STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and complaint investigation on 3/7-10/17 and 3/13/17.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure an exit door, walls in four resident rooms, the ceiling in one resident bathroom, a heat registry in one resident bathroom, floors in three resident rooms and floor tiles in two resident bathrooms were kept clean and in good repair. The findings are: 1. Observation on 3/7/17 at 10:47am revealed the first closet door in resident room #303 on the east east hall had an approximate five inch in length and one inch in height hole with cracked filling around the hole and along the inner edges. Interview with a Personal Care Aide (PCA) on 3/7/17 at 10:47am revealed the hole in the closet door in resident room #303 had been there for at least six months. Observations of resident rooms on the east hall on 3/7/17 from 10:47am until 11:55am revealed:	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 074	Continued From page 1 -There was dirt build up on the floor behind the door and in the corners in resident room #303. -There were two unpainted patched areas (one approximately six inches square and a second approximately 12 inches square) on the wall near the head of the bed next to the window in resident room #309. -There was dirt build up on the floors around the edges with increased build up in front of the closet doors in resident rooms #313 and #315. -There was an unpainted patched area approximately the size of a door knob on the wall between the closet doors of resident room #319. -There were cracked floor tiles around the toilet bases in resident rooms #323 and #324. Interview with the resident in room #319 on 3/7/17 at 11:34am revealed someone had patched the hole in the wall about three weeks ago and "just left it." Interview with the Maintenance Director on 3/9/17 at 5:03pm revealed: -He was not aware of the hole in the first closet door in resident room #303. -He thought the hole might be too large for a patch repair and was not sure if a replacement door was in the budget. -He had not noticed the patched and unpainted walls in resident rooms #309 and #319 nor the cracked floor tiles around the toilets in resident rooms #323 and #324. -There was a painting company that came to the facility once a month to patch and paint, and a maintenance company that came for non-routine major repairs and renovations. -He had been wearing "two hats lately" working in the kitchen and as the Maintenance Director, and it was hard to keep track of everything. -There was supposed to be a maintenance log for	D 074		

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	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 074	Continued From page 2	D 074		

staff to write down any repair concerns, but no one had been doing that for a couple months.

Interview with the covering Resident Care Coordinator, Administrator and Regional Director on 3/10/17 at 3:43pm revealed the repairs would start being addressed starting 3/13/17 by maintenance.

Interview with the Regional Director on 3/13/17 at 5:25pm revealed:
-The Maintenance Director worked as a housekeeper today (3/13/17) because the housekeeper called in.
-There were painters that came to the facility every one to two months, but the Maintenance Director was able to patch and paint small areas such as resident rooms #309 and #319.

2. Observations on the 200 Hall on 3/07/17 at 11:00 a.m. revealed:
-The inside of the door near exit 6 had a 12 inch X 36 inch black scuff marks which covered the lower half of the door.
-The heat registry near Room # 202 and under the handrail was bent.

Observation of Room # 223 on the 200 Hall on 3/07/17 at 12:00 p.m. revealed:
-The ceiling in the shared bathroom between Room # 223 and # 225 had brown areas around the air vent.
-The inside of the bathroom door had white paint splashed over a 6 inch X 4 inch splintered area that was near the middle hinge of the door.

Interview with the Maintenance Staff on 3/09/17 at 9:12 a.m. revealed:
-He was aware the inside of the door near exit 6 had black scuff marks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 074	Continued From page 3	D 074		

-A metal plate had been ordered for the exit door, but he did not know the delivery date or when the metal plate was ordered.
-He was aware the heat registry near Room # 202 was bent.
-He was aware that the bathroom ceiling of the shared bathroom between Rooms # 223 and # 225 needed to be re-painted from a previous leak.
-He was aware the inside of the bathroom of Room # 223 had a damaged area which needed to be repaired.
-"It was hard to say when he would fix the above needed repairs, because he sometimes did maintenance duties as well as housekeeping duties."
-A maintenance book was kept in the staff's lounge.
-The staff who discovered the needed repairs were responsible for reporting or documenting the needed repair in the log book.

Interview with a medication aide (MA) on 3/13/17 at 11:50 a.m. revealed:
-The Maintenance Director was notified of needed repairs at the facility by word of mouth.
-The personal care aides (PCA) notified her or the Maintenance Director of needed repairs at the facility by word of mouth.

Interview with a personal care aide (PCA) on 3/13/17 at 4:35 p.m. revealed she notified the Maintenance Director by word of mouth or note of needed repairs at the facility.

Interview with the Administrator on 3/13/17 at 5:32 p.m. revealed:
-She was aware the inside of the door near exit 6 had black scuff marks.
-A metal plate had been order for the door, but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 074	Continued From page 4 she did not know the expected delivery date or when the metal plate was ordered. - She was not aware the heat registry near Room # 202 was bent. -She was not aware the bathroom ceiling of the shared bathroom between Rooms #223 and #225 needed to be re-painted from a previous leak. -She was not aware the inside of the bathroom of Room # 223 had a damaged area which needed to be repaired. -The time frame for repairs would depend on what needed to be fixed. -The staff were responsible for reporting and documenting needed repairs in the maintenance book which was kept in the staff's lounge.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure there were no chronic urine odors present at the entrance to the facility and the east hall. The findings are: Observations on the east hall on 3/7/17 from 10:25am until 1:05pm revealed: -There was a strong odor of urine in the east hall from the dining room area down to resident	D 075		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 075	Continued From page 5	D 075		

rooms #323 and #324.
-There was a strong urine odor and a basket of dirty clothes with saturated clothing on the top of the basket in the first closet in resident room #303 and #316.
-There was a strong urine odor in resident rooms #309 and #325.
-There was a strong urine odor from the first bed in resident room #306 even though the bed linens were dry with no obvious stains.
-There was a male resident sleeping in a motorized chair with a strong odor of urine notable from three feet away in resident room #325.

Observation on 3/8/17 at 3:10pm revealed there was a strong odor of urine in the entrance hall, east hall and the laundry room across from resident room #329.

Observations on 3/9/17 at 4:04pm revealed:
-There was a urine odor in the east hall.
-There was a strong urine odor in resident room #305 with greater intensity in the second closet inside the resident room.

Interview with the covering Resident Care Coordinator, Administrator and Regional Director on 3/10/17 at 3:43pm revealed there was no comment regarding the urine odor noted at times in the front entrance hall and consistently in the east hall.

Observation on 3/13/17 at 10:08am revealed there was a strong urine odor in the front entrance hall, east hall and resident room #305.

Interview with a housekeeper on 3/13/17 at 1:00pm revealed:
-She had noticed the urine odor for approximately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 075	Continued From page 6 four months especially in the men's bathroom because the men urinated everywhere and left urine in the toilets. -She would spray with vinegar because that helped with the odor. -She reported the urine odor to the Administrator several times. Interview with the Regional Director on 3/13/17 at 5:25pm revealed: -There was no housekeeping staff on the weekends and staff were responsible for cleaning up spills and things like that. -Direct care staff were responsible for cleaning soiled linens and residents clothing after incontinence episodes.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure an environment for residents that was free of a chronic infestation of fruit flies present in resident rooms on the east hall, the east hallway area, the east hall men's shared bathroom and dining room entrance.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 7 The findings are: Observations on the east hall on 3/7/17 from 10:25am until 1:05pm revealed: -There were large fruit flies on the wall and on the closet doors in resident room #309. -There were large numbers (too numerous to count) of large fruit flies around the laundry basket, closet door and wall around the closet in resident room #316. -There were large fruit flies on the walls in resident room #306. -There were large fruit flies on the walls and curtains in the men's shared bath room. Observation on 3/8/17 at 12:50pm revealed there were several large fruit flies in the main doorway to the dining room. Observation on 3/9/17 at 4:35pm revealed there were several large fruit flies flying around and on the walls in the east hall near resident room #310. Interview with a Medication Aide (MA) on 3/10/17 at 11:31am revealed: -She had only seen fruit flies in one resident room (#310) and that was because one of the resident spilled soda and "stuff." -Staff would mop and clean up spills, but she thought the fruit flies came from the weather being warm also. Interview with a housekeeper on 3/13/17 at 1:00pm revealed: -She had noticed the fruit flies for approximately four months especially in the men's bathroom because the men urinated everywhere and left urine in the toilets. -She would spray with vinegar because that killed the fruit flies.	D 079		

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	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 079	Continued From page 8 -She reported the fruit flies to the Administrator several times. Interview with the Maintenance Director on 3/9/17 at 5:03pm revealed: -He was aware of the large fruit flies and had reported it to the pest control company a few months ago. -The pest control person had told him they looked like sewer flies. -The pest control company had not informed him of any treatment plans for the fruit flies, but he was not always at the facility when they came for regular treatments. Telephone interview with the technician from the pest control company on 3/13/17 at 11:59am revealed: -The fruit flies were attracted to urine and would be gone if proper cleaning was done. -The pest control company could spray and kill the fruit flies, but the fruit flies would just come back if the facility was not kept clean. -The presence of fruit flies had not been reported or they would have been addressed. -Fruit flies had been a problem in the past at the facility. Interview with the Regional Director on 3/10/17 at 3:43pm revealed she was not aware of any issues with fruit flies and would definitely follow up with the pest control company.	D 079		
D 183	10A NCAC 13F .0603(a) Management of Facilities with a Capacity or C 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents	D 183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 9 (a) An adult care home with a capacity or census of 81 or more residents shall be under the direct control of an administrator, who shall be responsible for the operation, administration, management and supervision of the facility on a full-time basis to assure that all care and services to residents are provided in accordance with all applicable local, state and federal regulations and codes. The administrator shall be on duty in the facility at least eight hours per day, five days per week and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home except as follows. If there is more than one facility on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor in this campus setting. For staffing chart, see Rule .0606 of this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure full time and consistent responsibility for the operation, administration, management and supervision of the facility which resulted in significant noncompliance with state rules and regulations related to staffing, personal care, supervision, health care, medication administration, housekeeping and furnishings and reporting incidents and accidents.	D 183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 10 The findings are: 1. Confidential staff interview revealed: -Staff normally reported directly to the Administrator because they did not have a Resident Care Coordinator (RCC). -There was a covering RCC from another facility who was in the building "a couple days a week," and the Regional Director who was in the building "a couple days a week." Interview with the covering Resident Care Coordinator (RCC) on 3/7/17 at 9:45am and 3/8/17 at 10:03am revealed: -She worked at another facility approximately two hours away, but was "covering this facility a few days a week until April 2017." -In her absence, the RCC role was covered by the Office Manager, Community Liaison and the Regional Director. -The Administrator was at a training and was not available on 3/7/17. -There was a covering Administrator expected at the facility on 3/7/17. Interview with the covering Administrator on 3/7/17 at 10:50am revealed she was covering for the facility on 3/7/17. Interview with a Primary Care Provider (PCP) on 3/10/17 at 11:47am revealed: -The PCP did not know who to go to with requests and any needed follow up for residents' care. -Sometimes it would be the Community Liaison, sometimes the Regional Director and sometimes a Supervisor. -Things did not run smoothly and communication was an issue. -It was a "hodge podge of different people	D 183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 11	D 183		

covering and nobody knows what's going on because nobody's here all the time."

Telephone interview with a second PCP on 3/13/17 at 1:06pm revealed she hoped to see improvement at the facility and that "they could get things together ... a lot of people come and go (Administrative staff)" and that made it hard to get things done.

Telephone interview with a Mental Health Provider (MHP) on 3/13/17 at 3:29pm revealed, she had found she needed to review residents Medication Administration Records and resident records to assure orders had been carried out because "there had been so many changes in RCCs and Administrators, and things tended to fall through the cracks."

Interview with the Regional Director (RD) on 3/13/17 at 5:25pm revealed:
-The Regional Director was responsible for overseeing the Administrator.
-Administrator was responsible for overseeing the RCC, Business Office Manager, Community Liaison, Dietary Manager, Maintenance and other facility staff.
-The Supervisor on duty was responsible for the immediate supervision of direct care staff, and the RCC was responsible for overseeing all direct care staff.
-The RCC normally handled clinical issues and the Administrator normally handled issues with the physical environment.

2. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents for record review which included Resident #5 not receiving nebulizer medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 12	D 183		

(Brovana and Pulmicort) resulting in emergency room treatment for an exacerbation of Chronic Obstructive Pulmonary Disease, receiving duplicate antipsychotic therapy (Perphenazine and Prolixin) for 6 weeks and receiving the incorrect dose of a muscle relaxer (Baclofen); Resident #4 receiving sliding scale insulin for two months without an order from the Primary Care Provider and did not receive a stool softener and laxative (Colace and Miralax) as ordered following a hospitalization for a bowel obstruction; and, 1 of 3 (Resident #10) as observed during the medication pass, not receiving an anti-reflux medication (Protonix) more than one hour after breakfast and not receiving antihistamine eye drops with current symptoms of dry and itchy eyes. [Refer to Tag 358 10A NCAC 13F .1004(a)(2) Medication Administration TYPE A1 VIOLATION]

3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents which resulted in one resident (#8) with a diagnosis of dementia and a history of leaving the facility requiring emergency medical treatment for exposure to the cold, to then leave the facility a second time and was found on the ground by a passerby; and a second resident (#9) who had a strong odor of cigarette smoke near his room reportedly discarding cigarettes butts in a trash can near an oxygen tank. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision TYPE A2 VIOLATION]

4. Based on observations, interviews and record reviews, the facility failed to assure appropriate health care referral and follow up for 4 of 7 sampled residents which resulted in a resident (#6) being found unresponsive following new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 13	D 183		

vomiting that was not reported to the primary care provider (PCP) after an unwitnessed fall; a second resident (#1) not having a working oxygen concentrator for three days and not having a recommended ultrasound for a growth on the spleen; a third resident (#5) with a diagnosis of Chronic Obstructive Pulmonary Disease and was oxygen dependent not having a working oxygen concentrator for 5 days requiring emergency medical treatment; and, a fourth resident (#4) having increased swelling of his left foot unreported to the PCP. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care TYPE A2 VIOLATION]

5. Based on observations, interviews and record reviews, the facility failed to assure adequate staff were available to provide supervision and personal care assistance including incontinence care, bathing and assistance to the dining room for meals related to direct care staff on duty being assigned routine housekeeping duties such as deep cleaning resident rooms and doing laundry for each shift on a daily basis. [Refer to Tag 189 10A NCAC 13F .0604(e)(2) Personal Care and Other Staff TYPE B VIOLATION]

6. Based on observations and interviews, the facility failed to assure an exit door, walls in four resident rooms, the ceiling in one resident bathroom, a heat registry in one resident bathroom, floors in three resident rooms and floor tiles in two resident bathrooms were kept clean and in good repair. [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings]

7. Based on observations and interviews, the facility failed to assure there were no chronic urine odors present at the entrance and east hall. [Refer to Tag 075 10A NCAC 13F .0306(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 14 Housekeeping & Furnishings] 8. Based on observations and interviews and record reviews, the facility failed to assure an environment for residents that was free of a chronic infestation of fruit flies present in resident rooms on the east hall, the east hallway area, the east hall men's shared bathroom and dining room entrance. [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping & Furnishings] 9. Based on observations, interviews and record reviews, the facility failed to attend to the personal care needs of 8 residents including incontinence care, bathing and showering and assuring clean clothing, towels and linens for residents. [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision] 10. Based on observations, interviews and record reviews, the facility failed to report to the Department of Social Services the death occurring in less than 24 hours of resident (#6) who fell and developed new nausea and vomiting at the facility. [Refer to Tag 451 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents] _____ The facility's failure to assure consistent responsibility for the operation of the facility resulted in significant noncompliance with state rules and regulations related to medication administration, personal care and supervision, health care and staffing. The facility's failure to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and neglect of the residents which constitutes a Type A1 Violation.	D 183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 183	Continued From page 15 Review of the Plan of Protection submitted by the facility dated 3/13/17 revealed: -The Administrator shall continue to oversee the overall operation of the adult care home to ensure that the facility is in compliance with state rules and regulations. -The Administrator shall continue to be onsite weekly to ensure that all areas of the adult care home are overseen and managed according to state rules and regulations. -The Resident Care Coordinator or designee will be responsible in the absence of the Administrator and will notify the Administrator in the event of an emergency along with documentation of the notification. -Continued random surveys with staff and residents by the Regional Director weekly for one month and then monthly thereafter to ensure [residents] needs are being met. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED 4/12/17.	D 183		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations:	D 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 16 (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure adequate staff	D 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 17	D 189		

were available to provide supervision and personal care assistance including incontinence care, bathing and assistance to the dining room for meals related to direct care staff on duty being assigned routine housekeeping duties such as deep cleaning resident rooms and doing laundry for each shift on a daily basis.

