Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R-C	
		HAL031003	B. WING		10/17	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
	OLUMBA DV OT	WALLACE,		220 / 2220 21 44 62 66222 6710		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department of a follow-up survey and 10/11/17 - 10/13/17 a complaint investigation	sure Section and the Duplin of Social Services conducted d complaint investigation on and 10/16/17 - 10/17/17. The cons were initiated by the timent of Social Services on and 08/24/17.				
D 074	10A NCAC 13F .0306 Furnishings	δ(a)(1) Housekeeping And	D 074			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (1) have walls, ceiling coverings kept clean	s shall: gs, and floors or floor				
	failed to assure the w clean and in good rep bathroom/shower roo bathrooms (201, 207,	ns and interviews, the facility ralls and floors were kept pair for 3 common runs, 3 private resident (210), 2 resident rooms om on 100 Hall, and the				
	The findings are:					
	207 on 10/11/17 at 10 -The toilet tissue hold -There were three sm diameter of a dime) in the broken tissue hold	ler was broken. nall holes (smaller than the n the wall on the right side of				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74121 2741	or contraction	IDENTIFICATION NO.	A. BUILDING:			
		HAL031003	B. WING		R-0 10/17	C 7/ 2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT	H NC 41 , NC 28466			
	CLIMMADV CT			PROVIDER'S PLAN OF CORRECTION	N	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 074	Continued From page	: 1	D 074			
		ne wall. and multiple brown and gray ous sizes throughout the				
		ent who resided in room 207 a.m. revealed she would like hat was not broken.				
	Hall on 10/11/17 at 10 -There was a light bro inches wide in size or	own stain greater than 6 n the floor tile of the shower. eft wall near the floor had colored stains which				
	room 201 on 10/12/1: -The floor in the bathin between the vinyl toilet, and gray stains squares in front of the -There was an 18 x 1 left of the toilet that w	ljoining bathroom to resident 7 at 3:08 p.m. revealed: room had dark brown stains type floor squares near the of varying sizes on the etoilet. 8 inch hole in the wall to the as covered with a piece of the material and taped to the				
	210 on 10/11/17 at 10 -There was no toilet t -The wall beside the t	othroom in resident room 0:35 a.m. revealed: issue holder on the wall. oilet had 12 inches by 12 ir that had not been sanded				
	Hall on 10/11/17 at 11 -Three of the walls ha of various sizes.	mmon bathroom on the 100 1:50 a.m. revealed: ad multiple light brown stains at toilet had dark brown and				

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STATE FORM BPR11 If continuation sheet 2 of 419

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						.C
		HAL031003	B. WING		1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
	to the Little of		JTH NC 41	, 3332		
GOLDEN	CARE		E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				,		
D 074	Continued From page	e 2	D 074			
	black colored stains.					
	-The paint on the wall	I behind the toilet was				
		hat were each 1 inch in				
	diameter and 1 area t	that was 3 inches by 1 inch				
	in diameter.					
	Observation of the de	overseen on the 100 Hell on				
	10/11/17 at 10:18 a.m	ayroom on the 100 Hall on				
		ed with a dirty film with				
	multiple black scuff m					
	•	shold of the entrance ways to				
		area with a buildup of black				
	stains that was appro	ximately 6 inches in				
	diameter.					
	Ob + + + + + +	. Il				
	on the 100 Hall on 10	allway at the main entrance				
	revealed:	7/11/17 at 10.29 a.m.				
		ed with a dirty film and				
	multiple black scuff m					
		light brown stained areas				
	near the walls.					
		allway at the back entrance				
	on the 100 Hall on 10	0/11/17 at 10:29 a.m.				
	revealed:	thick buildup of black stains				
	_	ruff marks all over the floor.				
	-The floor was sticky					
	_	out 3 inches in diameter on				
		oor in the hallway that				
	connected to the 100	Hall.				
		ent room 108 on 10/11/17 at				
	10:55 a.m. revealed: -The floor in front of the	ha hadaida tabla bad				
	multiple cracks and p					
		uff marks on the floor.				
		or had multiple small round				

Division of Health Service Regulation

fingerprint smudges.

STATE FORM 6899 DBPR11 If continuation sheet 3 of 419

Division of Health Service Regulation

	of Health Service Regu				(X3) DATE SURVEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION	
AIND PLAIN (O CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF S	DOVIDED OD CURRUIED		DDDEGG GITV GT	FF 7ID CODE	-
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	IE, ZIP CODE	
GOLDEN	CARE		UTH NC 41		
		WALLAC	CE, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	
1710		,	, ,,,,	DEFICIENCY)	
D 074	0 11 15	_	D 074		
D 074	Continued From page	e 3	D 074		
	Interview with a resid	ent in room 108 on 10/11/17			
	at 10:55 a.m. reveale	ed the floor and wall had			
	been that way "a long	g time" (over a year).			
		ent room 106 on 10/11/17 at			
	11:14 a.m. revealed:				
		of dark stains on the floor			
	and the floor was stic				
	T	scratch marks with missing			
	paint on the wall near	•			
		the wall about 3 inches in			
	diameter near the do	OI.			
	Interview with a resid	ent in room 106 on 10/11/17			
	at 11:14 a.m. reveale				
		s sticky and they never buff			
	the floors.	o onony and may nover bun			
	-The walls had been	scratched for "a while".			
		the painter who was in the			
		(10/17) to paint the walls in			
	her room.				
	-The painter told her	that he had to get			
	permission to paint it.				
		ommon shower room on the			
		104 on 10/11/17 at 11:44			
	I	e areas of missing tile on the			
		ne bathroom door in the			
	hallway.				
	Observation of the ha	allway on the 200 Hall on			
		n. revealed the floor was			
		ilm with multiple black scuff			
	marks.	Man manapio bidon dodii			
	Interview with Mainte	nance staff on 10/11/17 at			
	10:08 a.m. revealed:				
		ing on getting the painting			

Division of Health Service Regulation

done in the facility.

STATE FORM 6899 DBPR11 If continuation sheet 4 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDI		A. BUILDING:		COMPLETED		
			B. WING		R-C	
		HAL031003	B. WING	·····	10/17/2017	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 80	UTH NC 41	,		
GOLDEN (CARE					
		WALLAC	CE, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
TAG	KLOOLATOKT OK	ESCIDENTIF TING INFORMATION)	TAG	DEFICIENCY)	IAIL SINE	
D 074	Continued From page	e 4	D 074			
	The second secon					
		g around the end of June				
	2017.					
		e walls in the hallways,				
	dining room, and day	room near the front				
	entrance.					
		the residents' rooms yet.				
	•	on the floors but that was				
		r they finished the floors.				
	-The floors had scuff					
	refinishing and waxing					
	-They would also repl	ace any broken tiles.				
		dication aide/supervisor on				
	10/11/17 at 4:10 p.m.	revealed the owners were				
		ors done after they finished				
	painting the walls.					
	Interview with the Adr	ministrator on 10/12/17 at				
	10:02 a.m. revealed:					
	-The Manager contac	ted the painter after the last				
	survey in June 2017.					
	-The painter was dela	yed in coming to the facility				
	because there were o	other jobs ahead of the				
	facility.					
	-The painter just start	ed painting at the facility				
	about a month ago.	-				
		ted the walls in the common				
	areas but he still had	to paint the residents'				
	rooms.	·				
	-She contacted a floo	r company about 2 weeks				
		o finish painting before she				
	started on the floors.					
		the floors stripped and				
	waxed and to repair the					
	and a constant					
D 076	104 NCAC 12E 0200	S(a)(2) Haugakaaning And	D 076			
ס ז ט ע		S(a)(3) Housekeeping And	סיט ט			
	Furnishings					
	404 NOAC 40E 0000	N. Harris and S. H.				
	10A NCAC 13F .0306	Housekeeping And				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			, 551251110.		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		TH NC 41 E, NC 28466			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	d (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 076	Continued From page	e 5	D 076			
	Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.					
	review, the facility fail repair, including ches stands/bedside tables cabinet, headboard, a	ns, interviews, and record ed to have furniture in good t of drawers, night s, dressers, chairs, television and sofas, in 8 residents' om on the 100 Hall, and the				
	The findings are:					
	Observation of resident room 205 on 10/11/17 at 10:22 a.m. revealed the drawer to the nightstand was missing a handle and the finish was scratched.					
	at 10:22 a.m. reveale -She did not bring the -The furniture belonge	e furniture in her room. ed to the facility. en like that since she moved				
		ent room 207 on 10/11/17 at he finish on the nightstand				
	11:03 a.m. revealed: -There were two chai chairs had two tears i than 3 inches long ne	ent room 102 on 10/11/17 at rs in the room; one of the n the upholstery greater ear the top cushion.				

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Division of Health Service Regulation

(3) DATE SURVEY	
(X3) DATE SURVEY COMPLETED	
COMPLETED	
R-C	
10/17/2017	
(X5)	
COMPLETE DATE	
 	
 	
 	

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 7 of 419

Division of	of Health Service Regu	ılation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL031003	B. WING		R-0	C 7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
GOLDEN (CARE	4002 SOI	UTH NC 41			
	JAKE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 076	Continued From page	e 7	D 076			
	10/11/17 at 10:18 a.m. -There was a pink up multiple dark stains a -There was a beige let the seat about 6 inche material coming up the -There was approxim the front left side of the cotton material exposes. There was a blue lead a spring hanging down chair and the wooder -There was a blue 3 sheavily soiled with dahead rest areas of the -There was a blue clowith dried white and the seat, and back of the -The hand lever on the recliner was broken of sticking out about 1 at the chair. -There were 2 blue lewith wooden legs that missing stain, and on middle of the seat. -The wooden televisite doors with broken has sideways. -There was a pink up dark stains on the back wooden legs with screen and missing stain on the stain of the stain o	cholstered love seat with all over the back and seat. Eather recliner with a rip in es long with white cotton brough the ripped area. In eather a 2 inch ripped area on the same beige recliner with sed. In the ripped chair with an incomplete the section of the eather upholstered chair with an incomplete the section leather sofa that was the sofa. The coliner heavily soiled brown stains on the arms, chair. The right side of the blue cloth off with a piece of metal and 1/2 inches on the side of the chair straight back chairs at were scratched and the chair had cracks in the concabinet had two cabinet and seat of the chair and the seather chair with multiple ck and seat of the chair and the seather chair with scratches.				
	_I -The bedside table dr	rawer was loose and uneven				

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and did not close properly.

