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HUNTER HILL ASSISTED LIVING	891 NOELL LANE ROCKY MOUNT, NC 27804

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D 000	Initial Comments The Adult Care Licensure Section and the Nash County Department of Social Services conducted an annual and follow-up survey and complaint investigation on February 14-16, 2017. The complaint investigation was initiated by the Nash County Department of Social Services on January 23, 2017.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observation, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) in accordance to assessed needs with multiple falls, resulting in multiple injuries including closed head injuries, scalp laceration, and low back pain. The findings are: Review of Resident #1's current FL-2 dated 09/09/16 revealed: -Diagnoses included Parkinson's disease, abnormal gait and mobility, muscle weakness, morbidly obese, bipolar disorder, major depression, Type II Diabetes, coronary heart disease, atrial fibrillation, hypertension, sleep apnea, gastroesophageal reflux disease,	D 270		

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diverticulitis, hypolipidemia, and Vitamin D deficiency.
-Resident #1 was semi-ambulatory and required the use of a walker for ambulation.
-There was no documentation about Resident #1's cognitive status.
-Resident #1 was incontinent of bladder and bowel.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted to the facility on 02/18/16.
-Resident #1 had a state appointed limited guardian of person.

Review of Resident #1's Care Plan dated 10/17/16 revealed:
-Resident #1 was forgetful and disoriented at times.
-Resident #1 used a walker for ambulation.
-Resident #1 required one person assist for dressing, grooming and bathing.
-Resident #1 required one person assist to transfer from bed/chair to use of walker.
-Resident #1 was incontinent of bladder/bowel and required staff to help with personal care with her use of incontinence garments.
-The care plan did not address any fall precautions.

Review of Resident #1's Licensed Health Professional Support (LHPS) dated 12/01/16 revealed:
-Resident #1 was independent with ambulation with a rolling walker.
-Resident #1 required staff supervision one person staff assistance for transfers mobility.
-Resident #1 received physical therapy for gait training and balance since Resident #1 had

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frequent falls since the last LHPS review done on 09/16/16 (Number of falls was not specified).

Review of Resident #1's records revealed:
-Resident #1 resided in Room #140 from 09/09/16 until her hospitalization on 02/07/17.
-Resident #1's level of care need was upgraded to skilled nursing care on 01/24/2017.

Observation on the initial tour of the facility on 02/14/16 revealed Room #140 was the last room on the right side of the 100 hall farthest from the nurses' station.

Review of Resident #1's Emergency Department Summary Notes dated 10/30/16 revealed Resident #1 was seen for complaint of back pain and rib contusion related to a fall.

No incident report or progress note were available that coincided with the emergency room visit on 10/30/16 for Resident #1.

Review of Resident #1's Emergency Department Summary Notes dated 11/23/16 revealed Resident #1 was seen for an accidental fall and possible head injury.

Review of a facility progress note for Resident #1 dated 11/23/16 revealed:
-Resident #1 fell in the dining room and hit her head.
-Resident #1 was sent to the emergency room.
-There was no documentation of increased supervision or the implementation of fall precautions.

No incident report was available that coincided with the emergency room visit on 11/23/16 for Resident #1.

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D 270	Continued From page 3 Interview with a Medication Aide on 02/15/17 at 4:00pm revealed: -She was the Medication Aide on the 3-11 shift on 11/23/16. -She did not remember the exact events of Resident #1's fall on 11/23/16. -She had completed an incident report for the fall on 11/23/16 and put it in the Resident Care Coordinator's office. -Staff checked Resident #1 every two hours to assist with her personal care needs. -No fall precautions or increased supervision was implemented for Resident #1 after she fell on 11/23/16. Review of incident reports for Resident #1 revealed: -Resident #1 had a reported total of 16 falls with no apparent injuries between 12/15/16 and 02/04/17. -Resident #1 had a reported total of 8 falls that required emergency room treatment between 01/09/17 to 02/04/17. Review of an incident report for Resident #1 dated 01/09/17 revealed the resident was found on the floor in an unspecified facility location at 1:00 pm, complained of back pain and staff called 911. Review of Resident #1's Emergency Department Summary Notes dated 01/09/17 revealed Resident #1 was seen for acute lower back pain and status post fall. Review of Resident #1's record revealed there was no documentation of increased supervision or the implementation of any fall precautions for Resident #1 as a result of the fall on 01/09/17.	D 270		

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D 270	Continued From page 4 Attempted interview on 02/16/17 at 9:05am with staff with knowledge of Resident #1's fall on 01/09/17 was unsuccessful. Review of Resident #1's Progress Note dated 01/12/17 revealed: - Resident #1 fell on 01/12/17 at 12:00am and staff documented "we kept a 30 minutes check on her for the rest of the night". -There was no documentation of the 30 minute checks completed by staff for Resident #1 on 01/12/17. Interview with a second Medication Aide on 02/16/17 at 9:55am revealed: -Resident #1 needed assistance to get of out bed but Resident #1 kept trying to get out of bed without assistance on 01/12/17. -Resident #1 refused to use her call bell to ask for assistance even after staff had given the call bell to Resident #1 several times. -She initated the 30 minutes checks on Resident #1 on her own on 01/12/17 because she did not know what else to do to try to keep Resident #1 in bed. -She did not document the 30 minutes checks performed on Resident #1 on 01/12/17 since she just initiated the checks on her own. -She did not tell the Resident Care Coordinator (RCC) about the 30 minute checks done on 01/12/17 but she did complete an inicident report for 01/12/17 and she gave it to the RCC. -No other supervison or fall precautions were implemented. Review of an incident report for Resident #1 dated 01/16/17 revealed the resident was found on the floor in her room at 10:10pm and staff called 911 because Resident #1 had a "knot on	D 270		

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the back of her head".

Review of Resident #1's Emergency Department Summary Notes dated 01/16/17 revealed Resident #1 was seen for a fall and a closed head injury.

Review of Resident #1's record revealed there was no documentation of increased supervision or the implementation of fall precautions for Resident #1 as a result of the fall on 01/16/17.

Attempted interview on 02/16/17 at 9:08am with staff with knowledge of Resident #1's fall on 01/16/17 was unsuccessful.

Review of Resident #1's Progress Note dated 01/16/17 revealed:
-The Resident Care Coordinator and Executive Director talked to Resident #1 about her frequent falls; discussed Resident #1 to wear shoes for better footing; getting an order for a wheelchair for Resident #1 but the resident refused; and staff would revisit the order for the wheelchair if Resident #1 kept having falls.
-No other interventions were documented to prevent Resident #1 from falling.
-There was no documentation to increase supervision of Resident #1 as a fall precaution.
-There was no documentation the primary care provider was contacted regarding staff concerns with Resident #1 frequent falls, Resident #1's refusal of wheelchair, or increased supervision for Resident #1.

Review of a Facility 30 minute Checklist revealed the staff checked Resident #1 every 30 minutes from 01/20/17 at 7:00am through 01/30/17 at 6:30am to monitor for falls.

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Review of incident reports for Resident #1 revealed the resident had 3 unwitnessed falls with no apparent injuries on 01/21/17.

Review of an incident report for Resident #1 dated 01/22/17 revealed the resident was found on the floor in her room at 1:50am and staff called 911 because Resident #1 had "a knot and a small cut to her head".

Review of Resident #1's Emergency Department Summary Notes dated 01/22/17 revealed Resident #1 was seen for a fall and a scalp laceration.

Review of Facility 30 Minute Checklist revealed 30 minute checks for Resident #1 were documented as performed by staff on 01/22/17 during the 3rd shift.

Attempted interview on 02/16/17 at 9:05am with staff with knowledge of Resident #1's fall on 01/22/17 at 1:50am was unsuccessful.

Review of an incident report for Resident #1 dated 01/22/17 at 7:15pm revealed the resident was found sitting on the floor in her room and staff sent Resident #1 to the emergency room.

Review of Resident #1's Emergency Department Summary Notes dated 01/22/17 revealed Resident #1 was seen for a second time in the emergency room for a fall.

Review of Facility 30 Minute Checklist revealed 30 minute checks for Resident #1 were documented as performed by staff on 01/22/17 during the 2nd shift.

Attempted interview on 02/16/17 at 9:06am with

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staff with knowledge of Resident #1's fall on 01/22/17 at 7:15pm was unsuccessful.

Review of incident reports for Resident #1 revealed the resident had 5 unwitnessed falls with no apparent injuries between 01/23/17 through 01/31/17.

Review of Facility 30 Minute Checklist revealed no 30 minute checks were documented as performed by staff for Resident #1 after 01/30/17 at 6:30am.

Review of an incident report for Resident #1 dated 02/01/17 at 10:20pm revealed the resident was found sitting on the floor in her room and staff sent Resident #1 to the emergency room because Resident #1 had "a knot on the back side of her head".

Review of Resident #1's Emergency Department Summary Notes dated 02/01/17 revealed:
-Resident #1 was seen for a fall and a urinary tract infection.
-Facility needed to initiate fall precautions for Resident #1.

Attempted interview on 02/16/17 at 9:05am with staff with knowledge of Resident #1's fall on 02/01/17 was unsuccessful.

Review of an incident report for Resident #1 dated 02/03/17 at 2:30pm revealed the resident was found sitting on the floor in an unspecified location in the facility in with no apparent injuries and staff sent Resident #1 to the emergency room.

Review of Resident #1's Emergency Department Summary Notes dated 02/03/17 revealed:

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-Resident #1 was seen for complaint of back pain after a fall.
-Resident #1 reported she fell when she was walking to the bathroom.
-Resident #1 was diagnosed with lumbar strain, traumatic back pain, and a urinary tract infection.

Review of Resident #1's Progress Note date 02/03/17 revealed:
-Staff was assisting Resident #1 from the bed to the wheelchair and Resident #1 slipped and fell.
-Staff tried to guide Resident #1 to the floor but Resident #1 fell and hit her chin on a table.

Review of Resident #1's record revealed there was no documentation of increased supervision or the implementation of fall precautions for Resident #1 as a result of the fall on 02/03/17.

Attempted interview on 02/16/17 at 9:06am with staff with knowledge of Resident #1's fall on 02/03/17 was unsuccessful.

Review of an incident report for Resident #1 dated 02/04/17 at 2:45am revealed the resident was found sitting on the floor in her room and staff sent Resident #1 to the emergency room because of complaint of head pain.

Review of Resident #1's Emergency Department Summary Notes dated 02/04/17 revealed:
-Resident #1 was seen because she hit her head during a fall and complaint of back pain.
-Emergency room physician offered to admit Resident #1 but Resident #1 refused because she did not want to be in the hospital.
-Resident #1 reported she fell when she tried getting out of bed and she had frequent falls because of her Parkinson's disease.

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Review of Resident #1's record revealed there was no documentation of increased supervision or the implementation of fall precautions for Resident #1 as a result of the fall on 02/04/17.

Interview with a second Medication Aide on 02/16/17 at 9:55am revealed:
-She was working when Resident #1 was found on the floor in her room on the morning of 02/04/17 at 2:45am.
-Resident #1 reported she was trying to get out of bed but Resident #1 did not specify why the resident was trying to get out of bed.
-She initiated one-on-one supervision on her own for Resident #1 on 02/04/17 during 3rd shift.
-She was not sure if any other shifts did one-on-one supervision for Resident #1.