The findings are:

Telephone interview with a concerned citizen on 3/09/17 at 10:09 a.m. revealed:
-On 3/04/17 at 9:29am, another concerned citizen witnessed Resident #8 falling out of his wheelchair onto the ground near the school entrance (elementary school near the facility.)
-Resident #8 stated "I just need to get up. I am not hurt."
-The citizen was concerned about the resident's safety.
-The resident would not have been able to get up without help.
-Two other concerned citizens assisted Resident #8 into his wheelchair.
-The resident did not know where he lived.
-The citizen was familiar with the area, and knew a facility was a block away.
-One of the concerned citizens pushed Resident #8 in his wheelchair to the facility.
-The citizen drove to the facility on 3/04/17 and arrived around 9:40am.
-The citizen could not find out Resident #8's name.

Confidential interview with a fourth staff revealed:
-The facility was short of staff 3-4 days per week, sometimes every day and management was more focused on having staff "do laundry and get some dust off the walls."
-There were residents who might fall that could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 18	D 189		

not be seen if staff were down in the laundry room.
-There were times when staff on the previous shift did not do laundry so the PCA coming on would have to wash towels and linens before being able to clean and change or shower a resident because there were no clean towels available.
-Staff would have to "go down and put laundry in, feed residents, go change over laundry, get residents back down to their rooms, stop and check laundry ...it was constant."
-Staff were expected by management to clean residents' laundry first, but could not clean the residents' laundry first because they needed towels and sheets to be able to clean the residents after incontinent episodes and to give showers.
-It was not possible for one staff to care for all the residents on a hall, do laundry and clean residents' rooms.
-There were quite a few residents who needed two staff to lift, residents who required increased supervision, like Resident #8, and another resident who needed to be turned every hour to prevent skin breakdown.
-Residents' personal care was missed on a regular basis because there was only one staff on a hall.

Interview with a Personal Care Aide (PCA) on 3/9/17 at 4:33pm revealed the residents in rooms #301 and #305 ate meals in their rooms.

Observations on 3/9/17 from 4:33pm until 4:56pm revealed:
-The residents in rooms #301 and #305 were assisted by two PCAs to sit up in bed for the dinner meal.
-Both residents were set up with over-bed tables

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 19	D 189		

and their dinner trays which included pureed food and thickened liquids.
-One PCA assisted the resident in room #301 by removing covers on the plate, bowl and cups; positioning a bib and feeding the resident.
-The second PCA assisted the resident in room #305 by removing covers on the plate, bowl and cups; positioning a bib and prompting resident to eat.

Interview with a Medication Aide (MA) on 3/9/17 at 11:25am revealed the resident in room #305 was able to feed himself.

Observation on 3/10/17 at 10:55am revealed:
-The resident in room #301 was in his wheelchair using his feet to move forward out of the room toward the dining room.
-The resident in room #305 was sitting in his wheelchair in front of the television in his room.

Confidential interview with a second staff revealed:
-Staff were not always able to get residents who required assistance to the dining room, so they ate in their rooms.
-It was hard for staff to make sure residents were changed and showered when there was only one staff on the east hall.
-Staff were also responsible for doing deep cleaning in assigned resident rooms each day.

Observations on 3/7/17 from 10:25am until 1:05pm revealed:
-There was a strong urine odor and a basket of dirty clothes with saturated clothing on the top in the first closet in resident room #303 and #316.
-There was a resident sitting in a wheelchair in resident room #309 with blue sweatpants on that had a dark circle of wetness from the mid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 20	D 189		

abdomen area to both upper thighs.
-There was a strong odor of urine in resident room #309.

Interview with the resident in room #309 revealed the resident said in garbled speech, "I'm wet."

Observation on 3/7/17 at 11:55am revealed there was a male resident sleeping in a motorized chair with a strong odor of urine notable from three feet away in room #325.

Telephone interview with a family member on 3/13/17 at 10:13am revealed he was concerned about staff keeping an eye on the resident for wetness (urinary incontinence) since the resident had, had a history of frequent urinary tract infections. (The resident resided in room #305.)

Interview with a resident on 3/7/17 at 12:25pm revealed:
-The PCAs did not "hardly want to help residents get to the bathroom" and said things like "you're too big, I'm going to have to find some help" and then the staff just leave.
-The PCA left him on the toilet this morning, he had to call the office from his cell phone to get someone to help him get off the toilet."
-The lack of help mostly happened on the day shift.
-The PCAs did the laundry; his was last done on 3/5/17 because the PCA came in and said there was only one clean pair of pants left.
-He had not had a shower in "going on two weeks."
-He was supposed to get a shower on the evening shift, but there was always just one person working so he wouldn't get a shower.
-He had not been getting showers for "a good long time," and had not reported it because "they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 21	D 189		

should be able to look at the books and see" he had not been getting showers.

Interview with a second resident on 3/8/17 at 4:54pm and 3/13/17 at 12:26pm revealed:
-The resident had not gotten showers regularly until it was reported to the Department of Social Services (DSS) worker.
-"There's not enough staff to do our care and they worked the staff too much by putting extra duties on them such as washing down the bed and making each shift do laundry."
-She pees quite a bit so she needs her clothes changed frequently and washed frequently.
-Staff might wash her clothes once per month, not once per week.
-Her clothes used to get washed once per week but that changed at the beginning of the year (January 2017).

Observation on 3/8/17 at 12:55pm revealed:
-A PCA was "training" with the MA while also working as a PCA.
-The PCA said to the MA, "I'm going to check on the laundry."

Confidential interview with a third staff revealed:
-There were usually four Personal Care Aides (PCAs) and two Medication Aides (MAs) on duty for the whole building.
-There was one PCA for the east hall with 40 residents for first shift 3/7/17.
-All of the residents on the east hall needed "some type of help but there were about 10 or 11 who needed a lot of help; four residents were total care residents."
-There was a lot of staff leaving because there was not enough staff.
-The former laundry person was moved to full time housekeeping duties two months ago, so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 22	D 189		

there was no one to do laundry.
-PCA staff were expected to wash laundry every shift, every day.

Confidential interview with a fourth staff revealed:
-There was only one staff to work on the east hall on 3/9/17 for 1st shift.
-There were five residents on the east hall that were heavy care and required two staff to assist with transfers and changing, ten residents total who needed regular incontinence care and four residents who needed feeding assistance.
-Staff were responsible for checking and changing residents every two hours, showers on shower days, assisting with feeding and cleaning resident rooms which meant making sure there was no trash and making the beds.
-All three shifts were responsible for doing laundry for all the residents in the building except six who did their own or their laundry was sent out.
-Staff had been asking management for help on the east hall for "a long time."

Confidential interviews with seven additional staff revealed:
-The residents were not getting the care that they needed; there was just not enough staff to complete needed care.
-There was usually only one staff working on the east hall most of the time.
-Staff were not able to provide care to residents such as incontinence care and showering when there was just one person.
-The one staff was also responsible for feeding assistance at meal times, laundry and deep cleaning resident rooms according to a scheduled assignment daily.
-PCAs doing laundry and deep cleaning resident rooms probably took a lot of time away from them

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 23	D 189		

being able to provide personal care and supervision to residents.
-The housekeeping and laundry duties took two and half to three hours away from assisting residents with personal care.
-The 3rd shift staff does the regular laundry, 1st and 2nd shift staff did laundry if it was piled up or there were saturated clothing and linens.
-The facility had been without a laundry person since the end of November 2016.
-The laundry person now did housekeeping and personal care staff was doing the laundry.

Interview with a housekeeper on 3/7/17 at 10:48am revealed:
-She worked Monday through Friday from 7:00am until 3:00pm as a housekeeper.
-She had moved from working as the laundry person to working as a housekeeper four or five months ago.
-The PCAs had been responsible for washing linens, towels and the residents' clothing since she started working as a housekeeper.

Observation on 3/7/17 at 10:25am revealed:
-The linen closet on the east hall had three pillows on the bottom shelf of a four shelf metal shelving rack approximately 4 feet in length; the other three shelves were empty.
-There was a second four shelf metal shelving rack approximately four feet in length which had three hospital gowns, one pillow and a small throw blanket on the top shelf, two flat sheets on the second shelf, the third shelf was filled with flat sheets (approximately 25) and the bottom shelf had two fitted sheets.
-There was a third metal shelving rack with two shelves approximately three feet in length which had 8 light blankets and one pillow on the top shelf and 6 bed spreads on the bottom shelf.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 24 Review of "Housekeeping Daily Duties & Deep Cleaning Schedule Sheet" (undated) revealed: -"Care Aides: The cleanliness of our building is as important as the good care you are giving to our residents. Please check the cleaning schedule each day for the room # of focus, clean and initial each day." -The name of the current Administrator was typed at the bottom of the sheet. Review of the "East Hall 1st Shift Thorough Cleaning Schedule" dated the "Week of March 5-11, 2017" revealed: -There were two to three rooms for each day, Sunday through Saturday with the names of PCAs written on each day. -There were instructions for staff to initial once all tasks were completed. -Tasks were documented as: move furniture, vacuum/sweep & mop rooms, dust all furniture, wipe headboards, dust blinds, clean window sills, wipe down doors/door knobs & frames, wipe baseboards around the floor, dust corners for cobwebs and wipe walls in bathroom. -There were 7 staff initials out of the 16 assigned resident rooms. Review of the "PCA Assignment Sheet" (undated) revealed: -There were 35 residents listed with assigned laundry days. -There were 22 residents assigned for 1st shift PCAs to do their laundry. -There were 13 residents assigned for 3rd shift PCAs to do their laundry. Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed: -The facility was normally staffed with a	D 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 25 Medication Aide (MA), Supervisor, four Personal Care Aides (PCAs) a housekeeper and dietary staff. -There was no laundry person. -The PCAs did the laundry throughout the day on all three shifts. -Any soiled laundry was done immediately and resident clothing was otherwise done on the residents' regular shower days. -Residents were showered on a three day rotation and sponge bathed on the days in between showers. Interview with the Administrator on 3/10/17 at 3:43pm revealed the PCAs did residents' laundry in conjunction with each resident's shower days. Interview with the Regional Director on 3/10/17 at 3:43pm revealed: -There was one MA and one PCA on the east hall. -The aides were responsible for feeding and changing residents and doing the laundry. -The MA was responsible for administering medications and providing four hours of aide duty by helping out on the floor with personal care for residents. -MAs were responsible for four hours of aide duty on all three shifts. Interview with the Regional Director on 3/13/17 at 5:25pm revealed there was no housekeeping staff on the weekends and staff were responsible for cleaning up spills and things like that. _____ The facility's failure to assure adequate staff were available to provide supervision and personal care assistance resulted in residents not being	D 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 189	Continued From page 26 supervised, not receiving timely incontinence care, not being taken to the dining room for meals, being showered only once per week, and not having clean linen and clothing. The facility's failure to assure adequate and available staff was detrimental to the safety and well being of residents, which constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility dated 3/13/17 revealed: -Residents' needs will be reassessed by the Resident Care Coordinator and/or designee and the facility will continue to provide adequate staffing to meet all of the needs of the residents. -[There will be] continued random surveys monthly for three months then quarterly thereafter by the Administrator and/or Regional Director to ensure residents' needs are being met. -Staff will be monitored by the Administrator and/or designee weekly for four weeks and then monthly thereafter to ensure that the needs of residents are being met. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 4/27/17.	D 189		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 27	D 269		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to attend to the personal care needs of 8 residents including incontinence care, bathing and showering and assuring clean clothing, towels and linens for residents.

The findings are:

Observation on 3/7/17 at 11:09am revealed there was a resident sitting in a wheelchair in room #309 with blue sweatpants on that had a dark circle of wetness from the mid abdomen area to both upper thighs.

Interview with the resident in room #309 revealed the resident said in garbled speech, "I'm wet."

Observation on 3/7/17 at 11:55am revealed there was a male resident sleeping in a motorized chair with a strong odor of urine notable from three feet away in room #325.

Observations on 3/7/17 at 10:45am revealed there was a strong urine odor and a basket of dirty clothes with clothing saturated with urine on the top in the first closet in room #303.

Interview with a second resident on 3/7/17 at 12:25pm revealed:
-The Personal Care Aides (PCAs) did not "hardly want to help residents get to the bathroom" and said things like "you're too big, I'm going to have to find some help" and then the staff just leave.
-The PCA left him on the toilet this morning and he had to call the office from his cell phone to get someone to help him get off the toilet.
-The lack of help mostly happened on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 28	D 269		

shift.
-The PCAs did the laundry.
-His laundry was last done on 3/5/17 because the PCA came in and said there was only one clean pair of pants left.
-He had not had a shower in "going on two weeks."
-He was supposed to get a shower "like every other day" on the evening shift, but there was always just one person working so he wouldn't get a shower.
-He had not been getting showers for "a good long time," and had not reported it because "they should be able to look at the books and see" he had not been getting showers.

Interview with a third resident on 3/8/17 at 4:54pm and 3/13/17 at 12:26pm revealed:
-The resident had not gotten showers regularly until it was reported to the Department of Social Services (DSS) worker.
-Staff were rude and did not want to help residents.
-If residents reported staff, the staff would only give residents showers once per week.
-The resident had not gotten showers regularly until it was reported to the Department of Social Services (DSS) worker.
-"There's not enough staff to do our care and they worked the staff too much by putting extra duties on them such as washing down the bed and making each shift do laundry."
-She pees quite a bit so she needs her clothes changed frequently and washed frequently.
-Staff may wash clothes once per month, not once per week.
-Her clothes used to get washed once per week, but that changed at the beginning of the year.

Interview with a fourth resident on 3/8/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 29	D 269		

4:59pm revealed:
-On 3/8/17, the resident got the first shower she had had in a week.
-Staff would treat you "any kind of way; they were rude and cussed."
-The resident had reported specific staff to a Personal Care Aide (PCA) and the Community Liaison.
-Staff would get back residents for reporting staff by "cutting their showers to once per week."

