about a month ago and had not returned to work yet. -The Maintenance Director and the aides on the floor were helping out by doing things like emptying the garbage. -They were currently in the process of hiring another housekeeper and she was supposed to start next Wednesday, 11/23/16.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to be clean and uncluttered and free of roaches, bedbugs, and ants in residents' rooms (100, 101, 109, 201, 202, 305, 308, 310, 311, 315, 319, 322, 323, 324, 331), resident room bathrooms (324, 331, 333), common bathrooms (300 hall), common living rooms (300 hall), and the dining room. The findings are: Observation of resident Room 331 on 11/15/16 at	D 079		

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D 079	Continued From page 13 9:58 a.m. revealed: -There were stacks of bags with clothing and other personal belongings in 2 of 4 corners of the room. -There was a beige chair filled with bowls, clothing, a ketchup bottle, and other items underneath the stack piled in the chair. -There was a pair of shoes and a pink dish pan with items stored under the edge of the chair but protruding out from under the chair. -There was a pair of shoes and belts lying on the floor beside the chair and between the chair and the bed. -There was a plastic cup and food wrappers on the floor underneath the head of the bed. Observation of the bathroom in resident Room 331 on 11/15/16 at 10:00 a.m. revealed: -There were multiple brown stains and scratch marks in the bottom of the sink around the metal drain. -The walls of the shower had brown stains around the bottom 2 inches of the walls and brown streaks on the floor of the shower. -There was a blue rubber mat with brownish black stains built up on the bottom of the mat and seeping through the holes to the top of the mat. Interview with the resident in Room 331 on 11/15/16 at 9:58 a.m. revealed: -The resident moved from another room to Room 331 about 6 months ago. -Housekeeping staff empty the trash in her room every day and sometimes sweep and mop. -Housekeeping staff clean the sink and toilet and mop the floor in her bathroom every day. -The sink had been stained with cracks since she moved in the room. -There was mold on the rubber mat she used in the shower in the bathroom.	D 079		

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D 079	Continued From page 14	D 079		

-No one cleaned the shower in her bathroom or the rubber mat in the shower.
-She saw roaches in her room every day crawling across the floor.
-She saw roaches crawling in the cracks of the baseboard and in her bathroom.
-The exterminator came and sprayed once a month but it did not usually help with the roach problem.

Observation of the bathroom in resident Room 333 on 11/15/16 at 10:15 a.m. revealed:
-The walls of the shower had brown stains around the bottom 2 inches of the walls and brown spots on the floor of the shower.
-There were brown streaks up and down the shower wall and around the edges of the attached shower seat.
-The trash can in the bathroom was overflowing with trash hanging over the side of the trash can.

Interview with the resident in Room 333 on 11/15/16 at 10:15 a.m. revealed:
-She just returned to the facility from a rehabilitation facility yesterday.
-Housekeeping staff had always cleaned her room every day including the bathroom.
-Housekeeping staff would sweep and mop and dust if needed.
-She had not noticed the stains in the shower since she had just returned to the facility.
-The exterminator sprayed the facility for bedbugs every month but she had never had any bedbugs in her room.

Observation of the resident who resided in Room 324 on 11/15/16 at 10:30 a.m. revealed:
-The resident was sitting in his wheelchair in the hallway outside of his room.
-The exterminator was in the resident's room

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D 079	Continued From page 15 spraying and the bed linens were laying on the floor at the end of the bed. Observation of resident Room 324 on 11/15/16 at 10:50 a.m. revealed: -There were food crumbs scattered all over the floor from the doorway to the other side of the room. -There were two grapes on the floor in front of the mini refrigerator. -There was a shelf above the refrigerator with Ziploc bags full of snack foods, a loaf of bread, a can of potato chips, and an opened box of saltine crackers. Observation of the bathroom in Room 324 on 11/15/16 at 10:50 a.m. revealed: -There was a dead roach on the floor beside the sink cabinet. -There was a roach crawling on the ceiling above the sink area. -The shower curtain had pinkish brown stains on the bottom half of the curtain that spanned the width of the shower curtain. -There was a tan mat on the shower floor that had large brownish black stains all over the top of the mat that appeared to be mold. -There were brown stains streaked across the floor of the shower. Interview with the resident who resided in Room 324 on 11/15/16 at 10:50 a.m. revealed: -The resident had roaches in his room and when he turned the light on at night, the roaches would "fly all over" the room. -The exterminator sprayed his room once a month and it helped with the roaches. -He had bedbugs in his room about 6 months ago but he did not have any in his room now that he was aware of.	D 079		

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D 079	Continued From page 16 -The resident asked, "Why don't they clean my room?" -The housekeepers only vacuum about every 6 months. -There was only one housekeeper currently for the entire facility. -There was two housekeepers at one time but now there was only one. Observation of resident Room 319 on 11/15/16 at 11:00 a.m. revealed: -There was a jug with clear liquid and a clear plastic container with a white granular substance. -Some of the white granular substance was spilled on the carpet around the container. -A resident sitting on his bed in the room saw a roach crawling on the dresser beside his bed and killed the roach with his bare hand. -The resident then pointed to another roach crawling on the other side of the dresser near the roommate's bed. -The roach was crawling beside a cup turned upside down and into an opened drawer with a resident's CPAP machine and face mask. Interview with a resident in Room 319 on 11/15/16 at 11:00 a.m. revealed: -One housekeeper had to clean the whole facility so she only had time to empty the trash in the resident's room and maybe sweep. -The housekeeper did not sweep or dust. -There were roaches in the resident's room and the exterminator sprayed the room today, 11/15/16. -The roaches crawl on the floor and sometimes on the bed. -The exterminator sprayed every month but it did not help. -There were bedbugs in the resident's room about a year ago but they were gone now.	D 079		

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D 079	Continued From page 17	D 079		

-The resident's roommate kept sugar in a container for his coffee and the container sat on the floor most of the time and sometimes the sugar would spill out on the floor.

Interview with the exterminator on 11/15/16 at 10:30 a.m. revealed:
-They service the facility monthly by spraying all of the rooms for household pests including roaches, ants, spiders, and beetles.
-They also check every room for bedbugs during the monthly service visits and use an industrial steam machine to treat the bedbugs.
-The results fluctuate but they usually find live bedbugs in about 3 to 6 rooms during each monthly visit, usually on 300 hall or 100 hall.
-The residents had complained about roaches and bedbugs.
-He had spoken with management in the past (could not recall who or when) about cleanliness issues, clutter, and residents storing food in their rooms.
-He thought that was the reason they continued to have problems with roaches, ants, and bedbugs.
-They only came for routine monthly visits and had not been contacted to come for any visits in between the monthly visits.
-They were in the facility for their routine visit today, 11/15/16.
-He had seen live bedbugs today in a few rooms so far and he would document the rooms on the invoice once his visit was completed.

Interview with the resident in Room 323 on 11/15/16 at 10:40 a.m. revealed:
-He had come out of his room so the exterminator could spray for roaches.
-He had roaches in his room and the exterminator sprayed every month.
-It usually helped with the roach problem when

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D 079	Continued From page 18 they sprayed. -He did not have bedbugs in his room. Interview with the housekeeper on 11/15/16 at 11:12 a.m. revealed: -She was currently the only housekeeper for the entire facility. -It was impossible to clean the facility by herself because it was too large and too much for one person to do. -She cleaned the bathrooms daily by mopping and wiping them down. -Some days she could sometimes clean about 18 to 20 residents' rooms depending on how dirty the rooms were but some of the rooms were "too messy". -She did not have time to deep clean. -She had seen bedbugs in the past but not now. -She had seen roaches in residents' rooms and bathrooms. Observation of the men's common bathroom across from Room 315 on 11/15/16 at 11:18 a.m. revealed: -There was a caution: wet floor sign at the doorway. -The floor appeared to have been mopped and looked clean and dry. -There were two white towels with multiple brown stains in the bath tub. -There were yellow stains and dirt and debris in the bottom of the bath tub. -There were brown liquid stains on the toilet seat. -There was a strong odor of feces in the bathroom. -The wooden door to the bathroom did not latch and would not stayed closed. Interview with the housekeeper on 11/15/16 at 11:20 a.m. revealed:	D 079		

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-She had mopped the floor in the bathroom a few minutes ago.
-She saw the dirty towels in the bath tub.
-The personal care aides throw dirty towels on the floor or in the tub.
-The PCAs have to take the soiled towels and linens to the laundry room.
-She did not clean the tub because the PCAs had not removed the dirty towels.
-She left the bathroom and did not offer to remove the dirty towels or clean the tub.

Observation of resident Room 323 on 11/15/16 at 4:20 p.m. revealed:
-There were 5 small roaches crawling all around the floor in the room.
-The resident was not in the room at the time.