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING:		COMPLETED	
						,
		HAL031003	B. WING		R-0 10/17	7/2017
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE		
			UTH NC 41			
GOLDEN (CARE		CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 076	Continued From page	28	D 076			
	-There were multiple on the bedside tableThere was a wooder knob on the door on the door on the transfer was a 4 drawer and missing stain. Interview with a resident at 10:55 a.m. revealeThe furniture had been the facility was supposed but she did not know the did not kno	scratches and missing stain a cabinet with a missing he right. er dresser with scratches ent in room 108 on 10/11/17 d: en that way a long time. loosed to get new furniture when. ent room 106 on 10/11/17 at side tables with multiple g stain. er dresser with scratches ent in room 106 on 10/11/17 d the furniture had been that dication aide/supervisor on revealed she was not sure as to replace the furniture. ministrator on 10/12/17 at been removed but more will				
D 077	Furnishings	S Housekeeping And	D 077			
	10A NCAC 13F .0306	nousekeeping And	1			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		
	HAL031003	B. WING		R-C 10/17/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
OOL DEN OADE	4002 SOU	TH NC 41		
GOLDEN CARE	WALLACE	, NC 28466		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 077 Continued From page 9 Furnishings (a) Adult care homes shall: (4) have a North Carolina Divenvironmental Health approved classification at all times in for less and North Carolina Denvironmental Health sanital above at all times in facilities more; This Rule shall apply to new facilities. This Rule is not met as evide FOLLOW-UP TO TYPE B VI Based on these findings, the Violation was not abated. Based on observations, intereviews, the facility failed to a sanitation classification at all with a North Carolina Division Health Sanitation score of 85 times. The findings are: Review of the facility's most Environmental Health Sanitation score -Demerits were noted including the facility dated 05/03/17 region -The facility's sanitation score -Demerits were noted including -Floor tiles were worn at the -Walls needed painting through including hallways, dining, and -Some walls had holes, need rooms/restrooms. -Storage kept in the bathtub -Several resident restrooms	ved sanitation acilities with 12 beds ivision of tion scores of 85 or with 13 beds or and existing enced by: OLATION e previous Type B rviews and record maintain an approved times in the facility n of Environmental or above at all current tion inspection for vealed: e was 75. ing the following: entry to bathrooms. Ighout facility nd resident rooms. Ided repair in resident of one shower room.	D 077		

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DIVISION	of fleatin Service Regu	iation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ALE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDLIA	CAIL	WALLACE	, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
D 077	Continued From page	10	D 077			
ווטט	Continued From page	9 10	0077			
	-Hot water in several	rooms exceeded 116				
	degrees Fahrenheit (I	F) on the 200 Hall.				
		ere present throughout the				
	building.	ore precent amoughout are				
		o help prevent infestation.				
	I	ninator was needed on a				
	routine basis to tackle					
		age room was unorganized				
	and messy.					
	-A few personal chairs	s were worn/stained.				
	-Some dressers/side	tables were worn.				
	-Couches in common	rooms were dirty under the				
	cushions.	·				
	-Roaches were prese	nt in one resident				
	refrigerator.					
	_	alagning with same mildow				
		cleaning with some mildew				
	present in shower sta					
		e dirty and needed cleaning.				
		ers needed repair in some				
	rooms.					
	-General comments:	Hand hygiene does not				
	appear to be occurrin	g in a manner so as to				
	protect residents. Em	ployees should wash hands				
		e room and the next and				
	_	cations, foods as well as				
	_	es cannot properly wash				
		/aiding in diapering as there				
		or soap in many resident				
	rooms. Glove use doe					
		ng to reduce the spread of				
		es. A better hand hygiene				
	program is needed.					
		<u>.</u>				
	_	he survey from 10/11/17 -				
		7 - 10/17/17 revealed areas				
	documented on the sa	anitation report dated				
		been corrected included:				
		e facility needed cleaning				
	and repairing.	,				

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-Walls in residents' rooms and bathrooms

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DIVISION	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					5.0
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	TO VIDER OR OUT FEET				
GOLDEN (CARE		UTH NC 41		
		WALLA	CE, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 077	Continued From page	e 11	D 077		
	throughout the facility	wore in poor repair and			
		were in poor repair and			
	needed painting.				
		g room, dayrooms, and			
		as in poor repair and/or			
	needed cleaning.				
		bserved in the kitchen and			
	resident living areas.				
	-Light fixtures were no	ot working properly in a			
	common shower room	n and the kitchen.			
	-Hot water temperatu	res were greater than 116			
		s on the 100 and 200 Halls.			
	•	ooms and restrooms were			
		cessive storage including			
	personal hygiene iten				
		cleaning with some buildup			
	present in shower sta				
		ers needed repair in some			
	bathrooms.				
		hygiene were noted during			
	the medication pass of	observed on 10/12/17.			
	Refer to specific finding	ngs for the following:			
	-Tag 074, 10A NCAC				
	Housekeeping and Fu	()()			
	-Tag 076, 10A NCAC				
	Housekeeping and Fu				
	-Tag 079, 10A NCAC				
	Housekeeping and Fu				
	-Tag 105, 10A NCAC	13F .03T1(a) Otner			
	Requirements.				
	-Tag 113, 10A NCAC	13⊦ .0311(d) Other			
	Requirements.				
	•	13F .0904(a)(1) Nutrition			
	and Food Service.				
	-Tag 388, 10A NCAC	13F .1007(c) Medication			
	Administration.	. ,			
	Interview with the me	dication aide/supervisor on			
	10/11/17 at 9:32 a.m.	-			
	at 0.02 a.iii.		1	1	

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-The facility had not been re-inspected because

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
	OLUMBA DV OT		, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 077	Continued From page	e 12	D 077			
	facility to be finished inspector to come backing inspector when she called.	anted the painting of the before she called the health ck to the facility. ministrator on 10/12/17 at acility's sanitation grade was around to calling the health ck and re-inspect the facility. usually came "pretty quick"				
	The facility failed to correct and maintain a North Carolina Division of Environmental Health sanitation score of 85 or above at all times as evidenced by a sanitation score of 75 on the sanitation report dated 05/03/17. The facility had not corrected the problems identified by the health inspector, including the walls and floors throughout the facility had not been maintained in good repair or kept clean; residents' furniture was not kept in good repair; and water temperatures were greater than 116 degrees at two fixtures, resulting in one resident not washing her hands after toileting because she feared the water would burn her hands. The failure continued to be detrimental to the health, safety, and welfare of the residents, which constitutes an Unabated Type B Violation.					
	Review of the facility's Plan of Protection dated 10/17/17 revealed: -Cited sanitation deficiencies from 05/03/17 have been corrected and Division of Environmental Services' office has been notified to come back for sanitation inspection to maintain a sanitation grade of 85 and aboveTreatment by exterminator company every 2					

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-0	c
		HAL031003	B. WING		1	7/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU	ΓΗ NC 41 , NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 077	Continued From page	e 13	D 077			
D 0770	weeks until pest conti maintenance plan cor -Building inside painte patched or in process -In process of strippin -On-going sanitation a building will be mainta grade of 85 and abov -Administrator will do monitor facility sanitation	rol is resolved and ntinued. ed walls, holes in walls is. g/waxing floors. and maintenance of the ained to ensure a sanitation e. daily walk through to tion issues.				
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.		D 079			
	This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to assure the facility was clean, uncluttered and free of hazards in 3 resident rooms and a common shower room on the 100 Hall including issues with roaches in the facility.					

Division of Health Service Regulation

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-0 10/17	7/ 2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
001 DEN	0485	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 079	Continued From page	e 14	D 079			
	The findings are:					
	10:35 a.m. revealed: -There was a fly/insect over the resident's be- The fly/insect catche sticky tape that was a thumb tack that was heeilingThere were 10 dead catcherThere was 1 roach tr 2 dead roaches in itThere was 1 roach tr wall on the right side roaches in itThere was a can of skiller" on the resident his bed. Interview with a resident his bed. Interview with the fly beginning of the summand the sprayed the insect needed on flies or road-He had not seen any weeks". Interview with the med (MA/S) on 10/11/17 and -She was not aware to catcher hanging aboven she was not aware she catcher hanging aboven she was not aware she catcher hanging	ap behind the door that had ap on the floor against the of the room that had 5 dead spray labeled "Flying Insect 's night stand at the end of ent who resided in room 210 a.m. revealed: catcher above my bed at the mer." the roach traps in the room. t him the insect spray at the mer. ct spray in his room if				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 15 of 419

Division of Health Service Regulation

DIVISION	n nealth Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	•
			D WING		R-	_
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIL	DAIL
				,		
D 079	Continued From page	e 15	D 079			
	. •					
	catcher and roach tra					
		ny roaches or flies in Room				
	210.					
	-She "occasionally se	es roaches at the staff				
	desk."					
	Confidential interview	with a resident revealed the				
	resident saw a roach	about a week ago.				
	Interview with a cook	/medication aide on 10/11/17				
	at 8:20 a.m. revealed	:				
	-She had not seen an	ny roaches recently.				
	-The last time was 3 v	-				
		ast treatment was one month				
	ago.	act irediment was one month				
	ago.					
	Interview with a cook	on 10/11/17 at 11:30am				
	revealed:	on 10/11/17 at 11.30am				
	-She had not seen an					
	-	e exterminator came every 2				
	weeks.					
		y member on 10/12/17 at				
	12:22 p.m. revealed					
	•	the family member saw				
	roaches in a resident	's dresser drawer; it was full				
	of tiny roaches.					
	-About 6 weeks ago,	a second resident had a lot				
		m and the resident's family				
	member bought insec	•				
		spoke to the local health				
		e roaches and was told the				
	•	for roaches about one				
	month ago.	TO TOGOTICS ADOUT OTHE				
	monurago.					
	Intonvious with a paras	anal care aide on 10/12/17 ct				
		onal care aide on 10/13/17 at				
	9:55am revealed:	using to Might				
		aving to "fight roaches."				
		rayed twice a month, she				
	thought.					