Interview with the Community Liaison on 3/13/17 at 7:09pm revealed:
-She worked for the facility assisting the Regional Director, Residential Care Coordinator and residents with any issues and concerns.
-She also assisted with faxing orders to the pharmacy and covering shifts as a Medication Aide when the facility was short of staff.
-There was one resident who had come to her with reports of not receiving shower assistance regularly within the last month.
-She was not aware of any other residents.
-She talked with PCAs and then followed up with the resident.
-The PCAs reported the resident was showered.
-Both she and the resident reported shower concerns and staff involved to the Administrator.

Telephone interview with a family member on 3/13/17 at 10:13am revealed he was concerned about staff keeping an eye on Resident #4 for wetness (urinary incontinence) since the resident had, had a history of frequent urinary tract infections.

Review of the Resident #4's hospital discharge instructions dated 2/21/17 revealed the resident was treated for a urinary tract infection (UTI) on 2/19/17 and had prior episodes of UTI's.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 30 Confidential interview with a staff revealed: -Staff were not always able to get residents who required assistance to the dining room, so they ate in their rooms. -It was hard for staff to make sure residents were changed and showered when there was only one staff on the east hall. -Staff were also responsible for doing deep cleaning in assigned resident rooms each day. Confidential interview with a second staff revealed PCAs were responsible laundry and deep cleaning resident rooms which probably took a lot of time away from them being able to provide incontinence care every two hours, feeding assistance, assistance to the dining room, bathing/shower assistance and supervision to residents. Confidential interview with a third staff revealed: -There were times when staff on the previous shift did not do laundry so the PCA coming on would have to wash towels and linens before being able to change or shower a resident because there were no clean towels available. -Staff would have to "go down and put laundry in, feed residents, go change over laundry, get residents back down to their rooms, stop and check laundry ...it was constant." -Staff were expected by management to clean residents' laundry first, but could not clean the residents' laundry first because they needed towels and sheets to be able to clean the residents after incontinent episodes and to give showers. -It was not possible for one staff to care for all the residents on a hall, do laundry and clean residents' rooms. -There were quite a few residents who needed	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 31 two staff to lift and another resident who needed to be turned every hour to prevent skin breakdown. -Assisting residents with incontinence changes, bathing and showering was missed on a regular basis because there was only one staff on a hall. Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am and 3/10/17 at 4:58pm revealed: -The facility was normally staffed with a Medication Aide (MA), Supervisor, four Personal Care Aides (PCAs) a housekeeper and dietary staff. -Residents were showered on a three day rotation and sponge bathed on the days in between showers. Interview with the Regional Director (RD) on 3/10/17 at 3:43pm revealed there were always four PCAs in the building and they could always ask an aide from another hall to help with a resident's care if needed. Interview with the Administrator on 3/10/17 at 3:43pm revealed: -Staff were encouraged to "team up when a resident was combative, heavy or difficult." -Staff were expected to check and change residents every two hours. -Showers were typically given to residents three times a week. Upon request there was no written facility policy or procedure for the personal care of residents available for review on 3/10/17.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 32 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 observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents which resulted in one resident (#8) with a diagnosis of dementia and a history of leaving the facility requiring emergency medical treatment for exposure to the cold, to then leave the facility a second time and was found on the ground by a passerby; and a second resident (#9) who had a strong odor of cigarette smoke near his room reportedly discarding cigarettes butts in a trash can near an oxygen tank. The findings are: 1. Review of Resident #8's current FL-2 dated 12/29/16 revealed: -Diagnoses included Dementia. -The resident was intermittently confused and semi-ambulatory with a wheelchair. Review of Resident #8's current Care Plan dated 8/10/16 revealed: -Resident #8 was ambulatory with a wheelchair, sometimes disoriented, forgetful and needed reminders. -Resident #8 required supervision assistance with transfers and limited assistance with mobility.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 33 -There was no notation Resident #8 required increased supervision for wandering and/or leaving the facility. Telephone interview with a concerned citizen on 3/09/17 at 10:09 a.m. revealed: -On 3/04/17 at 9:29 a.m., another concerned citizen witnessed Resident #8 falling out of a wheelchair, leaning on his left elbow and lying on his left side on the ground near the school entrance (elementary school up the street from the facility.) -The wheelchair was on Resident #8's left side near his legs and did not have any foot rests. -Resident #8 stated "I just need to get up. I am not hurt ... he was trying to lead a Revolution." -The citizen was concerned about the resident's safety, because he would not have been able to get up without help and did not know where he lived. -The citizen was familiar with the area, and knew a facility was a block away. -Two other concerned citizens assisted Resident #8 into his wheelchair and one of the concerned citizens pushed Resident #8 in his wheelchair to the facility. -The citizen drove to the facility on 3/04/17 and arrived around 9:40 a.m. -Resident #8 stated he slipped out of the side door and this was not his first time slipping away from the facility. -He did not say the date of the last time he slipped away from the facility. -The citizen could not find out Resident #8's name. -Another resident at the facility stated Resident #8's room was 314. -The staff member or the charge person did not asked any questions or information regarding Resident #8's condition or whereabouts.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 34 -The charge person stated Resident #8 was supposed to be in the dining room. -The citizen did not ask the staff their names. Review of "Care Notes" for Resident #8 dated 12/11/16 through 3/5/17 revealed: -On 12/11/16 at 1:00pm a staff documented the resident was walking outside in front of the building where he reported he fell ...hit his head and was in pain. The resident was sent to the emergency room (ER). The resident's Power of Attorney (POA) was called but there was no answer and no machine, the Primary Care Provider (PCP) was notified. The resident would be on 15 minute checks on return to the building. -On 3/4/17 at 9:35am a Medication Aide (MA)/Supervisor documented Resident #8 was found outside on the ground by the road; he was checked and there were no visible bruises and he had no complaints of being hurt. The PCP was notified, there was no answer from the resident's POA and a message was left for his family member. Review of a facility "Incident-Accident Report" for Resident #8 dated 12/11/16 at 1:00pm revealed: -There were marks next to "other" for type of event and "none" for area of injury with a hand written entry "stated he hit his head." -The Regional Director (RD) documented leaving a message for Resident #8's Power of Attorney at 1:35pm on 12/11/16. -The RD documented the county Department of Social Services (DSS) was notified at 10:00am on 12/12/16. -The box was marked "No" for first aid and medical treatment; and "yes" that 911 was called, transported to the ER and admitted to the hospital. -Under "Was the physician called? Description of	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35	D 270		

recommendations from physician," the RD documented "yes."
-Under "Interventions implemented to manage accident/incident," the RD documented "kept safe until EMS (Emergency Medical Services) arrived."
-Under "Description of follow-up orders from ER, if applicable" the RD documented "see d/c (discharge) papers."

Review of ER discharge instructions for Resident #8 dated 12/11/16 revealed the resident was seen in the ER for a diagnosis of exposure to the cold.

Review of "Long Term Care Progress Notes" for Resident #8 dated 12/13/16 revealed:
-The Primary Care Provider (PCP) documented a follow up visit with Resident #8 after a recent ER visit where he was treated for a fall and exposure to the cold.
-Resident #8 was found in the parking lot (of the facility) laying on the ground; the resident stated he was there for two hours before someone found him.
-The resident's history was unreliable secondary to dementia.
-Resident #8 stated he fell, hit his head and hurt his left side; but when he was found, his right side was dirty and had noted abrasions on his right hand.
-The PCP documented under "Assessment/Plan" "Resident discouraged from ambulating without wheelchair and discouraged from going outside alone."

Review of a facility "Incident-Accident Report" for Resident #8 dated 3/4/17 revealed:
-Staff documented a fall/slip outside of the facility with no injuries occurred at 9:45am on 3/4/17.
-Staff documented leaving a message for Resident #8's family member and Power of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 36	D 270		

Attorney at 10:15am on 3/4/17.
-Staff documented Resident #8's Primary Care Provider (PCP) was notified at 10:00am on 3/4/17.
-The box was marked "No" for first aid, medical treatment, 911, transport to the ER (emergency room) and admitted to the hospital.
-Under "Was the physician called? Description of recommendations from physician," staff documented "let her know."
-Under "Interventions implemented to manage accident/incident," staff documented "staff mon (monitor) res (resident) closely."

Interview with a Medication Aide (MA)/Supervisor on 3/9/17 at 11:25am revealed:
-She was on duty in the facility when Resident #8 left and then returned to the facility on 3/4/17, but did not know the exact times of the incident.
-She remembered seeing Resident #8 at the medication room door on the east hall during the morning medication pass and thought he was going down to the dining room for breakfast, but he went out the front door instead.
-Staff did not know that Resident #8 had left the facility.
-A man, not affiliated with the facility, brought Resident #8 back to the facility.
-She had spoken with the man about Resident #8.
-She could not remember the details of what the man said about Resident #8.
-She "guessed" they found Resident #8 "out in the [facility's] parking lot" and could not remember if the man who brought him back said they found the resident "by the road or down the road."
-She had checked Resident #8 for injuries and there were none.
-The resident said he was fine and was going to round up the troops.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 37	D 270		

-Resident #8 had left the facility before.
-She did not know how many times, but he had never gone further than the parking lot.
-Resident #8 was a wanderer and had just had a wander guard bracelet put on by the Community Liaison because he left the facility a couple of days ago.
-She was not sure when exactly the bracelet was put on.
-Resident #8 was not on frequent checks or increased monitoring and did not have a wander guard bracelet before the 3/4/17 incident.

Attempted interview with the PCA assigned to Resident #8 on 3/4/17 for 1st shift on 3/13/17 at 6:42pm was unsuccessful.

Interview with Resident #8 on 3/9/17 at 4:04pm revealed:
-He did not remember leaving the facility on 3/4/17.
-He could not remember ever being found on the ground outside the facility.
-He thought he had lived at the facility for about three months and that his family lived in other parts of the building.

Telephone interview with Resident #8's family member on 3/13/17 at 11:42am revealed:
-She did not visit the facility regularly but did receive contact from the facility with any incidents or concerns.
-The last time she was contacted was a long time ago regarding Resident #8 hitting another resident.
-She had not received any contact from the facility related to any falls, injuries or leaving the facility.
-She did not think Resident #8 would attempt to leave the facility and his memory was hard to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 38 describe because he slept a lot and woke up confused. Attempted interview with Resident #8's Power of Attorney on 3/13/17 at 11:37am was unsuccessful. Interview with the Community Liaison on 3/9/17 at 3:20pm and 4:15pm, and on 3/10/17 at 7:33pm revealed: -She had put a wander guard bracelet on Resident #8 on 3/6/17 at approximately 9:30am. -The wander guard was placed following the incident on 3/4/17 when the resident was found outside the facility. -She had received a text message from the Office Manager at approximately 9:30am on 3/4/17 that the resident was near the pharmacy down the street from the facility. -She called the facility and when she finally got through to staff, Resident #8 was back in the facility. -She was not aware of the resident having any injuries. -She was not aware of any prior incidents with Resident #8 since her return to working in the facility in November 2016. -Wander guard bracelets had been in use at the facility for a while, maybe as long as she had worked at the facility which was four years. -There were five other residents, in addition to Resident #8, who had wander guard bracelets. Observation on 3/9/17 at 4:10pm revealed Resident #8 had a wander guard bracelet attached to the rear metal frame of his wheelchair. Interview with the Business Office Manager on 3/13/2017 at 10:40am revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 39	D 270		

-She saw Resident #8 in his wheelchair in front of the elementary school on 3/4/17 at around 9:20am.
-She called the facility twice and both times "the phone rang off the hook until my phone hung up."
-She then texted the Administrator and the Community Liaison at 9:26am.
-The Community Liaison texted back right away at 9:30am. and stated "let me call the Medication Aide."
-The Administrator texted at 1:30 p.m. to say "thank you, I could not answer you when this came through but thank you."
-She received another text from the Community Liaison to say the facility had the resident.
-Resident #8 had fallen out of his wheelchair and someone brought him back.
-The Community Liaison said that she had to call the facility four times and just let it ring before someone answered.
-Resident #8 now had a wander guard on his chair which was placed there last week (3/6/17).
-As far as she knew this was the first time he had gotten out of facility.

Second interview with the MA/Supervisor on 3/10/17 at 11:31am revealed:
-She was told by the Community Liaison that a wander guard bracelet was put on Resident #8's leg following the incident in December 2016 where he was found out in the facility parking lot, but the resident had taken the bracelet off.
-She did not know when Resident #8 took the bracelet off, but staff was aware he had removed the wander guard bracelet.
-Staff were expected to do checks on residents every two hours "and when they walked by every so often."
-"It was hard for staff to check every resident every two hours when there was only one staff on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 40	D 270		

the hall."
-She was not aware back in December 2016 that Resident #8 had a wander guard bracelet, but was told recently that he did and it was on his leg.

Observation on 3/7/17 from 9:45am until 8:30pm revealed there was no alarm sounding with the opening of the front entrance door.

Observations on 3/8/17 from 9:30am until 5:15pm, 3/9/17 from 8:45am until 6:00pm and 3/10/17 from 9:05am until 8:35pm revealed there was an intermittent alarm sound (resembling a door bell) each time the front entrance door was opened.

Interview with a Personal Care Aide (PCA) on 3/7/17 at 10:31am revealed there were no residents on the east hall that were wanderers or required increased supervision.

Observation on 3/8/17 at 10:50am revealed a continuous loud alarm sounded from the front entrance door and staff could be heard saying "[Name of Resident #8], where are you going? You have to come back in."

Interview with a second PCA on 3/9/17 at 9:28am revealed Resident #8 wandered from one hall to another but she had never seen or heard of him going outside.

Interview with a third PCA on 3/13/17 at 1:30pm revealed:
-She was training with another PCA for 1st shift on 3/4/17.
-It was her third day working at the facility.
-She could not remember any events related to Resident #8 leaving the facility.
-Resident #8 seemed to get confused and "a little

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 41	D 270		

turned around" meaning forgetting where he was and what he was doing.

Interview with a fourth PCA on 3/13/17 at 1:53pm revealed:
-Resident #8 was overall a nice guy but would get agitated sometimes.
-When the resident was agitated, it meant that he wanted to go outside.
-The PCA would try to take him out to the gated and secured area at the rear of the building when he was agitated and that would calm him down.
-Staff had to keep an eye on him because he would try to get out of the building and he would not know how to get back.
-The PCA only heard about him leaving on 3/4/17 and did not know how long he was gone or what happened.
-No one told the PCA until 3/9/17 that Resident #8 had got out of the building and was up the street.

Interview with a fifth PCA on 3/13/17 at 4:48pm revealed:
-Resident #8 was "a bit confused" and would go to the front door of the facility looking for family members.
-The resident needed extra supervision and was on every one hour checks.

Interview with a sixth PCA on 3/9/17 at 4:14pm revealed Resident #8 would wheel himself close to the front door of the facility but staff would see him and bring him back.

Interview with a second MA on 3/13/17 at 6:54pm revealed:
-She was told by other staff that Resident #8 went out of the building on 3/4/17 and somebody brought him back.
-She did not believe they knew how long he had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 42	D 270		

been outside or where he went.
-Resident #8 was confused at times and if he went outside he would not be able to find his way back.
-Resident #8 was not receiving any frequent checks and did not have a wander guard bracelet prior to 3/4/17.
-She did not know of any prior incidents of the resident leaving the facility and was not aware the resident was found outside on 12/11/16.

Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed she did not think there were any residents who wandered in the facility and she was not familiar with Resident #8.

Review of PCP orders, "Long Term Care Progress Notes" and "Examination or Contact by Physician" forms for Resident #8 dated 12/11/16 through 3/10/17 revealed:
-There were no orders for increased supervision and monitoring.
-There was no order for the wander guard bracelet.