Review of a second incident report for Resident #1 dated 02/04/17 at 1:50pm revealed the resident was found sitting on the floor in her room with no apparent injuries and staff sent Resident #1 to the emergency room.

Review of Resident #1's Emergency Department Summary Notes for a second emergency visit dated 02/04/17 at 2:36pm revealed Resident #1 had fallen, had multiple skin bruises, and hit her head during the second fall on 02/04/17.

Review of Resident #1's record revealed there was no documentation of increased supervision or the implementation of fall precautions for Resident #1 as a result of the second fall on 02/04/17.

Attempted interview on 02/16/17 at 9:08am with staff with knowledge of Resident #1's fall on 02/04/17 at 1:50pm was unsuccessful.

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D 270	Continued From page 10 Review of Resident #1's records revealed: -Resident #1 was hospitalized on 02/07/17 for altered mental status, urosepsis, urinary tract infection, and acute kidney injury. -Resident #1 was discharged from the hospital to a skilled nursing facility on 02/10/17. Telephone interview with the Physician Assistant (PA) with the primary care provider for Resident #1 on 02/15/17 at 10:19am revealed: -He worked with the primary care provider for Resident #1 and he had seen Resident #1 several times since she was admitted to the facility. -Resident #1 had several falls since January 2017 but he wasn't sure of the actual number of falls. -He was concerned with number of falls Resident #1 had experienced. -There had been a deterioration in Resident #1's ambulatory status in the last 2 to 3 months. -The resident had been using a walker for ambulation but Resident #1 started using a wheelchair in mid-January 2017 and she had received physical therapy. -Resident #1 was incontinent of bowel and bladder and required assistance from staff for her personal care. -The staff reported Resident #1 refused to use her call bell to ask for assistance and Resident #1 would fall when she tried to get up out the bed or go to the bathroom without help. -He thought "Resident #1 was attention seeking and that is why Resident #1 had so many falls". -Increased supervision by the facility staff could have been helpful to prevent some of Resident #1's falls. -He was not aware that Resident #1's room was located far from the nurse's station. -It would have been benefited Resident #1 if she	D 270		

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had a room assignment closer to the nurse's station for more frequent monitoring by the staff.
-He could not recall if he had given any interventions to the facility staff for fall prevention or fall precautions for Resident #1.
-The Resident Care Coordinator (RCC) had contacted their office around the end of January and discussed upgrading Resident #1's level of care.
-Based on the discussion with the RCC and Resident #1's history of frequent falls, Resident #1's level of care was upgraded to skilled nursing around the end of January.

Interview with the Administrator on 02/15/17 at 10:35am revealed:
-All residents were checked on every 2 hours.
-The facility implemented 30 minute checks on residents with histories of frequent falls.
-She was aware of Resident #1's frequent falls because Resident #1 would not use her call bell to ask for help.
-Resident #1's level of care had been upgraded because her frequent falls and Resident #1 had been transferred to skilled nursing facility on 02/10/17.

Telephone interview on 02/15/17 at 10:50am with Resident #1's Limited Guardian of Person revealed:
-She did not get to visit Resident #1 at the facility often because of the distance she lived away from the facility.
-She was aware Resident #1 had frequent falls.
-She was concerned with the supervision of Resident #1 by the staff at the facility and Resident #1's frequent falls.
-She was not sure how often the facility checked on Resident #1 or provided assistance to the resident.

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D 270	Continued From page 12 -Resident #1 needed help from the staff for personal care, toileting, dressing, and dressing. -Staff had reported Resident #1 refused to use her call bell to ask for help and Resident #1 would fall when she tried to things by herself. -She believed 30 minute checks had been implemented for Resident #1 sometime toward the end of January but she wasn't certain. -Resident #1 was forgetful sometimes and would forget to use the call bell to ask for assistance. -Resident #1 was "sometimes stubborn and refused to use the call bell because she wanted to do things for herself". -She had concerns with Resident #1's safety and having frequent falls but there was only so much the facility staff could do because the staff tried to respect Resident #1's wishes to do things independently for herself. -She was concerned that Resident #1's room assignment remained at the end of the hallway away from the nurse's station with Resident #1's frequent falls. -Resident #1 refused to move to a room closer to the nurse's station. -She thought Resident #1's level of care should have been upgraded sooner. -There was problem with the facility being able to provide the care Resident #1 wanted and keeping Resident #1 safe. -She was not sure of what other interventions the facility could implemented to prevent the number of falls Resident #1 experienced. Interview with a Medication Aide on 02/15/17 at 4:00pm revealed: -She had provided care to Resident #1 since the resident had been admitted to the facility. -Resident #1 was able to use a walker but she needed someone to help her with transferring, dressing, bathing, and toileting.	D 270		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 -Resident #1 had a lot of falls between the end of January 2017 and February 2017 but she was not sure how many. -Resident #1 fell a lot because Resident #1 did not ask for help and tried to do things on her own. -She did not think to check on Resident #1 more often because she knew Resident #1 was trying to be independent. -Incident reports were completed for all falls and given to the RCC. -She had some concerns that Resident #1 had fallen so much and the number of times Resident #1 had been sent to the emergency room because of her falls. -There was not much more the staff could do to prevent Resident #1 from falling because Resident #1 refused to use her call bell to ask for assistance when she needed. -The staff was not instructed to start 30 minute checks for Resident #1 until almost the end of January by the RCC. -The RCC had instructed the staff around the end of January 2017 to conduct 30 minute checks for Resident #1 on all shifts and one-on-one care was given to Resident #1 during the 3rd shift for fall precautions. -Resident #1 fell just about every day from 02/01/17 through 02/07/17. -Prior to the implementation of 30 minute checks, staff checked Resident #1 every 2 hours just like all of the other residents in the facility. -During that time, the staff instructed Resident #1 to use her call bell to ask for help and to use her wheelchair instead of her walker. -The facility did have a fall policy but she was not sure what other interventions were supposed to be put in place for residents with history of frequent falls. Interview with a second Medication Aide on	D 270		

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D 270	Continued From page 14 02/16/17 at 9:55am revealed: -She had worked for the facility for 3 years primarily on 3rd shift. -Resident #1 was usually in bed asleep during her shift. -Resident #1 had a lot of falls in last 2-3 months and she wasn't sure how many falls. -Staff would hear Resident #1 hollering and find Resident #1 on the floor. -Resident #1 reported she had fallen because she was trying to reach an item in room or Resident #1 tried to get up to go the bathroom. -Resident #1 wanted to get up to the bathroom even though she wore incontinence briefs and she did not like to ask for help. -Resident #1 would not use the call bell to ask staff for help. -From September 2016 to February 2017, Resident #1 had 4 or 5 falls during 3rd shift and was sent to the emergency room twice because the resident hit her head trying to get out of bed. -Staff normally checked Resident #1 for any personal care needs every 2 hours just like all the residents in the facility. -When Resident #1 started having a lot of falls around late January 2017, the RCC told the staff to start doing 30 minutes checks on Resident #1. -She was not sure what the facility's fall policy was on supervision of residents with frequent falls. -She did have concerns that 30 minute checks were not implemented sooner for Resident #1 and that Resident #1's room was so far down the hall away from the nurse's station. -She had not voiced her concerns to anyone. -It was difficult trying to watch Resident #1 more frequently since her room was so far down the hall. -She had asked the RCC why Resident #1 had not been moved closer to the nurse's station and	D 270		

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D 270	Continued From page 15 the RCC said Resident #1 did not want to move from the room. Telephone interview with a nurse for the Primary Care Provider (PCP) for Resident #1 on 02/16/17 at 10:00am revealed: -She worked with the PCP for Resident #1 and she was familiar with Resident #1's history. -Resident #1 required someone to assist her with toileting, ambulation, bathing, dressing, grooming, and transferring because the tremors Parkinson's disease. -Resident #1 had a walker but had a recent order for a wheelchair. -Their office was not aware Resident #1 had more than 20 falls from December 2016 to February 2017. -The Resident Care Coordinator (RCC) did come to their office around the end of January 2017 and requested to upgrade the level of care for Resident #1 for placement in a skilled nursing facility due to Resident #1's frequent fall history. -She thought the facility provided adequate care but "Resident #1 was resistance to care and may have been more than the facility could handle". -She called back to the facility because she was concerned about Resident #1 and to check if Resident #1 had a walker. -Unspecified staff told her Resident #1 fell a lot because the resident would not call for help with the Resident #1's personal care needs. -The primary care provider then wrote a wheelchair order for Resident #1 as a fall intervention for Resident #1 on 01/26/17. -The staff at the facility had not asked for Resident #1 to have a wheelchair or requested any interventions from the primary care provider to address Resident #1's frequent falls prior to when the RCC came to their office.	D 270		

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D 270	Continued From page 16 Telephone interview on 02/16/17 at 11:00am with the Resident Care Coordinator (RCC) revealed: -She was concerned with the number of falls Resident #1 had in the last 2 to 3 months. -Resident #1 needed staff to help her with toileting, ambulation, bathing, dressing, grooming, and transferring because Resident #1 was too unsteady to do perform these tasks independently. -Resident #1 often refused to use the call bell to call for help and that is why Resident #1 had so many falls. -The care plan for Resident #1 had not been updated to address Resident #1's frequent falls and her refusal to use her call bell. -All falls for Resident #1 were documented on facility Incident Reports. -The guardian and the primary care provider were notified of all Resident #1's falls. -She had talked with Resident #1 to encourage her to ask the staff for help so Resident #1 would not fall. -She and staff made sure the call bell was accessible to Resident #1 but the resident still refused to use the call bell. -She did not specify when but she had tried to move Resident #1 to a room closer to the nurse's station but Resident #1 refused to move to another room. -Staff had not performed any fall precautions or increased supervision of Resident #1's personal care needs prior to 01/20/17 when the RCC instructed the staff to start 30 minute checks for Resident #1. -It was hard for staff to monitor Resident #1 for safety because Resident #1 refused to use her call bell and her room was located so far from the nurse's station. -She contacted Resident #1's physician sometime after 01/20/17 because Resident #1	D 270		

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D 270	Continued From page 17 was still having falls and she believed Resident #1 required a higher level of care than the facility could provide. -Resident #1's primary care provider wrote an order for a wheelchair for Resident #1 after the RCC contacted their office to upgrade Resident's level of care. -The facility did not get a bed alarm or chair alarm for Resident #1 so staff would be alerted if Resident #1 got up without assistance. -She had not thought of suggesting floor mats to prevent injuries if Resident #1 fell if she tried to get out of bed. -She had not really considered any other interventions because she did not think of them at the time and she did not think anything else would work since Resident #1 would not even use her call bell to ask for assistance. The facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) with frequent falls. Resident #1 experienced 25 falls from 12/18/16 to 02/04/17. Documented falls that resulted in closed head injuries, scalp laceration, low back pain, and bruises. The failure to supervise the resident or to implement any other interventions by the facility placed the resident at substanital risk for harm. The facility's neglect to provide supervision the constitutes a Type A2 Violation. Review of the facility's Plan of Protection dated 2/16/17 revealed: -When a resident has a repeat fall or other situation and the physician has been notified three times without a response, an appointment will be made with the physician. -The Resident Care Coordinator will accompany the resident to the appointment. -The facility will get order for physical therapy, to	D 270		