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 16 of 419

Division of Health Service Regulation

	of Health Service Regu					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
AND LEAN (J. JONNEOTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COIN	
						R-C
		HAL031003	B. WING		10)/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET /	ADDRESS, CITY, STATI	= ZIR CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER			E, ZIP CODE		
GOLDEN	CARE		OUTH NC 41			
	Г	WALLA	CE, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE AP		DATE
				DEFICIENCY)		
D 079	Continued From page	2.16	D 079			
2010	Continued From page	3 10				
		ent room 108 on 10/16/17 at				
	8:55am revealed there was a live roach crawling					
	on the floor.					
	Confidential intention	with a second resident				
	revealed:	with a second resident				
	-There were roaches	in the facility				
		d been coming to the facility				
	but the resident was	•				
		aches in the drawers of the				
	bedside table a coup	le of weeks ago.				
	-The resident asked t	the exterminator to spray				
	their room a couple o	f weeks ago.				
	Confidential interview	with a third resident				
	revealed:	with a tima resident				
	-The resident saw roa	aches in their room "once in				
	a while".					
	-The resident saw a r					
		athroom and "mashed it with				
	my foot".					
	Confidential interview	with a fourth resident				
	revealed:	with a lourer resident				
		ch problem about a month				
	ago.					
	_	en roaches crawl across				
	their bed.					
	-Another resident gav	ve them a can of roach spray				
	and they had sprayed					
	-It was getting better.					
	Observation of re-id-	ent room 100 on 10/11/17 -1				
	10:31 a.m. revealed:	ent room 109 on 10/11/17 at				
		resident's bathroom was				
	, , ,	e racks of clothing hanging				
	on the bathroom doo					
		e bathroom had multiple				

Division of Health Service Regulation

racks of clothing hanging on it.

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Division of	<u>of Health Service Regu</u>	ılation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
		1141 004000	B. WING		R-C
		HAL031003	D. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
	OLIMANA DV OT		·	DDOL/IDEDIO DI ANI OE CODDECTIO	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 079	Continued From none	- 47	D 079		
D 079	Continued From page	e 17	0079		
	-There was a bedside	e commode stored in the			
	bathroom with clothes	s and empty clothes racks			
	laying on top of it.				
		ookcase in the resident's			
	bathroom filled with p	ersonal hygiene items and			
	linens near the bathro	oom sink.			
	-There was a bottle o	of bleach spray and bleach			
	wipes on the top shel	If of the bookcase in the			
	bathroom.				
	-There was limited space to access the sink with				
	the bookcase and the	e bedside commode.			
	Observation of the co	ommon shower room on the			
	100 Hall beside room	104 on 10/11/17 at 11:44			
	a.m. revealed:				
	-There were scratch r	marks and yellow and brown			
	stains on the toilet se	eat.			
	-There was a Geri-ch	air tray stored in the shower			
	stall on the right.				
		inent brief laying on the back			
	of the toilet.				
		d some light brown stains on			
	the side and the legs.				
	_	ains in the grout of the tiled			
	shower.	lan af a san a sauna			
		Im of soap scum on the			
	walls of the shower.	no rupping down the			
		ns running down the wall			
	below the metal hand	pach on the floor near the			
	sink.	oach on the hoor fleat the			
	SIIIK.				
	Interview with the me	edication aide/supervisor on			
	10/11/17 at 4:10 p.m.				
		sually cleaned the showers			
	every day.	and offering			
		done in about 2 to 3 rooms			
	per day.	20			
		brought extra items that			
			1		

Division of Health Service Regulation

cluttered residents' rooms.

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DIVISION C	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					D 0	
		1141 004000	B. WING		R-C	
		HAL031003	B: WiiNO		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN (CARE		E, NC 28466			
			·			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-)	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
5.0=0			5.050			
D 079	Continued From page	e 18	D 079			
	-The exterminator cor	mpany came to the facility				
	about once a month.	,				
	-She saw a roach in t	he kitchen in the ice box				
	yesterday (10/10/17).					
		oach out of the ice box but it				
	got away.					
	•	or 12 roaches every day in				
	the kitchen or dining r					
	•	ad gotten better about 2				
	weeks ago.	ida gotton botton about 2				
	_	ld flip a light on and roaches				
	were everywhere.	a mp a ngm on ana reaches				
	Interview with the Adr	ministrator on 10/12/17 at				
	10:02 a.m. revealed:					
		erminator company came to				
		eks and targeted treatment				
	for the roaches.	ione and targeted treatment				
		y left invoices when they				
	came but she would o					
	-There had been an in					
	roaches but they were					
	-	nes in the kitchen last week.				
	0110 0011 1 01 2 10001	Too in the Michael Mack				
	Review of invoices fro	om the exterminator				
	company revealed:					
		doors and dining/cafeteria				
	were treated for roach	_				
		ol (roaches) for room 106 -				
		oom, janitor closet, and				
	emergency closet.	,,,				
		doors, dining/cafeteria, and				
	bathrooms were treat					
		doors and dining/cafeteria				
	were treated for roach					
		doors and dining/cafeteria				
	were treated for roach					
		reparation areas, entry				
		nd a couple of resident				

Division of Health Service Regulation

rooms were treated for roaches.

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Division of Health Service Regulation

DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			B. WING		R-C	
		HAL031003	B. WING		10/17/	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
	10115211 011 001 1 21211					
GOLDEN	CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR I	LOC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MAIE	DATE
				,		
D 079	Continued From page	e 19	D 079			
	-09/26/17: The kitche	n, dining area, and a couple				
		re treated for roaches.				
	-There were no invoice	ces for October 2017.				
		20.00.00.00000.00000.000000000000000000				
D 000	40 A NO A O 42 E 0200	C(a)(C) Have also a pine. And	D 080			
טסט ט		6(a)(6) Housekeeping And	D 000			
	Furnishings					
	404 NOAO 40E 0000	N. I. I				
	10A NCAC 13F .0306	Housekeeping And				
	Furnishings					
	(a) Adult care homes					
	(6) have a supply of b	oath soap, clean towels,				
	washcloths, sheets, p	illow cases, blankets, and				
	additional coverings a	adequate for resident use on				
	hand at all times;					
	This Rule shall apply	to new and existing				
	facilities.	•				
	This Rule is not met	as evidenced by:				
		ns and interviews, the facility				
		lequate supply of towels,				
	washcloths, and incor					
		to provide personal care for				
	a current census of 2	•				
	a carroin concac or 2	o recidente.				
	The findings are:					
	o manigo aro.					
	Observation of the clo	oset on the 100 hall				
	identified by a medica					
		eset on 10/11/17 at 4:04 p.m.				
	revealed there were 4 washcloths, 18 bath					
	towels, and 1 "chuck"	incontinence pad.				
	Observation of the lar	undry room on 10/11/17 at				
	4:12 p.m. revealed:	,				
	-There was one wash	ing machine and one				
	clothes dryer.	mig macrimo ana one				
		e was in use; the dryer was				
	not in use.	e was in use, the dryer was				
		irty laundry observed in the				
	- mere was not any d	irty laundry observed in the				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT	'H NC 41			
		WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 080	Continued From page	20	D 080			
	above the washing m a handwritten note wh washcloths in trash! F gloved hands and put 36 cloths in the last 6 they?"	posted on a cabinet door achine dated 08/10/17 with nich read "Do not throw Rinse them out with your in laundry! I have bought weeks, now where are				
		ere were 2 washcloths, 16				
	Interview with a personal care aide (PCA) on 10/12/17 at 8:06 a.m. revealed: -There were times when there were no washcloths; a few weeks ago, she cut up a towel to use to bathe residents. -The Manager and the first shift medication aide/supervisor (MA/S) were aware. -The Manager had been out; the Administrator was filling in since the Manager was out.					
	11:45 a.m. revealed the bath towels and no in	en closet on 10/12/17 at here were 2 washcloths, 4 continence pads.				
	a.m. revealed: -There was "plenty" o useThe residents got a c on their shower daysStaff on all shifts was	f linen for the residents to				
	revealed:	on 10/12/17 at 11:50 a.m. hen needed on all shifts				

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ווטופוזיום	i Health Service Regu	iauon				—
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				_	D 0	
			R WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TV WIL OF F	DER OR OUT FEILIN			, 0002		
GOLDEN	CARE		ITH NC 41			
		WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DETICIENCY)		_
D 080	Continued From page	e 21	D 080			
	-There was no laundr	ry schedule.				
	-There should be pler	nty of washcloths and towels				
	for resident use.					
	-A (named) staff mem	ber just put out 18				
	,	wels for resident use within				
	the last "month or so.					
	the last month of so.					
	Observation of the lin	en closet on 10/12/17 at				
	-	ere was one washcloth, 6				
	bath towels and one i	incontinence pad.				
		PCA on 10/12/17 at 6:45				
	p.m. revealed:					
	-The facility did not su	upply disposable				
	incontinence pads; th	ey had a few				
	non-disposable incon	tinence pads, but not				
	enough.	•				
	•	upply wipes, so staff had to				
		y their own to use for the				
	residents.	y then own to doc for the				
		eart on weahalatha				
	-Staff were always sh					
	•	first shift MA/S brought in				
	two stacks of washclo					
		w where the washcloths				J
	went.					
	Observation of the lin	en closet on 10/13/17 at				
	7:53 a.m. revealed th	ere were 8 washcloths, 15				
	bath towels and one i	incontinence pad.				
						J
	Interview with a MA/S	on 10/13/17 at 5:30 p.m.				
	revealed:	·				
		once in a while on wash				
	cloths.					
		, the MA/S noticed they were				ļ
	iow on washcioths, bl	ut they had plenty of towels.				
	Observation for the					
		en closet on 10/17/17 at				
	12:37 p.m. revealed t	here were no washcloths,				

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12 bath towels and 3 incontinence pads.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 080	Continued From page	e 22	D 080		
	Observation of the PCA on 10/17/17 at 12:40 p.m. revealed the PCA was removing towels and washcloths from the dryer and folding the laundry in the laundry room. Interview with the PCA on 10/17/17 at 12:40 p.m.				
	revealed there were enough washcloths and towels. Observation of a second PCA on 10/17/17 at 12:41 p.m. revealed the PCA was placing towels and washcloths in the linen closet.				
		en closet on 10/17/17 at here were 3 washcloths, 19 ontinence pads.			
	Confidential interview with a resident revealed: -The facility ran out of washcloths and towels "sometimes." -The other day, they had towels, but not wash				
	clothsThe resident had gotten her own washcloths, because she had to shower without a washcloth in the pastSome residents did not have their own washcloths and towels.				
	Confidential interview with a second resident revealed: -They ran out of washcloths "sometimes" and she did not have a wash cloth to wash her face in the morningShe had not complained to anyoneThe Manager said she would get more washcloths a while ago.				
		with a Home Health Nurse .m. revealed there were			