Interview with Resident #8's Primary Care Provider (PCP) on 3/10/17 at 11:47am and 3/13/17 at 1:45pm revealed:
-Resident #8 had a diagnosis of Dementia and when he first came to the facility he could walk.
-Staff underestimated him now that he was in a wheelchair.
-Resident #8 was hospitalized after being found outside in December 2016 because he was extremely anemic.
-She did not know of any interventions, increased supervision or use of a wander guard bracelet being put in place following the resident being found outside on 12/11/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 43 -He should have absolutely had increased supervision and monitoring following the incident on 12/11/16. -She was notified by staff of Resident #8 leaving the facility on 3/4/17 but was not aware of any interventions such as more frequent checks being put into place upon his return to the facility. Interview with the Regional Director (RD) on 3/10/17 at 3:43pm revealed: -Resident #8 was placed on every 15 minute checks following the incident on 12/11/16. -Staff were expected to notify the Administrator for any resident with confusion leaving the building or being found outside. -"Staff knew to report anything out of the ordinary to the Administrator." Based on interviews, two MAs, five PCAs, the RCC and the Business Office Manager were not aware Resident #8 had a history of leaving the facility and had been on every 15 minute checks; and one PCA reported the resident was on every one hour checks. Upon request on 3/10/17 and 3/13/17 there was no documentation of every 15 minute checks done on Resident #8 following the incident on 12/11/16 available for review. Upon request on 3/10/17 and 3/13/17 there was no written facility policy or procedure for the supervision of residents available for review. 2. Review of Resident #9's current FL-2 dated 8/12/16 revealed: -Diagnoses included acute and chronic respiratory failure with hypoxia, peripheral vascular disease (PVD), Broncho pneumonia,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44	D 270		

muscle weakness, gastroesophageal reflux disease (GERD).
-There was an order for oxygen 3 liters by nasal cannula as needed.

Observation of the facility on 3/7/17 from 11:00 a.m.-12:30 p.m. revealed:
-No "oxygen in use" signs were not posted inside the facility.
-"No smoking signs" were posted at the front entrance, back entrance smoking area or inside the facility.

Observation of Room # 223 on 3/10/17 at 11:30 a.m. revealed:
-An open box of cigarettes was lying in the trash can.
-One cigarette butt was found in the box, and two cigarette butts were found in the trash.
-An un-racked oxygen tank was sitting about 24 inches away from the trash can.

Observation of the facility on 3/13/17 from 4:00-4:30 p.m. revealed:
-"Oxygen in use signs" were posted beside the doors of Room # 103, #106 and #223.
-"No smoking signs" had been posted in the facility.

Review of the facility's tobacco use policy had been signed by the Resident #9 on 08/18/16.

Review of the facility's smoking policy (no date) revealed:
-"Smoking will be allowed outside the gazebo area only."
-"Residents who are found to be unsafe with smoking materials will not be allowed to keep the material in their possession.''
-"The facility reserves the right to confiscate all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45	D 270		

smoking material and to discharge the resident if the resident fails to abide by the use of the Tobacco Policy."

Interview with Resident #9 on 3/10/17 at 12:10 p.m. revealed:
-He denied smoking in his room or bathroom.
-He threw the cigarettes butts in the trash can in his room instead of throwing them away in the cigarettes receptacles in the smoking area.

Interview with a resident on 3/13/17 at 3:45 p.m. revealed:
-He had not smelled cigarette smoke in the shared bathroom between 223 and 225.
-He did not use the shared bathroom between Rooms # 223 and # 225 because his electric wheel chair would not fit in the bathroom.

Interview with the Resident Care Coordinator (RCC) on 3/10/17 at 12:15 p.m. revealed:
- She replaced the oxygen tank and put the oxygen tank in a rack.
-She had not observed Resident #9 smoking in his room.
-Staff had not reported that Resident #9 smoked in his room.

Interview with a Personal Care Aide on 3/10/17 at 11:45 a.m. revealed:
-She had not observed Resident #9 smoking in his room.
-"I heard other staff say they smelled cigarette smoke in Resident #9's room."

Interview with another Personal Care Aide on 3/13/17 at 4:35 p.m. revealed she had not observed Resident #9 smoking in his room.

Interview with the Administrator on 3/13/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 46 5:32 p.m. revealed: -She was not aware Resident #9 had been disposing of his cigarettes butts in his trash can instead of cigarettes receptacles in the smoking area. -Effective 3/14/17, Resident #9 would no longer be able to keep his cigarettes or lighters. -The resident would be supervised on smoke breaks. The facility's failure to supervise two residents resulted in one resident (#8) with a diagnosis of dementia and a history of leaving the facility requiring emergency medical treatment for exposure to the cold, and then leaving the facility a second time being found on the ground by a passerby. The facility's failure to supervise Resident #8 and #9 resulted in serious neglect and substantial risk of physical harm, which constitutes a Type A2 Violation. Review of the Plan of Protection submitted by the facility dated 3/10/17 revealed: -[There will be] retraining with staff to ensure that [they] are providing supervision [according to] each resident's needs, care [plan] and current symptoms by 3/13/17. -A wander guard list will be made available and placed in each medication room for those residents with increased supervision needs. -There will be continued random chart audits/resident surveys from the Regional Director/designee to assure staff are following the policy and procedures of responding to accidents and incidents involving resident's care effective 3/10/17 and ongoing.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 47 -Any staff not following physicians' orders will receive re-training and/or disciplinary action up to termination. -Staff is to be monitored by the Administrator and/or Resident Care Coordinator to ensure they are following policy and procedures on a weekly basis. THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED 3/12/17.	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: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure appropriate health care referral and follow up for 4 of 7 sampled residents which resulted in a resident (#6) being found unresponsive following new vomiting that was not reported to the primary care provider (PCP) after an unwitnessed fall; a second resident (#1) not having a working oxygen concentrator for three days and not having a recommended ultrasound for a growth on the spleen; a third resident (#5) with a diagnosis of	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 48	D 273		

Chronic Obstructive Pulmonary Disease and was oxygen dependent not having a working oxygen concentrator for 5 days requiring emergency medical treatment; and, a fourth resident (#4) having increased swelling of his left foot unreported to the PCP.

The findings are:

1. Review of Resident #6 FL-2 dated 10/25/2016 revealed:
-Diagnoses included Hypertension, Pacemaker and Heart Failure.
-There was a physician's order for Warfarin 4 mg Monday thru Friday and 5 mg on Saturday and Sunday (Coumadin is a blood thinner).

Interview with a resident's family member during initial tour of the facility on 03/07/2017 at 11:15 a.m. revealed:
-Resident #6 fell out of her wheelchair and staff got her up and put her in bed.
-Resident #6 threw up for several hours and no one came to check on her.
-Resident #6's roommate kept an eye on her until she was told to go to bed.
-Later that night roommate woke up to staff calling for the Medication Aide because Resident #6 was unresponsive.
-Resident #6 was pronounced dead at the hospital.

Interview with a Medication Aide on 03/09/2017 at 4:55 p.m. revealed:
-She worked second shift on the day Resident #6 was found on the floor on 02/18/2017 at 3:00 p.m..
-She checked Resident #6 and found no apparent injuries.
-She asked Resident #6 if she wanted to go to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 49	D 273		

the hospital and Resident #6 said no.
-Family and Physician was notified and Incident/Accident Report was completed.
-Resident #6 was placed in her wheelchair and then transferred to her bed.
-About one hour later, Resident #6 complained of nausea and vomited some phlegm and food she had eaten earlier in the day.
-Resident #6 stated "it must have been something I ate."
-She gave Resident #6 medication for nausea and vomiting per standing order.
-The medication for nausea was effective in stopping the nausea and vomiting.
-Resident #6 had two loose stools during second shift, the evening before she was sent out to the hospital.
-Resident #6 was sleeping when she left at the end of second shift at 10:00 p.m.
-When she came in the next morning at 6:00 a.m. to work first shift, Emergency Medical Services was in Resident #6's room.
-Resident #6 was unresponsive, but had a pulse and was moaning.
-Emergency Medical Services never had to perform Cardiopulmonary Resuscitation.
-Resident #6 was transported to the hospital by Emergency Medical Services at 6:20 a.m.
-The facility received a call from the hospital informing us that Resident #6 had passed away at 7:20 a.m.
-The facility was told that her heart stopped.
-Resident #6 had not complained of any chest pain prior this incident.

Interview with a Personal Care Aide on 03/09/2017 at 5:30 p.m. revealed:
-Resident #6 was not feeling okay on 2/18/2017.
-Resident #6 threw up four or five times, which looked "pinkish" like food she ate earlier that day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 50 -She checked on Resident #6 every thirty minutes until she got calm and was not so upset. -The Medication Aide gave Resident #6 medication for nausea and vomiting. -It took a little time for the medication to work and Resident #6 fell asleep for about one hour. -She drank some water that was at her bedside, laid back down to watch television and went back to sleep. -She did not know what happened on third shift, but when she came back in the next afternoon she was told that Resident #6 was at the Emergency Room. Interview with another Personal Care Aide (PCA) on 03/10/2017 at 4:55 p.m. revealed: -Between the hours of 3:00 p.m. and 4:00 p.m., on 02/18/2017 Resident #6's roommate called out for assistance. -When she entered the room, Resident #6 was on the floor on her stomach. -The Medication Aide came and checked Resident #6 and we got her up and placed her back in her wheelchair. -Resident #6 started throwing up 10 to 15 minutes after been placed back in her wheelchair. -We got Resident #6 to calm down and stop throwing up, and then we laid her down in her bed. -Resident #6 started throwing up again 15 minutes after laying her in her bed. -The Medication Aide gave her some medication for nausea and vomiting. -After she stopped throwing up she had one big loose bowel movement and we cleaned her up. -She checked on Resident #6 every 10 to 15 minutes between herself and another Personal Care Aide. -Resident #6 stated she was a little sore around her waistline.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 51	D 273		

-The PCA informed the Medication Aide and she said she would give her something for pain.
-Resident #6 was in her bed and had dozed off when she left her shift for the night.
-When she came in the next evening for her shift, she was told Resident #6 had been sent to the hospital.

Interview with a second Medication Aide (MA) on 3/10/17 at 6:45pm revealed:
-Resident #6 was not herself the evening of 02/18/2017 after she fell she was vomiting and that was not normal.
-She did not believe Resident #6 had ever fallen before.
-Resident #6 was fine on 1st shift, then fell on 2nd shift and started throwing up on 2nd or 3rd shift "then she was gone".
-She had come to work the following day and received a call from the hospital at 6:20am or 7:20am that Resident #6 had died at the hospital.

Interview with the Nurse Practitioner on 03/10/2017 at 12:00 p.m. revealed:
-She received a call from the facility informing her that Resident #6 was unresponsive on 02/19/2017 and was sent out to the Emergency Room.
-She later received a call from the Emergency Room informing her that Resident #6 had expired on 02/19/2017 at 7:20 a.m.
-The facility has standing orders for nausea, vomiting and diarrhea.
-She would expect to be called for a fall even if the facility did not send the resident to the hospital.

Review of an Incident Accident Report dated 02/18/2017 for Resident #6 revealed:
-Resident #6 was found on the floor of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 52	D 273		

resident's room at 3:00 p.m. on 02/18/2017.
-The Physician was called and recommendations from the physician was to keep a close eye on the resident.
-Intervention implemented was to check on the resident more frequently.

Review of Resident #6's laboratory results and physician's orders revealed:
-Prothrombin Time (PT- is a blood test that measures how long it takes blood to clot) was 22.0 and the International Normalize Ratio (INR- is a calculation based on results of a PT and is used to monitor individuals who are being treated with the blood-thinning medication Coumadin) was 1.86.
-The date of above PT/INR was 02/15/2017.
-There was a physician's order dated 02/16/2017 to discontinue Coumadin 6 mg daily.
-There was a physician's order to start Coumadin 6 mg per oral Monday through Friday but on Saturday and Sunday give Coumadin 7.5 mg.
-Repeat PT/INR on Wednesday 02/22/2017.

Review of Resident #6's Care Notes revealed:
-On 02/18/2017 at 3:40 p.m. Resident #6 was found on the floor, stated that she slid out of her wheelchair, there was no bruising or skin tear, no complaint of pain or discomfort, stated she did not hit her head, she was assisted back into her wheelchair and family member was notified.
-On 02/19/2017 Resident #6 was observed to be unresponsive in the a.m., breathing was shallow, 911 was called, resident was transported to hospital, family member and primary care physician were notified.

Review of Resident #6's hospital records dated 02/19/2017 revealed:
-Diagnoses included Unresponsive Episode,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 53	D 273		

Hypoxia, Unspecified Hypotension and Cardiac Arrest.
-Resident history per hospital records was that she was checked by facility staff at 3:00 a.m. and was in normal state of health.
-Resident was checked again by facility staff at 6:00 a.m. and found to be unresponsive.
-Resident expired at 7:20 a.m.

Review of Emergency Medical Services (EMS) notes dated 02/19/2017 revealed:
-The EMS was dispatched to a seizure call and arrived at facility to find a 92 year old female displaying altered mental status.
- Facility staff reported to the EMS that resident #6 was at her baseline 3 hours prior to the EMS arrival and just prior to calling 911 the staff went in to check the resident only to find her unresponsive.
-The facility staff reported to the EMS that Resident #6 had been sick with a cough for the past two weeks.
-Resident #6 was not verbal with the EMS so oral history was not possible.

Interview with the Administrator on 03/10/2017 at 3:15 p.m. revealed:
-She was informed of Resident #6's passing on 02/19/2017.
-The report concerning death of Resident #6 was faxed to social services.
-Copy of faxed report will be provided.

No report was provided by the end of survey.