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D 270	Continued From page 18 perform 30 minute checks, wheelchair orders, and evaluate for bed height. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 18, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to follow-up with the physician for falls that required emergency room visits for 1 of 5 residents sampled (#1). The findings are: Review of Resident #1's current FL-2 dated 09/09/16 revealed: -Diagnoses included Parkinson's disease, abnormal gait and mobility, muscle weakness, morbidly obese, bipolar disorder, major depression, Type II Diabetes, coronary heart disease, atrial fibrillation, hypertension, sleep apnea, gastroesophageal reflux disease, diverticulitis, hypolipidemia, and Vitamin D deficiency. -Resident #1 was semi-ambulatory and required the use of a walker for ambulation. -There was no documentation about Resident	D 273		

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D 273	Continued From page 19 #1's cognitive status. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 02/18/16 and had a state appointed limited guardian of person. Review of Resident #1's Care Plan dated 10/17/16 revealed the resident used a walker for ambulation and required extensive assistance for toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #1's Licensed Health Professional Support dated 12/01/16 revealed: -Resident #1 required physical assistance with ambulation with an assistive device. -Resident #1 required staff supervision with both mobility and one person staff assistance for transfers. Review of facility incident reports revealed Resident #1 had 25 documented falls from 10/30/16 through 02/04/17. Review of Emergency Department Summary Notes for Resident #1 from 10/30/16 through 02/04/17 revealed: -Resident #1 was seen in the emergency room 11 times as a result of falls with variable diagnoses of back pain, closed head injuries, scalp laceration, and lumbosacral strain. -Discharge instructions were given with each emergency room visit for Resident #1 to follow-up with her primary care provider within 1 to 2 days of discharge and implement fall precautions for all visit from 10/30/16 through the first emergency room visit on 02/04/17. -Discharge instructions were given on the second emergency visit on 02/04/17 for Resident #1 to	D 273		

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follow-up with her primary care provider within 2 to 4 days of discharge and implement fall precautions.

Review of Resident #1's records revealed:
-There was no documentation of any follow-ups with the primary care provider after any of the emergency room visits for Resident #1.
-There was an incident report dated 01/14/17 that was initialized by the physician with a faxed confirmation sheet.

Telephone interview with the Physician Assistant (PA) with the primary care provider for Resident #1 on 02/15/17 at 10:19am revealed:
-He had provided care for Resident #1 several times since she was admitted to the facility.
-Resident #1 had several falls since January 2017 but he wasn't sure of the actual number of falls.
-He remembered seeing 1 or 2 incident reports for Resident #1 from January 2017 that had been faxed from the facility.
-Around the end of January 2017, after discussion with the Resident Care Coordinator (RCC), the primary care provider upgraded Resident #1's level of care to skilled nursing due frequent falls.
-If their office had known Resident #1 had so many repeated falls, he would have ordered strict fall precautions for Resident #1 or suggested upgrading Resident #1's level of care to skilled nursing sooner.
-He could not remember any calls from the staff at the facility staff regarding Resident #1's frequent falls.

Interview with the Administrator on 02/15/17 at 10:35am revealed:
-The RCC was responsible to notify the primary

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care provider of resident falls.
-All resident falls were documented on the facility incident reports.
-All incident reports were faxed to the primary care provider by the RCC.
-The RCC had contacted the primary care provider about the frequent falls for Resident #1 but she was not sure when.

Telephone interview on 02/15/17 at 10:50am with Resident #1's Limited Guardian of Person revealed:
-She was aware Resident #1 had frequent falls since January 2017.
-The facility usually called her when Resident #1 had a fall.
-She was not sure if facility called the primary care provider each time Resident #1 had a fall.
-She knew the primary care provider was aware of Resident #1's frequent falls by the end of January 2017 because Resident #1's level of care had been upgraded so Resident #1 could be transferred to a skilled nursing facility.
-She was not sure why the level of care had not been upgraded sooner for Resident #1.
-She stated, "the facility could have been more diligent in sharing concerns about Resident #1's falls with the primary care provider prior to upgrading Resident #1's level of care".

Interview with a Medication Aide on 02/15/17 at 4:00pm revealed:
-Incident reports were completed for all residents' falls.
-All incident reports are given to the RCC.
-The RCC was responsible to notify the primary care provider when a resident fell or had any status changes.
-The medication aides usually did not call the primary care provider.

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-Resident #1 went to the emergency room a lot for falls in January and February 2017.
-She did not know what discharge instructions were given for Resident #1 when she went to the emergency room.
-The RCC was responsible to review discharge orders when the residents went to the emergency room.
-She did not know if Resident #1 had followed up with the primary care provider after her emergency room visits.

Interview with a second Medication Aide on 02/16/17 at 9:55am revealed:
-Resident #1 did go to the emergency room several times in last couple of weeks for falls.
-She was not aware of what the discharge instructions were for Resident #1 from the emergency room.
-All hospital discharge paperwork was given to the RCC to review.
-The medication aides did not normally call the primary care provider for a resident unless it was an emergency.
-All falls were documented on facility incident reports and given to the RCC.
-She sometimes faxed incident reports to the primary care provider when she completed them.
-The facility had confirmation sheets for all incident reports faxed to Resident #1's primary care provider.
-The RCC was responsible to notify the primary care provider of all resident status changes.

Telephone interview with the nurse for the Primary Care Provider (PCP) for Resident #1 on 02/16/17 at 10:00am revealed:
-Their office was not aware of the number of falls for Resident #1 until the RCC contacted them around the end of January 2017 to upgrade

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Resident #1 level of care.
-She found faxed copies of incident reports for Resident #1 dated 07/22/16, 08/03/16, 01/11/17, and 01/16/17.
-She could not find any records that the facility had called regarding Resident #1's frequent falls, incident reports, or follow-up for emergency room visits.
-The facility may have contacted the person on call but she could not find a record of that.
-If the primary care provider had been notified of the facility's concens with Resident #1's frequent falls for Resident #1, the primary care provider would have upgraded Resident #1 level of care sooner than 01/24/17.
-She was not aware of any follow-up appointments made for Resident #1 after her emergency room visits.
-The primary care provider normally went out to the facility to the see Resident #1 but she could not recall any request from the facility for post emergency room visit follow-ups.

Telephone interview on 02/16/17 at 11:00am with the Resident Care Coordinator (RCC) revealed:
-All falls for Resident #1 were documented on facility Incident Reports.
-She faxed all of the incident reports to Resident #1's primary care provider to notify of all Resident #1's falls.
-She thought when she faxed the incident reports to the primary care provider that was sufficient notification.
-Faxing the incident reports to the primary care providers was the way the facility notified the primary care providers when a resident had a fall.
-She did not call the primary care provider to verify their receipt of the incident reports.
-She did not recall receiving any phone calls from the primary care provider to follow-up on the

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D 273	Continued From page 24 faxed incident reports for Resident #1. -She was not aware of the discharge instructions from the emergency room visits for Resident #1 for the resident to follow-up with the primary care provider in 1 to 2 days. -It was her responsibility to make all follow-up appointments and referrals for the residents. -She did not make any follow-up appointment for Resident #1 after her emergency room visits because the primary care provider came out to the facility to see residents about every 2 to 4 weeks. -She could not remember if she discussed her concerns with Resident #1's falls with the primary care provider when he came out to the facility. -She went to Resident #1's primary care provider around that time 01/20/17 because Resident #1 was still having falls and she believed Resident #1 required a higher level of care than the facility could provide. -She had not contacted Resident #1's primary care provider before because she thought the primary care provider knew about Resident #1's falls from the faxed incident reports to the primary care provider's office. Interview with the Owner of the Facility on 02/16/17 at 12:20pm revealed the Resident Care Coordinator was responsible to make the follow-up appointments for all residents. Based on interviews and record reviews, the facility failed to follow-up with the physician for 1 of 5 residents sampled (#1) who had frequent falls and emergency rooms visits. The failure of the facility to follow-up with the primary care provider for Resident #1 after emergency room visits for falls with injuries resulted in substanital risk for additional physical harm which constitures a Type A2 Violation.	D 273		

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D 273	Continued From page 25 Review of the Plan of Protection dated 02/16/17 revealed: -After a medical doctor visit, hospital visit or the like, the RCC and/a backup Supervisor will call the provider's office to ensure appropriate follow up. -The Administrator will review this information with each incident to ensure that this is being done. -If the facility determines that the facility can no longer care for the resident then the discharge process will be initiated per protocol. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 18, 2017.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walk-in cooler, walk-in freezer, ice dispenser, and floors in the kitchen and dining areas were cleaned, in good repair, and free of contamination. The findings are: Observation of the walk-in cooler on 2/14/17 at 12:05 p.m. revealed:	D 282		

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D 282	Continued From page 26 -The door of the walk-in cooler had dark brown stains on the rubber seal of the door from the top of the door and down the side of the door. -The entire floor of the walk-in cooler was rotten, springy, and unstable with several dark brown and black rust stained areas. Observation of the walk-in freezer on 02/14/17 at 12:10 p.m. revealed: -Five of sixteen metal shelves had dark brown rust stains. -Two fan covers located in the walk-in freezer were dirty with dark brown areas and had dark brown and black tarlike stains. -Several black, sticky particles were on the ceiling near the two fans. -Several areas on the shelves had dried food particles. -The floor of the walk-in freezer had several dark brown, black and grey stained areas with dried food on all four corners. Observation of the ice dispenser located in the dining room area on 2/14/17 at 12:15 p.m. revealed the base of the ice dispenser was dirty with a white, sticky substance. Review of the Sanitation Report for the kitchen/dining room areas dated 12/19/16 revealed: -The ice dispenser located in the dining room area was cited as "out of compliance." -The ice dispenser was dirty and needed to be cleaned. -The inside of the cabinet below the ice dispenser was in "poor repair and not easily cleanable." Interview with the Dietary Manager on 2/14/17 at 12:20 p.m. revealed: -The kitchen and dining room areas were cleaned	D 282		

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daily as needed by kitchen staff.
-The racks of the walk-in freezer and walk-in cooler areas were cleaned once monthly by the kitchen staff.
-The racks in the walk-in cooler and walk-in freezer rust over after cleaning and the rust could not be prevented.
-Maintenance cleaned the fans and fan covers in the walk-in cooler and walk-in freezer but she was unsure as to how often he cleaned these.
-She monitored the cleaning of the kitchen and dining room areas on a daily basis.
-Maintenance had repaired the floor in the walk-in cooler by placing a large piece of metal on the floor and a black tarlike substance over it.
-She said the floor in the walk-in cooler was still "unstable" but better than it was.
-She was unaware if maintenance was going to repair or replace the floor in the walk-in freezer.