Interview with the Maintenance Director on 11/15/16 at 4:30 p.m. revealed:
-A new door was installed for the common men's bathroom across from Room 315 about 2 to 3 days ago.
-The previous door was damaged by wheelchairs and the facility was told to replace it during a recent state construction survey.
-There was too big of a gap from the new door to the door casing which prevented the door from latching and staying closed.
-He did not install the door but it needed to be fixed and he would check on it.
-He usually tried to shampoo the carpet at least weekly but it had been over a month since he last had time to shampoo the carpet.
-He had been helping transport residents to appointments for the last 2 to 3 weeks and had not had time to shampoo the carpet.

Interview with the Interim Administrator on 11/15/16 at 4:55 p.m. revealed:

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-He had been helping at this facility for about two weeks.
-He usually worked as an Administrator at a sister facility.
-A Regional Director for the corporation was currently working as the Administrator for this facility but she was not available today.
-The exterminator company came to the facility monthly for routine inspections and treatments.
-The facility had bedbugs, roaches and ants.
-The Administrator would be able to give more specific information about the exterminator services when she returned to the facility.

Interview with an Administrator from a sister facility on 11/15/16 at 5:07 p.m. revealed:
-She was at the facility today to provide support and assistance to the Interim Administrator.
-Housekeeping staff should vacuum carpeted areas daily.

Interview with the resident in Room 322 on 11/17/16 at 10:52 a.m. revealed:
-He had seen bedbugs in his room about 4 to 5 months ago and felt something bite him.
-He caught 1 of the bedbugs 4 to 5 months ago and put it in a container and gave it to the maintenance staff.
-The exterminator sprayed his room every month.
-They also washed his clothes and bed linens.
-He had not seen any bedbugs in his room since 4 to 5 months ago.
-He had a lot of ants on the floor behind his bed and near his refrigerator in his room yesterday.
-The exterminator sprayed his room yesterday.
-He was told he had a couple of bedbugs in his room yesterday but he did not see any.
-He had not noticed any bites from the bedbugs since 4 to 5 months ago.

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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 079	Continued From page 21 Interview with a resident in Room 308 on 11/17/16 at 11:00 a.m. revealed: -He was told they found bedbugs in his room this week when the exterminator sprayed his room. -He had not seen any bedbugs in his room or had any bites. A confidential interview revealed: -Whenever a [named] resident would leave the dining room, roaches were found in that spot "every time" . -If the resident went to the drink table roaches were seen at the drink table in the dining room "it was like he was dropping them". -He had roaches in his room, he had informed the staff, but his room had not been treated for roaches. -He had never had bed bugs, but he had seen roaches on the walls and on the floor. Interview with the Administrator on 11/17/16 at 6:30 p.m. revealed: -Housekeepers were responsible for day to day cleaning in residents' rooms including mopping, dusting, and vacuuming. -Housekeepers were responsible for daily cleaning of all bathrooms including cleaning the tubs, toilets, showers, and floors. -Shower curtains are cleaned as needed by housekeeping staff. -Third shift staff helped with some cleaning in common areas such as wiping hand rails. -Deep cleaning including moving furniture to clean she be done on a scheduled basis but she did not know the facility's deep cleaning schedule. -Deep cleaning was not done on a routing basis in the facility as it should be. -The facility usually had two housekeepers working from 7am - 3pm from Monday - Saturday.	D 079		

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D 079	Continued From page 22 -One of the housekeepers was injured about a month ago and had not returned to work yet. -The Maintenance Director and the aides on the floor were helping out by doing things like emptying the garbage. -They were currently in the process of hiring another housekeeper and she was supposed to start next Wednesday, 10/23/16. -The exterminator came to the facility monthly for routine visits and sprayed for roaches. -The exterminator checked for bedbugs and treated any bedbugs found during routine monthly inspections. -The exterminator found live bedbugs in 4 resident rooms on 11/15/16 during the routine monthly visit and treated those 4 rooms. -The residents' laundry was also taken out for washing. -They have used the same exterminator company since at least 2012. -She thought the bedbug and roach problems at the facility were better now. Review of service tickets from the pest control company from 09/2016 - 11/2016 revealed: -09/20/16: Treated residents' rooms and common areas for household pests. Live bedbugs were found in rooms 202, 305, 308, 310, 311, and 315. Vacuumed and steamed at 300 plus degrees. -10/18/16: Treated residents' rooms and common areas for household pests. Live bedbugs were found in rooms 202, 308, 310, 315, and 322. -11/15/16: Treated residents' rooms and common areas for household pests. Live bedbugs were found in rooms 109, 201, 308, 310, and 322. Vacuumed and steamed at 300 plus degrees. Ants in rooms 100, 101, and 322.	D 079		

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D 269	Continued From page 23	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure personal care task were carried out for 2 of 7 (Resident #3 and Resident #4) sampled residents, one that required assistance with incontinence care and bathing (Resident #3) and one with a physician order for a leg brace (Resident #4). 1. Review of the Resident #3's Resident Register revealed an admission date of 9/29/16. Review of Resident #3's current FL-2 dated 10/11/16 revealed: -Diagnoses included history of 8 cerebrovascular accident (CVA), recurrent falls and seizure disorder. -The resident was intermittently disoriented. -The resident was semi-ambulatory with a wheelchair. -The resident was incontinent of bladder and bowel. -The resident required assistance with bathing and dressing. Review of Resident #3's Care Plan dated 10/6/16 revealed:	D 269		

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D 269	Continued From page 24 -The resident was oriented. -The resident was ambulatory with a wheelchair. -The resident had limited strength on upper extremities. Review of the facility's resident shower schedule revealed that Resident #3 was scheduled to shower during 2nd shift on Tuesday, Thursday and Saturday. Interview with Resident #3 on 11/16/16 at 4:15 pm and 11/17/16 at 8 am revealed: -The last time someone cleaned him was last Thursday (11/10/16); it was a shower. -No one had sponge bathed him on Tuesday (15th). -The resident reported the staff took 15-20 minutes to get to him when he called staff. -The resident did not get a shower or bed sponge on Wednesday (16th). Interviews with a 2nd shift personal care aide regarding Resident #3's shower on 11/16/16 at 4:10 pm revealed: -She worked the 2nd shift on Tuesday (11/15/16). -She gave a sponge bath in the bed on Tuesday to Resident #3 (11/15/16). Interview with Resident #3's Power-of-Attorney (POA) on 11/16/16 at 8 am revealed: -On 6/6/16 the resident had an appointment with a neurologist; when the resident arrived to the appointment, he had coffee spill on his shirt from breakfast (it was 3:00pm appointment) and his pants were soaked with urine. -The POA changed the resident's garment. -His backside was red and had dried feces on the buttocks. -When the POA asked about the dried feces, the resident said it was from the night before and that	D 269		

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when he called staff to go to the toilet, the resident was told that it was too much trouble to get him up so the staff told the resident to urinate or have a bowel movement in the pull-ups and call the staff to change when he was finished.
-The POA notified the former RCC and the former administrator of the concerns.
-On 8/23/16, the POA met with the facility management and discussed her concerns.
-On 10/10/16, the resident told the POA that he has not been out of the bed for several days.

Interview with a 1st shift personal care aide (PCA) regarding Resident #3 on 11/15/16 at 9:30 am revealed:
-The resident was oriented and alert.
-The resident was the heaviest care resident in the facility.
-The resident required a minimum of 2 staff or sometimes more staff to transfer him.
-The resident stayed in bed most of the time except for meals.
-A few of the staff were aware that there was a Hoyer Lift in the facility but never used the hoyer lift on the resident and The resident did not have a Hoyer Lift pad to use.

Interview with the interim administrator on 11/16/16 at 4:45 pm revealed:
-The staff were supposed to check off the personal care sheets as they complete the tasks.
-The staff were not supposed to pre-chart the personal care sheets.

Interview with the 2nd shift PCA on 11/16/16 at 4:30 pm revealed:
-She signed off on all the personal care tasks for Resident #3 and other 200 hall residents.
-She had time to do documentation so she completed them in advance before she

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D 269	Continued From page 26 completed the actual tasks. Review of the facility's "Personal Care Sheet" on 11/16/16 at 4:30 pm revealed that all the tasks for 16th were checked off with staff's initial. 2. Review of Resident #4's FL-2 dated 9/27/16 revealed diagnoses included Type 2 diabetes, cerebrovascular accident (CVA) and urinary tract infection. Review of Resident Registry revealed Resident #4 was admitted to the facility on 9/13/16. Review of Resident #4's Care Plan dated 10/18/16 revealed: -Resident required "extensive assistance" with bathing and dressing. -Resident required "limited assistance" with toileting and ambulation. Observation and interview with Resident #4 on 11/15/16 at 10:15 am and 1:00pm revealed: -The Resident was sitting in her wheelchair in her room. -Resident #4 was not wearing her leg brace on her left leg. -The leg brace was in a chair in the room. -The Resident had 3 showers since admission into the facility. -Staff did not bathe her on scheduled days, sometimes and she had to attend to her own hygiene because she didn't want to have body odor. -The Resident's leg was swollen and she could not wear the brace. -The Resident had not worn the leg brace in about a week, because her leg was swollen.	D 269		