2. Review of Resident #1's FL-2 dated 01/30/2017 revealed:
-Diagnoses included Chronic Respiratory Failure, Congestive Heart Failure, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 54 Atrial Fibrillation. -There was a physician'S order for as needed oxygen. A. Interview with Resident #1's family member during initial tour of the facility on 03/07/2017 at 11:15 a.m. revealed: -Resident #1's Oxygen concentrator stopped working over the weekend of 03/04/2017. -The Oxygen concentrator company provided trouble shooting over the phone, but did not make house calls on the weekends. -The facility told Resident #1 and her family that the O2 Company would be out on Monday to repair or change out the O2 concentrator. -The O2 company did not come on Monday as the resident and family was told. -The family member called Oxygen company and was told that the Oxygen company was told by the facility on Saturday that the Oxygen concentrator was working so they closed the ticket out. -Over the weekend the resident had to use portable Oxygen tanks that only lasted 1 ½ to 2 hours. -No one came to check to see if the Oxygen tank had run out of Oxygen and swap out tanks. -Resident #1 had to go find someone Saturday and Sunday nights to swap out Oxygen tanks for her each time she ran out of Oxygen. -The Oxygen company brought out a new Oxygen concentrator for Resident #1 on Monday evening after speaking with her family member. Interview with two Personal Care Aides on 03/13/2017 at 12:55 p.m. revealed: -Something was wrong with Resident #1's Oxygen concentrator on Saturday. -They went to the Medication Aide and reported when the resident complained of any shortness of	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 55 breath. -The Medication Aide went into Resident #1's room but they could not say what she did for the resident. Interview with a Medication Aide (MA) on 03/09/2017 at 4:55 p.m. revealed: -She worked second shift on 03/04/2017, from 2:00 p.m. to 10:00 p.m. -She was told by the off going first shift MA that something was wrong with Resident #1's Oxygen concentrator. -Resident #1 was switched over to the back-up Oxygen and staff kept changing the tanks out during the shift. -She only had to change out Oxygen tanks twice every 3 to 4 hours. -It was reported off to the oncoming shift to use portable Oxygen tanks until her Oxygen concentrator could be fixed on Monday and staff was to check on the resident every two hours. -She did not know what occurred during the third shift. -Resident #1 reported that the Oxygen tank was changed once on first shift, but did not mention how often on third shift. -The Oxygen company did not come on Monday on first shift to change out Resident #1's Oxygen concentrator. -She thought that the Oxygen company was supposed to come on Monday because they did not come on the weekend. -Resident #1's family member was on the phone with the Oxygen company after the resident complained of shortness of breath. -She gave Resident #1 a breathing treatment which was effective. -The Oxygen company brought in a new Oxygen concentrator to swap out that same Monday evening.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 56 Interview with another Medication Aide (MA) on 03/13/2017 at 1:05 p.m. revealed: -She worked first shift on Sunday, 03/05/2017 from 6:00 a.m. to 2:00 p.m. -It was reported that another Medication Aide called the Oxygen company on Saturday to report that Resident #1's Oxygen concentrator was not working correctly. -She knew that the Oxygen company was not coming out on Sunday. -Resident #1 did not complain of any shortness of breath on that shift. -She changed out Oxygen tank more than twice that shift because the resident was running out of Oxygen. -Resident #1 was okay when she left for the day on Sunday. -Resident #1's Oxygen tank was not empty and she was actually lying down sleeping. -She reported off to second shift that Resident #1's Oxygen concentrator was not working properly and to make sure they checked her Oxygen tank. -She reported off that the Oxygen company was called on Saturday and she did not know when they were coming. Review of Resident #1's Physical Therapy Notes revealed: -On 03/06/2017 resident had poor endurance with drop in Oxygen saturation to 89%, recovering with Oxygen at 5 liters nasal cannula to 94%. and facility staff was notified of need for new Oxygen tank for Physical Therapy use. -On 03/08/2017 resident had poor endurance with increased Oxygen use required to maintain Oxygen saturation, Oxygen saturation from 89% to 97% with continuous use of Oxygen at 2 liters per minute.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 57 Review of Resident #1's Care Notes revealed: -On 03/08/2017 at 9:50 a.m. resident's Physical Therapist reported she has required her Oxygen this week more than usual, resident's primary care physician was notified and will see resident at her next facility visit. -Facility staff will monitor resident closely. Resident #1 was not available for interview because she was sent out to the hospital for complaints of shortness of breath on 03/08/2017. B. Interview with Resident #1's family member during initial tour of the facility on 03/07/2017 at 11:15 a.m. revealed: -Resident #1 fell at the beginning of February 2017 and was sent out to the Emergency Room. -The facility did not call to notify the family member that Resident #1 was sent out to the Emergency Room but they did call to inform the family member that Resident #1 was back from the Emergency Room. -A computerized axial tomography (CAT/CT) Scan was done while Resident #1 was at the Emergency Room. -Resident #1 told the family member that she need an Ultrasound or CAT scan of the spleen. -There was nothing on the discharge summary about Resident #1 needing an Ultrasound or CAT scan of the spleen. -The family member got Resident #1's completed Medical Records from the hospital two weeks ago which showed that Resident #1 needed a follow-up appointment for her spleen. -Resident #1 needed an Ultrasound or CAT scan for a possible growth on her spleen. -A copy of the Medical Record was given to the Business Office Manager (BOM) by the family member two weeks ago on second shift because	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 58	D 273		

no other staff was available.
-The BOM highlighted a section on page 19 of the Medical Record concerning the need for Ultrasound or CAT scan of the spleen.
-The BOM wrote on the first page of the Medical Record to see highlighted section on page 19.
-The family member was told that the Medical Record would be passed on to the Resident Care Coordinator (RCC).

Review of Resident #1's hospital Medical Record dated 02/09/2017 revealed:
-On page 19, there was a highlighted section which read there is a decreased attenuated lesion along the lateral margin of the spleen which measures 13 mm.
-This finding was not seen with certainty on patient's older CT scan of 01/19/2015, further evaluation of this finding is clinically required.
-CT scan of the abdomen could be considered versus a splenic Ultrasound.

Interview with the Business Office Manager on 03/13/2017 at 10:40 a.m. revealed:
-Resident #1's family member came to her during second shift around 3:00 p.m. or 3:30 p.m. on Thursday or Friday about a follow-up appointment concerning a tumor the Emergency Room found on resident's spleen.
-Resident #1's family member got the completed record from the Emergency Room.
-She gave the paperwork to the Resident Care Coordinator (RCC) after highlighting the needed areas.
-The RCC took the paperwork and placed it in the doctor's notebook for the doctor to look at and follow-up.
-The Medical Record paperwork was never followed-up.
-Resident #1's family member came to me the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 59	D 273		

following week after giving me the paperwork to inform me that it was not followed up on.
-She went to the Administrator and told her that Resident #1's family was concerned about the follow-up appointment.
-She went to the RCC concerning the follow-up appointment for Resident #1.

Interview with the Nurse Practitioner (NP) on 03/10/2017 at 12:00 p.m. revealed:
-The facility staff would make appointment for CAT scan or Ultrasound.
-When the results came back the NP would read and refer out to be followed-up

Interview with the Resident Care Coordinator (RCC) on 03/13/2017 at 5:52 p.m. revealed:
- The Medical Record paperwork was given to the facility a week or two after Resident #1 return from the Emergency Room by the Business Office Manager.
- The Medical Record paperwork was given to the Nurse Practitioner for review.
-The reviewed Medical Record paperwork was given back to the facility with no new orders.
-The Medical Record paperwork was filed in Resident #1's chart.
- The Medical Record paperwork was refaxed to the Nurse Practitioner today (03/13/2017) and she will see Resident #1 tomorrow to make a determination.

Interview with the Administrator on 03/13/2017 at 12:17 p.m. revealed:
-She learned from Resident #1's family member that there was other information that was not on the discharge paperwork.
-Resident #1's family member picked up the extra paperwork from the hospital.
-The Administrator asked Resident #1's family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 60	D 273		

member if the paperwork had gone to Resident Care Coordinator and she said yes.
-She did not know if the follow-up had been completed.
-The Resident Care Coordinator "is very meticulous about these things."

3. Review of Resident #5's current FL-2 dated 8/18/16 revealed:
-Diagnoses included Obstructive Chronic Bronchitis.
-Primary Care Provider (PCP) orders included two liters continuous oxygen.

Interview with Resident #5 on 3/7/17 at 10:55am revealed:
-His oxygen machine had been broken since last week; it didn't have any air coming out of it and the little ball didn't move.
-He felt his lungs were tight and he was only able to stay in the bed and rest.
-The oxygen tank at the foot of his bed was empty.
-He had asked the staff this morning for a new tank, but they had not brought one.
-He was supposed to be on two liters of oxygen all the time.

Interview with a Personal Care Aide (PCA) on 3/7/17 at 10:58am revealed Resident #5 had reported his oxygen concentrator was not working to her this morning (3/7/17) and she reported it to the Medication Aide (MA)/Supervisor.

Interview with the 1st shift MA/Supervisor on 3/7/17 at 11:02am revealed:
-She had called the vendor number listed on the sticker on Resident #5's machine this morning.
-The vendor did not have Resident #5 listed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 61	D 273		

their system.
-She was going to try and see if his "thing [nasal cannula]" would fit on one of the tanks in here [storage room on the west hall.]
-She hoped he had an order for the oxygen because he "had it forever."
-She did not know how long the oxygen tank would last, but hoped it would last until his concentrator was fixed.
-She was going to check Resident #5's record to see if there was a different phone number or vendor.

Observation on 3/7/17 at 11:08am revealed the MA/Supervisor had placed Resident #5 on two liters of oxygen via a portable oxygen tank.

Review of "Care Notes" for Resident #5 dated 2/25/17 through 3/7/17 revealed:
-On 3/7/17 (no time) the MA/Supervisor documented that Resident #5's oxygen concentrator was not working, the supplier number on the machine did not have an order for the resident, blood oxygen saturation level was 87% with the resident having shortness of breath and difficulty breathing, the PCP was notified and a new order for oxygen was faxed to the medical equipment supplier.
-There were no other entries prior to 3/7/17 regarding Resident #5's oxygen concentrator.

Interview with Resident #5 on 3/7/17 at 11:08am revealed:
-His concentrator broke last Thursday (3/2/17) and he told "everybody" including the PCAs and MA.
-He could not remember the names of staff he told.
-His breathing was better with the oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 62 Interview with the 1st shift MA/Supervisor on 3/7/17 at 1:05pm revealed she had "addressed the issue" with Resident #5's oxygen concentrator meaning she had contacted the PCP and a medical supply company with the help of the Resident Care Coordinator (RCC) on 3/7/17. Interview with the 2nd shift MA/Supervisor on 3/7/17 at 4:38pm and 5:47pm revealed: -Resident #5 had told her his oxygen concentrator was not working on Friday (3/3/17) at about 5 or 5:30pm. -The little ball that went up and down depending on how much oxygen he was supposed to get, would not move. -She called the number on his concentrator on 3/3/17, but they said there was no record of the resident's name matching the concentrator. -She then contacted the medical equipment supplier the facility used on 3/3/17, and provided the resident's insurance information. -The facility's supplier was supposed get the oxygen orders clarified with the doctor's office and then get back to facility staff. -She did not know what happened over the weekend (3/4/17 and 3/5/17) because she was not working and did not hear anything about Resident #5's oxygen concentrator on 3/6/17. -She was pretty sure the RCC had gotten an order for the oxygen and they had been using portable oxygen tanks for Resident #5 since 3/3/17. -The RCC was already gone on 3/3/17 but the MA/Supervisor did report Resident #5's broken oxygen concentrator to the Administrator on 3/3/17. Review of "Physician's Orders" on a six month medication review form for Resident #5 dated 11/1/16 revealed there was an order for two liters	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 63 continuous oxygen signed by the PCP. Review of a "Examination or Contact by Physician" sheet for Resident #5 dated 1/17/17 revealed there was an order for continuous oxygen at two liters per minute signed by the PCP. Interview with the covering Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed she did not know why the oxygen was reordered on 1/17/17 for Resident #5 or what was done with the order because she was not the RCC at that time. Interview with the Regional Director (RD) on 3/9/17 at 11:43am revealed: -She did not know why the oxygen was re-ordered on 1/17/17; it may have been a clarification from the six month medication review dated 11/1/16. -The hand writing on the order was not hers and it may have been from a previous RCC helping out at the facility at that time. Interview with the PCP on 3/10/17 at 11:47am revealed: -Resident #5 was previously on hospice and she believed hospice wrote the original orders for supplemental oxygen. -She did not know why the order for oxygen was re-written on 1/17/17. Review of Resident #5's Licensed Health Professional Support (LHPS) evaluation dated 12/16/16 revealed: -Resident #5 had LHPS task for oxygen administration and monitoring. -The assessment documented Resident #5 required oxygen at two liters via a nasal cannula.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 64 Review of Resident #5's current Care Plan dated 2/22/17 and signed by the PCP revealed there was no notation the resident was ordered for continuous supplemental oxygen or of a medical equipment supplier. Review of Resident #5's March 2017 Medication Administration Record (MAR) revealed there was a preprinted entry for oxygen at two liters continuously that staff initialed as administered each shift from 3/1/17 through 3/17/17 except 3rd shift on 3/4/17, 3/6/17 and 3/7/17. Observation on 3/7/17 at 4:48pm revealed: -There were 30 small and two large portable oxygen tanks in a storage room on the west hall, of which only one had an unbroken sticker on the connection piece indicating it was full. -Four of the small and the two large tanks had the regulators attached showing the volumes were in the empty or near empty red marking. Interview with the 2nd shift MA/Supervisor on 3/7/17 at 4:48pm revealed: -She thought there were more new and full portable oxygen tanks available in the storage room. -All of the portable oxygen tanks were empty except the one tank with the unbroken seal. -She was going to have call the supplier and request more portable oxygen tanks. Interview with the RCC on 3/7/17 at 4:42pm, 5:06pm and 5:20pm revealed: -She was not aware of Resident #5's broken oxygen concentrator until late morning on 3/7/17. -Resident #5 received hospice services including management of his oxygen supply until March 2016, and it was not known who Resident #5's	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 65	D 273		

oxygen supplier was after that.
-"Evidently he had brought his own stuff [oxygen concentrator] when he came [to the facility] in 2011."
-She had contacted Resident #5's doctor who was in the process of writing a note (4:42pm on 3/7/17) to get a new oxygen concentrator from the facility's supplier.
-The supplier would deliver the oxygen the evening of 3/7/17 if they had received a note from Resident #5's doctor.
-Resident #5 had oxygen available from portable tanks kept at the facility.
-She and the Regional Director were working on getting additional portable oxygen tanks and/or a loner oxygen concentrator for Resident #5 to use.
-She could not speak to what happened when the resident was admitted to the facility; he may have had a different supplier then.
-Any resident admitted to the facility would have a supplier identified.

Telephone interview with the Primary Care Provider (PCP) on 3/7/17 at 4:52pm revealed:
-She was informed on 3/7/17 that Resident #5's oxygen concentrator was not working and was in the process of writing a note for the medical equipment supplier.
-Resident #5 was supposed to be on 2 liters of oxygen continuously, but usually only wore it at night.
-Resident #5 had been on continuous oxygen prior to when the PCP took over his care approximately a year ago; "it was not a new order by any means."
-She believed hospice managed Resident #5's oxygen supply, but he had been discharged from hospice a few months ago related to frequent hospital admissions for shortness of breath and difficulty breathing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 66 Review of an "Examination or Contact by Physician" form for Resident #5 dated 3/7/17 revealed: -There was an order for oxygen at two liters continuous. -There was a notation the resident's blood oxygen saturation level was 87% at rest and less than 84% with exertion. -The PCP signed and dated the form 3/7/17. Telephone interview with the Receptionist at the facility's medical equipment supplier on 3/7/17 at 5:08pm revealed: -She had spoken with three different people from the facility on 3/7/17 regarding Resident #5 and explained she did not have the necessary paperwork to supply him with oxygen. -The facility staff had apparently been using other residents' oxygen to supply Resident #5 because they had also requested additional portable tanks. -Each resident had their own concentrator and portable tanks which were billed to their insurance. -For proper billing to provide oxygen supply, the company required a progress note from the PCP documenting the blood oxygen saturation level of the resident showing need for supplemental oxygen. -The supplier would need this progress note from the PCP prior to 5:30pm for same day delivery. Interview with Resident #5 on 3/7/17 at 5:20pm revealed he had had the oxygen concentrator in his room since he got to the facility six years ago. Interview with the Administrator on 3/7/17 at 5:06pm and 5:45pm revealed: -When a resident was discharged from hospice services, hospice would take their supplies with	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 67	D 273		

them.
-The facility should not run out of back up portable oxygen tanks for residents who were on oxygen.
-Staff were expected to call and order additional tanks when the supply was low.
-Six additional tanks were being delivered to the facility the evening of 3/7/17, three from hospice and three from the facility's medical supplier.

Interview with the RCC on 3/7/17 at 6:10pm revealed there were five residents in the facility receiving supplemental oxygen via a concentrator who also required a back-up portable oxygen tank.