Interview with the Maintenance Worker on 2/14/17 at 12:05 p.m. revealed:
-He tried to repair the floor in the walk-in cooler by placing a large metal sheet over the rotting part of the floor and covered it in black sealant.
-The floor in the walk-in cooler was still "springy but not as bad as it was before he repaired it."
-He was not aware if the floor in the walk-in cooler was going to be repaired or replaced later.
-He was not aware of the condition of the floors in the walk-in freezer.
-He was responsible for cleaning the fans, fan covers, and ceilings of the walk-in freezer.
-He was not sure of the last time he had cleaned the fans or fan covers or ceilings in the walk-in freezer.
-He was unaware of the cabinet beneath the ice dispenser was in need of repair.
-The facility had not contacted him regarding cleaning needed of the fans in the walk-in freezer

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D 282	Continued From page 28 or the condition of the floors in the walk-in cooler and walk-in freezer areas. Interview with the Administrator on 2/15/17 at 12:00 p.m. revealed: -The dietary manager was responsible for ensuring the dining and kitchen areas were cleaned and were in working order. -She expected to be informed of any issues by the kitchen staff and/or dietary manager. -Cleaning of the dining and kitchen areas should occur every day as needed. -The shelves in the walk-in freezer were cleaned every six months or when needed. -The floor in the walk-in cooler had been an "ongoing issue" but had been repaired by maintenance. -She was not aware of any problems with the cleanliness or any needed repairs for the kitchen, dining room, walk-in cooler, and walk-in freezer areas.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a total of three snacks were served per day to all residents.	D 298		

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D 298	Continued From page 29 The findings are: Review of the facility's menus on 2/14/17 at 12:05 p.m. revealed snacks were not documented as offered three times daily for any resident. Further review of the menus revealed no therapeutic snack menus for residents who were prescribed a therapeutic diet were documented. Observations in the facility from 10:30 a.m. through 11:55 a.m. on 2/14/17 revealed no snacks were offered to the residents. Interview with Dietary Aide on 2/14/17 at 11:35 a.m. revealed: -She said snacks were offered and served three times a day but in the "dining room only." -The residents who came to the dining room that morning received a snack. -Snack times were between meals "around 10:00 a.m., 3:00 p.m. and 8:00 p.m." -She did not follow a menu when preparing snacks for the residents. -She knew the residents and went by memory to prepare all of their snacks. Observations in the facility from 2:45 p.m. through 4:50 p.m. on 2/14/17 revealed no snacks were offered to the residents. Confidential Interviews with fourteen residents on 2/14/17 through 2/16/17 revealed: -They were only offered a snack twice a day but in the dining room area. -The residents had not been served or offered snacks after breakfast or lunch on 2/14/17. -The residents were not offered snacks after breakfast on 2/15/17. -"If you did not go to the dining room, you would not get a snack at all.	D 298		

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D 298	Continued From page 30 -They wanted a snack when they were not feeling well but were told "they had to come to the dining room or they would not get one." -The residents said they had asked for a snack to be taken to their room or to a peer's room when they were not feeling well but they were told by facility staff they could not because all snacks had to be served and eaten in the dining room. -They asked could facility staff bring a snack to their rooms if they were asleep so they would not miss their snack and were told "no" because this was against the "rules." -The residents were told they could not eat their snacks in their bedrooms because of the "trash and bugs" caused by eating in their rooms. -The residents did not receive Diabetic or Pureed snacks. Interview with the Dietary Manager on 2/14/17 at 12:12 p.m. revealed: -The Cooks, including herself, prepared snacks by referring to the facility diet list as needed for the type of diet each resident received. -Snacks were offered three times each day "after breakfast around 10:00 a.m., after lunch around 3:00 p.m., and after supper around 8:00 p.m." -Each resident was offered a "healthy" snack once they arrived in the dining room at the snack times. -Snacks were served in the dining room area to all residents who came down to the dining room. -No snacks were taken to the residents rooms because of "the trash and potential for bugs." -If a resident was sick, snacks were not taken to the residents' rooms unless a doctor's order was written. -If a resident was asleep and missed snack time, the kitchen staff were not allowed to take their snacks to their rooms.	D 298		

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D 298	Continued From page 31 Observations in the facility from 10:05 a.m. through 11:45 a.m. on 2/15/17 revealed no snacks were offered to the residents. Interview with the Administrator on 2/16/17 at 10:48 a.m. revealed: -She was not aware that the menus did not include three snacks per day for the residents. -She was unaware there had to be a matching therapeutic snack menu for all residents on therapeutic diets. -Residents could request to eat their snacks in their bedrooms if they were not feeling well. -There was not a written facility policy stating residents had to go to the dining room in order to receive their snacks.	D 298		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure therapeutic diets, including supplements, were served as ordered by the residents' physican for 3 of 6 sampled residents (#2, #3, and #7). The findings are: 1. Review of Resident #2's current FL-2 dated 09/30/16 revealed:	D 310		

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-A diagnosis of hypertension, anemia, atherosclerotic heart disease, sciatica, familial hypophosphatemia, kidney failure, thrombocytopenia, and spinal stenosis.
-A regular diet was noted.

Review of Resident #2's Diet Order dated 9/30/16 revealed:
-The physician had signed and dated the diet order on 9/30/16.
-The resident received a "Regular" diet with sugar free house supplements listed.

Review of the facility diet listing of Resident #2 on 2/14/17 revealed:
-The facility list was dated for 2/14/17.
-The resident received a "No Added Salt" diet.
-No regular or sugar-free supplements were listed.

Interview with the Cook on 2/14/17 at 12:15 p.m. revealed:
-She followed the facility diet list when preparing meals for all residents.
-Resident #2 received a Regular diet with no supplements.
-She thought it was okay for Resident #2 to add salt to his food but she did not add salt or sugar to any residents' food.

Observation of dinner meal on 2/14/17 at 5:30 p.m. revealed Resident #2 was not offered supplements prior to, during, or after his supper meal.

Interview with a Personal Care Aide (PCA) on 2/14/17 at 5:45 p.m. revealed Resident #2 received a regular diet and no supplements.

Interview with Resident #2 on 2/14/17 at 5:56

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p.m. revealed he was not offered supplements between or with meals.

Interview with the Dietary Manager on 2/14/17 at 12:25 p.m. revealed:
-All dietary staff, including herself, followed the facility diet list when preparing meals for the residents.
-She did not know she was supposed to follow the Dietician approved menu with specified diets and portion sizes.
-No resident received a physician ordered therapeutic diet to the best of her knowledge.
-The Medication Aides (MA's) or the Administrator kept the facility diet list updated as needed.
-She said Resident #2 received a Regular diet and then looked at the facility diet list and added the resident actually received a No Added Salt diet.
-She said Resident #2 did not receive supplements.
-She said salt and sugar were not added by the Cooks to the residents' food.
-She was aware Resident #2 carried his own condiments and would add salt to his food.

Observation of lunch meal on 2/15/17 at 12:10 p.m. revealed Resident #2 was not offered supplements prior to, during, or after his lunch meal.

Telephone Interview with the nurse of the physician for Resident #2 on 2/15/17 at 11:13 a.m. revealed Resident #2 should receive a No added Salt diet with sugar free supplements as ordered by the physician.

Interview with the Administrator on 2/15/17 at 10:48 a.m. revealed:
-She was aware Resident #2's diet needed to be

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clarified and was working on do so with the doctor's office.
-She said Resident #2 "probably needed a No Added Salt diet because of his diagnosis but was not sure how he ended up receiving a Regular diet."
-She would clarify Resident #2 having supplements or not with the doctor as well because he ate well at mealtimes.
-She would follow-up with the Dietary Manager regarding updating the facility diet list with therapeutic diets and supplements for all residents as prescribed and deemed appropriate.
-She would follow-up with the Dietary Manager and Cooks regarding following the dietician approved menu with specified diets and portion sizes for guidance during meal preparation for all residents.

2. Review of Resident #3's current FL-2 dated 7/12/16 on 2/14/17 revealed:
-A diagnosis of hypertension, general muscle weakness, gastroesophageal reflux disease, hyperlipidemia, and coronary heart disease.
-No diet order was specified.

Review of Resident #3's Diet Order dated 7/12/16 on 2/14/17 revealed:
-It was signed and dated by the physician on 7/12/16.
-The resident was ordered a "No Added Salt / Chopped" diet with sugar free house supplements.

Review of the facility diet listing dated 2/14/17 on 2/14/17 revealed:
-Resident #3 received a "No Added Salt" diet.
-A Chopped diet was not listed.
-No regular or sugar-free supplements were listed.

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D 310	Continued From page 35 Interview with the Cook on 2/14/17 at 12:15 p.m. revealed: -She followed the facility diet list when preparing meals for all residents. -Resident #3 received a Regular diet with no supplements. -She did not have any residents who received a Chopped diet. Observation of dinner meal on 2/14/17 at 5:30 p.m. revealed: -All residents received fried fish patties, succotash, sliced carrots, fruit, a roll, 8 ounces of tea and water. -Resident #3 was not offered supplements prior to, during, or after his supper meal. -Resident #3's meal was prepared and served as a Regular diet. -Resident #3 should have received a physican ordered diet dated 7/12/16 as a No Added Salt /Chopped diet with sugar free house supplements. Interview with a Personal Care Aide (PCA) on 2/14/17 at 5:45 p.m. revealed: -She was not aware Resident #3 received a Chopped diet with No Added Salt. -She said Resident #3 received a regular diet and no supplements. Interview with the Dietary Manager on 2/14/17 at 12:25 p.m. revealed: -All dietary staff, including herself, followed the facility diet list when preparing meals for the residents. -She did not know she was supposed to follow the Dietician approved menu with specified diets and portion sizes. -No resident received a physician ordered	D 310		

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therapeutic diet to the best of her knowledge.
-The Medication Aides (MA's) or the Administrator kept the facility diet list updated as needed.
-Resident #3 received a Regular diet but then added, after looking at the facility diet list, the resident actually received a No Added Salt diet.
-Resident #3 did not receive a Chopped diet or supplements.

Observation of lunch meal on 2/15/17 at 12:10 p.m. revealed:
-All residents received pork chop, greens, baked sweet potato, corn bread, chocolate dessert, 8 ounces tea, and water.
-Resident #3 was not offered supplements prior to, during, or after his lunch meal.
-No salt was placed on the residents' tables.
-Resident #3 should have received a physican ordered diet dated 7/12/16 as a No Added Salt /Chopped diet with sugar free house supplements.

Telephone Interview with the nurse of the physician for Resident #3 on 2/15/17 at 11:13 a.m. revealed Resident #3 should have been receiving a No added Salt / Chopped diet with sugar free supplements as ordered by the physician. She would clarify the resident's diet effective 2/15/17.

Interview with the Administrator on 2/15/17 at 10:48 a.m. revealed:
-She was not aware Resident #3's diet needed to be clarified but she was working on doing so with the doctor's office.
-She would clarify Resident #3's diet and any supplements required with the doctor.