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D 269	Continued From page 27 Observation and interview with Resident #4 on 11/16/16 at 1:00 pm revealed: -Resident was sitting in her wheelchair in her room. -Resident was wearing her leg brace on her left leg. -Resident stated her left leg was still swollen; however, resident was able to wear the brace due to she had on an older pair of shoes. -Resident stated she had not been wearing the brace earlier this week, because it would not fit on her foot in her new shoes. -She told the Resident Care Coordinator and the Administrator, but the doctor had not been aware she was not wearing the brace. Review of the November 2016 Aide Weekly Task Schedule revealed: -Resident #4 was scheduled to receive a tub bath/shower on Tuesday, Thursday and Sunday during first shift. -On dates 11/10/16, 11/13/16 and 11/15/16, a Personal Care Aide signed that a tub/shower was completed during first shift. -On dates 11/09/16 through 11/15/16, a Personal Care Aide signed that placement of brace had been completed on first and second shifts. -On 11/16/16, a Personal Care Aide signed that placement of brace had been completed on first and second shifts.	D 269		
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.	D 273		

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D 273	Continued From page 28 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 5 of 8 residents (#1, #2, #3,#6, #9) sampled as related to a resident with seizures missing a neurology appointment and failure to notify the neurologist and primary care provider of hospital visits due to seizures (#9); a resident with prostate cancer missing an oncology appointment to get intravenous fluids due to kidney function problems and dehydration (#9); a resident with mental health diagnoses missing multiple appointments with mental health providers before and after a physical altercation with another resident (#6); failure to notify the physician of a resident's toe wound resulting in an infected toe ulcer (#1); failure to follow-up with a cardiology referral for a resident with a pacemaker and episodes of dizziness and syncope resulting in falls (#2); and failure to obtain a wheelchair safety harness for a resident with right sided paralysis and weak upper body strength resulting in falls (#3). The findings are: 1. Review of Resident #9's current FL-2 dated 10/25/16 revealed the resident's diagnoses included seizures, encephalopathy, and urinary tract infection. A. Review of Resident #9's current FL-2 dated 10/25/16 revealed the resident had orders to receive at least 3 medications for seizures, including Dilantin. Review of care notes for Resident #9 dated	D 273		

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02/21/16 revealed:
-Resident #9's roommate stated Resident #9 was jerking.
-Staff went to check on Resident #9 and he was in a daze.
-The resident started coming around but could not use his left side (hands or foot).
-Emergency Medical Services (EMS) was called and the resident was taken to the hospital.
-The primary care provider (PCP) was notified.

Review of a visit note for Resident #9's neurology office dated 04/13/16 revealed:
-The resident was to continue current medications and there were no new orders.
-They would check labs today including drug levels.
-The resident was to return to the clinic in 6 months.

Review of a lab report for Resident #9 dated 04/13/16 revealed the resident's Dilantin level was 20.7 (reference range 10 - 20). (Dilantin is a seizure medication.)

Review of an emergency room (ER) form dated 05/23/16 revealed:
-Resident #9's diagnoses was convulsions.
-The resident was to follow up with PCP in 3 days.

Review of Resident #9's provider visit notes revealed no documentation of a follow-up visit with the PCP in 3 days after the ER visit on 05/23/16.

Review of care notes for Resident #9 dated 05/25/16 (time not documented) revealed:
-Resident #9's roommate witnessed the resident having seizures.

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D 273	Continued From page 30 -Staff witnessed him having 5 small seizures. -The resident went to the hospital. Review of an ER form dated 06/08/16 revealed: -Resident #9's diagnoses was convulsions. -The resident was to follow up with PCP in 1 day. Review of Resident #9's provider visit notes revealed no documentation of a follow-up visit with the PCP in 1 day after the ER visit on 06/08/16. Review of care notes for Resident #9 dated 10/18/16 (12:00 noon) revealed: -The resident was found in the television room on West hall having a seizure. -The resident's blood pressure was 208/85 and his pulse was 119. -EMS was called and the PCP was notified. Review of an ER visit form dated 10/18/16 revealed: -Resident #9's diagnoses was convulsions. -The resident's Dilantin level was low at 8.5 (reference range 10 - 20) on 10/18/16. -The resident was to follow-up with PCP in 1 week. Review of a progress note by Resident #9's PCP dated 10/25/16 revealed: -The resident was being seen for a routine wellness visit. -The resident denied any concerns and staff reported no issues. -The assessment/plan section of the form noted the resident's seizures were stable with treatment. -There was no documentation about the resident's hospital visit for seizures.	D 273		

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Interview with Resident #9's primary care provider (PCP) on 11/17/16 at 5:00 p.m. revealed:
-She was aware of the resident's hospital visit for seizures in October 2016.
-She saw the resident for a routine visit on 10/25/16.
-She did not originally prescribe the resident's Dilantin (seizure medication) and she was not sure when the levels were last checked.
-She would give the facility an order to check the Dilantin levels every 3 months.
-She thought the facility used to have a standing order to get the levels checked every 3 months but it may have been discontinued.
-She was not sure she had been notified and had follow-up visits for all of the seizures without checking her records.

Review of Resident #9's October 2016 and November 2016 medication administration records (MARs) revealed the resident was receiving at least 3 different medications for seizures as ordered including Keppra 750mg twice a day, Dilantin 100mg 3 times a day, Zonisamide 200mg at bedtime.

Interview with a nurse at Resident #9's neurology office on 11/17/16 at 8:40 a.m. revealed:
-Resident #9 had not been seen at the neurology office since 04/13/16.
-The resident was supposed to be seen for a follow-up in 6 months but that was never scheduled.
-The neurology office called the facility on 05/10/16 at 4:52 p.m. and spoke with a "caregiver" to let them know the resident needed to come back for a follow-up.
-The facility staff told the neurology office they would call back to schedule the 6 month follow-up for October 2016.

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D 273	Continued From page 32 -The facility did not call back. -They were not notified of Resident #9 having any seizures including the recent hospital visit on 10/18/16. -During the last visit on 04/13/16, labs were done and results would have been sent to the facility. -No changes were made during the visit on 04/13/16 and the resident was to continue Keppra, Dilantin, and Zonisamide. -Resident #9 needed to be seen for a follow-up visit. Interview with Resident #9 on 11/17/16 at 3:58 p.m. revealed: -He did not remember seeing a neurologist. -He usually got his medications every day. -He remembered going to the emergency room recently but he could not remember why he went. -He thought his seizures were controlled. Review of a verbal order by Resident #9's PCP dated 11/16/16 revealed the PCP ordered a Dilantin level be checked stat. Review of a lab report for Resident #9 dated 11/18/16 revealed: -The resident's Dilantin level was low at 8.9 (reference range 10 -20). B. Review of a visit note for Resident #9's oncologist dated 10/21/16 revealed: -The resident's diagnoses included prostate cancer and normocytic anemia. -Multiple lab tests were done during the visit including a lab for creatinine which was elevated at 1.5 (reference range 0.6 - 1.3) indicating the resident's kidneys were not functioning properly. -The resident was to return for a follow-up visit on 11/02/16.	D 273		

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D 273	Continued From page 33 Review of a lab report for Resident #9 dated 10/26/16 revealed the resident's creatinine level was elevated at 1.28 (reference range 0.70 - 1.18). Review of Resident #9's provider visit notes revealed no documentation that Resident #9 had been seen by the oncologist since 10/21/16. Interview with the Resident Care Coordinator (RCC) on 11/16/16 at 3:40 p.m. revealed: -The facility did not currently have a transporter. -She was trying to schedule the appointments and get staff to fill in as a transporter to take residents to appointments. -Documentation on the appointment book showed Resident #9 had an appointment on 11/02/16 but it was rescheduled because the facility had no one to transport the resident to the appointment on 11/02/16. -The appointment had been rescheduled for tomorrow, 11/17/16 at 11:00 a.m. but she was not sure when it was rescheduled. Interview with Resident #9's oncologist on 11/16/16 at 4:25 a.m. revealed: -Resident #9 had an appointment with his office scheduled on 11/02/16. -The resident did not show up for the appointment and no one called to cancel the appointment. -The resident was supposed to get an intravenous infusion during the visit on 11/02/16 because of an elevated creatinine level and for dehydration. -The resident has an appointment for 11/17/16 but the oncologist could not tell when the appointment was scheduled. -The resident may have to get an intravenous infusion during the visit on 11/17/16 depending on lab results.	D 273		

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D 273	Continued From page 34 A second interview with Resident #9's oncologist on 11/17/16 at 11:15 a.m. revealed: -Resident #9 was in his office waiting to be seen today. -He was not sure if the resident would be getting intravenous fluids at today's visit until he checked the resident. -He would send paperwork back with the resident to the facility from today's visit. Review of a visit note for Resident #9's oncologist dated 11/17/16 revealed: -The resident's diagnoses included prostate cancer and normocytic anemia. -The oncologist ordered multiple laboratory tests including tests to check the resident's kidney functions and electrolytes (for dehydration). Interview with Resident #9 on 11/17/16 at 3:58 p.m. revealed: -He saw his oncologist earlier today. -He did not remember getting any intravenous fluids. -He thought he was supposed to go back next month. -He did not know if he had missed any appointments with the oncologist. Interview with the Administrator on 11/17/16 at 4:45 p.m. revealed: -The facility's transporter usually set up appointments for residents. -The transporter would give any paperwork from appointments to the RCC. -The facility's transporter position had been vacant since 10/24/16. -The RCC was currently responsible for setting up the appointments and coordinating to get other staff to fill in for the transporter.	D 273		