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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL031003	B. WING		R- 10/1	C 7/2017
NAME OF PE	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 10/1	172011
		4002 SOUT		· - , - · · · · · · · · · · · · · · · · · 		
GOLDEN	JAKE	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 080	Continued From page	23	D 080			
	times when there wer available for residents	re no towels or washcloths is to use.				
	4:45 p.m. revealed -There were enough with the residents. -She was aware of the have towels and wash	washcloths and towels for e rule that residents were to ncloths available at all times. ould make sure they were ow, would get more.				
D 105	10A NCAC 13F .0311	(a) Other Requirements	D 105			
	105 10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.					
	This Rule is not met a FOLLOW-UP TO TYPE The Type B Violation	PE B VIOLATION.				
	Non-compliance cont					
	reviews, the facility fa equipment was maint operating condition as fixtures not working p shower rooms and the cover with a gap arou	ns, interviews, and record iled to assure the electrical ained in a safe and sevidenced by the light roperly in two community e kitchen; a phone jack and it in a resident room; and wer with a hole in a second				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			7 56.25	A. BOILDING.		C
		HAL031003	B. WING			7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		ITH NC 41 E, NC 28466			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORI	RECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 105	Continued From page	e 24	D 105			
	10:34 a.m. revealed to plate cover was too s	ent room 207 on 10/11/17 at he telephone jack switch mall and did not cover the ng a gap in the wall around s exposed.				
		ent who resided in room 207 a.m. revealed the phone like that.				
	Hall on 10/11/17 at 1	ommon bathroom on the 100 1:55 a.m. revealed there was e overhead light fixture, osed.				
	10:35 a.m. revealed: -There was a hole in the left side wall of ro	f the light switch in the				
	Hall across from room a.m. revealed: -There was a missing fixture, leaving the bu -The cover to the ligh the wall over the bath	t fixture was leaning against tub. cord next to the toilet used				
	kitchen from Environr dated 08/29/17 revea -Several light bulbs n kitchen. -Several lights were o	eeded shielding in the				

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Division of Health Service Regulation

Division (of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					R-	.C
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE 710 CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER			II E, ZIP GODE		
GOLDEN	CARE	4002 SOU	TH NC 41			
COLDEN	O, ((L	WALLACE	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
			1	DEFICIENCY)		
D 105	Continued From page	25	D 105			
D 100	Continued From page	5 25	5 100			
	100 Hall beside room	104 on 10/11/17 at 11:44				
	a.m. revealed:					
	-The fluorescent light	on the ceiling did not have a				
	cover or a bulb.					
		bulbs over the sink was				
	burned out.	balbo over the sink was				
		throom due to 2 of 3 light				
		throom due to 2 or 3 light				
	bulbs not working.					
		1.120				
	Interview with the sec					
		S) on 10/11/17 at 4:10 p.m.				
	revealed:					
		r room on the 100 Hall				
	beside room 104 was	the bathroom that was				
	used the most by resi	idents.				
	-The lights had been	burned out in the common				
	shower room for abou	ut a week.				
	Interview with the firs	t shift MA/S on 10/13/17 at				
	10:20 a.m. revealed:					
		of the burned out lights in the				
	common bathroom or					
		nen the burned out lights				
	would be replaced or	•				
	would be replaced of	repaired.				
	Observation of the kit	tchen on 10/16/17 at 9:50				
	a.m. revealed:	ichen on 10/10/17 at 9.50				
		45				
		on the ceiling near the dry				
		ot working and there were				
		nissing pieces of the light				
	cover.					
	_	on the ceiling near the ice				
	machine had only 1 o	of 4 bulbs working and it was				
	flickering.					
	-The fluorescent light	on the ceiling near the				
	refrigerator had only 2					
		t on the ceiling near the 3				
		d only 2 of 4 bulbs working.				
		on the ceiling near the				
	stove was not working	y.				

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			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/	2017
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	FE, ZIP CODE		
GOLDEN	CARE	4002 SOUT WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 105	Continued From page	: 26	D 105			
	revealed: -The lights had been it lights had been it light. Interview with Mainter 10:08 a.m. revealed: -They had been work: -They had replaced light last state survey in July Interview with the Adr 11:45 a.m. revealed: -She would have the kitchen replaced.	ninistrator on 10/17/17 at whole lighting fixture in the ulbs checked and replaced				
D 113	10A NCAC 13F .0311 (d) The hot water sysprovide an adequate skitchen, bathrooms, laclosets and soil utility temperature at all fixtube maintained at a mi (38 degrees C) and sl F (46.7 degrees C). Texisting facilities. This Rule is not met a FOLLOW-UP TO TYF	stem shall be of such size to supply of hot water to the aundry, housekeeping room. The hot water ures used by residents shall nimum of 100 degrees F hall not exceed 116 degrees This rule applies to new and	D 113			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		E, NC 28466	PROVIDER'S PLAN OF CORRECTION	V 045		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 113	Continued From page	e 27	D 113			
	Violation was not aba	ted.				
	failed to assure the hemaintained at a mining Fahrenheit (F) to a m for 7 of 13 water fixture bathrooms and the co	aximum of 116 degrees F res sampled in the residents' ommon hall bathrooms on s of the facility, including 3				
		•				
	on 10/11/17 at 10:15	ent who resided in room 202 a.m. revealed sometimes oom sink "gets very hot".				
	210 on 10/11/17 at 10	othroom in resident room 0:35 a.m. revealed the water onk was 120 degrees F with				
	on 10/11/17 at 10:35	ent who resided in room 210 a.m. revealed the water in s "very hot like I like it".				
	Observation of the common bathroom on the 200 Hall on 10/11/17 at 10:20 a.m. revealed the water temperature at the sink was 120 degrees F with visible steam.					
	revealed:	ent on 10/11/7 at 4:20 p.m. mmon) bathroom on the 200 ash your hands.				

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Division of	of Health Service Regu	lation			•	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPI	LETE
D 113	Continued From page	e 28	D 113			
	-She could not wash bathroom) after using was too hot. -She had told "everyo	her hands in there (common the bathroom, because it one" but nobody cared.				
	12:22 p.m. revealed:	y member on 10/12/17 at nmon bathroom on the 200 too hot."				
		it to staff several times, but				
	resident rooms 205 a	ared bathroom between nd 206 on 10/11/17 at 10:22 ter temperature at the sink				
	on 10/11/17 at 10:22	ent who resided in room 205 a.m. revealed sometimes oom sink and shower was				
	207 on 10/11/17 at 10	athroom in resident room 0:34 a.m. revealed the water nk was 120 degrees with				
	on 10/11/17 at 10:34 -The water in the bath -"That water will burn	nroom was "hot."				
	of the 100 Hall near the bathroom had a -The water temperature.	ommon bathroom at the end the laundry room revealed: sink and a toilet. The at the sink was 120 The with no steam observed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 113	Continued From page	e 29	D 113			
	10:29 a.m. revealed: -There was a toilet ar -The water temperatu degrees F with no ste	re at the sink was 120 cam observed.				
	Interview with a resident residing in room 109 on 10/11/17 at 10:40 a.m. revealed: -The water temperature was not too hot or too					
	cold for herShe could adjust the water temperature.					
	at 10:08 a.m. reveale -The plumber had bee back" (could not give -The water temperatu	en to the facility "a while date). ires should be right. any problems with the				
	(MA/S) on 10/11/17 a -She did not check was facility.	dication aide/supervisor t 10:15 a.m. revealed: ater temperatures at the of anyone checking the hot				
	at 4:10 p.m. revealed -A family member rep temperatures were to (did not know timefrat -A resident had comp too hot during the last	orted the water o hot but it had been a while me). lained about the water being t state survey in June 2017. of any current problems with ot. of what the water				

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-She was not aware of a thermometer for staff to

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Division of Health Service Regulation

DIVISION	n Health Service Regu	iation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					B C
	HAI 031003 B. WING			R-C	
		HAL031003	2: :::::0		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
		WALLAC	E, NC 20400		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
1710		,		DEFICIENCY)	
D 113	Continued From page	e 30	D 113		
	check water temperat	tures			
	-She did not check wa				
		of anyone checking water			
		it was done on first shift.			
	•				
	-She would post some				
	bathrooms warning al	bout the not water			
	temperatures.				
		ministrator know about the			
	hot water temperature	2 8.			
	land a market and a first Annual Annu	:-i-tt 40/40/47 -t			
		ministrator on 10/12/17 at			
	10:02 a.m. revealed:				
	-	er had been out on medical			
		nths and was unavailable for			
	interview.				
	•	r yesterday (10/11/17) to			
	work on the hot water	•			
		down the thermostat on the			
	hot water heater.				
	_	as only one hot water heater			
	at the facility but she				
		d any water temperatures at			
	the facility.				
		temperature log being kept			
	at the facility to her kr	nowledge.			
		temperature in the common			
		of the 100 Hall on 10/12/17			
	at 3:20 p.m. revealed				
		ire at the sink was 120			
	degrees F with no ste				
		sign about the hot water			
	posted in the bathroo	m.			
		temperature resident room			
	109 on 10/12/17 at 3:	•			
		re at the sink was 120			
	degrees F with no ste				
	-There was a caution	sign about the hot water			