Observation on 3/7/17 at 6:54pm revealed Resident #5 was lying in bed and the portable oxygen tank he was using was empty.

Interview with the RCC and Administrator on 3/7/17 at 6:54pm revealed three new tanks had just been delivered and one would be taken to Resident #5.

Observation on 3/7/17 at 7:20pm revealed:
-Resident #5 was in the hallway near the medication room, yelling and unable to catch his breath between words.
-He had a portable oxygen tank in a wheeled holder and was saying he could not breathe and was not getting any air.
-The MA/Supervisor was saying to the Administrator and RCC that Resident #5 had said he could not feel the air from the oxygen tank, threatened to slap her and was demanding to go to the emergency room (ER).
-The MA/Supervisor said to the Administrator and RCC that she checked the resident's oxygen tank, it was set at 2 liters and she could feel and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 68	D 273		

hear the air from the cannula.
-Resident #5 said to the Administrator and RCC that the MA/Supervisor did not know how to talk to people and that he knew best how he was feeling.
-Resident #5 continued to have a hard time breathing and speaking.
-The RCC and Administrator assisted Resident #5 back to his room and instructed the MA/Supervisor to call Emergency Medical Services (EMS) to have the resident taken to the ER.

Review of a "Care Note" for Resident #5 dated 3/7/17 revealed:
-The MA documented at 7:30pm, "I went down to [Resident #5's name] room to check his oxygen tank. He was receiving air. I told him to put the cord to his ear. He called me a [curse word]. He wanted to go to the hospital. You [curse word] you come down here to upset me. I want to go to the hospital. I said we don't have any more tanks. That's the last one. It's working OK. He got up and tried to swing at me. I tried to get away from him. He tried to hit me at least three times. He came out the room down the hall to the medication room. The fire department, EMS (Emergency Medical Services) and police were notified. His family, charge nurse at [name of hospital] were notified of his behaviors."

Interview with the Administrator on 3/7/17 at 7:48pm revealed she could not remember being notified by staff on 3/3/17 of Resident #5's broken oxygen concentrator.

Interview with the RCC on 3/7/17 at 8:19pm revealed:
-The RCC and Administrator had gone room to room to identify all residents on supplemental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 69	D 273		

oxygen.
-A sign was placed in the oxygen storage room with the facility's suppliers name and phone number.
-They had also placed supplier information in resident records and posted oxygen in use signs on the residents' doors who were using oxygen.

Observation on 3/8/17 at 9:30am revealed Resident #5 was sleeping in his bed wearing a nasal cannula connected to a small portable oxygen tank set at two liters which had approximately ¼ tank remaining.

Interview with the RCC on 3/8/17 at 10:03am revealed:
-The medical equipment supplier was delivering Resident #5's new oxygen concentrator by noon on 3/8/17.
-Resident #5 had returned from the ER late evening on 3/7/17 with a new prescription order which was sent to the pharmacy.

Review of emergency room discharge instructions for Resident #5 dated 3/7/17 revealed the resident was seen and treated in the emergency room for a diagnosis of Chronic Obstructive Pulmonary Disease Exacerbation and given a prescription for Prednisone 20mg three tablets daily for five days.

Observation on 3/8/17 at 12:53pm revealed:
-Resident #5 was using a new portable oxygen tank which was more than ¾ full.
-The facility's medical equipment supplier was setting up a new oxygen concentrator.
-There was a "Caution oxygen" in use sign now posted outside the door for Resident #5.

Attempted interview with Resident #5's guardian

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 70	D 273		

on 3/8/17 at 12:44pm was unsuccessful.

4. Review of Resident # 4's current FL-2 dated 2/21/17 revealed diagnoses included Diabetes Mellitus, Hypertension, Vascular Dementia and history of a Stroke.

Observation on 3/7/17 at 10:50am revealed:
-Resident #4 was sitting in a wheelchair in front of a television in his room with his feet resting on the floor; his left foot was more than twice the size of his right foot and he had yellow non-slip socks on both feet.
-There was a sign on the second closet door that noted, "When [name of Resident #4] gets up ...please make sure his TED hose are put on him. This is very important."

Interview with Resident #4 on 3/7/17 at 10:50am revealed his left foot was always swollen, he was used to it and did not think staff did anything different for it.

Telephone interview with Resident #4's Guardian on 3/13/17 at 10:13am revealed:
-Resident #4 had a longstanding problem with swelling in his left foot related to a past hip surgery.
-There was a "special stocking" staff at the facility put on his left leg to help the swelling.

Review of Resident #4's previous FL-2 dated 10/12/16 revealed there was a Primary Care Provider (PCP) order for TED (Thromboembolism deterrent hose) stockings on in the morning and off at bedtime daily.

Review of "Admission/Readmission Orders" for Resident #4 dated 12/28/16 and signed by the PCP revealed there was an order to discontinue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 71	D 273		

the TED hose.

Review of "Care Notes" for Resident #4 dated 12/19/16 through 2/21/17 revealed there was no documentation the PCP was notified of the increased swelling in Resident #4's left foot and there were no entries after 2/21/17.

Interview with a Personal Care Aide (PCA) on 3/9/17 at 9:28am revealed:
-Resident #4 had been able to stand in January 2017, but his feet were so swollen now he needed two staff to help him stand.
-She did not know how long the resident's feet had been swollen, it had been a while.
-The MA/Supervisor knew about the swelling of Resident #4's feet because it was not new.

Interview with a second PCA on 3/9/17 at 4:33pm revealed:
-"You just get a feel for everybody" and that was how staff knew what type of care each resident needed, there was no "book" listing the type of assistance each resident needed.
-Resident #4 was supposed to have TEDs on and she "just knew" that.

Interview with a third PCA on 3/13/17 at 4:48pm revealed:
-Resident #4 had swelling off and on in his feet for about three years; "it would go down and then swell right back up."
-She reported it to the MA/Supervisor who was on duty 2nd shift 3/7/17, and the Supervisor was supposed to take care of it.

Interview with a Medication Aide (MA)/Supervisor on 3/9/17 at 11:25am revealed:
-Resident #4's feet were "actually small for him right now" and the swelling had "just started

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 72	D 273		

back."
-He was getting wraps done on his feet by Home Health (HH), but that stopped because his feet got small.
-Any changes in a resident's condition were reported to the Primary Care Provider (PCP) who was supposed to come to the facility on 3/8/17, but did not.
-The MA had told the Resident Care Coordinator (RCC) about the increased swelling in Resident #4's left foot this morning (3/9/17).

Interview with a second MA on 3/13/17 at 4:41pm revealed:
-Resident #4's left foot had been swollen for approximately five months.
-The resident did have TED hose at one time but those were discontinued.
-It was difficult to put shoes on the resident so he wore non-slip socks and staff put his feet up at night to help the swelling.

Telephone interview with the HH Office Assistant on 3/13/17 at 12:26pm revealed:
-Resident #4's last HH nursing visit was on 12/28/17 and he was discharged on 1/11/17.
-HH would not have recommendations for care of Resident #4's left lower extremity after discharge from HH; that would be according to his Primary Care Provider (PCP) orders.

Observation on 3/13/17 at 10:08am revealed Resident #4 was sitting in a wheelchair in front of a television in his room with his feet resting on the floor; his left foot remained significantly swollen and he had yellow non-slip socks on both feet.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 3/13/17 at 1:06pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 73 -She was not aware of any increased swelling in Resident #4's left foot. -The orders for TED stockings had been discontinued because the swelling had improved. -Resident #4 has had off and on issues with edema. -She last saw the resident on 2/22/17. -She came to the facility on Wednesdays when she had someone on her list to see. -Staff were responsible for contacting the PCP's office to request a visit/have a resident placed on her list to be seen. Interview with the Care Coordinator (RCC), Administrator and Regional Director (RD) on 3/10/17 at 3:43pm revealed staff were expected to report changes in resident condition and anything out of the ordinary to the Administrator. _____ The facility's failure to assure appropriate health care referral and follow up for 5 of 7 sampled residents resulted in Resident #6 being found unresponsive following new vomiting that was not reported to the PCP after an unwitnessed fall; and Resident #5 who had a diagnosis of COPD and was oxygen dependent not having a working oxygen concentrator for 5 days requiring emergency medical treatment for shortness of breath. The facility's failure to provide adequate health care referral and follow up resulted in serious neglect and substantial risk of harm which constitutes a Type A2 Violation. _____ Review of the Plan of Protection submitted by the facility dated 3/10/17 revealed: -Retrain staff between 3/10/17 and 3/13/17 on	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 74 identification and reporting of residents' to assure appropriate referral and follow up. -Any residents with any changes in condition or status, the health care provider will be notified immediately of the changes; appointments to be made accordingly and documented in referral and follow up book by transportation coordinator, Administrator and/or Resident Care Coordinator. -Any new orders for oxygen therapy will be established with a durable medical equipment company by the Resident Care Coordinator and/or designee. -Any lab orders will be written down in the referral and follow-up notebook. -There will be continued routine reporting from on any changes/incidents with residents that would require referral and follow up effective 3/10/17 and ongoing. -There will be continued random chart audits/resident surveys once monthly from the Regional Director and/or designee to assure referral and follow up is done in a timely and accurate manner effective 3/10/17 and ongoing. -Staff will be trained on Residents' Rights 3/9/17. THE CORRECTION DATE FOR TYPE A2 VIOLATION SHALL NOT EXCEED 3/12/17.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 75 and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents for record review which included Resident #5 not receiving nebulizer medications (Brovana and Pulmicort) resulting in emergency room treatment for an exacerbation of Chronic Obstructive Pulmonary Disease, receiving duplicate antipsychotic therapy (Perphenazine and Prolixin) for 6 weeks and receiving the incorrect dose of a muscle relaxer (Baclofen); Resident #4 receiving sliding scale insulin for two months without an order from the Primary Care Provider and did not receive a stool softener and laxative (Colace and Miralax) as ordered following a hospitalization for a bowel obstruction; and, 1 of 3 (Resident #10) as observed during the medication pass, not receiving an anti-reflux medication (Protonix) more than one hour after breakfast and not receiving antihistamine eye drops with current symptoms of dry and itchy eyes. The findings are: 1. Review of Resident #5's current FL-2 dated 8/18/16 revealed: -Diagnoses included Obstructive Chronic Bronchitis, Vascular Dementia and Symbolic Dysfunction. -Medication orders included Brovana 15mcg/2ml via nebulizer every 12 hours, Pulmicort 0.5mg/2ml via nebulizer twice daily, Albuterol 0.083%/3ml via nebulizer every four hours as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 76	D 358		

needed for cough, wheezing or shortness of breath; Perphenazine 4mg every morning. (Brovana is used to prevent bronchoconstriction in Chronic Obstructive Pulmonary Disease, Pulmicort is used to control and prevent wheezing and shortness of breath, Albuterol is used to treat or prevent bronchospasm and Perphenazine is used to treat schizophrenia.)

a. Observation on 3/7/17 at 7:20pm revealed:
-Resident #5 was in the hallway near the medication room, yelling and unable to catch his breath between words.
-He had a portable oxygen tank in a wheeled holder and was saying he could not breathe and was not getting any air.
-The MA/Supervisor was saying to the Administrator and RCC that Resident #5 had said he could not feel the air from the oxygen tank, threatened to slap her and was demanding to go to the emergency room (ER).
-The MA/Supervisor said to the Administrator and RCC that she checked the resident's oxygen tank, it was set at 2 liters and she could feel and hear the air from the cannula.
-Resident #5 said to the Administrator and RCC that the MA/Supervisor did not know how to talk to people and that he knew best how he was feeling.
-Resident #5 continued to have a hard time breathing and speaking.
-The RCC and Administrator assisted Resident #5 back to his room and instructed the MA/Supervisor to call Emergency Medical Services (EMS) to have the resident taken to the ER.

Review of a "Care Note" for Resident #5 dated 3/7/17 revealed:
-The MA documented at 7:30pm, "I went down to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 77	D 358		

[Resident #5's name] room to check his oxygen tank. He was receiving air. I told him to put the cord to his ear. He called me a [curse word]. He wanted to go to the hospital. You [curse word] you come down here to upset me. I want to go to the hospital. I said we don't have any more tanks. That's the last one. It's working OK. He got up and tried to swing at me. I tried to get away from him. He tried to hit me at least three times. He came out the room down the hall to the medication room. The fire department, EMS (Emergency Medical Services) and police were notified. His family, charge nurse at [name of hospital] were notified of his behaviors."

Interview with the Resident Care Coordinator (RCC) on 3/8/17 at 10:03am revealed Resident #5 had returned from the ER late evening on 3/7/17 with a new prescription order which was sent to the pharmacy.

Review of emergency room discharge instructions for Resident #5 dated 3/7/17 revealed the resident was seen and treated in the emergency room and received two nebulizer treatments for a diagnosis of Chronic Obstructive Pulmonary Disease Exacerbation and given a prescription for Prednisone 20mg three tablets daily for five days.

Review of "Care Notes" for Resident #5 dated 3/9/17 revealed:
-At 7:50 the MA documented, "This morning while giving resident his meds (medications) I heard a noise like his O2 (oxygen) was coming out, I checked it, he had turned it up to 12 saying he needed to catch his breath. I told him it had to stay on 2, he again stated he needs to catch his breath then he will turn it down."
-The RCC documented notifying the PCP that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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D 358	Continued From page 78 Resident #5 had turned his oxygen up to 12. Interview with a Medication Aide (MA) on 3/9/17 at 11:25am revealed MAs would ask Resident #5 if he wanted an as needed Albuterol nebulizer treatment when he complained about not getting any air or having shortness of breath, but he would refuse and say he just needed to catch his breath. Observation on 3/9/17 at 4:23pm revealed Resident #5 was walking in the hallway with a portable oxygen tank using extra effort to breathe. Interview with Resident #5 on 3/9/17 at 4:23pm and 5:11pm revealed: -He requested nebulizer treatments "all the time" but the MA would only "bring them sometimes." -He had not received any nebulizer treatment this morning (3/9/17) or last evening, could not remember the last time he had received a nebulizer treatment and did not think he had received one in the last week. Review of "Physician's Orders" on a six month medication review form for Resident #5 dated 11/1/16 revealed: -There was an order for Brovana 2ml nebulizer twice daily, may combine with Pulmicort nebulizer. -There was an order for Pulmicort one treatment via nebulizer twice daily. -There was an order for Albuterol one vial via nebulizer every four hours as needed for cough. Review of Resident #5's January 2017 Medication Administration Record (MAR) revealed: -There was a preprinted entry for Brovana 2ml via nebulizer twice daily, may combine with Pulmicort	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 79	D 358		

nebulizer where staff documented administering 1/1/17 through 1/31/17 except 1/16/17 at 8pm and 1/23/17 at 8pm.
-There was a preprinted entry for Pulmicort 2ml via nebulizer twice daily where staff documented administering 1/1/17 through 1/31/17 except 1/16/17 at 8pm, 1/22/17 at 8am and 1/23/17 at 8pm.
-There was a preprinted entry for Albuterol one vial via nebulizer every four hours as needed for cough and there were no doses documented as administered.

Review of Resident #5's February 2017 MAR revealed:
-There was a preprinted entry for Brovana 2ml via nebulizer twice daily, may combine with Pulmicort nebulizer where staff documented administering 2/1/17 through 2/28/17 except 2/8/17 at 8pm, 2/17/17 at 8pm and 2/18/17 at 8pm.
-There was a preprinted entry for Pulmicort 2ml via nebulizer twice daily where staff documented administering 2/1/17 through 2/28/17 except 2/8/17 at 8pm, 2/17/17 at 8am and 8pm, 2/18/17 at 8am and 8pm and 2/26/17 at 8am.
-There was a preprinted entry for Albuterol one vial via nebulizer every four hours as needed for cough and there were no doses documented as administered.