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D 273	Continued From page 35 -They were in the process of interviewing applicants to fill the vacant transporter position. 2. Review of Resident #6's current FL-2 dated 10/15/16 revealed: -The resident's diagnoses included non-cardiac chest pain, hyponatremia, and acute diastolic heart failure. -The resident was ambulatory and had sight limitations. Review of a previous FL-2 dated 04/15/15 for Resident #6 revealed her diagnoses also included schizoaffective disorder, bipolar disorder, and history of psychosis. Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 11/20/15. Review of Resident #6's current assessment and care plan dated 12/14/15 revealed: -The resident was oriented. -The resident required limited assistance with bathing, dressing, eating, and ambulation. -The resident was independent with toileting. Review of a facility care note dated 10/25/16 (8:45 p.m.) for Resident #6 revealed: -Resident #6 confronted another resident in the other resident's room. -The other resident began yelling help and the medication aide went into the room. -The other resident was observed kicking at Resident #6. -Resident #6 was escorted from the room. -Resident #6 said the other resident had removed a sign from Resident #6's door and Resident #6 got upset. -Resident #6's on-call guardian was notified and	D 273		

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message was left for the primary care provider (PCP).
-The Administrator was called and advised putting Resident #6 on one-on-one monitoring.

Review of a local EMS report dated 10/25/16 at 9:08 p.m. revealed.
-A resident (Resident #5) stated she had been assaulted while lying in bed.
-The resident stated she was struck in the face repeatedly.
-The incident was not witnessed by staff.
-Upon EMS arrival, the resident was sitting upright in a wheelchair.
-The resident's right eye was swollen and "appeared to be ruptured".
-The resident had no vision out of the right eye and no problems in the left eye.
-The resident was transported to a local hospital emergency room.

Review of a facility care note dated 10/26/16 (6am - 2pm) for Resident #6 revealed:
-Resident #6's mental health provider's office was called 3 times today to discuss incident with resident.
-Three messages were left and they were awaiting return calls.
-The resident was placed on 15 minute checks.

Review of a note dated 10/24/16 from the mental health therapist for Resident #6 revealed:
-The resident's next appointment for medication management was 11/02/16 at 1:30 p.m.
-The resident's next appointment for therapy was 11/08/16 at 12:00 p.m.

Review of Resident #6's provider visit notes revealed no documentation of a follow-up visit with the mental health providers on 11/02/16 or

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D 273	Continued From page 37 11/08/16. Interview with a medication aide (MA) on 11/17/16 at 1:15 p.m. revealed: -Resident #6 had altercations with other residents besides Resident #5 but it had been a long time ago. -Resident #6 had a few "little" verbal arguments with other residents about cigarettes but none that she could recall in the last two months. -Resident #6's PCP and mental health provider were aware of the altercation on 10/25/16. -She was not sure about any missed appointments with mental health for Resident #6. Interview with the Resident Care Coordinator (RCC) on 11/17/16 at 5:10 p.m. revealed: -Resident #6's appointment with the mental health nurse practitioner on 11/02/16 was rescheduled because the facility was unable to take the resident to the appointment because they did not have a transporter. -The resident may have missed other appointments as well. -The transporter position was vacant and appointments had been missed by residents because they had to try to fill in the transporter duties with staff who were normally assigned to other tasks. Interview with Resident #6 on 11/17/16 at 4:10 p.m. revealed: -She was out of her medication for depression last month and she went 13 days without sleep. -She thought the doctor had taken her off her medication and she did not know why. -She had anxiety when she was not taking her depression medication (could not recall the name of the medication). -She finally got put back on the medication and	D 273		

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she was better now and she had been sleeping okay.
-She thought she saw mental health providers about twice a month.
-She was not aware of missing any appointments with her mental health providers.
-She thought she was supposed to see them again in about 6 weeks or 2 months.
-She recently had a confrontation with a resident who no longer lived at the facility.
-The other resident took a sign off of her door so Resident #6 went to the other resident's room to ask why she took the sign off.
-The other resident threw a shoe at Resident #6 and slapped her.
-She either "punched or slapped" the other resident.
-The other resident hollered and said her eye was bleeding.
-She thought her primary care and mental health providers were aware of the altercation.
-She had another altercation with a different resident about 3 weeks prior to this one about cigarettes and hit the other resident in the chest but she apologized and the resident was not hurt.
-She had not had any arguments or altercations since then (referring to the altercation on 10/25/16).

Telephone interview with a medical assistant from Resident #6's mental health providers' office on 11/17/16 at 4:30 p.m. revealed:
-Within the last 8 months, Resident #6 did not show up for about 50% of her appointments.
-Resident #6 had an appointment to be seen by the therapist and nurse practitioner (NP) on 10/05/16.
-The resident was not seen by either provider on 10/05/16 because it was a "no call, no show" meaning the resident did not show up and no one

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called to say the resident was not coming to the appointment.
-Resident #6 had an appointment with the NP on 10/19/16 but the facility called and rescheduled that appointment for 11/02/16.
-The facility rescheduled the appointment on 11/02/16 with the NP for 11/11/16.
-Resident #6 was seen by the NP on 11/11/16 and the resident's next appointment with the NP was scheduled for 01/10/17.
-Resident #6 had an appointment and was seen by the therapist on 10/24/16 and the next appointment was scheduled for 11/08/16.
-The appointment for 11/08/16 with the therapist was cancelled and had not been rescheduled.
-The facility notified the mental health provider's office on 10/26/16 about Resident #6 being in an altercation with another resident on 10/26/16.
-It was noted the other resident went to the hospital as a result of the altercation.

Interview with the Administrator on 11/17/16 at 4:45 p.m. revealed:
-Resident #6 had little outbursts prior to the altercation on 10/25/16 with Resident #5.
-The facility's transporter usually set up appointments for residents.
-The transporter would give any paperwork from appointments to the RCC.
-The facility's transporter position had been vacant since 10/24/16.
-The RCC was currently responsible for setting up the appointments and coordinating to get other staff to fill in for the transporter.
-They were in the process of interviewing applicants to fill the vacant transporter position.
-She was not aware Resident #6 had missed any mental health appoitments.

Attempts to contact Resident #6's primary care

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provider, mental health therapist, and mental health prescribing provider during the survey were unsuccessful.

3. Review of the current FL-2 for Resident #1 dated 5/23/16 revealed diagnoses included Type 2 Diabetes, osteoarthritis and depression.

Review of the Resident Register for Resident #1 revealed he was admitted to the facility on 5/28/15.

Interview with Resident #1 on 11/15/16 at 10:45am revealed:
-He needed to see a doctor about his left foot.
-The great toe on his left foot was bleeding and had been bleeding for about a month.
-He told one of the medication aides (MA) about his foot bleeding, she dressed it with a band aid, but he still had not seen a doctor.

Observation of Resident #1 on 11/15/16 at 10:45am revealed:
-He was wearing a regular closed in shoe on the right foot.
-He was wearing a slide in shoe with an open toe and open heel shoe on the left foot.
-He was wearing a sock on the left foot, he held his foot up to show the great toe.
-Through a hole in the sock, the great toe on the left foot had a wet substance on it and an area of redness could be seen.

Review of Care Notes for Resident #1 revealed:
-On 10/6/16 at 9:30am, the MA documented, the great toe on Resident #1's left foot looked like it was bleeding. The MA removed his sock and cleaned and dressed his toe. The MA asked Resident #1 what happened to his toe and he said he did not know, he thought he might have

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D 273	Continued From page 41 stumped his toe, the great toe on the left foot looked like he might have slammed it. Interview with a Medication aide (MA) on 11/15/16 at 4:00pm revealed: -She had been aware that Resident #1 complained about having a cut on left his foot. -Resident #1 had ran into a door, she was not working that day, but she had been informed by another MA. She thought it might have been about a week and a half ago, she could not recall the date, and she did not write it down. -She had wrapped Resident #1's toe once around that time. -It looked like a little cut when it first happened, she had put triple antibiotic ointment on it and covered it with a band aid. -Resident #1 had not said anything else about his foot and she had not looked at it again. -She had not called his physician, but she was pretty sure the MA who told her about the cut on his foot would have call his physician. -She would take a look and the resident's foot and redress the wound. Observation on 11/15/16 at 4:10pm revealed: -The before mentioned MA cleaned and dressed Resident #1's great toe on his left foot. -The left great toe was swollen and the bottom of his toe had a red spot about 8cm in diameter, surrounded by a circle of black crusted scab about 20cm in diameter, there was no bleeding or drainage present. -The MA sprayed the left great toe with saline, applied a triple antibiotic ointment, dressed it with a 4 inch gauze wrap and secured the wrap with a large band aid as per physician standing order. Review of Care Notes for Resident #1 dated 11/15/16 revealed:	D 273		