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posted in the bathroom.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	^ADE	4002 SOUT	H NC 41		
GOLDEN	CARE	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 113	Continued From page	e 31	D 113		
	bathroom between re on 10/12/17 at 3:43 p -The water temperatudegrees FThere was a caution posted in the bathroo Recheck of water tem 207 on 10/12/17 at 3: -The water temperatudegrees FThere was a caution posted in the bathroo Recheck of water tem 202 on 10/12/17 at 3: -The water temperatudegrees F.	sign about the hot water m. sign about the hot water m. sign about the hot water m. sign about the sink was 102 sign about the hot water m. sign about the hot water m. sign about the sink was 108 sign about the hot water m.			
	bathroom on the 200 -The water temperatudegrees F at 3:29 p.n. -The water temperatudegrees F at 3:31 p.n.	re in the shower was 102 n. sign about the hot water			
	10:50 a.m. revealed:	aff came yesterday I down the second			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 % BOILDING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
	Г	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 113	Continued From page	32	D 113		
	Recheck of the water bathroom at the end of	temperature in the common of the 100 Hall on 10/13/17 the water temperature at			
	9:00 a.m. revealed: -She had checked the they were running low turned down on the h-She had called the M the facility today, 10/1 thermostats on the ho	laintenance staff to come to			
	the Administrator reversities a column be checked daily in or Hall, one resident roo common bath on the bath on the 200 HallWater temperatures days, 10/14/17 - 10/1All water temperature degrees F with the expon 10/15/17, when it water temperature.	for a water temperature to ne resident room on the 100 m on the 200 Hall, one 100 Hall, and one common were documented for 3 6/17. es ranged from 102-110 reception resident room 201 was 90 degrees F. re was noted to be adjusted not water temperature in			
	temperatures were m degrees F resulted in used by residents bei with steam observed. wash her hands after	lity to assure hot water aintained between 100 - 116 at least 3 bathroom fixtures ng above 116 degrees F One resident would not toileting for fear of the hot nds. Residents and family			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
ANDILAN	or doring of the state of the s	IDENTIFICATION NOWIDEN.	A. BUILDING: _			
		HAL031003	B. WING		R- 10/1	C 7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
	Г	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 113	Continued From page	e 33	D 113			
	too hot. There was n facility to monitor or of temperatures. The fatemperatures betwee continued to be detring safety of the residents. Unabated Type B Vio Review of the facility's 10/12/17 revealed: -Hot water heater contemperature log implesured in the contemperature in the contemperature of the supervisor or determinent of the content of the cont	allure to maintain hot water in 100 - 116 degrees F mental to the health and is and constitutes an lation. S Plan of Protection dated atrol turned down and water emented. Is very hot" sign placed purchased and water d daily. esignee will be responsible				
D 127	10A NCAC 13F .0403 Medication Staff	B(c) Qualifications Of	D 127			
	supervise the administ except persons author licensure laws to adm complete six hours of	and staff who directly stration of medications, orized by state occupational ninister medications, shall continuing education edication administration.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	COMPLETED
			A. BOILDING.		
			B. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
COLDEN	CARE	4002 SO	UTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 127	Continued From page	e 34	D 127		
	This Rule is not met	as evidenced by: ns, record reviews and			
		failed to assure 1 of 4			
		npled (A) completed six			
		ducation annually related to			
	medication administra				
	observed during med	ication administration			
	_	tion errors were identified.			
	The findings are:				
	Review of Staff A's pe	ersonnel record revealed:			
	-Staff A was hired on	11/20/00 as a personal care			
	aide (PCA), medication	on aide (MA) and supervisor.			
		nentation of continuing			
	education (CE) relate				
		f A's personnel record for			
	2016 or 2017.				
	Observation of Staff A	A during the survey revealed:			
	-Staff A worked as the	· ·			
		10/16/17, and 10/17/17.			
	-Staff A was observed	d during the morning			
	medication passes or	n 10/12/17 and 10/17/17 and			
	8 errors were identifie	ed during these medication			
	passes.				
	Interview with Staff A revealed:	on 10/17/17 at 9:55 a.m.			
	-She had been emplo	yed at the facility since			
	2000.	as a MA and Supervisor.			
	-She had not had any				
	-She thought she had				
	previously, but could				
	Interviews with the Ac	dministrator on 10/16/17 at			
	8:40 a.m. and 9:00 a.				
		er was in charge of the			
	personnel files.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 127	Continued From page	35	D 127		
	the medication aides hours of CE annually. If the MAs had the rebe in the plastic box vorthe Manager had be months and was unavorthe checked with the the personnel files. In a Manager could round information for the personnel files and making sure and requirements. No one took over reserved.	equired hours of CE, it would with their personnel files. Hen on leave for about 2 vailable for interview. He facility's Manager about the find any more resonnel files. He sponsible for the personnel all staff met qualifications reponsibility of the personnel her went on medical leave. In to check behind the			
D 131	10A NCAC 13F .0406 (a) Upon employment home, the administration any live-in non-reside tuberculosis disease is measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, I	in compliance with control of the Commission for Health in 10A NCAC 41A .0205 amendments and editions. of available at no charge by ment of Health and Human of Control Program, 1902 Raleigh, NC 27699-1902. as evidenced by: and record reviews, the of 1 of 5 staff sampled (C) culosis (TB) disease upon	D 131		

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DIVISION	of Health Service Regu	lation			
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	R: A. BUILDING:		COMPLETED
			B. WING		R-C
		HAL031003	B. WING	· · · · · · · · · · · · · · · · · · ·	10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
			, ,		
GOLDEN CARE 4002 SOL					
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	TATE DATE
D 131	Continued From page	e 36	D 131		
	Commission for Healt	th Services.			
	The findings are:				
	Review of Staff C's pe	ersonnel record revealed:			
	-There was no hire da	ate documented in the			
	record.				
	-Staff C was rehired a	as a personal care aide.			
		tation that Staff C had a			
		(TB) skin test placed on			
	06/26/17 and read as				
		nentation of additional TB			
	skin tests for Staff C i				
	Skill lesis lui Stall C i	ii tile record.			
	Tolophono intonvious	with Stoff C on 10/16/17 of			
	I	vith Staff C on 10/16/17 at			
	2:40 p.m. revealed:	filit-i- Assesset 0040			
		ne facility in August 2016,			
		ate), and came back as a			
	rehire twice.				
	-She was last rehired				
	T	o get a second TB skin test			
	but she had not done	it yet.			
	Interviews with the Ac	dministrator on 10/16/17 at			
	8:40 a.m. and 5:30 p.	m. revealed:			
	-She was not aware t	hat Staff C did not have a			
	second TB skin test.				
	-She checked with the	e facility's Manager about			
	the personnel files.				
	-The Manager could r	not find any more			
	information for the pe				
		sponsible for the personnel			
	_	all staff met qualifications			
	and requirements.	and a same and a same a			
		een on leave for about 2			
	months and was unav				
		sponsibility of the personnel			
		er went on medical leave.			
	-There was no systen	n to check benind the	[[

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Manager or to monitor the personnel files.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
	OLIMANA DV. OT		E, NC 28466	DROWNERIO DI ANI OF CORRECTION	
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 137	37 10A NCAC 13F .0407(a)(5) Other Staff Qualifications		D 137		
	(a) Each staff persor shall:(5) have no substant	7 Other Staff Qualifications in at an adult care home stated findings listed on the in Care Personnel Registry 1E-256;			
	This Rule is not met FOLLOW-UP TO TYPE	-			
	Based on these findir Violation was not aba	ngs, the previous Type B ated.			
	facility failed to assure E) had no substantiate	and record reviews, the e 3 of 5 staff sampled (B, C, ted findings listed on the n Care Personnel Registry o G.S. 131E-256.			
	The findings are:				
	1. Review of Staff B's personnel record revealed: -Staff B was hired on 10/25/16 as a personal care aide (PCA)There was documentation of a health care personnel registry (HCPR) check for Staff B dated 05/01/17 with no substantiated findingsThere was no documentation of a HCPR check prior to 05/01/17.				
	revealed: -She was hired before	on 10/17/17 at 5:20 p.m. e August 2016, because she cility before her birthday,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		
		HAL031003	B. WING	·	R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
GOLDEN	CARE		OUTH NC 41		
	T		CE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 137	Continued From page	e 38	D 137		
	-She was hired as a PCAHer duties included administering medication, bathing, grooming, incontinent care and supervision of residentsShe started administering medication on 10/09/17. Based on interviews and record reviews, there were allegations of abuse and neglect related to Staff B. [Refer to findings under Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry.]				
	Refer to interview wit 10/16/17 at 8:40 a.m.	h the Administrator on			
	2. Review of Staff C's personnel record revealed: -There was no documentation of Staff C's hire date or positionThere was documentation of a health care personnel registry (HCPR) check for Staff C dated 07/20/17 with no substantiated findingsThere was no documentation of a HCPR check prior to 07/20/17.				
	revealed: -Staff C was hired in a 09/01/17.	on 10/16/17 at 2:39 p.m. August 2016 and rehired on on aide and personal care			
	were allegations of di C. [Refer to findings to 13F .1205 Health Car	and record reviews, there rug diversion regarding Staff under Tag D438 10A NCAC re Personnel Registry.]			
	Refer to interview wit 10/16/17 at 8:40 a.m.	h the Administrator on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	- CONCINCOTION	COMPLETED	
			A. BOILDING.		
			D WING		R-C 10/17/2017
		HAL031003	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN CARE WALLACE		E, NC 28466			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
D 137	Continued From page	e 39	D 137		
	2. Daview of Ctoff Flo				
		personnel record revealed: 4/4/17 as a personal care			
		•			
		on aide (MA) and supervisor. tation of an HCPR check on			
	Staff E dated 5/1/17 v				
		Will no substantiated			
	findingsThere was no docum	nentation of an HCPR check			
	prior to 5/1/17.	ichtation of an Fior IX check			
	prior to 0/1/17.				
	Interview with Staff E	on 10/16/17 at 3:13 p.m.			
	revealed:				
	-She had been emplo	yed since March or April			
	2017.				
	-She was a PCA, MA	and Supervisor.			
	-Her duties included a	administering medication,			
	bathing, showering, d	ressing and feeding			
	residents, incontinent	care and getting residents			
	out of bed.				
		h the Administrator on			
	10/16/17 at 8:40 a.m.				
	Indominate the Adv				
	8:40 a.m. revealed:	ministrator on 10/16/17 at			
		hould be done upon hire to			
		substantiated findings.			
		e facility's Manager about			
	the personnel files.	c racinty 3 Mariager about			
	-The Manager could r	not find any more			
	information for the pe				
		sponsible for the personnel			
	_	all staff met qualifications			
	and requirements.	,			
		een out on medical leave for			
	about 2 months and v				
	interview.				
	-No one took over res	sponsibility of the personnel			
		er went on medical leave.			
	-There was no systen				
	Manager or to monito				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
			E, NC 28466			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 137	Continued From page	e 40	D 137			
	findings were listed of Care Personnel Registration Staff B was alleged to residents and Staff C diverted controlled sureported to the Health during the survey. The detrimental to the safe residents by not verify substantiated findings neglect and drug diversand constitutes an Urreported to the facility' 10/16/17 revealed: -HCPR checks will be all staff and document placed in the personro beginning work. -The Administrator wifindings and all personal staff and all personal st	abstances. Both staff were in Care Personnel Registry is failure continued to be ety and welfare of the sying staff had no is listed on the registry for earsion allegations upon hire, inabated Type B Violation. S Plan of Protection dated is required and completed on itation acquired on-line and				
D 139	10A NCAC 13F .0407 Qualifications	7(a)(7) Other Staff	D 139			
	(a) Each staff person (7) have a criminal ba	7 Other Staff Qualifications at an adult care home shall: ackground check in . 114-19.10 and 131D-40;				
	This Rule is not met FOLLOW-UP TO TYPE	-				
	Based on these findir	ngs, the previous Type B				