Review of Resident #5's March 2017 MAR revealed:
-There was a preprinted entry for Brovana 2ml via nebulizer twice daily, may combine with Pulmicort nebulizer where staff documented administering 3/1/17 through 3/8/17 except 3/5/17 at 8pm and 3/7/17 at 8pm.
-There was a preprinted entry for Pulmicort 2ml via nebulizer twice daily where staff documented administering 3/1/17 through 3/8/17 except 3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 80 at 8am, 3/7/17 at 8pm and 3/8/17 at 8am. -There was a preprinted entry for Albuterol one vial via nebulizer every four hours as needed for cough and there were no doses documented as administered. Observation of medications on hand for Resident #5 on 3/8/17 at 12:55pm revealed: -There was a plastic bag with a pharmacy label for Albuterol nebulizers with Resident #5's name indicating the nebulizers were dispensed on 1/16/16. -There were two unopened packages containing 5 vials each with an expiration date of 3/2017 inside the plastic bag. Observation of medications on hand for Resident #5 on 3/10/17 at 11:10am revealed: -There was a plastic bag with a pharmacy label for Brovana nebulizers with Resident #5's name indicating the nebulizers were dispensed 3/1/17 with 8 unopened packages containing four vials and one opened package with three vials remaining. -There was a plastic bag with a pharmacy label for Pulmicort nebulizers with Resident #5's name indicating the nebulizers were dispensed 3/1/17 with 9 unopened packages containing five vials and one opened package with four vials remaining. -There was a plastic bag with a pharmacy label for Albuterol nebulizers with Resident #5's name indicating the nebulizers were dispensed 3/8/17 with 5 unopened packages containing five vials. Interview with the MA on 3/10/17 at 11:10am revealed: -There were no other nebulizer treatments on hand for Resident #5. -When the new batch came from the pharmacy	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 81	D 358		

each month, all of the previous batch of medications were removed except as needed medications.
-MAs requested all medication refills when needed by calling or faxing the pharmacy.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 3/10/17 at 10:57am revealed:
-The pharmacy did not cycle or batch fill any nebulizer treatments for the facility; refills would have to be requested by staff.
-Resident #5's Brovana was dispensed last on 3/1/17 for 120ml or 60 nebulizer treatments which was a 30 day supply; prior to 3/1/17 the last dispense was on 11/18/15 which was also a 30 day supply.
-Resident #5's Pulmicort was dispensed on 3/1/17 for 120ml or 60 treatments which was a 30 day supply; prior to 3/1/17 the last dispense date was 12/20/16 which was also a 30 day supply and prior to 12/20/16 the Pulmicort appeared to have been discontinued in August 2016.
-Resident #5's Albuterol was dispensed 3/9/17, January 2016 and November 2015; each for a 30 day supply.

Review of pharmacy dispensing records for Resident #5 dated 11/2/15 through 3/9/17 revealed:
-A 30 day supply (120ml) of Brovana was dispensed on 11/15/15 and 3/1/17.
-A 30 day supply (120ml) of Pulmicort was dispensed on 12/15/15, 12/20/16 and 3/1/17.
-A 10 day supply (150ml) of Albuterol was dispensed on 11/18/15 and 1/4/16.

Interview with Resident #5 on 3/10/17 at 5:00pm revealed:
-He had not received a nebulizer treatment for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 82	D 358		

while, he had just gotten one today (3/10/17).
-He did not know he was supposed to be getting a nebulizer treatment twice daily and had only been getting them "every now and then."

Interview with Resident #5's Primary Care Provider (PCP) on 3/10/17 at 11:47am revealed:
-If Resident #5 complained of shortness of breath she would expect staff to give an Albuterol nebulizer because that was what it was ordered for.
-Not getting the ordered nebulizers (Brovana and Pulmicort) would have definitely contributed to the resident feeling short of breath, if he had received the nebulizers as ordered he might not have felt short of breath.
-If the resident refused his nebulizer treatments (Brovana and Pulmicort), after three refusals she expected staff to notify her.
-She was not aware that Resident #5 had not been receiving nebulizer treatments as ordered.

Interview with the Resident Care Coordinator (RCC), Administrator and Regional Director (RD) on 3/10/17 at 3:43pm revealed:
-There was no response specific to what nebulizer treatments were being administered to Resident #5 based on the dispensing history.
-The RD said medication aides were trained on the medication cart and expected to administer medications as ordered.

b. Review of "Physician's Orders" on a six month medication review form for Resident #5 dated 11/1/16 revealed there was an order for Perphenazine 8mg daily at bedtime with "D/C (discontinue) 7/11/16" hand written over the entry.

Review of a "Physician's Order Form" for Resident #5 dated 1/17/17 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 83 -There was an order to discontinue Perphenazine 8mg daily at bedtime. -There was an order to start Seroquel XR 100mg daily at bedtime. (Seroquel is used to treat schizophrenia and bipolar disorder.) -The orders were signed by the Mental Health Provider (MHP). Review of a physicians order for Resident #5 dated 1/17/17 revealed: -There was a notation that insurance would not approve Seroquel XR. -There was an order to discontinue Seroquel XR. -There was an order to start Prolixin 2.5mg twice daily. (Prolixin is used to treat schizophrenia.) -The orders were signed by the MHP. Review of Resident #5's January 2017 Medication Administration Record (MAR) revealed: -There was a preprinted entry for Perphenazine 8mg daily at bedtime where staff documented administering 15 doses from 1/1/17 through 1/17/17, then documented the order was discontinued on 1/17/17. -There was a hand written entry for Prolixin 2.5mg twice daily where staff documented administering 13 doses from 1/25/17 through 1/31/17. Review of Resident #5's February 2017 MAR revealed: -There was a preprinted entry for Perphenazine 8mg daily at bedtime where staff documented administering 25 doses from 2/1/17 through 2/28/17. -There was a hand written entry for Prolixin 2.5mg twice daily where staff documented administering 51 doses from 2/1/17 through 2/28/17.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 84 Review of Resident #5's March 2017 MAR revealed: -There was a preprinted entry for Perphenazine 8mg daily at bedtime where staff documented administering five doses from 3/1/17 through 3/8/17. -There was a preprinted entry for Prolixin 2.5mg twice daily where staff documented administering 14 doses from 3/1/17 through 3/8/17. Observation of medications on hand for Resident #5 on 3/8/17 at 12:55pm revealed: -There was a pharmacy labeled bubble pack with Resident #5's name for Perphenazine 8mg daily at bedtime indicating 31 tablets were dispensed 3/6/17 and 30 tablets remained. -There was a pharmacy labeled bubble pack with Resident #5's name for Prolixin 2.5mg twice daily indicating 31 of 62 tablets were dispensed 3/6/17 and 29 tablets remained. Interview with the Medication Aide (MA) on 3/8/17 at 12:55pm revealed there was probably another bubble pack of 31 tablets in the back up supply of the Prolixin for Resident #5 because only one bubble pack was kept on the medication cart. Interview with Resident #5 on 3/8/17 at 4:51pm revealed he felt alright, calm and did not have any back pain. Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed she did not know anything about the Perphenazine and Prolixin orders because she was not the RCC at the time those orders were written for Resident #5. Interview with the Regional Director (RD) on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 85 3/9/17 at 11:43am revealed: -The initials on the January 2017 MAR were hers and she discontinued the Perphenazine according to the order dated 1/17/17. -She was responsible for checking the MARs at the end of each month to assure orders were carried over and anything discontinued was marked off. -The Perphenazine not being discontinued for February 2017 was an oversight on her part. -She notified the Mental Health Provider (MHP) last evening (3/8/17) that Resident #5 had been receiving both Perphenazine and Prolixin for the month of February. -The MHP discontinued the Perphenazine and continued the Prolixin. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm revealed: -The last order the pharmacy had was for Perphenazine 4mg two tablets daily at bedtime on an FL-2 dated 7/16/16 for Resident #5. -On 1/17/17 there was an order to discontinue the Perphenazine with the start of Seroquel. -The Seroquel was not started related to insurance coverage and there was a note that facility staff requested Perphenazine be continued until staff could get further clarification from the Primary Care Provider (PCP). -The Seroquel was discontinued and Prolixin 2.5mg twice daily was started from an order dated 1/17/17 but was not faxed to the pharmacy until 1/25/17. -Both Perphenazine and Prolixin were antipsychotics and should not be given together because it would be a duplication of therapy. -The continuation of the Perphenazine along with the Prolixin may not have been picked up on with the clarification request for Seroquel.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 86 Telephone interview with Resident #5's Mental Health Provider (MHP) on 3/13/17 at 3:29pm revealed: -Perphenazine and Prolixin should not be given together because they were both antipsychotics and could cause dizziness, trembling and lethargy which had not been seen or reported in Resident #5. -The facility notified the PCP on 3/9/17 that the resident was receiving both and the Perphenazine was discontinued on 3/9/17. c. Review of a Primary Care Provider order for Resident #5 dated 12/6/16 revealed there was an order for Baclofen 5mg three times daily. (Baclofen is used to treat muscle spasms and pain.) Review of an "Examination or Contact by Physician" form for Resident #5 dated 12/27/16 revealed there was an order to increase Baclofen to 10mg three times daily. Interview with Resident #5 on 3/8/17 at 4:51pm revealed he felt alright, calm and did not have any back pain. Review of Resident #5's January 2017 Medication Administration Record (MAR) revealed there was a preprinted entry for Baclofen 10mg half tablet (5mg) three times daily where staff documented administering 90 doses from 1/1/17 through 1/31/17. Review of Resident #5's February 2017 MAR revealed there was a preprinted entry for Baclofen 10mg half tablet (5mg) three times daily where staff documented administering 74 doses from 2/1/17 through 2/28/17.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 87 Review of Resident #5's March 2017 MAR revealed there was a preprinted entry for Baclofen 10mg half tablet (5mg) three times daily where staff documented administering 19 doses from 3/1/17 through 3/8/17. Observation of medications on hand for Resident #5 on 3/8/17 at 12:55pm revealed there was a pharmacy labeled bubble pack with Resident #5's name for Baclofen 10mg half tablet = 5mg three times daily indicating 16 of 47 tablets were dispensed 3/6/17 and 25 half tablets remained. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm revealed: -The Baclofen was originally ordered on 12/6/16 for Resident #5 at 5mg three times daily. -Dispensing information would be difficult to interpret because it was counted and billed in whole 10mg tablets, but packaged in half tablet doses of 5mg. -The pharmacy did not have an order dated 12/27/16 for Baclofen 10mg three times daily. Telephone interview with Resident #5's Primary Care Provider (PCP) on 3/13/17 at 1:45pm revealed she was not aware that Resident #5 did not receive the Baclofen at 10mg three times daily as ordered on 12/27/16. Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed she did not know anything about the order dated 12/27/16 for Baclofen 10mg three times daily. Interview with the Regional Director (RD) on 3/9/17 at 11:43am revealed she did not know anything about the order dated 12/27/16 for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 88 Baclofen 10mg three times daily. Refer to interview with a Medication Aide (MA) on 3/13/17 at 6:54pm. Refer to interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am. Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 3/10/17 at 3:43pm. Refer to interview with the Regional Director (RD) on 3/10/17 at 3:43pm. Refer to review of the facility's Medication Administration Policy. 2. Review of Resident #4's current FL-2 dated 2/21/17 revealed: -Diagnoses included Altered Mental Status, Diabetes Mellitus and Vascular Dementia. -There was an order to check finger stick blood sugar levels before meals and at bedtime. -There were no orders for sliding scale insulin (SSI). a. Review of an "Admission/Readmission Orders" form for Resident #4 dated 12/28/16 revealed there were no orders for SSI. Review of an "Examination or Contact by Physician" form for Resident #4 dated 2/1/17 revealed there was an order to discontinue SSI. Review of Resident #4's January 2017 Medication Administration Record (MAR)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 89	D 358		

revealed there was a preprinted entry for blood sugar checks with Novolog SSI subcutaneously (SQ) before meals: for blood sugar less than 80 give orange juice, 151-200 give 0 units, 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 10 units and greater than 401 call MD with a hand written entry to "see flow sheet." (Novolog is a fast acting insulin used to regulate blood sugar levels.)

Review of "Blood Sugar Monitoring" form for Resident #4 dated January 2017 revealed:
-There was a hand written entry for Novolog SSI SQ before meals: for blood sugar less than 80 give orange juice, 151-200 give 0 units, 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 10 units and greater than 401 call MD.
-From 1/1/17 through 1/31/17 there were 85 blood sugar results documented ranging from 93-337 and staff documented administering Novolog SSI for 9 of the 10 occasions where the blood sugar was greater than 201.

Review of Resident #4's February 2017 MAR revealed:
-There was a preprinted entry for blood sugar checks three times daily before meals and a hand written entry to "record on flow sheet."
-There was a hand written entry to check blood sugar before meals, notify MD if blood sugar was less than 70 or greater than 500 and "see sheet."

Review of "Blood Sugar Monitoring" form for Resident #4 dated February 2017 revealed:
-There was a hand written entry for Novolog SSI SQ before meals: for blood sugar less than 80 give orange juice, 151-200 give 2 units, 201-250 give 2 units, 251-300 give 4 units, 301-350 give 6 units, 351-400 give 10 units and greater than 401

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 90	D 358		

call MD.
-From 2/1/17 through 2/28/17 there were 84 blood sugar results documented ranging from 74-308 and staff documented administering Novolog SSI for 7 of the 7 occasions where the blood sugar was greater than 201.

Review of Resident #4's March 2017 MAR revealed there was a preprinted entry for blood sugar check before bedtime and a second preprinted entry for blood sugar checks before meals with a hand written entry to record on flow sheet.

Review of "Blood Sugar Monitoring" form for Resident #4 dated March 2017 revealed:
-There was a hand written entry to check blood sugar before meals and at bedtime and notify MD if less than 70 or greater than 500.
-From 3/1/17 through 3/13/17 there were 49 blood sugar results documented ranging from 97-321.