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D 273	Continued From page 42 -Resident's right toe was redressed today, it has healed but he needs to be seen again by the doctor to be cleaned around the wound, there is no bleeding and no drainage. -Office closed call clinic back in the morning for an appointment Interview with the MA on 11/15/16 at 4:15pm revealed: -Resident #1's left great toe did not look the same today as it did when she dressed it about a week or so ago. -When she first saw the left toe it was split, red and bleeding a little bit. -If his toe had the red area in the middle with the black crusted scab around it she would have called the physician at that time. -She would call the physician and inform him of how Resident #1's foot looked now. Interview with Resident #1 on 11/16/16 at 9:10am revealed: -He had seen the physician about the wound on his left great toe in April 2016. -He had not seen his physician since he re-injured his left great toe last month. -He had not ever had any problems with his right foot at all, he had only seen the physician about his left foot. -He could not remember how he had originally injured his foot. -He did not have any pain to his foot because he had neuropathy, he would just notice the blood. Interview with Administrator from a sister facility on 11/16/16 at 12:43pm revealed: -She was at the facility today to provide support and assistance to the Interim Administrator. -Resident #1 had injury to his left toe, he had never had any injury to the right great toe.	D 273		

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D 273	Continued From page 43 -Staff documented a past injury on the wrong (right) foot and did not notify the physician of the new injury. -He had not seen the physician for the right foot, the MA had documented the wrong foot on the care notes. -She would send the resident out to urgent care because they were having a hard time getting a physician appointment. Review of Care Notes dated 11/16/16 revealed: -Resident #1 returned from urgent care with new orders for an antibiotic to start (tonight). -Wound care on resident's left great toe was received. -If area has not improved will attempt to go to PCP in 1 week or return to urgent care. -Left foot airing out with an oral antibiotic ointment applied. -Resident #1 had a physician appointment scheduled for 12/5/16. Review of discharge orders from urgent care dated 11/16/16 revealed: -Resident has ulcer on his left great toe. -The wound was debrided and cleaned. Leave wound open to air and keep dry and clean. Apply topical antibiotic 2-3 times daily, take antibiotic 2 times a day for 7 days. -Follow up visit with primary care physician if not improved in one week. -If not improved in 1 week of if symptoms worsen report to emergency room or return to urgent care. Attempts to contact Resident #1's physician were not successful. 4.Review of the Resident #2's Resident Register revealed an admission date of 6/3/16.	D 273		

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D 273	Continued From page 44 Review of Resident #2's current FL-2 from the hospital dated 8/4/16 revealed: -Diagnosis included renal insufficiency. -The resident was intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #2's Care Plan dated 7/1/16 revealed the resident was oriented and memory was adequate. Review of Resident #2's hospital discharge summaries revealed: -The resident was hospitalized from 6/26/16 due to a congestive heart failure (CHF); the resident has chronic unsteadiness and dizziness and was discharged on 6/28/16. -The resident was hospitalized from 8/2/16 due to feeling dizzy after standing up after lying in bed; this usually occurred upon standing up from sitting or lying down. Review of Resident #2's Primary Care Physician (PCP)/Nurse Practitioner (PC) visit notes revealed: -During 8/9/16 visit, the resident denied of having dizziness and confusion. -Noted during the 10/13/16 visit, the resident complained of "dizziness." It was noted that the resident had a history of congestive heart failure (CHF), syncope, a left chest wall permanent pacemaker (PPM) and Bradycardia. -On 10/13/16, there was an order for a cardiologist referral to interrogate PPM and assess syncope/dizziness. Review of Resident #2's physicians' visit notes revealed there was no record of cardiologist visit. Interview with Resident #2 on 11/16/16 at 11:30	D 273		

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and 11/17/16 at 1:20 pm and 4 pm revealed:
-The resident felt dizzy all the time.
-The resident told the doctor and the staff about the dizziness; the resident did not recall the time frame.
-The resident used to be able to walk a few feet without any ambulation devices but not any more due to dizziness.
-The resident had fallen many times because he felt dizzy; the resident described the falls as "jumping off" but he has not been reporting the falls to the staff.
-The resident's pacemaker was put in 1985.
-The resident last saw his cardiologist a year ago; the resident did not know when his pacemaker was checked.

Interview with Resident #2's NP on 11/17/16 at 4:30 pm revealed:
-The resident is was alert and " thinkable "she knew there was something to be concerned about, his dizziness was a concern.
-She ordered a referral to cardiologist after the resident complained of dizziness and get his pacemaker to be interrogated (the process used to ensure the pacemaker is functioning properly).
-The NP was not aware that the resident had not seen a cardiologist until yesterday (11/16/16).

Interview with the 1st shift medication aide #1 on 11/17/16 at 8:05 am revealed:
-Resident #2 has reported in the past of dizziness when he stood up too fast; the staff did not recall time frame.
-Resident #2 has not fallen during her shift.

Interview with Administrator from a sister facility on 11/16/16 at 1:00pm revealed:
-She was at the facility today to provide support and assistance to the Interim Administrator.

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D 273	Continued From page 46 -She was not aware of Resident #2's cardiology referral from 10/13/16. -The facility made a cardiologist appointment today for 11/18/16 at 10 am. Interview with the Resident Care Coordinator (RCC) on 11/17/16 at 11:45 am and 1:04 pm revealed: -She was an interim RCC and started to work at the facility sometime in October 2016. -A machine to check the pacemaker functionality was kept in the medication room. -She was not aware of Resident #2 had a pacemaker. -She was not aware of the resident's cardiology referral from 10/13/16. -She found the facility's "Referral and Follow Up Tracking" log this morning but there was nothing in it except for a blank tracking form. -When the orders came in, she used the appointment to keep up with all the physician referrals. Interview with the Administrator on 11/17/16 at 12:40 pm revealed: -She was not aware of Resident #2 having a pacemaker. -She was not aware the resident had an order from the physician to see a cardiologist. -She did not know if Resident #2 had a pacemaker checking machine or not. -She did not know which resident had the machine; they were kept in the medication room or RCC room. -Usually the residents had their own machine to check or they go to their cardiologist to check. -The facility had a system in place to track medical appointments and referrals. -All of residents' orders for referrals went through the facility's RCC and the referral orders were	D 273		

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documented on their tracking form.
-The RCC and transportation staff set up the referrals.

5. Review of the Resident #3's Resident Register revealed an admission date of 9/29/15.

Review of Resident #3's current FL-2 dated 10/11/16 revealed:
-Diagnoses included history of 8 cerebrovascular accident (CVA), recurrent falls and seizure disorder.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory with a wheelchair.

Review of Resident #3's "Physician Orders" forms revealed:
-On 6/16/16, the neurologist ordered a "Trunk Support (belting)" for leaning.
-On 8/16/16, the Nurse Practitioner (NP) signed off on a wheelchair "Butterfly Chest Harness" to assist with the resident's leaning in a wheelchair.

Review of Resident #3 NP's signed visit notes dated 8/16/16 revealed:
-There was an order for safety harness for a wheelchair to prevent falls.
-There was a recommendation to be considered for skilled placement given the resident's increased needs.

Observation of Resident #3's room on 11/16/16 at 9:00am revealed there was a seat belt attached to the wheelchair but there was no harness.

Observation of Resident #3 on 11/16/16 at 11:30am in the dining room revealed:
-The resident was sitting in a wheelchair at the table.

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-The resident was not wearing a seat belt.
-The Personal Care Aide (PCA) buckled the seat belt onto the resident.
-The resident was able to unbuckle and buckle the seat belt without staff assistance.

Interview with Resident #3's NP on 11/15/16 at 3:15 pm and 11/17/16 at 4:30pm revealed:
-The resident had 8 strokes and has no muscle control on his right side, that's why he leans to the right side.
-The resident should be in a skilled nursing facility and that she has told the facility many times.
-The NP did not see the chest harness; the staff did not use the seatbelt on the wheelchair because the facility staff thought the seatbelt was considered restraints.
-The NP told the facility staff multiple times that seat belt and harness were not restraint because the resident was alert and oriented.
-The NP reordered the chest harness because the resident had weak upper strength and she wanted to keep the resident upright for his leaning problem.
-The staff reported they were concerned about the resident falling off his wheelchair so they kept the resident in bed for the last 2 weeks.

Review of Resident #3's Care Notes revealed:
-On 3/24/16 at 10:30 am, the resident fell out of his chair, trying to pick up a remote on the floor.
-On 10/12/16 at 1:00 pm, the resident was coming out of the dining room and fell out of his wheelchair; the resident's physician was notified and instructed the staff to follow up on an order for harness.
-On 10/12/16 at 2:00 pm, the staff called the medical supply vendor to inquire about the harness; the vendor said that the harness had to

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be paid out of pocket and then the resident needed to be measured; the vendor would call back with price.