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Division c	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
	HAL031003 B. WING			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN CARE 4002 SOUT		TH NC 41			
COLDEN	UARE	WALLACE	, NC 28466		
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-)
TAG			TAG	CROSS-REFERENCED TO THE APPROPE	
			1	DEFICIENCY)	
D 139	Continued From page	e 41	D 139		
	Violation was not aba	ited.			
		and record reviews, the			
	•	e 5 of 5 staff sampled (A, B, all background check in			
	· · · · · · · · · · · · · · · · · · ·	. 114-19.10 and 131D-40.			
	The findings are:				
		personnel record revealed:			
		a medication aide (MA) and			
	supervisor on 11/20/0	00. criminal background check			
		f A's personnel record.			
		nentation of a state wide			
		check being completed for			
	Staff A upon hire.				
	Interview with Staff A revealed:	on 10/17/17 at 9:55 a.m.			
	-She had been emplo	oved since 2000.			
	•	a criminal background			
	•	ng employed but it has been			
	a long time ago.				
	Refer to interview with	h the Administrator on			
	10/16/17 at 8:40 a.m.				
	2. Davious of Otoffic D	noroonnol rooped revealed:			
		personnel record revealed: 10/25/16 as a personal care			
	aide (PCA).	10/20/10 45 4 poisonal bails			
	-There was documen	tation of a signed consent			
	•	or a criminal background			
	check to be complete				
		nentation of a state wide check completed for Staff B			
	upon hire.	ones completed for other b			
		4044747 4 5 66			
I	Interview with Staff R	on 10/17/17 at 5:20 n m	1		1

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revealed:

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Division of	<u>of Health Service Regu</u>	.lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SU COMPLET		
AND PLAN	JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		IED
		HAL031003	B. WING		R-C 10/17) // 2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE	_	
GOI DEN	GOLDEN CARE 4002 SOUT		ITH NC 41			
GOLDLIN	JANE	WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 139	Continued From page	÷ 42	D 139			
	-She was hired before was working at the fa which was in AugustShe was hired as a Femedication aide (MA) -Staff B remembered the criminal backgroutShe did not know if the check was completed. Refer to interview with 10/16/17 at 8:40 a.m. 3. Review of Staff C's -There was no documedateStaff C was rehired a aide (PCA), medicationThere was no documedateThere was no documedateThere was no documed the criminal background of the criminal background of the criminal background of the criminal background check to	e August 2016, because she icility before her birthday, PCA, and was now a isigning the paperwork for and check to be completed, the criminal background d. the Hadministrator on is personnel record revealed: mentation of Staff C's hire at the facility as a personal on aide (MA) and supervisor, mentation of a signed hal background check to be mentation of a state wide check for Staff C upon hire. If on 10/16/17 at 2:39 p.m. at the facility in August 2016 upervisor, orking at the facility two 19/01/17. Daperwork for the criminal be done, but did not know if and check was completed. the the Administrator on in the Administrator on in the Administrator on				
	4. Review of Staff D's	s personnel record revealed:				

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-There was no documentation of Staff D's hire

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
	HAL031003	B. WING		R-C 10/17/2017	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN CARE	4002 SO	UTH NC 41			
WALLACE,		E, NC 28466			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 139 Continued From page	43	D 139			
dateStaff D was hired a perometer of the completed of the staff D upon hire. Interview with Staff D or revealed: -She started working a she was hired as a Perometer of the completed. Refer to interview with 10/16/17 at 8:40 a.m. 5. Review of Staff E's shaff E was hired on 4 and supervisorThere was documentaby Staff E on 4/2/17 for check to be completed. Interview with Staff E or staff E upon hire.	ersonal care aide (PCA). ation of a signed consent or the criminal background l. entation that a state wide heck had been completed on 10/17/17 at 8:55 a.m. at the facility in May 2017. CCA. minal background check he remembered signing the hinal background check to the Administrator on personnel record revealed: h/4/17 as a medication aide ation of a signed consent or the criminal background l. entation of a state wide heck being completed for on 10/16/17 at 3:13 p.m. yed since March or April apervisor. se so the criminal	D 139			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R-C
		HAL031003	B. WING	B. WING	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET			E, ZIP CODE	
COL DEN	CARE	4002 SO	UTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 139	Continued From page 44		D 139		
	Refer to interview with 10/16/17 at 8:40 a.m.	n the Administrator on			
	8:40 a.m. revealed:	ninistrator on 10/16/17 at			
	been done upon hireShe checked with the	e facility's Manager about			
	the personnel filesThe Manager could not find any more				
		sponsible for the personnel all staff met qualifications			
	_	en out on medical leave for			
	about 2 months and w interview.	ponsibility of the personnel			
		r went on medical leave.			
	-There was no system Manager or to monito				
		ity to assure 5 of 5 staff wide criminal background			
	check upon hire resulunaware of any crimir	ted in the facility being nal background findings that			
	the residents. This co	o the welfare and safety of ntinuing non-compliance			
	constitutes an Unabat Violation.				
	10/16/17 revealed:	s Plan of Protection dated			
	immediately on all per				
	be completed immedi	ut background checks will ately by Administrator.			
		Il review personnel files required documentation is			

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Division of Fleatin Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
AND PLAN	OI CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
						С
		HAL031003	B. WING		10/17/2017	
		TIAE031003			10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SQI	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
			20400	T		
(X4) ID		ATEMENT OF DEFICIENCIES V MUST BE DEFCEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	,,,,,	DEFICIENCY)		
D 151	10A NCAC 13F .0501	(c) Personal Care Training	D 151			
	And Competency					
	10A NCAC 13F .0501	Personal Care Training And				
	Competency					
	(c) The Department	shall exempt staff from the				
	80-hour training and o	competency evaluation				
	program who are:					
	(1) licensed health p	rofessionals:				
	(2) listed on the Nurs					
	(3) documented as h	- ·				
		our or 75-80 hour training				
	•	icy evaluation program				
	• •	artment since January 1,				
		le .0502 of this Section.				
	1330 according to rea	ile .0302 of this dection.				
	This Rule is not met	as evidenced by:				
		as evidenced by. ns, interviews and record				
		iled to assure 2 of 5 staff				
		provided personal care to				
		ssfully completed an 80-hour				
		and competency evaluation				
	program.					
	T. C. I.					
	The findings are:					
	4 Davidana (0) ((D)					
		personnel record revealed:				
		10/25/16 as a personal care				
	aide (PCA) .					
		d on the Nurse Aide Registry.				
		nentation of personal care				
	training for Staff B.					
		on 10/17/17 at 5:20 p.m.				
	revealed:					
		e August 2016, because she				
	was working at the fa	cility before her birthday,				
	which was in August.					
	-She was hired as a F	PCA.				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:			
		HAL031003	B. WING		l l	R-C 0/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
GOLDEN	CARE	4002 SC	OUTH NC 41			
GOLDLIN	CAIL	WALLA	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 151	Continued From page	e 46	D 151			
	-Her duties included administering medication, bathing, grooming, incontinent care and supervision of residents.					
	Refer to interview wit 10/16/17 at 9:31 a.m.	h the Administrator on				
	2. Review of Staff E's personnel record revealed: -Staff E was hired on 4/4/17 as a personal care aide, medication aide and supervisorShe was not listed on the Nurse Aide RegistryThere was no documentation of personal care training for Staff E. Interview with Staff E on 10/16/17 at 3:13 p.m. revealed: -Staff E was hired in March or April 2017 as a PCA, MA and SupervisorShe had only taken two personal care classesHer duties included administering medication, bathing, showering, dressing and feeding residents, incontinent care and getting residents out of bed.					
	Refer to interview wit 10/16/17 at 9:31 a.m.	h the Administrator on				
	9:31 a.m. revealed: -She was the Adminis -She was going to ge organizedShe questioned whe personal care training already employedShe would contact the other facilities used for the she would look online.	ministrator on 10/16/17 at strator at the facility. It the personnel records there the staff still needed the grhours since staff were the pharmacy to see who or personal care training. The state offered personal care				

training.

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DIVISION OF RESIDENCE REQUIATION		0/0) 14/11/7/10/15	COLUCTRUCTION	LOVAN BATE OURNEY		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
, "ID I LAN	PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		JOWN LETED	
	HAL031003 B. WING			R-C 10/17/2017		
					,	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(7.0)	TE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
				DEFICIENCY)		
D 164	10A NCAC 13F .0505	Training On Care Of	D 164			
D 10 4	Diabetic Resident	Training On Care Of	D 104			
	Diabelic Resident					
	104 NCAC 13E 0505	5 Training On Care Of				
	Diabetic Residents	Training On Cale Of				
		hall assure that training on				
		with diabetes is provided to				
		to the administration of				
	insulin as follows:	to the administration of				
		provided by a registered				
		rmacist or prescribing				
	practitioner.	initiacist of prescribing				
	•	lude at least the following:				
		diabetes and care involved				
	in the management o					
	(b) insulin action;	r diabetes,				
	(c) insulin storage;					
		g and injection techniques				
	for insulin administrat					
		evention of hypoglycemia				
	and hyperglycemia, ir					
	symptoms;	3 3 3 1 1				
	(f) blood glucose mo	nitoring: universal				
	precautions;	<i>5.</i>				
	(g) universal precaut	ions;				
	(h) appropriate admir	nistration times; and				
	(i) sliding scale insuli					
	-					
	This Rule is not met	as evidenced by:				
	FOLLOW-UP TO TYP	PE B VIOLATION				
	Based on these finding	ngs, the previous Type B				
	Violation was not aba	ted.				
		ns, interviews, and record				
	reviews, the facility fa					
		E) sampled received training				
	by a licensed health p	professional on the care of				