3. Review of Resident #7's current FL-2 dated 10/12/16 on 2/15/17 revealed:

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D 310	Continued From page 37 -A diagnosis of diabetes mellitus type II, hypertension, depression, muscle weakness, lack of coordination, and dementia. -No diet was specified. Review of Resident #7's Diet Order dated 11/09/16 on 2/14/17 revealed: -A signed and dated diet order by the physician on 11/09/16. -A "No Concentrated Sweets / No Added Salt" diet with chopped meats hand written on the diet order. Review of the facility diet listing dated 2/14/17 on 2/14/17 revealed Resident #7 received a "No Concentrated Sweets / No Added Salt" diet with chopped meats. Interview with the Cook on 2/14/17 at 12:15 p.m. revealed: -She followed the facility diet list when preparing meals for all residents. -She thought Resident #7 received a Regular diet. -She did not add salt or sugar to any residents' food. -She did not serve Resident #7 chopped meats. -She was unaware Resident #7 received No Concentrated Sweets / No Added Salt diet with chopped meats. -She prepared Resident #7's meals from "memory and did not refer to the posted facility diet list on a daily basis." Observation of dinner meal on 2/14/17 at 5:30 p.m. revealed: -All residents received fried fish patties, succotash, sliced carrots, fruit, a roll, 8 ounces of tea and water. -Resident #7's meat was served between two	D 310		

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buns uncut and not chopped.

Interview with a Personal Care Aide (PCA) on 2/14/17 at 5:45 p.m. revealed:
-She thought Resident #7 received a regular diet without any modifications.
-Resident #7 ate well by herself and did not need her meats cut or chopped.
-She was not aware Resident #7 received a no added salt and sugar diet with chopped meats.
-Resident #7 was physician ordered on 11/09/16 to receive a No Concentrated Sweets / No Added Salt diet with chopped meats.

Interview with Resident #7 on 2/14/17 at 6:05 p.m. revealed:
-The resident thought she was supposed to receive a regular diet.
-Another resident at her table always cut up her food for her and helped her.
-Her meats were always served whole and could not recall a time when they were served differently.
-She felt she could eat her food and her meats much better when it was cut up for her but could not explain why.

Interview with the Dietary Manager on 2/14/17 at 12:25 p.m. revealed:
-All dietary staff, including herself, followed the facility diet list when preparing meals for the residents.
-She did not know she was supposed to follow the Dietician approved menu with specified diets and portion sizes.
-No resident received a physician ordered therapeutic diet to the best of her knowledge.
-The Medication Aides (MA's) or the Administrator kept the facility diet list updated as needed.
-She said Resident #7 received a Regular diet

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D 310	Continued From page 39 and then looked at the facility diet list and added the resident actually received a "No Added Salt and No Concentrated Sweets diet with chopped meats." -She was unsure why Resident #7's meats were being served whole but she would correct that immediately and follow the facility diet list for food preparation. -The Cooks did not add salt and sugar to the residents' food. Observation of lunch meal on 2/15/17 at 12:10 p.m. revealed: -All residents received pork chop, greens, baked sweet potato, corn bread, chocolate dessert, 8 ounces tea, and water. -No salt was placed on the residents' tables. -Resident #7's meat was served uncut and not chopped. Telephone Interview with the nurse of the physician for Resident #7 on 2/15/17 at 11:13 a.m. revealed Resident #7 should receive a No Concentrated Sweets / No Added Salt diet with chopped meats as ordered by her physician. Interview with the Administrator on 2/15/17 at 10:48 a.m. revealed: -She was not aware Resident #7's diet was not being served as ordered by her physician. -She would ensure Resident #7's meats were prepared as ordered at mealtimes.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes:	D 312		

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D 312	Continued From page 40 (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure that residents needing help with eating were assisted for 2 of 6 residents sampled (#7, #5). The findings are: 1. Review of Resident #7's current FL-2 dated 10/12/16 and Care Plan dated 11/12/16 revealed: -A diagnosis of diabetes mellitus type II, hypertension, depression, muscle weakness, lack of coordination, and dementia. -Extensive staff assistance was required for the resident when eating. Observation of dinner meal on 2/14/17 at 5:30 p.m. revealed: -All residents received fried fish patties, succotash, sliced carrots, fruit, a roll, 8 ounces of tea and water. -Resident #7's meat was served between two buns uncut and not chopped. -Resident #7 was not assisted by staff to cut up or to chop her meat. -Another resident at Resident #7's table was asked by her to cut up her food. The resident at her table cut up Resident #7's meat and the other food on her plate. -Staff were serving resident plates one by one and were not present in the dining room while Resident #7's food was cut up by another resident at her table.	D 312		

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D 312	Continued From page 41 Interview with a Personal Care Aide (PCA) on 2/14/17 at 5:45 p.m. revealed: -She thought Resident #7 received a regular diet without any modifications. -Resident #7 ate well by herself and did not need her meats cut or her food chopped. -She was not aware Resident #7 required staff assistance with eating her food. Interview with Resident #7 on 2/14/17 at 6:05 p.m. revealed: -Another resident at her table always cut up her food for her and helped her. -Her meats were always served whole and could not recall a time when they were served differently. -She could eat her food and her meats much better when it was cut up for her. -She could not cut up her own food and needed someone to help her do that. -She did not want to bother the staff with helping her eat because they were too busy helping other residents get their food. Interview with the Dietary Manager on 2/14/17 at 12:25 p.m. revealed: -She was unaware Resident #7 needed help cutting up her food. -She thought Resident #7 could eat on her own. -She thought another resident at her table was being "nice" to her by cutting her food for her. Observation of lunch meal on 2/15/17 at 12:10 p.m. revealed: -All residents received pork chop, greens, baked sweet potato, corn bread, chocolate dessert, 8 ounces tea, and water. -Resident #7's meat was served uncut and not chopped.	D 312		

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D 312	Continued From page 42 Interview with a second Personal Care Aide on 2/15/17 at 12:15 p.m. revealed: -She did not know Resident #7 needed help from staff with eating. -She thought it was "okay for her peer at her table to help her out with preparing her food to be eaten." -She knew it took Resident #7 "a little bit longer to eat but thought that was her way." -She would have assisted the resident with eating if she had known. Interview with the Administrator on 2/15/17 at 10:48 a.m. revealed: -She would ensure Resident #7's meats were prepared as ordered and she received staff help at mealtimes. -She would follow-up with all staff regarding residents who require staff assistance during mealtimes to ensure the residents who needed staff assistance received it. -She would also ensure residents knew staff were there to assist all residents who needed help with eating their food. 2. Review of Resident #5's current FL-2 dated 9/10/16 and Care Plan dated 10/12/16 revealed: -A diagnosis of diabetes mellitus type II, hypertension, depression, hypercholesterolemia, and unsteady gait. -Limited staff assistance was required for the resident when eating. Observation of dinner meal on 2/14/17 at 5:30 p.m. revealed: -All residents received fried fish patties, succotash, sliced carrots, fruit, a roll, 8 ounces of tea and water. -Resident #5's food was served as a regular diet. -Resident #5 was not assisted by staff to cut up	D 312		

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D 312	Continued From page 43	D 312		

or to chop his food.
-Another resident at Resident #5's table was asked to cut up his food for him. The resident at his table cut up Resident #5's food.
-Staff were serving resident plates one by one and were not present in the dining room while Resident #5's food was being cut up by another resident at his table.

Interview with a Personal Care Aide (PCA) on 2/14/17 at 5:45 p.m. revealed:
-She thought Resident #5 received a regular diet without any modifications.
-Resident #5 "ate well but slowly" by himself and did not need staff help.
-She was not aware Resident #5 required staff assistance with eating his food.

Interview with Resident #5 on 2/14/17 at 6:05 p.m. revealed:
-He wanted his food cut up before eating at mealtimes but needed some help.
-Another resident at his table always cut up his food for him and helped him and others at the table.
-He could eat his food easier when it was cut up.
-He needed help sometimes but had not asked staff.
-He did not request staff help because he did not want to bother them.
-He could not cut up his food by himself and needed someone to help him.
-He did not want to cause any trouble by bothering the staff.

Interview with the Dietary Manager on 2/14/17 at 12:25 p.m. revealed:
-She was unaware Resident #5 wanted or needed help cutting up his food.
-She thought Resident #5 could eat "good on his

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D 312	Continued From page 44 own even though it took him a while." -She thought another resident at the table was being "nice" to him and others by cutting up their food and did not know that would be a "problem." Observation of lunch meal on 2/15/17 at 12:10 p.m. revealed: -All residents received pork chop, greens, baked sweet potato, corn bread, chocolate dessert, 8 ounces tea, and water. -Resident #5's meat was served uncut and not chopped. -Another resident at the table was asked by Resident #5 to cut up his food for him to eat it. Interview with a second Personal Care Aide (PCA) on 2/15/17 at 12:15 p.m. revealed: -She did not know Resident #5 needed help from staff with eating. -She thought it was "okay for a peer at his table to help out with preparing his food for him." -She knew Resident #5 "ate slowly but did not know that was an issue." -She would have assisted the resident with eating if she had known. Interview with the Administrator on 2/15/17 at 10:48 a.m. revealed: -She would follow-up with all staff regarding residents who require staff assistance during mealtimes to ensure the residents who needed staff assistance received it. -She would also ensure residents knew staff were there to assist all residents who needed help with eating their food.	D 312		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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D 338	Continued From page 45 An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to treat all residents with respect, consideration, dignity, and with full recognition of his or her individuality as evidenced by staff addressing residents in a disrespectful tone of voice and by not recognizing the residents' right to eat meals and snacks in their rooms when not feeling well or when requested. The findings are: 1. Confidential interviews with fourteen residents on 2/14/17 through 2/15/17 revealed: -Staff were "sometimes good and sometime weren't so good, but they are doing the best they could they guessed." -Some staff were nice and some were not. -Staff were not "nice" to residents the majority of the time. -The staff made them feel like they were "bothering them when they would ask for help and they did not want to be a bother to anyone." -Staff made residents get up by "talking loudly or rough to them" when residents did not want to get up. -Staff did not help the residents when they asked for "help to the bathroom and dining room because they said they had something else to do." -Staff treated some residents, the "quieter ones, okay" most times. -The residents feared retaliation for voicing	D 338		

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concerns and some had decided "not to say anything, anymore."
-The residents feared "being put out and they had no other place to go."
-The residents did not understand why staff never spoke back when the residents had spoken to them.
-Staff ignored the residents and kept walking when residents were trying to ask them a question.
-When staff ignored them, they felt frustrated.
-Residents had been threaten by facility staff about being "put out if the resident made a phone call and discussed with anyone what was going on in the facility. The facility staff further stated to the residents that they could do something about those residents."
-The residents were getting "tired and fed up" with staffs' attitudes.
-Residents had spoken with the owner of the facility regarding how staff spoke to them and treated the residents. The owner stated that "the apple did not fall far from the tree" and nothing changed for them after that."
- Residents said "the Executive Director and the Administrator did not need to run a place like this because they did not understand or care about the residents."
-The residents did not want to move but "just would like for things to get better and for staff to stop being nasty to them."
-All staff could improve on their "attitudes and bad behaviors."
-They knew the staff were busy but wanted them to put the residents first.
-The residents wished the staff were friendlier.
-It made the residents "feel bad when the staff were rude and nasty but they didn't think they meant to be that way."
-The Medication Aide (MA) on second shift was

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"rude" to the residents and spoke "harshly" to them on a daily basis depending on how she felt that day."
-The MA probably had "a lot on her mind and a lot to do that caused her to act that way."
-When facility staff spoke to the residents in a loud, harsh, or rough tone, it made them feel sad, angry, frustrated, and disrespected."