Review of Resident #3's NP visit notes revealed:
-On 5/24/16, the staff were concerned about the resident's safety due to his constant leaning to the right side.
-On 8/16/16, the staff were afraid that the resident might fall out of his wheelchair.

Interview with Resident #3 on 11/16/16 at 11:30 am and 4:15 pm revealed:
-The resident was not aware that there were orders for a seat belt and a harness for him to use.
-The resident never used a seat belt while sitting in the wheelchair.
-The resident fell out of the wheelchair once.
-Today was the first time using the seat belt.

Interview with Resident #3's Power-of-Attorney (POA) on 11/16/16 at 8 am revealed:
-The resident moved into the facility a year ago; first 3 months, he was somewhat mobile (could take a few steps) and transfer himself but now he cannot do neither.
-She was aware of the resident's right side leaning concerns.
-The resident told the POA that he had fallen out of his wheelchair in October 2016.
-She was aware of the order for the harness for safety purpose because she was at the neurologist appointment in June.
-In July, she inquired about the harness with the former Resident Care Coordinator (RCC) multiple times and she was told that the harness was considered a restraint and it could not be used at the facility.
-She was not aware of any vendor coming out to

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take a measurement for the harness.
-The facility notified the POA of the resident's insurance not paying for the harness and it had to be paid out pocket which the POA told them she would pay for it and just let her know the price.
-On 10/25/16, during the meeting with the administrator, the POA was told for the 3rd time that the harness would be an out of pocket expense and for the 3rd time, the POA told them it was fine and just needed the details.

Interviews with the 1st shift's PCAs regarding Resident #3 on 11/15/16 at 10:00am and 11/16/16 8:00am revealed:
-The resident was oriented and alert.
-The resident was able to use a whistle (call bell) around his neck to get staff attention when he needed their assistance.
-The resident was the heaviest care resident in the facility.
-The resident required minimum of 2 staff or sometimes more staff to transfer him.
-The resident was a fall risk due to his leaning to the right side.
-The resident stayed in bed most of the time except for meals because the resident was too heavy " dead weight " get him transferred in and out of the bed.
-The resident had a seat belt on his wheelchair but never used it while he was in the wheelchair.
-The facility staff did not know that they could use the seat belt for the resident.
-A few of the staff were aware of the Hoyer Lift in the facility but they never used it on the resident.
-The staff reported that Resident #3 did not have Hoyer Lift pad to use.

Interview with the 2nd shift PCA regarding Resident #3 on 11/16/16 at 4:30 pm revealed:
-The resident was a heavy care and it required at

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least 2-3 staff to transfer the resident.
-This staff was not sure if the resident's seat belt on the wheelchair had been used.

Interview with the Interim Administrator on 11/17/16 at 12:30 pm revealed:
-She was aware of Resident #3's harness order and knew that former RCC called around for prices.
-She was told by staff that the resident's family was aware of the price and the family chose not to spend the money to get it.
-She was not aware of Resident #3's order for skilled nursing level recommendation.
-The only reason she talked to the resident's POA about the nursing home option was for the financial reason because if the resident was eligible for Medicaid and the cost of care would be paid by the State and better for their finance.
-She may have mentioned the Hoyer Lift to Resident #3's POA but did not know for sure.
-Resident #3's POA was more interested in getting PT/OT/Psych referrals to improve the resident's quality of life.
-The facility had a in-service training for the staff on Hoyer Lift.

Review of the In-Service training roster revealed:
-The facility had Hoyer Lift training on 7/26/16.
-17 direct care staff attended the training.

The facility failed to meet the health care needs for 5 residents (#1, #2, #3,#6, #9) by not transporting Resident #9 with a seizure disorder to a neurology appointment and not notifying the neurologist and primary care provider of multiple seizures resulting in emergency room visits; by not transporting Resident #9 with prostate cancer to an oncology appointment to get intravenous

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D 273	Continued From page 52 fluids for kidney function problems and dehydration resulting in continued kidney function problems; by not transporting Resident #6 to multiple mental health appointments before and after a physical altercation with another resident; by not notifying Resident #1's physician of a toe wound resulting in an infected toe ulcer requiring debridement and antibiotics; by not following up with a cardiology referral for Resident #2 with a pacemaker, dizziness, syncope, and falls; and by not obtaining a wheelchair safety harness for Resident #3 with right sided paralysis and weak upper body strength resulting in falls. The failure of the facility to assure a system for the coordination of health care for the safety and well-being of the residents resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ Review of the Plan of Protection received from the facility on 11/16/16 revealed: -Staff will be retrained on the identification and reporting of residents needs to assure appropriate referral and follow up. November 16, 2016 through November 18, 2016 any residents with any changes in condition or status, the healthcare provider will be notified immediately of the changes; appointments to be made accordingly and documented in the referral and follow up notebook by the Transportation Coordinator, Administrator, and or Resident Care Coordinator. -For Residents #1, the healthcare provider will be notified immediately and recommendations will be followed by designated staff. -For Resident #9, he will have an appointment on 11/17/16 with oncology and neurology will be called to reschedule his appointment for follow up.	D 273		

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D 273	Continued From page 53 -Continued routine reporting from staff on any changes/ incidents with residents that would require referral and follow up, beginning 11/16/16 and ongoing. -Continued random chart audits/ resident surveys once a month from the Regional Director/ Designee to assure referral and follow up is done in a timely and accurate manner beginning 11/16/16. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 17, 2016 .	D 273		
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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 8 residents (#8, #9, #10) observed during the medication passes, including errors with insulin (#10), an antibiotic for	D 358		

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infection (#8), a lubricant eye drop (#9), and a calcium supplement (#9) and 2 of 7 residents (#4, #6) sampled for record review including errors with a medication for anxiety (#6) and a topical pain medication (#4).

The findings are:

1. The medication error rate was 13% as evidenced by the observation of 4 errors out of 30 opportunities during the 8:00 a.m. / 9:00 a.m. and the 11:00 a.m. / 12:00 noon medication passes on 11/16/16.

A. Review of Resident #10's current FL-2 dated 10/12/16 revealed:
-The resident's diagnoses included type II diabetes, hypoglycemia, neuropathy, hypertension, vascular dementia with history of cerebrovascular accident, transient ischemia attack, urinary tract infection, and anemia.
-There was an order for Novolog sliding scale insulin before meals with the following scale: <80 = orange juice; 151 - 200 = 0 units; 201 - 250 = 2 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 10 units; and .401 = call physician. (Novolog is rapid-acting insulin used to lower blood sugar.)
-There was an order for Novolog insulin 4 units before lunch, hold if blood sugar is <70.

Review of Resident #10's November 2016 blood sugar flow sheet revealed:
-The resident's Novolog sliding scale insulin order was printed at the top of the page.
-The resident's blood sugars were documented 3 times daily before meals at 7:00 a.m., 11:00 a.m., and 4:00 p.m.
-There were no other insulin orders listed on the blood sugar flow sheet.

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D 358	Continued From page 55 Observation of the medication pass on 11/16/16 revealed: -The Resident Care Coordinator (RCC) stated she was working as a medication aide today. -It was not unusual for her to fill in as a medication aide at times. -Resident #10's blood sugar was 182 at 12:26 p.m. -The RCC stated Resident #10 would not receive any insulin because his sliding scale started at 201. -She was looking at the blood sugar flow sheet in front of the resident's medication administration records (MARs). -She documented the blood sugar on the log and that no insulin was administered. -She did not look at the MAR pages for the resident. -She told the resident he would not be getting any insulin and he could go to the dining room for lunch. Interview with the RCC on 11/16/16 at 12:26 p.m. revealed: -She had finished Resident #10 and he would not be getting any insulin. -The residents eat at different times because the dining room could not hold all of the residents at one time. -She had some other residents to administer medications to in a few minutes. Observation in the dining room on 11/16/16 revealed: -Resident #10 was served lunch and began eating at 12:30 p.m. -Resident #10 was not observed to get any medication administered in the dining room from 12:28 p.m. - 12:33 p.m.	D 358		

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D 358	Continued From page 56 Observation on 11/16/16 at 12:34 p.m. revealed a personal care aide came to conference room and stated the RCC was about to start another medication pass. Observation on 11/16/16 at 12:35 p.m. - 12:39 p.m. revealed: -The RCC was in the medication room on 300 hall and checked a different resident's blood sugar at 12:35 p.m. -The RCC then started flipping through the medication administration records (MARs) and turned to the MAR pages for Resident #10. -The RCC pointed at an entry on the on the MAR for Novolog 4 units before lunch that was scheduled to be administered at 12:00 noon. -The RCC pointed to her initials for today's dosage at 12:00 noon. Review of the November 2016 MAR for Resident #10 revealed: -There was a printed entry for Novolog sliding scale order and a handwritten note to "see flow sheet". -There was a printed entry for Novolog 4 units before lunch and hold if blood sugar is <70 and it was scheduled to be administered at 12:00 noon. Interview with the RCC on 11/16/16 at 12:39 p.m. revealed: -She had overlooked the order to give the scheduled dose of Novolog 4 units when being observed during the medication pass. -She had administered the 4 units to the resident in the dining room right after being observed during the medication pass earlier. Interview with Resident #10 in the dining room on 11/16/16 at 12:41 p.m. revealed he did not	D 358		