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	of Health Service Regu		T		T	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COWIFE	ETED
						С
		HAL031003	B. WING		1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOL	JTH NC 41			
COLDLIN	OAIL	WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	KIATE	DAIL
				,		
D 164	Continued From page	e 48	D 164			
	diahetic residents prid	or to administering insulin to				
	residents.	or to darining insami to				
	redidente.					
	The findings are:					
	J 1 J 1					
	1. Review of Staff C's	personnel record revealed:				
	-There was no docum	nentation of Staff C's hire				
	date or position.					
	-There was no docum	nentation that diabetic				
	training had been con	npleted in Staff C's				
	personnel record.					
		s medication administration				
	records and blood su	gar logs revealed				
	-Staff C administered	insulin on 10/02/17,				
	10/03/17, and 10/07/	17 - 10/09/17.				
	-Staff C administered					
	09/06/17, 09/07/17, 0	9/10/17 - 09/12/17,				
	09/15/17, 09/16/17, 0					
	09/24/17, and 09/29/	17.				
		vith Staff C on 10/16/17 at				
	2:40 p.m. revealed:					
		ne facility in the past, left,				
	and came back as a r					
	-She was last rehired					
		ering medications again				
	around the end of Serence rehired.	ptember 2017 after she was				
		edications including insulin.				
		training that she could				
	recall.	training that she could				
		s scheduled for a class one				
	time but she missed t					
	Based on record revie	ews, Staff C documented				
		lins for Resident #3 and				
	Resident #16 includin	ig when there were errors				
		not documented as being				
		ng to the orders. [Refer to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	CTDEET A	DDRESS, CITY, STA	TE ZIR CODE	•
NAME OF P	ROVIDER OR SUPPLIER		JTH NC 41	TE, ZIP CODE	
GOLDEN	CARE		E, NC 28466		
0(0.15	STIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	d over
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 164	Continued From page	2 49	D 164		
	Tag D358 10A NCAC Administration.]	13F .1004(a) Medication			
	Refer to interviews wi 10/16/17 at 8:40 a.m.	th the Administrator on and 9:31 a.m.			
		nentation that diabetic			
	records and blood sug- -Staff E administered 10/02/17, and 10/04/1 -Staff E administered 09/10/17, 09/12/17, 0	insulin on 10/01/17, 17 - 10/12/17. insulin on 09/09/17,			
	revealed: -Staff E took the diaborago.	on 10/16/17 at 3:13 p.m. etic training about a month a certificate of completion.			
	administration of insu Resident #16 includin and the insulins were administered accordin	ews, Staff E documented lins for Resident #3 and g when there were errors not documented as being ng to the orders. [Refer to 13F .1004(a) Medication			
	Refer to interviews wi 10/16/17 at 8:40 a.m.	th the Administrator on and 9:31 a.m.			
	Interviews with the Ac 8:40 a.m. and 9:31 a.	Iministrator on 10/16/17 at m. revealed:			

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
		A. BOILDING.		R-C
	HAL031003	B. WING		10/17/2017
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARE				
		, NC 28466		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE COMPLETE
Continued From page	e 50	D 164		
the personnel files. -The Manager could r information for the pe -The Manager was re files and making sure and requirements. -The Manager had be months and was unay -No one took over res files after the Manage -There was no system Manager or to monito -She had contacted th certificates for staff th diabetic training offere -She received a copy	not find any more rsonnel files. sponsible for the personnel all staff met qualifications een on leave for about 2 vailable for interview. sponsibility of the personnel er went on medical leave. In to check behind the Ir the personnel files. In e pharmacy and got at had taken the recent eed at the facility. of the staff sign-up sheet.			
The facility failed to assure 2 of 4 medication aides had received diabetic training prior to the administration of insulin, including documented and observed errors with long-acting and sliding scale insulin administration for at least two resident receiving insulin including one resident who had multiple blood sugars over 400 and as high as 600. This failure continued to be detrimental to the health, safety and welfare of the residents who were diabetics and received insulin and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -The pharmacy's nurse contacted to schedule diabetic training class. -All medication aides must attend. -The Administrator will monitor to ensure all				
F	CARE SUMMARY ST. (EACH DEFICIENC' REGULATORY OR I Continued From page -She checked with the the personnel filesThe Manager could r information for the pe -The Manager was re files and making sure and requirementsThe Manager had be months and was unavened and requirementsThe Manager or to monitory one took over restiles after the Manager or to monitoryShe had contacted the certificates for staff the diabetic training offered she received a copy (Staff C and Staff E we will be considered to the facility failed to a aides had received diadministration of insurand observed errors will be considered to the heat of the facility failed to the heat of the heat of the facility failed to the heat of the heat of the facility failed to the heat of the he	ROVIDER OR SUPPLIER STREET ADD A002 SOUT WALLACE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 -She checked with the facility's Manager about the personnel filesThe Manager could not find any more information for the personnel filesThe Manager was responsible for the personnel files and making sure all staff met qualifications and requirementsThe Manager had been on leave for about 2 months and was unavailable for interviewNo one took over responsibility of the personnel files after the Manager went on medical leaveThere was no system to check behind the Manager or to monitor the personnel filesShe had contacted the pharmacy and got certificates for staff that had taken the recent diabetic training offered at the facilityShe received a copy of the staff sign-up sheet. (Staff C and Staff E were not on the sheet.) The facility failed to assure 2 of 4 medication aides had received diabetic training prior to the administration of insulin, including documented and observed errors with long-acting and sliding scale insulin administration for at least two resident receiving insulin including one resident who had multiple blood sugars over 400 and as high as 600. This failure continued to be detrimental to the health, safety and welfare of the residents who were diabetics and received insulin and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -The pharmacy's nurse contacted to schedule diabetic training classAll medication aides must attendThe Administrator will monitor to ensure all medication aides have completed class and new	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 -She checked with the facility's Manager about the personnel filesThe Manager could not find any more information for the personnel filesThe Manager was responsible for the personnel files and making sure all staff met qualifications and requirementsThe Manager had been on leave for about 2 months and was unavailable for interviewNo one took over responsibility of the personnel files after the Manager went on medical leaveThere was no system to check behind the Manager or to monitor the personnel filesShe had contacted the pharmacy and got certificates for staff that had taken the recent diabetic training offered at the facilityShe received a copy of the staff sign-up sheet. (Staff C and Staff E were not on the sheet.) The facility failed to assure 2 of 4 medication aides had received diabetic training prior to the administration of insulin, including documented and observed errors with long-acting and sliding scale insulin administration for at least two resident receiving insulin including one resident who had multiple blood sugars over 400 and as high as 600. This failure continued to be detrimental to the health, safety and welfare of the residents who were diabetics and received insulin and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -The pharmacy's nurse contacted to schedule diabetic training classAll medication aides must attendThe Administrator will monitor to ensure all	ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 50 -She checked with the facility's Manager about the personnel filesThe Manager could not find any more information for the personnel filesThe Manager as responsible for the personnel files and requirementsThe Manager had been on leave for about 2 months and was unavailable for interviewNo one took over responsibility of the personnel files after the Manager went on medical leaveThere was no system to check behind the Manager or to monitor the personnel filesShe had contacted the pharmacy and got certificates for staff that had taken the recent diabetic training offered at the facilityShe had contacted the pharmacy and got certificates for staff that had taken the recent diabetic training offered at the staff sign-up sheet. (Staff C and Staff E were not on the sheet.) The facility failed to assure 2 of 4 medication aides had received diabetic training prior to the administration of insulin, including documented and observed errors with long-acting and sliding scale insulin administration for at least two resident receiving insulin including one resident who had multiple blood sugars over 400 and as high as 600. This failure continued to be detrimental to the health, safety and welfare of the residents who were diabetics and received insulin and constitutes an Unabated Type B Violation. Review of the facility's Plan of Protection dated 10/16/17 revealed: -The pharmacy's nurse contacted to schedule diabetic training diassAll medication aides have completed class and new

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL031003	B. WING		10/17	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
240.45	CHIMMADVCT		, NC 28466	DROVIDER'S DLANTOE CORRECTION		0.50
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 164	Continued From page	e 51	D 164			
	attend.	ass will be scheduled cation aides are required to				
D 165	10A NCAC 13F .0506 Training On Physical Restraints		D 165			
	10A NCAC 13F .0506 Restraints	Training On Physical				
	responsible for caring symptoms that warranthe use of alternatives	ne shall assure that all staff of or residents with medical nt restraints are trained on s to physical restraint use sidents who are physically				
	This Rule is not met FOLLOW-UP TO TYPE	•				
	The Type B Violation Non-compliance cont					
	reviews, the facility fa					
	The findings are:					
	transfer residents with position to another, from while assisting residents.	used by caregivers to n mobility issues from one om one location to another dents to ambulate who have e. For example, a gait belt is				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
			7 56.25			С
		HAL031003	B. WING			7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		ITH NC 41 E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIATE	COMPLETE DATE
D 165	Continued From page	e 52	D 165			
	used to move a resident to a wheelchair.	ent from a standing position				
	03/20/17 revealed dia atrial fibrillation, high Normalized Ratio, a t	13's current FL-2 dated agnoses included chest pain, INR (International est to monitor excessive and peripheral vascular				
	a.m. revealed he was wheelchair, restrained	ent #13 on 10/11/17 at 11:50 in the dining room in his d with a gait belt; the gait eisdent's waist and secured eelchair.				
	Observation of Resident #13 on 10/11/17 at 1:35 p.m. revealed: -The resident was sitting in a wheelchair in the dayroom on 100 HallThere was a gait belt around the resident's stomach that was hooked together on the back side of the wheelchair.					
	p.m. revealed he was	ait belt around his stomach				
	12:22 p.m. revealed: -He was on the front memberHe was restrained to belt around his stoma back side of the wheel	his wheelchair with a gait ach that was hooked on the elchair. nt #13's family member on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
		WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 165	Continued From page	53	D 165			
	when he was in his w -The staff member wh down applied and ren needed.	no got Resident #13 up and noved the gait belt as				
	(MA/S) on 10/17/17 a -Resident #13 wore th was in his wheelchair -The staff member wh toileted him applied a -Resident #13's gait b documentedShe was trained "a w	ne gait belt whenever he . no got Resident #13 up or nd removed his gait belt. belt use was not while ago" on restraint use. had any recent training on				
	10/17/17 at 5:20pm re -She had never had a application or use of I					
	-Staff A was hired on medication aide (MA) -There was documen Health Professional Sevaluation on 3/27/03 vest, waist/belt restratabletop, lap pillow, was practices to restrance to restrance.	tation on the Licensed Support (LHPS) competency I that Staff A was validated in int, pelvic, Geri chair with rist restraint and alternative raint use. If the Administrator, who was mentation of restraint training				

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			755.125.110.		R-(c
		HAL031003	B. WING		1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		TH NC 41			
0/0/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	E, NC 28466	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 165	Continued From page	e 54	D 165			
	revealed: -She had been emplosupervisorShe had not had any Refer to interview with 10/16/17 at 8:40 a.m. 2. Review of Staff B's -Staff B was hired on -There was no job title. There was documen Health Professional Sevaluation on 10/25/1 in vest, waist/belt resitabletop, lap pillow, ware practices to restrabletop, lap pillow, ware practices to restrable by a prevealed: -She was no documin Staff B's personnel Interview with Staff B revealed: -She thought she had restraints one month -She was validated by a nurseShe did not recall what Interview with Staff B revealedStaff B was hired be she was working at the birthday, which was in -She was hired as a prow a medication aid -She had done restraints.	personnel record revealed: 10/25/16. e or description tation on the Licensed Support (LHPS) competency 6 that Staff B was validated traint, pelvic, Geri chair with rist restraint and alternative raint use. The nentation of restraint training record. In training on the use of ago. In the Administrator, who was no taught the class. In the August 2016, because the facility before her naugust. The personal care aide, but was				

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-She had not had any recent training.