Observation of Medication Aide (MA) on 2/14/17 at 5:03 p.m. revealed:
-The MA went to three residents rooms and requested "they get up to go to the dining room to eat or they wouldn't eat."
-One resident asked repeatedly "could he please finish his nap first" but the MA insisted he needed to get up "if he really wanted to eat."
-Another resident said "she did not feel well and asked could her food be brought to her" and the MA replied "no" that she needed to go to the dining room to eat.
-The third resident began to get up when requested by the MA and asked "why did he have to go down there?' The MA responded "so he could eat his supper meal."
-The MA's voice was loud and carried into the hallway.

Observation of the supper meal on 2/14/17 at 5:45 p.m. revealed:
-Resident #2 had asked staff to get Resident #5 some salt for his food.
-The MA entered the dining room, speaking to Resident #2 as she walked toward him, and said "how many times do I have to tell you, just because you can eat whatever you want, doesn't mean the other residents can eat the way you can eat!"
-The MA spoke in a loud tone of voice to Resident #2.

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-Other residents were eating their supper meal and had stopped.
-Resident #2 became upset, slid his chair away from the table, and tried to explain to the MA what had happened.
-When Resident #2 began to state that Resident #5 had asked him for the salt first, the MA said, "It doesn't matter, it doesn't matter! You can't do that! You can ask for salt to give to other residents who couldn't have any! How many times do I have to tell you that?"
-Resident #2 tried to explain what happened again while the MA continued responding in a loud tone of voice.
-Resident #2 got up from the table and left the dining room after saying "he was tired of being talked to any kind of way and he was only trying to help the residents who were his friends."
-The other residents began to explain to the Nurse's Aide, who had entered the dining room, that Resident #2 "had not done anything wrong and was only trying to help."

Interview with the Administrator on 2/16/17 at 10:48 a.m. revealed:
-She was not aware the residents felt they were being mistreated in any way.
-She expected all staff to treat all residents with respect and dignity.
-Staff were expected to conduct themselves in a professional manner at all times.
-No resident had reported to her that they were being treated in a disrespectful manner.

2. Confidential Interviews with eleven residents on 2/15/17 through 2/16/17 revealed:
-A resident was not feeling well, on a few occasions, and asked could someone bring her lunch and supper meal to her room but was told "no."

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D 338	Continued From page 49 -The residents said did not understand why they could not eat their food in their rooms especially when not feeling well. -"When you did not make it down to the dining room to eat, no one checked on the residents to see if they wanted to still eat their food or snack." -They were served three meals and offered snacks at least twice a day but only in the dining room area. -"If you did not go to the dining room, you would not get a meal or snack at all." -They wanted food and snack when they were not feeling well but were told "they had to come to the dining room or they would not get their food or snack." -The residents had asked for a meal and a snack to be taken to their room or to a peer's room when they were not feeling well but they were told by facility staff they could not because all meals and snacks had to be served and eaten in the dining room. -They asked could facility staff bring their meal or a snack to their rooms if they were asleep so they would not miss a meal or a snack and were told "no" because this was against the "rules." -The residents were told they could not eat meals and snacks in their bedrooms because of the "trash and bugs" caused by eating in their rooms. Interview with Dietary Aide on 2/14/17 at 11:35 a.m. revealed: -Snacks were offered and served three times a day but in the "dining room only." -The residents who came to the dining room that morning received a snack. -Snack times were between meals "around 10:00 a.m., 3:00 p.m. and 8:00 p.m." -She did not follow a menu when preparing snacks for the residents. -She knew the residents and went by memory to	D 338		

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D 338	Continued From page 50 prepare their snacks. Interview with the Dietary Manager on 2/14/17 at 12:12 p.m. revealed: -Meals and snacks were offered three times each day but "were only served in the dining room." -Each resident was served a hot meal and a "healthy" snack once they arrived in the dining room at the specified meal and snack times. -No meals and snacks were taken to the residents rooms because of "the trash and potential for bugs." -If a resident was sick, meals and snacks were not taken to the residents' rooms unless a doctor's order was written to do so. -If a resident was asleep and missed a meal or a snack, the kitchen staff were not allowed to take their meals and snacks to them. Observation of a resident on the 100 Hall on 02/14/17 at 5:15 p.m. revealed the resident was in bed asleep while dinner was being served in the dining room. Observation of the dining room on 02/14/17 at 5:38 p.m. revealed dinner was finished and all residents in the dining room had been served by the staff. Observations of the same resident on the 100 Hall on 02/14/17 from 5:40 p.m. - 5:50 p.m. revealed: -The resident was still in bed asleep. -No staff had attempted to wake up the resident when dinner was served. -No staff had offered the resident anything to eat while dinner was served. Interview with the same resident on the 100 Hall at 02/14/17 at 5:55 p.m. revealed:	D 338		

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-The resident reported she did not feel well and she was hungry.
-She did not feel well enough to go the dining room for dinner.
-No staff had offered any dinner.
-If she did not get up and go to the dining room then she would not get anything to eat for dinner.
-The staff told her that residents were not allowed to eat in their rooms even if the resident was sick.
-The staff did not offer the residents anything to eat if the residents did not go to the dining room.
-She had not eaten meals several times because she did not feel well enough to go the dining area.
-She could not specify how many times she had missed meals because she did not go to the dining room.
-It would be nice if she could get some food brought to her room because she was not feeling well.

Interview with a Medication Aide on 02/14/17 at 6:00 p.m. revealed:
-Residents had to come to the dining room for all meals.
-She would talk with the dietary staff to see if an exception could be made for the resident today.

Interview with two Personal Care Aides in the dining room on 02/14/17 at 6:03 p.m. revealed it was the facility policy that resident not eat in their rooms.

Interview with a Dietary Aide in the dining room on 02/14/17 at 6:03 p.m. revealed the dietary staff was not allowed to take food to the residents' rooms because it was the policy that all residents' meals were served in the dining room.

Interview with the same Medication Aide on 02/14/17 at 6:05 p.m. revealed:

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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 338	Continued From page 52 -It was the facility policy that resident not eat in their rooms but it was not a written policy. -The staff had been instructed by the Administrator that residents were not allowed to have meals in their rooms. Interview with the Administrator on 02/14/17 at 6:07 p.m. revealed: -The facility strongly encouraged residents to take all meals in the dining room. -She would make an exception and have the staff to offer the resident on the 100 Hall something for dinner. Observation of the resident on 100 Hall and the Medication Aide on 02/14/17 from 6:10 p.m. - 6:15 p.m. revealed the Medication Aide did offer food to the resident and the resident was served a fish sandwich and a glass of ice tea. Interview with a Medication Aide on 02/15/17 at 4:00 p.m. revealed: -Staff were supposed to try to get all residents to dining room for their meals. -If a resident was not able to come to the dining room for meals because of health reasons then the staff would bring the food to the resident's room. She was unable to specify when this was put in place by the facility. Interview with a second Medication Aide on 02/16/17 at 9:55 a.m. revealed: -Staff was instructed by the Administrator that residents were not allowed to have meals in their room. -This was an unwritten rule that had been given to her when she started working at the facility 3 years ago. -If a resident did not come to dining room then the resident did not get that meal.	D 338		

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D 338	Continued From page 53 -If she knew a resident had not eaten, she would offer them a snack like some crackers and juice. -She was not sure if any other staff offered any food to residents if the residents did not come to the dining room for their meals. Telephone interview on 02/16/17 at 11:00 a.m. with the Resident Care Coordinator (RCC) revealed: -Staff was instructed that no meals were to be served outside of the dining room by the Administrator. -All residents are strongly encouraged to come to the dining room for all meals. -Staff did not offer any food to residents who stayed in their rooms during meal times. Interview with the Administrator on 2/16/17 at 10:48 a.m. revealed: -The residents could request to eat their meals and snacks in their bedrooms if they were not feeling well. -She expected staff to encourage the residents to go to the dining room for meals and snacks to aid in preventing trash build up and bugs. -There was not a written facility policy stating residents had to go to the dining room in order to receive their meals and snacks.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;	D 344		

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D 344	Continued From page 54 (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to clarify and verify medication orders for 1 of 5 residents (#12) sampled who was administered fast acting insulin used to treat diabetes without a dosage on the current FL-2. The findings are: Review of Resident #12's FL-2 dated 2/9/17 revealed: -Diagnosis included bipolar 1 disorder, type 2 diabetes mellitus, hypertension, tachycardia, vitamin B12 deficiency, coronary artery disease, kidney stones and benign prostatic hyperplasia. -There was a physician's order for Humalog KwikPen Maximum of 10 units a day sliding scale 3 times daily before meals subcutaneously as directed. (Humalog is a rapid acting insulin that lowers blood sugar. The manufacturer recommends Humalog be taken 15 minutes before eating a meal.) -There were no physician's order for parameters of the sliding scale insulin. -There was a physician's order for a finger stick blood sugar twice a day. Review of the Resident Register for Resident #12	D 344		

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D 344	Continued From page 55 revealed an admission date of 2/13/17. Review of the February 2017 Electronic Medication Administration Record (eMAR) revealed: -There was no entry to check Resident #12's finger stick blood sugar. -There was an entry for Humalog "max of 10 units a daily sliding scaled three times a day before meals subcutaneously. *clarify parameters*". -Humalog was scheduled to be administered at 8:00 am, 12:00 pm, and 5:00 pm before meals. Review of Resident #12's physician's orders and nursing notes revealed there was no documentation the primary care provider was contacted to clarify the medications on the FL-2 dated 2/9/17. Interview with the Medication Aide on 2/14/17 at 5:45 pm revealed: -She had not taken Resident #12's finger stick blood sugar on 2/14/17 because there was no order on the eMAR. -She interpreted the Humalog order on the eMAR to mean to administer 10 units of the insulin. -She did not contact any physician's to clarify medication orders. -The Resident Care Coordinator was in charge of medication orders. Interview with a second Medication Aide on 2/16/17 at 10:16 am revealed: -She had worked at the facility as a Medication Aide/Supervisor for about 1 year. -She worked on third shift from 11:00 pm - 7:00 am. -She would be the only Medication Aide/Supervisor on third shift. -If there was a problem with an order on the	D 344		

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eMAR that she did not understand, she would check the chart.
-If the order in the chart was unclear, she would call the Resident Care Coordinator (RCC).
-If the RCC was unavailable, she would hold the medication until the next morning.
-She did not have contact information to contact the Executive Director or the Administrator.
-She would not contact the primary care provider directly.
-She was not responsible for clarifying any physician's orders.

Interview with a pharmacist for the facility's contracted pharmacy on 2/15/17 at 10:11 am revealed:
-The pharmacy received medication orders for Resident #12 on 2/9/17.
-The pharmacy contacted the primary care provider (PCP) by fax on 2/9/17 to clarify orders for finger stick blood sugars and sliding scale insulin parameters.
-The pharmacy noted on the Electronic Medication Administration Records to clarify order for sliding scale insulin.
-It was also the facility's responsibility to contact the PCP to clarify orders.
-The insulin order needed to be clarified prior to administration of insulin.