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D 358	Continued From page 57 receive any insulin today at lunch. Observation in the dining room on 11/16/16 at 12:42 p.m. revealed: -The RCC asked Resident #10 if he remembered the RCC giving him insulin today before he ate his lunch. -Resident #10 shook his head back and forth and indicated he did not get insulin at lunch. Interview with the RCC on 11/16/16 at 12:43 p.m. revealed: -She did not give insulin to Resident #10 at lunch. -She could not remember who she gave insulin to at lunch she must be thinking of another diabetic resident she had given insulin to. -She could not explain why she documented Resident #10's 12:00 noon dose of Novolog as being administered. -She would contact Resident #10's primary care provider (PCP) about the error since the resident was already eating lunch. Interview with the RCC on 11/16/16 at 12:50 p.m. revealed she recalled giving the insulin to another diabetic resident who also received 4 units of Novolog. Interview with the named diabetic resident on 11/16/16 at 12:55 p.m. revealed he received insulin in the dining room when he ate his lunch today. Interview with the RCC on 11/16/16 at 1:40 p.m. revealed: -She had contacted the PCP for Resident #10 and the PCP sent an order to go ahead and administer the missed dose of Novolog. -She would administer the dose now.	D 358		

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D 358	Continued From page 58 Observation on 11/16/16 at 1:50 p.m. revealed Resident #10 was administered 4 units of Novolog insulin after the meal instead of before the meal as ordered. Review of Resident #10's November 2016 blood sugar log revealed: -The resident's blood sugar was 212 at 4:00 p.m. on 11/16/16. -The resident's blood sugar ranged from 103 - 342 from 11/01/16 - 11/17/16. Interview on 11/16/16 with an Administrator from a sister facility on 11/16/16 revealed: -She was at the facility today to provide support and assistance to the Interim Administrator while the current Administrator was not in the facility. -Medication aides were trained to read the MARs. -Medication aides were supposed to use the blood sugar flow sheets and the MARs when administering insulin. B. Review of Resident #8's current FL-2 dated 07/27/16 revealed the resident's diagnoses included altered mental status, acute renal failure, hypertension, hyperlipidemia, dementia, schizophrenia, gastroesophageal reflux disease, and stage III chronic kidney disease. Review of a physician's order dated 11/08/16 revealed: -The resident was diagnosed with sinusitis. -There was an order for Augmentin 875mg 1 tablet every 12 hours for 7 days. (Augmentin is an antibiotic used to treat infections.) Review of Resident #8's November 2016 medication administration record (MAR) revealed: -There was a handwritten entry for Augmentin 875mg 1 tablet every 12 hours for 7 days.	D 358		

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D 358	Continued From page 59 -Augmentin was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -The first dose was documented as administered on 11/09/16 at 8:00 a.m. and the last dose documented as administered was on 11/15/16 at 8:00 a.m. -The last tablet was scheduled to be administered on 11/15/16 at 8:00 p.m. but it was blank and not documented on 11/16/16 during the 8:00 a.m. medication pass. -The word, "stop", was written in the block for 11/16/16 indicating the last dose should have been administered on 11/15/16. Observation of the 8:00 a.m. medication pass on 11/16/16 revealed: -The medication aide (MA) prepared morning medications for Resident #8. -The MA found a bubble card of Augmentin 875mg with 1 tablet left in the card of 14 tablets dispensed pm 11/08/16 for Resident #8. -The MA looked at the MAR and stated the Augmentin tablet should have been administered at 8:00 p.m. the previous night. -The MA asked if she could administer the last tablet of Augmentin even though it was not the correct time. -The MA was instructed to follow her normal procedures when she had a question about a medication. -The MA stated she would normally ask the Resident Care Coordinator (RCC) but the RCC was on another hall in the facility administering medications. -The MA stated she would go ahead and administer the Augmentin since it was an antibiotic and it needed to be finished. -Augmentin 875mg was administered to Resident #8 at 8:53 a.m. on 11/16/16 instead of 8:00 p.m. on 11/15/16.	D 358		

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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 358	Continued From page 60 -The MA did not document the administration of the Augmentin on 11/16/16 on the MAR. Interview with the RCC on 11/16/16 at 11:40 a.m. revealed: -If a MA had a question about a medication during a medication pass or anytime, the MA was supposed to go to the RCC for assistance. -The RCC would contact the physician if she was unable to answer a question about a medication. -The MA should have come to the RCC about the Augmentin and the RCC would have contacted the physician to find out what to do. -The RCC would write a medication error report and notify the physician about the error with the Augmentin. Interview with Resident #8 on 11/16/16 at 2:30 p.m. revealed: -She was taking an antibiotic for sinusitis. -She was not sure if she had missed any doses of the antibiotic. -She was feeling better since she had started taking the antibiotic. C. Review of Resident #9's current FL-2 dated 10/25/16 revealed: -The resident's diagnoses included encephalopathy, seizures, and urinary tract infection. -There was an order for Calcium 600mg 1 tablets 3 times a day on Mondays and Fridays and 1 tablet twice a day on all other days. (Calcium is a supplement.) -There was an order for Vitamin D2 50,000 units 1 capsule once a week. (Vitamin D is a supplement.) -There was an order for Systane Solution instill 1 drop in each eye 3 times a day. (Systane is a lubricant eye drop.)	D 358		

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D 358	Continued From page 61 Review of Resident #9's November 2016 medication administration record (MAR) revealed: -There was a printed entry for Calcium 600mg take 1 tablet 3 times a day on Mondays and Fridays and it was scheduled to be administered at 8:00 a.m., 2:00 p.m. and 8:00 p.m. -There was a printed entry for Calcium 600mg take 1 tablet twice a day on Tuesday, Wednesday, Thursday, Saturday, and Sunday and it was scheduled to be administered at 8:00 a.m. and 8:00 p.m. -There was an entry for Vitamin D2 50,000 units 1 capsule once a week at 8:00 a.m. and the next dose was due on 11/21/16. -There was an entry for Systane Solution instill 1 drop into each eye 3 times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. Observation of the 8:00 a.m. medication pass on 11/16/16 revealed: -The Resident Care Coordinator (RCC) stated she was working as a medication aide today. -It was not unusual for her to fill in as a medication aide at times. -Resident #9 was administered one Calcium 600mg tablet with Vitamin D 800 units instead of a plain Calcium 600mg tablet as ordered at 9:11 a.m. -The Calcium with Vitamin D tablet was in a manufacturer bottle with the resident's name handwritten on the bottle. -Resident #9 was administered Systane Ultra 1 drop in each eye instead of Systane Solution as ordered at 9:14 a.m. -The Systane Ultra was in a manufacturer bottle / box with the resident's name handwritten on the box. Interview with the RCC on 11/16/16 at 10:26 a.m.	D 358		

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revealed:
-Resident #9's family usually brought his medications the facility from an outside pharmacy.
-When the family brought the medication to the facility, the MA on duty was supposed to compare the medications brought to the MARs and the orders to make sure it matched.
-The RCC did not notice the Calcium with Vitamin D and the Systane Ultra did not match the medications listed on the MAR.
-None of the MA had reported noticing the wrong medications were brought in by the family.
-The RCC did not know when the family had brought in the supply of Calcium with Vitamin D or Systane Ultra eye drops since they were over-the-counter medications and not labeled by a pharmacy.
-She would contact Resident #9's primary care provider (PCP) about the medication errors.

Telephone interview with Resident #9's PCP on 11/17/16 at 5:00 p.m. revealed:
-She did not originally prescribe the Vitamin D for Resident #9 so she was unsure if any Vitamin D levels has been drawn recently.
-She would order a Vitamin D level for Resident #9 to check his current levels.

Vitamin D levels for Resident #9 were requested but none were provided by the end of the survey on 11/17/16.

2. Review of Resident #6's current FL-2 dated 10/15/16 revealed:
-The resident's diagnoses included non-cardiac chest pain, hyponatremia, and acute diastolic heart failure.
-The resident was ambulatory and had sight limitations.