Interview with the Resident Care Coordinator (RCC) on 3/13/17 at 5:54pm revealed:
-She did not know who would have been responsible for the orders dated 12/28/16 and 2/1/17 for Resident #4 for Novolog sliding scale insulin (SSI).
-She was not aware the SSI was not ordered 12/28/16 and discontinued on 2/1/17, and that the resident continued to receive SSI for January and February 2017.
-She would notify the Primary Care Provider.
-When residents returned from the hospital, the discharge orders were reviewed by the Medication Aide (MA) or the RCC, faxed to pharmacy and then transcribed on the Medication Administration Record (MAR) by the MA or the RCC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 91 Telephone interview with a Pharmacist from the facility's contracted pharmacy on 3/13/17 at 10:48am revealed: -The last order for Novolog sliding scale insulin (SSI) for Resident #4 was dated 6/22/16 and the pharmacy did not discontinue medications at assisted living facilities without an order from the Primary Care Provider (PCP). -The pharmacy did not have a copy of the hospital discharge orders dated 12/20/16 or the clarification/admission/readmission orders dated 12/28/16 for Resident #4. -The pharmacy did have the order to discontinue the Novolog SSI dated 2/1/17. Telephone interview with Resident #4's Primary Care Provider (PCP) on 3/13/17 at 1:06pm revealed: -Resident #4 was not supposed to be given SSI in January and February 2017 and she was not aware that he continued receiving SSI. -She was concerned with the increased risk of medication error associated with administering SSI which was why she discontinued the SSI. Interview with the Regional Director on 3/13/17 at 7:36pm revealed she did not know anything about the orders dated 12/28/16 and 2/1/17 for Resident #4. b. Review of an "Admission/Readmission Orders" form for Resident #4 dated 12/28/16 revealed; -There was an order for Colace 100mg twice daily. (Colace is a stool softener used for constipation.) -There was an order for Miralax 17gm daily. (Miralax is a laxative used for constipation.) Review of hospital admission summary for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 92 Resident #4 dated 12/20/16 revealed: -The resident "was found to have a significant stool burden causing a colonic obstruction ...he was given enemas (two) resulting in significant stool output. He has had this happen a few times in the past ...the [family member] has concerns about the number of medications the [resident] is on." -"Discontinued the oral iron due to constipation ...decreased Lasix (diuretic) to 40mg daily as he appeared dehydrated this admission which can worsen constipation ...started Colace 100mg twice daily and Miralax daily." Review of Resident #4's January, February and March 2017 Medication Administration Records (MARs) revealed there was no entry for Colace or Miralax. Observation of medications on hand for Resident #4 on 3/10/17 at 11:15am revealed there was no Colace or Miralax on hand for Resident #4. Interview with the Resident Care Coordinator (RCC) on 3/13/17 at 5:54pm revealed: -She did not know who would have been responsible for the orders dated 12/28/16 for Resident #4's Colace and Miralax. -She was not aware the Colace and Miralax had not been transcribed on the Medication Administration Record (MAR) nor administered to Resident #4. -She would notify the Primary Care Provider. -When residents returned from the hospital, the discharge orders were reviewed by the Medication Aide (MA) or the RCC, faxed to pharmacy and then transcribed on the MAR by the MA or the RCC. Telephone interview with a Pharmacist from the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

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D 358	Continued From page 93	D 358		

facility's contracted pharmacy on 3/13/17 at 10:48am revealed:
-The pharmacy did not have a copy of the hospital discharge orders dated 12/20/16 or the clarification/admission/readmission orders dated 12/28/16 for Resident #4.
-The pharmacy did not have any orders for Colace or Miralax for Resident #4.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 3/13/17 at 1:06pm revealed the Miralax and Colace should have been started and she expected staff to follow orders as they were written.

Interview with the Regional Director on 3/13/17 at 7:36pm revealed she did not know anything about the orders dated 12/28/16 for Resident #4.

Refer to interview with a Medication Aide (MA) on 3/13/17 at 6:54pm.

Refer to interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am.

Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 3/10/17 at 3:43pm.

Refer to interview with the Regional Director (RD) on 3/10/17 at 3:43pm.

Refer to review of the facility's Medication Administration Policy.

3. The medication error rate was 5% as evidenced by the observation of 2 errors out of 26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 94	D 358		

opportunities during the 9:00 a.m. pass on 3/08/17 and during the 9:00 a.m. pass on 3/09/17.

Review of Resident #10's current FL-2 dated 3/02/17 revealed:
-The resident's diagnoses included chronic congestive heart failure (CHF), osteoarthritis (OA), blindness left eye, hypertension (HTN), history of transient ischemic attack (TIA) and general muscle weakness.
-There was an order for Pataday solution 0.2% one drop in each eye once daily. (Pataday is an antihistamine eye drop used to treat eye irritation symptoms.)
-There was an order for Protonix 40 mg one tablet every morning before breakfast. (Protonix is an anti-reflux medication used to treat indigestion.)

Observation of the medication pass on 3/08/17 at 9:41 a.m. revealed:
-The Medication Aide (MA) prepared morning medications for Resident #10.
-Protonix 40 mg was administered to Resident #10 at 9:41 a.m. on 3/08/17 instead of 8:00 a.m. or before breakfast.
-Pataday eye drops were not administered to Resident #10 during the medication pass on 3/8/17 at 9:41 a.m.

Observation at 10:00 a.m. on 3/8/17 of Resident #10's blister pack revealed a label which read Protonix 40 mg before breakfast.

Review of Resident #10's February 2017 medication administration record (MAR) revealed:
-There was a computer printed entry for Pataday solution 0.2% instill one drop into each eye daily, and it was scheduled to be administered daily at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 95 9:00 a.m. -Pataday was not documented as administered from 2/01/17-2/28/17 at 9:00 a.m. There were no reasons documented with the omissions. Review of Resident #10's March 2017 medication administration record (MAR) revealed: -There was a computer printed entry for Pataday solution 0.2% instill one drop into each eye daily, and it was scheduled to be administered at 9:00 a.m. -Pataday was not documented as administered from 3/01/17-3/08/17 at 9:00 a.m. There were no reasons documented with the omissions. -There was a computer printed entry for Protonix 40 mg one tablet every morning before breakfast. -Protonix was documented as administered on 3/8/17 at 8:00 a.m. Interview with the medication aide (MA) on 3/8/17 at 10:45 a.m. revealed: -She had administered Protonix 40 mg to Resident #10 on 3/08/17 at 10:41 a.m. -Resident #10 had eaten breakfast at 8:00 a.m. on 3/08/17 -She had not administered eye drops to Resident #10 on 3/08/17 at 10:41 p.m. -She did not know why Pataday drops were not documented on March 2017 medication administration record (MAR). -She could not find Pataday eye drops in the medication cart for Resident #10. Observation at 10:45 a.m. on 3/08/17 of Resident #10's medication revealed Pataday eye drops were not on hand. Interview with the pharmacists on 3/20/17 at 12:11 p.m. revealed the pharmacy had no dispensing record for Pataday solution 0.2% instill	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 96 one drop into each eye daily until 3/8/17. Interview with Resident #10 on 3/08/17 at 12:40 p.m. revealed: -She was not given her eye drops on 3/08/17 during the morning medication pass. -It had been over a month since she was given her eye drops. - Her right eye was watery and itchy. -She would rub her right eye to stop it from itching, and sometimes her right eye was sore. -She had not reported it to the staff. -She ate breakfast on 3/08/17 at 8:00 a.m.. -Protonix was given after breakfast on 3/08/17. -She had no stomach problems on 3/08/17. -Protonix was normally given before breakfast. Interview with the Resident Care Coordinator (RCC) on 3/8/17 at 11:15 a.m. revealed: -She notified Resident #10's Physician Assistant (PA) on 3/10/17 at 11:00 that Protonix 40 mg was administered after breakfast. -Protonix was given 1 hour and 41 minutes after breakfast. -She also notified the PA that Pataday eye drops were not administered for the months of February 2017 and March 1-8. 2017. -The PA discontinued Pataday eye drops for Resident #10. -The PA would come to the facility on 03/10/17 to assess Resident #10's right eye. -She did not reordered Pataday eye drops for Resident #10. Review of the verbal order dated 3/08/17 revealed: -An order to discontinued Pataday eye drops. -The PA signed the order on 03/10/17. Interview with the Administrator on 3/13/17 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 97 5:32 p.m. revealed: -She was aware of the 5% error rate for the medication pass. -The medication aides (MA) would be retrained on administering medications and random monitoring would be done during the medication passes. Refer to interview with a Medication Aide (MA) on 3/13/17 at 6:54pm. Refer to interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am. Refer to telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 3/10/17 at 3:43pm. Refer to interview with the Regional Director (RD) on 3/10/17 at 3:43pm. Refer to review of the facility's Medication Administration Policy. _____ Interview with a Medication Aide (MA) on 3/13/17 at 6:54pm revealed: -The Resident Care Coordinator (RCC) would have been responsible for all orders. -The MAs did not do anything with PCP orders. -In the absence of the RCC, the Regional Director took care of all PCP orders. Interview with the Resident Care Coordinator (RCC) on 3/9/17 at 10:16am revealed: -The RCC was responsible for all Primary Care	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 358	Continued From page 98	D 358		

Provider (PCP) orders for all residents.
-The Medication Aides (MAs) were responsible as well, for faxing PCP orders to the pharmacy and writing orders on the Medication Administration Record (MAR).
-The MAs would leave all orders in a box located in the RCC office for the RCC to review.
-The RCC reviewed all orders and performed any necessary follow up.
-When the covering RCC was not in the facility, whoever covered the RCC duties would know to check the box.
-The process of MAs placing orders in the box in the RCC office was put into place when the covering RCC started at the facility 2/8/17.
-She did not know what the process was before 2/8/17.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 3/8/17 at 4:00pm revealed:
-The pharmacy received orders from the facility and some electronic prescriptions (e-script) from the Primary Care Provider's (PCP) office.
-If the pharmacy received an e-script from the PCP's office, the pharmacy would get a copy to the facility by sending with the prescription fill or by faxing.
-If a PCP order needed clarification, the pharmacy normally contacted the PCP and the facility staff.

Interview with the Resident Care Coordinator (RCC) on 3/10/17 at 3:43pm revealed she did random monitoring of medication passes but had not done one at this facility.

Interview with the Regional Director (RD) on 3/10/17 at 3:43pm revealed:
-The MAs were trained on the medication cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 99 and expected to administer medications according to the PCP's order. -There were "in house people who randomly monitor medications for quality control purposes." -The RD would randomly check medication passes if she was at the facility. -The last time there was an "in house" monitoring was in January or February 2017 when the company nurse was training staff at the facility. Review of the facility's Medication Administration Policy revealed: -Medications, prescriptions and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Medications will be administered within one (1) hour before or one (1) hour after the prescribed or scheduled time unless an emergency situation precludes the administration. -Staff will provide documentation on the MAR after observing the residents taking the medications and before administration to another resident. -The MAR will be updated and changed when medication or treatment orders from the prescribing practitioner changes. _____ The facility's failure to administer medications as ordered resulted in significant errors including Resident #5 not receiving nebulizer medications (Brovana and Pulmicort) resulting in emergency room treatment for an exacerbation of Chronic Obstructive Pulmonary Disease and receiving duplicate antipsychotic therapy (Perphenazine and Prolixin) for 6 weeks; Resident #4 receiving sliding scale insulin for two months without an order from the PCP and did not receive a stool	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 100 softener and laxative (Colace and Miralax) as ordered following a hospitalization for a bowel obstruction. The facility's failure to administer medications as ordered by the provider resulted in serious physical harm and neglect, which constitutes a Type A1 Violation. _____ Review of the Plan of Protection submitted by the facility dated 3/10/17 revealed: -[There will be] retraining with staff on administering medications and/or treatments per physician orders on 3/10/17 through 3/13/17. -The Director, Resident Care Coordinator and/or designee are to audit medication administration records to assure that medications are being given per physician's orders. -The Director, Resident Care Coordinator and/or designee are to [conduct] monthly audits of medication passes to assure staff are giving medications per physician's orders. -Any staff not following physician's orders will receive re-training and/or disciplinary action up to termination. -Staff will be retrained on residents' rights by 3/9/17. THE CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED 3/12/17.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D 451	Continued From page 101 accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to report to the Department of Social Services the death occurring in less than 24 hours of a resident who fell and developed new nausea and vomiting at the facility (#6). The findings are: Review of Resident #6 FL-2 dated 10/25/2016 revealed diagnoses included Hypertension, Pacemaker and Heart Failure. Review of Resident #6's Care Notes revealed: -On 02/18/2017 at 3:40 p.m. Resident #6 was found on the floor, stated that she slid out of her wheelchair, there was no bruising or skin tear, no complaint of pain or discomfort, stated she did not hit her head, she was assisted back into her wheelchair and family member was notified. -On 02/19/2017 Resident #6 was observed to be unresponsive in the a.m., breathing was shallow, 911 was called, resident was transported to hospital, family member and primary care physician were notified. Review of Resident #6's hospital records dated 02/19/2017 revealed: -Diagnoses included Unresponsive Episode, Hypoxia, Unspecified Hypotension and Cardiac Arrest. -Resident history per hospital records was that she was checked by facility staff at 3:00 a.m. on 02/19/2017 and was in normal state of health.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 102 -Resident was checked again by facility staff at 6:00 a.m. at 02/19/2017 and found to be unresponsive. -Resident expired at 7:20 a.m.on 02/19/2017. Interview with the Administrator on 03/10/2017 at 3:15 p.m. revealed: -She was informed of Resident #6's passing on 02/19/2017. -Report concerning death of Resident #6 was faxed to social services, not sure of date of fax. -Copy of faxed report will be provided. No report was provided by end of survey.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to overall management of the facility, medication administration and health care. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure full time and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: _____ B. WING _____	R 03/13/2017

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

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D912	Continued From page 103 consistent responsibility for the operation, administration, management and supervision of the facility which resulted in significant noncompliance with state rules and regulations related to staffing, personal care, supervision, health care, medication administration, housekeeping and furnishings and reporting incidents and accidents. [Refer to Tag 183 10A NCAC 13F .0603(a) Management of Facilities with a Capacity or Census of 81 or More Residents TYPE A1 VIOLATION] 2. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents for record review which included Resident #5 not receiving nebulizer medications (Brovana and Pulmicort) resulting in emergency room treatment for an exacerbation of Chronic Obstructive Pulmonary Disease, receiving duplicate antipsychotic therapy (Perphenazine and Prolixin) for 6 weeks and receiving the incorrect dose of a muscle relaxer (Baclofen); Resident #4 receiving sliding scale insulin for two months without an order from the Primary Care Provider and did not receive a stool softener and laxative (Colace and Miralax) as ordered following a hospitalization for a bowel obstruction; and, 1 of 3 (Resident #10) as observed during the medication pass, not receiving an anti-reflux medication (Protonix) more than one hour after breakfast and not receiving antihistamine eye drops with current symptoms of dry and itchy eyes. [Refer to Tag 358 10A NCAC 13F .1004(a)(2) Medication Administration TYPE A1 VIOLATION] 3. Based on observations, interviews and record reviews, the facility failed to assure appropriate health care referral and follow up for 4 of 7	D912		

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D912	Continued From page 104 sampled residents which resulted in a resident (#6) being found unresponsive following new vomiting that was not reported to the primary care provider (PCP) after an unwitnessed fall; a second resident (#1) not having a working oxygen concentrator for three days and not having a recommended ultrasound for a growth on the spleen; a third resident (#5) with a diagnosis of Chronic Obstructive Pulmonary Disease and was oxygen dependent not having a working oxygen concentrator for 5 days requiring emergency medical treatment; and, a fourth resident (#4) having increased swelling of his left foot unreported to the PCP. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care 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 reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision of residents and personal care and other staffing. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 2 sampled residents which resulted in one resident (#8) with a diagnosis of dementia and a history of leaving the facility requiring emergency medical treatment for exposure to the cold, to	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 105 then leave the facility a second time and was found on the ground by a passerby; and a second resident (#9) who had a strong odor of cigarette smoke near his room reportedly discarding cigarettes butts in a trash can near an oxygen tank. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision TYPE A2 VIOLATION] 2. Based on observations, interviews and record reviews, the facility failed to assure adequate staff were available to provide supervision and personal care assistance including incontinence care, bathing and assistance to the dining room for meals related to direct care staff on duty being assigned routine housekeeping duties such as deep cleaning resident rooms and doing laundry for each shift on a daily basis. [Refer to Tag 189 10A NCAC 13F .0604(e)(2) Personal Care and Other Staff TYPE B VIOLATION]	D914		