Telephone interview with the Primary Care Provider on 2/15/17 at 1:02 pm revealed:
-She signed the FL-2 on 2/9/17 but Resident #12 was not admitted to the facility until 2/13/17.
-She had not received a call from the facility until 2/14/17 regarding an order to for Resident #12's finger stick blood sugar.
-She was not asked on 2/14/17 about the insulin order for Resident #12.
-The Humalog insulin order for Resident #12 was

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not complete and she should have been contacted to clarify the order.
-She would call the facility today (2/15/17) to clarify the insulin order.

Interview with the Administrator on 2/16/17 at 10:50 am revealed:
-She did not clarify any medication orders.
-It was the Resident Care Coordinators (RCC) responsibility to clarify physician's orders.
-She was not sure who was put in charge of medication orders when the RCC was not at the facility.
-She assumed the Medication Aides would clarify medication orders if needed.
-She was not sure if the RCC had contacted the Primary Care Provider (PCP) to clarify any orders for Resident #12.
-There was no documentation that the facility had attempted to contact the PCP to clarify any orders for Resident #12.
-She had contacted the PCP on 2/14/17 when the problem was brought to her attention about the order.
-She spoke with the PCP on 2/15/17 to attempt to get clarification of the insulin order for Resident #12.
-The PCP on 2/15/17 needed to further review the insulin order for Resident #12, so the insulin order was placed on hold.
-The insulin for Resdient #12 was placed on hold after the resident refused his morning doseage of insulin.
-The Medication Aides would not adminsiter the insulin to Resident #12 until the order was further clarified.
-The facility was in the process of establishing a different PCP for Resident #12 so that he could be seen at the facility so that his medication orders could be further reviewed.

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D 344	Continued From page 58 Telephone Interview with the RCC on 2/16/17 at 11:00 am revealed: -It was her responsibility to clarify physician's orders. -If she was not available, she would delegate a Medication Aide/Supervisor to clarify medication orders. -She had been out of the office since 2/10/17. -She was not sure if any of the orders for Resident #12 had required clarification. -The pharmacy would notify the facility by fax if there was a problem with an order or if an order needed clarification. -She had not been at the facility so she was not aware of any issues with Resident #12's orders. -She had not contacted the PCP to clarify any orders for Resident #12. Review of the facility's medication order policy revealed: -All medication orders would be in writing by the prescribing provider; they would be obtained upon admission, when orders change and every 6 month thereafter. -Medication orders would be verifed by staff with a physician or prescribing provider when the orders are not clear or are incomplete. -Medication orders would include the date, medication name, strength of medication, dosage of medication, route of medications, frequency of administration and reason for use if the medication was prescribed as needed. -Verification or clarification would be kept in the residents' chart. The facility's failure to clarify and verify a physician's order from the FL-2 resulted in Humalog 10 units of a fast acting insulin being administered once to Resident #12. The failure of	D 344		

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D 344	Continued From page 59 the facility to clarify and verify physician's orders resulted in substantial risk of injury to the resident and constitutes a Type A2 Violation. Review of the Plan of Protection provided by the facility on 2/16/17 revealed: -Training would be provided to staff on how to verify physician's orders to ensure they are correct on the Electronic Medication Administration Record. -Once the medication orders had been faxed to the pharmacy and loaded on the Electronic Medication Administration Record, the Resident Care Coordinator, Administrator or the third shift Supervisor in Charge would be the only staff allowed to approve medcations for administration. -New resident admissions if possible would be done during the week and paper work would be sent to the facility prior to the resident arriving so that orders could be clarified if needed. -Pharmacy would perform an upcoming inservice on acceptance of orders on the Electronic Medication Administration Record. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 18, 2017.	D 344		
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	D 358		

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D 358	Continued From page 60 and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 6 of 19 residents (#8,#9, #10, #11, #12, #13) observed during the medication passes, including errors with medications for diabetes for 2 residents (#12 and #13), medication for inflammation in the mouth (#8), a vitamin supplement (#9), medication for constipation (#11), and eye drops for the treatment of chronic dryness (#10). The findings are: The medication error rate was 28% as evidenced by observation of 7 errors out of 25 opportunities during the 11:00 am medication pass on 2/14/17 and the 4:00/5:00 pm medication pass on 2/14/17. 1. Review of Resident #12's FL-2 dated 2/9/17 revealed: -Diagnoses included bipolar 1 disorder, type 2 diabetes mellitus, hypertension, tachycardia, vitamin B12 deficiency, coronary artery disease, kidney stones and benign prostatic hyperplasia. -There was a physician's order for Humalog KwikPen maximum of 10 units a day sliding scale 3 times daily before meals subcutaneously as directed. (Humalog is a rapid acting insulin that lowers blood sugar. The manufacturer recommends Humalog be taken 15 minutes before eating a meal.) -There were no physician's order for parameters of the sliding scale insulin.	D 358		

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D 358	Continued From page 61 -There was a physician's order for finger stick blood sugar twice a day. Review of the Resident Register for Resident #12 revealed an admission date of 2/13/17. Review of the February 2017 Electronic Medication Administration Record (eMAR) on 2/14/17 revealed: -There was no entry to check Resident #12's finger stick blood sugar. -There was an entry for Humalog "max of 10 units a daily sliding scaled three times a day before meals subcutaneously. *clarify parameters*". -Humalog was scheduled to be administered at 8:00 am, 12:00 pm, and 5:00 pm before meals. Observation of the medication pass on 2/14/17 at 4:26 pm revealed: -The Medication Aide did not obtain a finger stick blood sugar. -The Medication Aide prepped the new insulin pen and dialed up 10 units. -The Medication Aide entered Resident #12's room and administered the 10 units of insulin in the resident's abdomen. Observation on 2/14/17 at 5:35 pm revealed Resident #12 received his meal tray and started to eat which was 1 hour and 9 minutes after he received his Humalog Insulin. Interview with Resident #12 on 2/14/17 at 4:30 pm revealed: -He was admitted to the facility on 2/13/17. -He was a diabetic and required insulin. -He checked his own finger stick blood sugar at home twice a day, in the morning and around dinner time. -His finger stick blood sugar had not been	D 358		

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checked since he was admitted to the facility on 2/13/17.
-He adjusted his Humalog insulin dosage based on what his blood sugar results were.
-He was not sure how many units the Medication Aide administered to him on 2/14/17.
-He felt like his blood sugar was low because he felt "woosy".

A second interview with Resident #12 on 2/15/17 at 3:30 pm revealed:
-The staff had checked his finger stick blood sugar last night on 2/14/17 and this morning 2/15/17.
-On 2/14/17 in the evening the result was 135.
-On 2/15/17 in the morning the result was 118.
-He did not receive insulin this morning 2/15/17 because he refused to take it, because he did not need insulin.
-His blood sugar had never been as low as 118 since he was diagnosed with diabetes.
-He was not supposed to be on that much insulin.

Interview with the Medication Aide on 2/14/17 at 5:45 pm revealed:
-She had not taken Resident #12's finger stick blood sugar on 2/14/17 because there was no order on the eMAR.
-She interpreted the Humalog order on the eMAR to mean to administer 10 units of the insulin.

Interview with the Adminsitrator on 2/14/17 at 5:50 pm revealed:
-She was not sure if the physican had been contacted to clarify the finger stick blood sugar order and the Humalog sliding scale insulin order for Resident #12.
-She would contact the physican to clarify orders for Resident #12.

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D 358	Continued From page 63 Interview with a pharmacist at the facility's contracted pharmacy on 2/15/17 at 10:11 am revealed: -The pharmacy received medication orders for Resident #12 on 2/9/17. -The pharmacy contacted the primary care provider (PCP) on 2/9/17 to clarify orders for finger stick blood sugars and sliding scale insulin parameters. -The pharmacy noted on the Electronic Medication Administration Records to clarify order for sliding scale insulin. -It was also the facility's responsibility to contact the PCP to clarify orders. -The insulin order needed to be clarified prior to administration of insulin. -The policy of the pharmacy is to go ahead and send medications like insulin because the resident needs that type of medication. -Sometimes the facility was able to obtain clarification from the PCP faster than the pharmacy and then the insulin would already be at the facility to administer to the resident. Telephone interview with the Primary Care Provider on 2/15/17 at 1:02 pm revealed: -Resident #12 missed his follow up appointment prior to his admission to the facility. -She signed the FL-2 on 2/9/17 but Resident #12 was not admitted to the facility until 2/13/17. -She had not received a call from the facility until 2/14/17 regarding checking his blood sugar. -Resident #12's most recent A1C (average blood sugar level over 3 months) was 6, which is good for the resident. -Resident #12 did not need sliding scale insulin (SSI). -Resident #12 should not have been administered the Humalog SSI without checking the resident's finger stick blood sugar.	D 358		

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-The order for Resident #12 was not complete and should not have been administered.
-She was going to call the facility and give them an order to discontinue Resident #12's Humalog SSI.

Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am.

Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm.

2. Review of Resident #13's FL-2 dated 8/12/16 revealed:
-Diagnoses included congestive heart failure, diabetes mellitus type 2, pneumonia, gout, neuropathy, anemia esophageal reflux and hypertension.
-A physician's order for Novolog insulin - Inject 5 units subcutaneously 3 times a day with meals. (Novolog is a rapid acting insulin that lowers blood sugar. The manufacturer recommends Novolog be taken 15 minutes before eating a meal.)

Review of a subsequent physician's order for Resident #13 dated 9/8/16 revealed Novolog insulin inject 5 units subcutaneously 3 times a day with meals.

Observation of the medication pass on 2/14/17 at 4:45 pm revealed Resident #13 was administered Novolog 5 units subcutaneously.

Observation of the dinner meal on 2/14/17 revealed Resident #13 was served his meal tray at 5:32 pm, which was 47 minutes after his insulin was administered.

Interview with Resident #13 on 2/15/17 at 3:50

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pm revealed:
-The resident was a diabetic.
-He received insulin 3 times a day.
-They gave him his insulin over 30 minutes prior to meals almost everyday.
-Sometimes he felt like his blood sugar was dropping because he felt "weak" and "tingly".
-He knew he needed to eat within 30 minutes of getting the insulin or his blood sugar would be low.

Interview with the Medical Assistant at the Primary Care Providers office on 2/16/17 at 9:02 am revealed:
-Insulin prescribed to be given with meals should be given no more than 10-15 minutes prior to a resident eating.
-Any more than 10-15 minutes, a resident's blood sugar could drop to a critical low level.
-The facility should ensure that when they administer insulin prescribed to be given with meals, the resident has something to eat.

Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am.

Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm.

3. Review of Resident #8's FL-2 dated 5/12/16 revealed diagnoses included congestive heart failure, osteoarthritis, back pain, diabetes mellitus type 2 and atrial fibrillation.

Review of a subsequent physician's order dated 2/3/17 revealed Magic Mouth Wash - Swish and spit 5 milliliters three times a day after meals. (used to treat inflammation of the mouth).