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D 358	Continued From page 63 -There was an order for Clonazepam 0.5mg 1 tablet twice daily. (Clonazepam is used to treat anxiety.) Review of a previous FL-2 dated 04/15/15 for Resident #6 revealed her diagnoses also included schizoaffective disorder, bipolar disorder, and history of psychosis. Review of a hospital discharge summary dated 09/27/16 for Resident #6 revealed: -There was an order for Clonazepam 0.5mg twice a day. -There was an order for Clonazepam 1mg nightly. Review of a hospital discharge summary for Resident #6 dated 10/15/16 revealed there was an order to continue taking Clonazepam 0.5mg twice a day. Review of a list of orders from Resident #6's mental health provider dated 11/11/16 revealed: -There was an order for Clonazepam 0.5mg 1 tablet twice daily. -There was an order for Clonazepam 1mg 1 tablet at bedtime. Review of Resident #6's September 2016 medication administration record (MAR) revealed: -There was a computer printed entry for Clonazepam 0.5mg take 1 tablet twice a day. -Clonazepam 0.5mg was not documented as administered from 09/23/16 at 8:00 a.m. - 09/27/16 at 8:00 p.m. due to the medication being "on order". -There was a handwritten entry for Clonazepam 1mg 1 tablet nightly at 8:00 p.m. and it was documented as administered from 09/28/16 - 09/30/16.	D 358		

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D 358	Continued From page 64 Review of Resident #6's October 2016 MAR revealed: -There was a computer printed entry for Clonazepam 0.5mg take 1 tablet twice a day. -Clonazepam 0.5mg was not administered from 10/14/16 at 8:00 p.m. - 10/16/16 due to the resident being in the hospital. -Clonazepam 0.5mg was not documented as administered on 10/17/16 at 8:00 p.m. and no reason for the omission. -There was a handwritten entry for Clonazepam 1mg 1 tablet nightly at 8:00 p.m. -Clonazepam 1mg was not administered on 10/14/16 - 10/16/16 due to the resident being in the hospital. -Clonazepam 1mg was blank with no reason for the omissions on 10/06/16, 10/11/16, and 10/17/16. -Clonazepam 1mg was not administered from 10/28/16 -10/31/16 due to the medication being "out of stock". Review of Resident #6's November 2016 MAR revealed: -There was a computer printed entry for Clonazepam 0.5mg take 1 tablet twice a day. -Clonazepam 0.5mg was documented as administered at 8:00 a.m. and 8:00 p.m. from 11/01/16 - 11/17/16. -There was a computer printed entry for Clonazepam 1mg take 1 tablet at bedtime. -Clonazepam 1mg was documented as administered at 8:00 p.m. from 11/01/16 - 11/10/16 but marked through with "initialed in error not given". -There was no Clonazepam 1mg documented as administered from 11/01/16 - 11/11/16. -There was a handwritten entry for Clonazepam 1mg at bedtime and it was documented as administered at 9:00 p.m. from 11/12/16 -	D 358		

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D 358	Continued From page 65 11/16/16. Review of a controlled substance (CS) log for Resident #6's Clonazepam 1mg revealed: -The CS log was labeled for 30 tablets of Clonazepam 1mg that were dispensed on 09/27/16. -Staff documented the first tablet was administered on 09/28/16 and the last of the 30 tablets was administered on 10/27/16 at 8:00 p.m. Review of a CS log for Resident #6's Clonazepam 1mg revealed: -The CS log was labeled for 30 tablets of Clonazepam 1mg that were dispensed on 11/11/16. -Staff documented the first tablet was administered on 11/12/16 at 8:00 p.m. and the last tablet administered was on 11/16/16 at 8:00 p.m. with a remainder of 25 tablets. -There was no CS logs documenting any Clonazepam 1mg was administered from 10/28/16 - 11/11/16 (15 days). Review of pharmacy dispensing records from 08/2016 - 11/2016 for Resident #6 revealed: -60 Clonazepam 0.5mg tablets were dispensed on 08/08/16. -30 Clonazepam 0.5mg tablets were dispensed on 08/30/16. -60 Clonazepam 0.5mg tablets were dispensed on 09/29/16. -60 Clonazepam 0.5mg tablets were dispensed on 10/16/16. -60 Clonazepam 0.5mg tablets were dispensed on 11/11/16. Review of pharmacy dispensing records from 09/2016 - 11/2016 for Resident #6 revealed:	D 358		

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D 358	Continued From page 66 -30 Clonazepam 1mg tablets (30 day supply) were dispensed on 09/27/16. -30 Clonazepam 1mg tablets (30 day supply) were dispensed on 11/11/16. Interview with a medication aide on 11/17/16 at 1:15 p.m. revealed: -She could not recall why Resident #6 ran out of Clonazepam 0.5mg in September 2016. -Medications aides were supposed to reorder medications before they ran out when there was about a week's supply left on hand. -The resident ran out of Clonazepam 1mg tablets at the end of October 2016 and first part of November 2016 because the resident could not get a refill until she was seen by the provider. -Some of the resident's appointments had been rescheduled because they did not currently have a transporter at the facility. -When they ran out of Resident #6's Clonazepam, she was also in the process of trying to get some clarification about the 0.5mg and 1mg tablets. -Resident #6 took the Clonazepam to help her rest at night. Interview with Resident #6 on 11/17/16 at 4:10 p.m. revealed: -She was out of her medication for depression last month and she went 13 days without sleep. -She thought the doctor had taken her off of her medication and she did not know why. -She had anxiety when she was not taking her depression medication (could not recall the name of the medication). -She finally got put back on the medication and she was better now and she had been sleeping okay. Telephone interview with a medical assistant from	D 358		

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Resident #6's mental health providers' office on 11/17/16 at 4:30 p.m. revealed:
-Within the last 8 months, Resident #6 did not show up for about 50% of her appointments.
-The facility requested a refill on the resident's Clonazepam on 10/26/16 but the resident needed to be seen by the nurse practitioner (NP) before a refill could be authorized.
-Their records indicated Resident #6 was supposed to be taking the Clonazepam 0.5mg and 1mg tablets.
-She was unsure about the scheduled times for the Clonazepam.
-The NP was unavailable for interview.

Attempts to contact Resident #6's primary care provider during the survey were unsuccessful.

Review of a new FL-2 signed by the PCP and dated 11/16/16 revealed:
-There was an order for Clonazepam 0.5mg 1 tablet twice daily.
-There was an order for Clonazepam 1mg 1 tablet at bedtime.

3. Review of Resident #4's FL-2 dated 09/27/16 revealed:
-The resident's diagnoses included type 2 diabetes mellitus, cerebrovascular accident, and urinary tract infection.
-There was an order for Tramadol 50mg 1 tablet by mouth every 6 hours as needed for pain. (Tramadol is a pain reliever.)

Review of the Resident Register revealed Resident #4 was admitted to the facility on 09/13/16.

Review of progress notes by a medical provider dated 10/04/16 for Resident #4 revealed:

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-Resident #4 stated the Tramadol was ineffective.
-There was an order for Capsaicin cream 0.025% apply to lower back twice a day as needed for pain. (Capsaicin cream is a topical pain reliever.)

Review of Resident #4's October 2016 medication administration record (MAR) on 11/16/16 revealed:
-There was a handwritten entry for Capsaicin cream 0.025% apply to lower back twice a day as needed for pain.
-There was no documentation of any Capsaicin cream being administered to the resident.

Review of Resident #4's November 2016 MAR revealed there was no entry for Capsaicin cream on the MAR.

Observation of Resident #4's medications on 11/16/16 at 1:30 p.m. revealed there was no Capsaicin cream on hand for the resident.

Interview with a medication aide / supervisor on 11/16/16 at 1:30 p.m. revealed:
-The Capsaicin cream was not ordered in October 2016 when it was prescribed on 10/04/16.
-She did not know why the Capsaicin cream order was transcribed on the October 2016 MAR but not the November 2016 MAR.
-She did not know why the cream was not ordered from the pharmacy.
-The cream would be ordered tonight on 11/16/16 for Resident #4.

Review of a Medication Error Report regarding Resident #4 dated 11/17/16 revealed:
-The medication error was for topical Capsaicin cream.
-The reason for making the error noted was the

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D 358	Continued From page 69 resident had never asked for the cream since it was ordered and staff had never checked the cart for it. -The effect error had on resident was no effect due to the resident never asked for it. -The medical provider was notified about the error on 11/17/16. -The medical provider's response was for the faciltiy to continue the order for the Capsaicin cream if the resident still needed it. Observation of Resident #4's medications on hand on 11/17/16 at 9:30 a.m. revealed there was a tube of Capsaicin Cream on the medication cart labeled correctly for the resident. Interview with Resident #4 on 11/17/16 at 10:20 a.m. revealed: -She did not recall her medical provider ordering Capsaicin cream as needed for lower back pain on 10/04/16. -She would have requested the Capsaicin cream for her lower back pain if it she had been aware and if the cream was available in the facility.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every	D912		

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D912	Continued From page 70 resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 5 of 8 residents (#1, #2, #3,#6, #9) sampled as related to a resident with seizures missing a neurology appointment and failure to notify the neurologist and primary care provider of hospital visits due to seizures (#9); a resident with prostate cancer missing an oncology appointment to get intravenous fluids due to kidney function problems and dehydration (#9); a resident with mental health diagnoses missing multiple appointments with mental health providers before and after a physical altercation with another resident (#6); failure to notify the physician of a resident's toe wound resulting in an infected toe ulcer (#1); failure to follow-up with a cardiology referral for a resident with a pacemaker and episodes of dizziness and syncope resulting in falls (#2); and failure to obtain a wheelchair safety harness for a resident with right sided paralysis and weak upper body strength resulting in falls (#3). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]	D912		