Observation of the medication pass on 2/14/17 at

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D 358	Continued From page 66 11:40 am revealed: -The Medication Aide poured 15 milliliters (mL) of Magic Mouth Wash into a medication measuring cup. -The Medication Aide turned to walk into Resident #8's room to administer the Magic Mouth Wash. -The Medication Aide from stopped from administering 15 mL instead of 5 mL of Magic Mouth Wash to Resident #8. Observation of the medication pass on 2/14/17 at 11:40 am revealed: -The Medication Aide handed Resident #8 the cup of magic mouthwash, did not give any instructions and walked out of the room. -Resident #8 put the Magic Mouth Wash in her mouth, swished it around and swallowed it. Interview with the Medication Aide on 2/14/17 at 11:42 am revealed: -She had worked at the facility for 4-5 months. -She worked with another Medication Aide for 3 shifts when she first started working at the facility and then she worked alone. -She had worked as a Medication Aide at another facility prior to working at this facility. -She thought she had measured 5 mL of Magic Mouth Wash in the medication cup. -Resident #8 was to swish and swallow the Magic Mouth Wash. -She did not realize Resident #8 was supposed to swish and spit the Magic Mouth Wash. -Resident #8 was independent and knew how to take the medication. Interview with Resident #8 on 2/14/17 at 11:40 am revealed: -She had not had lunch. -She had previously had Magic Mouth Wash and at that time she swished and swallowed the	D 358		

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medication.
-She was given the Magic Mouth Wash before meals.
-The Medication Aides at the facility did not tell her to swish and spit the Magic Mouth Wash.
-Some of the Medication Aides did not watch her take her medication; they brought them in the room and dropped them off.
-She always took all of her medications.

Observation of the lunch meal on 2/14/17 revealed Resident #8 was served lunch at 11:57 am.

Interview with the Medical Assistant at the Primary Care Provider's office on 2/16/17 at 9:02 am revealed:
-Resident #8 should have been swishing and spitting out the Magic Mouth Wash.
-The facility should have assured that Resident #8 was swishing and spitting the Magic Mouth Wash.
-It would not cause harm to the resident to swallow the Magic Mouth Wash, and would still provide treatment for the current problem.

Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am.

Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm.

4. Review of Resident #9's FL-2 dated 5/3/16 revealed:
-Diagnoses included chronic airway obstruction, dysphagia, general muscle weakness, difficulty walking, acute kidney failure, chronic pain syndrome, esophageal reflux and dementia other with behavior.
-There was a physician's order for Calcium 600

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milligrams (mg) with Vitamin D 400 mg (vitamin supplement) twice a day.

A subsequent physician's order dated 9/13/16 revealed Calcium/Vitamin D 600 mg-400 mg twice a day with meals.

Observation of the medication pass on 2/14/17 at 11:52 am revealed Resident #9 was administered Calcium/Vitamin D 600 mg-400 mg.

Observation of the lunch meal on 2/14/17 revealed Resident #9 was served lunch at 12:00 pm, which was 8 minutes after the administration of the Calcium/Vitamin D 600 mg-400 mg.

Telephone interview with the Primary Care Provider on 2/15/17 at 2:36 pm revealed she did not feel Resident #9's Calcium/Vitamin D 600 mg-400 mg needed to be given in regards to food or meals.

Interview with Resident #9 on 2/15/17 at 3:40 pm revealed:
-The resident did not know what time she got medications.
-She did not have any side effects from her medications.

Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am.

Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm.

5. Review of Resident #10's FL-2 dated 7/18/16 revealed:
-Diagnoses included hypertension, diabetes, brain tumor, organic brain syndrome and chronic edema.

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-There was a physician's order for Artificial Tears 1.4% (used to treat dry eyes) - Instill 1 drop in each eye 4 times a day, 5 minutes between drops.
-There was a physician's order for Restasis 0.05% (used to treat chronic dry eye syndrome) - 1 drop in each eye twice a day.

Review of a subsequent physician's order for Resident #10 dated 9/8/16 revealed:
-Restasis 0.05% - Instill 1 drop into each eye twice a day (must be given at least 15 minutes after other drops).
-Artificial Tears 1.4 % - Instill 1 drop into each eye 4 times day (wait 3-5 minutes between different eye drops).

Review of the Resident Register for Resident #10 revealed an admission date of 7/18/16.

Observation of the medication pass on 2/14/17 at 4:04 pm revealed:
-Resident #10 was administered Artificial Tears 1.4% eye drops, 1 drop in each eye at 4:04 pm.
-Resident #10 was administered Restatis 0.05% eye drops, 1 drop in each eye at 4:05 pm.

Interview with Resident #10 on 2/16/17 at 11:30 am revealed:
-He knew he received a lot of eye drops.
-He had eye problems but did not know what it was called.
-He was not sure how the eye drops were supposed to be administered.
-He thought the eye drops helped his eyes.

Interview with the Medical Assistant at the Primary Care Provider's office on 2/16/17 at 9:02 am revealed:
-Resident #10 should receive the Artificial Tears

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eye drops separate from the Restasis eye drops.
-Resident #10 should be getting the Restasis 0.05% eye drops 15 minutes after other eye drops.
-The Restasis eye drops would not work correctly when given that close to any other eye drops.

Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am.

Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm.

6. Review of Resident #11's FL-2 dated 11/11/16 revealed:
-Diagnoses included major motor seizure, schizophrenia/paranoid type, hypercholesterolemia and moderate mental retardation.
-A physician's order for Amitiza 8 micrograms (mcg) (used to treat chronic onstipation)- take 1 twice a day with meals.

Observation of the medication pass on 2/14/17 at 4:21 pm revealed Resident #11 was administered Amitiza 8 mg.

Observation of the dinner meal on 2/14/17 revealed Resident #11 was served his meal tray at 5:30 pm, 1 hour and 11 minutes after the administration of the Amitiza 8 mg.

Interview with Resident #11 on 2/14/17 at 5:15 pm revealed:
-The resident was not sure what time he received his medications.
-He was not sure what medications he took.
-He felt fine after he was given his medications.

Interview with the Medical Assistant at the

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D 358	Continued From page 71 Primary Care Provider's office on 2/16/17 at 9:02 am revealed: -It was unsure of the effectiveness of the Amitiza if taken with or without food. -The medication was typically given with food. -If the order was for the Amitiza to be given with food, the facility should have administered within 15 minutes of the resident eating. Refer to telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am. Refer to interview with the Adminsitrator on 2/15/17 at 2:30 pm. _____ Telephone interview with the Resident Care Coordinator on 2/16/17 at 11:00 am revealed: -She did not train the Medication Aides in regards to administer medications. -A Registered Nurse trained all the Medication Aides prior to them administering medications independently. Interview with the Adminsitrator on 2/15/17 at 2:30 pm revealed: -She was not aware the Medication Aides were not administering medications as prescribed. -She was not responsible to training Medication Aides. -All the Medication Aides had received the 15 hour Medication Training course and the Medication Skils Checklist. -A Registered Nurse performed all the necessary trainings to the Medication Aides. _____ The facility's failure to administer medications as ordered by the physician resulted in a Medication Pass error rate of 28% (7 errors out of 25 opportunities) including Resident #12 receiving 10 units of fast acting insulin in which there was no	D 358		

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D 358	Continued From page 72 physician's order to adminsiter; Resident #13 which received fast acting insulin and did not receive dinner until over 1 hour after the insulin was administered resulting in the resident feeling weak. The failure of the facility to administer medications as ordered resulted in substantial risk of harm to residents and constitutes a Type A2 Violation. _____ Review of the Plan of Protection provided by the facility on 2/15/17 revealed: -The two Medication Aides responsible for the errors would be taken off the medication cart pending re-education by the Registered Nurse. -A meeting with the Medication Aides would be held on 2/15/17. -The 5 hour medication training course and the medication skills checklist would be completed prior to medication cart orientation. -Medication Aides would work with a preceptor for 5-10 days. -The 10 hour medication training course would then be completed. -All new medication orders would be reviewed by the Resident Care Coordinator or the Supervisor in Charge when needed. -The night shift Supervisor in Charge would review all medication orders each night. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 18, 2017.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those	D 378		

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D 378	Continued From page 73 requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure medications were maintained secured and not accessible to residents, except when they were under direct observation of medication staff. The findings are: Observation on 2/14/17 at 11:40 am during a medication pass revealed: -There were no residents in the hallway. -The medication cart was outside of room 109. -The Medication Aide administered 5 milliliters (mL) of Magic Mouth Wash (used to treat inflammation of the mouth) out of a bottle with approximately 400 mL of medication. -The Medication Aide opened the drawer to the medication cart and pulled out of a vial of artificial tears eye drops (used to treat dry eyes) and a calcium with vitamin D tablet (used as a vitamin supplement). -The Medication received a page over the intercom that she had a phone call. -There was no phone on the hallway. -The Medication Aide locked the medication cart and took the keys. -The Medication Aide left the bottle of Magic Mouth Wash, bottle of artificial tears eye drops and one calcium with vitamin D in a soufflé cup on top of the medication cart. -The Medication Aide walked off the hallway, approximately 50 yards and out of visual sight of the cart.	D 378		

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Observation on 2/14/17 at 11:45 am revealed:
-There were no residents in the hallway.
-The Medication Aide returned to the medication cart.
-The Medication Aide poured a cup of water, picked up the calcium with vitamin D tablet in the soufflé cup and the eye drops and went into the prescribed resident's room to administer them.
-The Magic Mouth Wash bottle remained on the top of the medication cart while the Medication Aide was in the resident's room.

Interview on 2/14/17 at 11:47 am with the Medication Aide revealed:
-She had worked at the facility for about 6 months.
-She had worked as a Medication Aide prior to working at the facility.
-She knew she should not leave medications on top of the cart without supervision.
-She never left medications on top of the cart before today (2/14/17).
-She was nervous because of the surveyor observing the medication pass.
-She forgot to put the medications in the medication cart and lock it before she walked away.

Interview on 2/14/17 at 4:20 pm with the Administrator revealed:
-The Medication Aides knew not to leave medications on top of the cart unsupervised.
-She did not know why the Medication Aide left the medications on top of the cart unsupervised.
-She would address this incident with the Medication Aide.

Review of the facility's Medication Storage policy revealed all medications, prescription and non-prescription, administered by the facility staff,

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D 378	Continued From page 75 including those requiring refrigeration, would be kept locked except when staff responsible for medication administration were in close proximity and could see the medications.	D 378		
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 observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration and clarification of medication orders. The findings are: 1. Based on observations, interviews and record reviews the facility failed to assure medications were maintained secured and not accessible to residents, except when they were under direct observation of medication staff. [Refer to Tag D344, 10A NCAC 13F .1002 (b) Medication Orders (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 6 of 19 residents (#8,#9, #10, #11, #12, #13) observed during the	D912		

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D912	Continued From page 76 medication passes, including errors with medications for diabetes for 2 residents (#12 and #13), medication for inflammation in the mouth (#8), a vitamin supplement (#9), medication for constipation (#11), and eye drops for the treatment of chronic dryness (#10). [Refer to Tag D358, 10A NCAC 13F .1004 (a) Medication Administration (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure all residents were free from neglect related to supervision and health care. The findings are: 1. Based on interviews, observation, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #1) in accordance to assessed needs with multiple falls, resulting in multiple injuries including closed head injuries, scalp laceration, and low back pain. [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to follow-up with the physician for falls that required emergency room visits for 1 of 5 residents sampled (#1). [Refer to Tag D273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)].	D914		