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DIVISION	i Health Service Regu	iation			ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	υ
					R-C	
		HAL031003	B. WING		10/17/2	017
		TALUS 1003			1 10/17/2	017
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
001.55	CARE	4002 SOU	TH NC 41			
GOLDEN (CAKE	WALLACI	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE C	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETICIENCY)		
D 165	Continued From page	e 55	D 165			
	1 0					
	Defeate intension with	h tha Advairiateatan an				
		h the Administrator on				
	10/16/17 at 8:40 a.m.					
	3 Review of Staff C's	personnel record revealed:				
		nentation of Staff C's hire				
	date.	ichtation of Stall 6.3 filic				
	-She was hired as a p	personal care aide				
	medication aide (MA)					
	, ,	tation on the Licensed				
		Support (LHPS) competency				
		' that Staff C was validated				
		traint, pelvic, Geri chair with				
		rist restraint and alternative				
	care practices to rest					
		y the Administrator, who was				
	a nurse.	y are rearmined ator, who was				
		nentation of restraint training				
	in Staff C's personnel					
	ota o o porocio.					
	Telephone interview v	vith Staff C on 10/16/17 at				
	2:40 p.m. revealed:					
		ne facility in the past, left,				
	and came back as a r	·				
	-She was last rehired					
	-She did not have res	traint training.				
		nt at the facility with "a belt"				
	and there was an ord					
	Refer to interview with	h the Administrator on				
	10/16/17 at 8:40 a.m.					
	4. Review of Staff D's	personnel record revealed:				
		nentation of Staff D's hire				
	date or job title.					
		tation on the Licensed				
	Health Professional S	Support (LHPS) competency				
	evaluation on 5/1/17	that Staff D was validated in				
	vest, waist/belt restra	int, pelvic, Geri chair with				

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tabletop, lap pillow, wrist restraint and alternative

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		D.0
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		4002 SOUT	'H NC 41		
GOLDEN	CARE	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 165	Continued From page	e 56	D 165		
	care practices to restr -She was validated by a nurse. -There was no docum in Staff D's personnel	raint use. y the Administrator, who was nentation of restraint training			
	revealed: -She was hired in Ma aide (PCA).	y 2017 as a personal care nt training when working at			
		ith Staff D on 10/17/17 at e was trained "by herself" on raint belt.			
	Refer to interview with 10/16/17 at 8:40 a.m.	n the Administrator on			
	-Staff E was hired on (MA) and supervisorThere was documen Health Professional Sevaluation on 4/4/17 vest, waist/belt restratabletop, lap pillow, ware practices to restrance.	personnel record revealed: 4/4/17 as a medication aide tation on the Licensed support (LHPS) competency that Staff E was validated in int, pelvic, Geri chair with rist restraint and alternative raint use. y the Administrator, who was			
	a nurseThere was no documin Staff E's personnel	nentation of restraint training record.			
	revealed: -She was hired in Ma and supervisorShe had not had any	on 10/16/17 at 3:13 p.m. rch or April 2017 as a MA restraint training. n the Administrator on			

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DIVISION	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	ED
					R-C	
		HAL031003	B. WING		10/17/2	2017
		0.70557.10	DD500 0171/ 071	T. J.D 00D5		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		TH NC 41			
		WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 165	Continued From page	e 57	D 165			
	10/16/17 at 8:40 a.m.					
		ministrator on 10/16/17 at				
	8:40 a.m. revealed:	- focilitudo Namonous about				
	the personnel files.	e facility's Manager about				
	-The Manager could r	not find any more				
	information for the pe					
		sponsible for the personnel				
	_	all staff met qualifications				
	and requirements.	on an madical lagua for				
	about 2 months and v	en on medical leave for				
	interview.	vas uriavaliable ioi				
		sponsibility of the personnel				
		er went on medical leave.				
	-There was no systen					
	Manager or to monito	r the personnel files.				
D 176	10A NCAC 13F .0601 Facilities	(a) Management Of	D 176			
	10A NCAC 13F .0601	Management Of Facilites				
	(a) An adult care hor	ne administrator shall be				
		tal operation of an adult care				
	home and shall also b	•				
		vice Regulation and the				
		social services for meeting				
	•	ules of this Subchapter. when there is one, shall				
		oility with the administrator				
		e home and for meeting				
		ules of this Subchapter.				
	The term administrate	•				
	co-administrator when	re it is used in this				
	Subchapter.					

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D MINO		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	TE ZID CODE	
INAME OF T	NOVIDEN ON 3011 LIEN		, ,	TIE, ZII GODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DETIGIENOT)	
D 176	Continued From page	÷ 58	D 176		
	Communication page	, 60			
	This Rule is not met	as evidenced by:			
	FOLLOW-UP TO TYP	PE A1 VIOLATION			
	Based on these findir	igs, the previous Type A1			
	Violation was not aba	•			
	Based on observation	ns, interviews, and record			
		rator failed to assure the			
	· ·	operations, and policies and			
	_				
		ility were developed and			
		tain each residents' right to			
		m, abuse, and neglect as			
	evidenced by the Mar	nager			
	(Administrator-in-Cha	rge) refusing to allow staff			
	to contact 911 for a re	esident (#11), who was not			
	feeling well and was	confused; refusing to			
	_	s of abuse and report two			
		re Personnel Registry for			
		tions received in August			
		to maintain substantial			
		ules and statutes governing			
		related to health care,			
		•			
	medication administra	_			
	personal care and su	,			
	personnel registry, inf				
	-	eeping and furnishings,			
		vice, controlled substances,			
	1	her staff qualifications,			
		ions for medication aides,			
	training on diabetic re	sidents, screening for			
	controlled substances	and criminal background			
		n are the responsibility of the			
	Administrator/Adminis				
		5 - 3			
	The findings are:				
	Interview with the Adr	ministrator on 10/12/17 at			
	10:02 a.m. revealed:				
		nistrator-in-Charge) had			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL031003	B. WING		R-C 10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOL	ITH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 59	D 176		
	she would not be'Things kind of mush	nager arge) was coming back, but aroomed."			
	(MA/S) on 10/12/17 a -The Manager (Admin was on leave, monito filingOn Monday (10/09/1 this week, the Manag texted her and told he Administrator would h Manager's dutiesShe and the Adminis monitoring systems s (Administrator-in-Cha to 2 months). Confidential interview	nistrator-in-Charge), who ared medications and did the 7) or Tuesday (10/10/17) of the (Administrator-in-Charge) er that the MA/S and the nave to take over the strator had not started any since the Manager arge) had been out (about 1			
	-"Nobody knew what	to do". anyone until talking to the			
	Manager (Administra 911 for emergencies"It's not up to the Ma (Administrator-in-Cha says"The staff had no idea Manager firstThere was an incide where the staff called (Administrator-in-Cha	another staff say to call the tor-in-Charge) before calling anager arge), but they do what she a why staff would call the at about 6 months ago			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C	
HAL031003		B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 60	D 176		
	not recall who the res	ident was.			
	Interview with a family member on 10/12/17 at 12:22 p.m. revealed: -The Manager (Administrator-in-Charge)was a bully to the family member and staffStaff "cowered" down to her.				
Interviews with the Administrator on 10/13/17 at 10:30 a.m., 10:54 a.m. and 6:36 p.m., and on 10/16/17 at 9:45 a.m. revealed: -The facility did not have a written policy for injuries of unknown origin and she was not aware of any specific process the facility used or followed for injuries of unknown origin. -Her expectation for unexplained injuries was for the MA/S to send the resident to the hospital or notify the Primary Care Provider. -The facility had no written policies on an emergency, on what to do if a resident refused to go to the hospital, or for changes in resident status to assure the physician was notified. -The facility had not had a policy or system in place to assure staff called 911 or for documentation related to emergencies. -There was not a written policy on sexual, verbal or physical abuse.					
Noncompliance was identified in the following rule areas: 1. Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) as related to failing to notify the primary care physician (PCP) of elevated blood sugars over 400 as ordered for a diabetic resident (#3) on 14 of 15 occasions; of unexplained injuries of skin tears and bruising for two residents (#1, #2); of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE	
		4002 SOUT	H NC 41		
GOLDEN	CARE	WALLACE			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 61	D 176		
		behaviors from a resident			
	(#6); of a resident's (#				
	, , , ,	incomfortable and refusing			
		nt complaints of not feeling			
	well, burning upon uri	ination, decreased appetite			
	and increased confus	ion prior to a hospitalization			
		s (#11); of a resident (#10)			
	with a change in statu	•			
		weating, altered mental			
		be sent to the hospital for			
	_	aluation, who was later			
		s bed; failing to assure Ith services was completed			
		ral wound (#2); and failing			
		#1) was sent to the hospital			
	,	oulder abscess and a head			
		gin. [Refer to Tag D273, 10A			
		Health Care (Unabated Type			
	A1 Violation)].	` ,			
		ions, record reviews, and			
	_	failed to assure three			
	, , , , , , , , , , , , , , , , , , , ,	#15) were protected from			
		sault from Resident #6 who			
		nts' rooms, stole a resident's			
	. ,	et into bed with a resident			
	(#15), and touched a without consent (#14)	resident in a sexual manner			
	, ,	ere free from physical abuse			
	_ · · · · · · · · · · · · · · · · · · ·	nd Staff D); failed to assure			
) were free of neglect by			
		's (#6) personal care needs			
	_	rced to sit at the nurse's			
		B), and personal care was			
		t (#8), who was left lying on			
	top of a heating pad a	and received burns and			
	blisters to her back; a	nd failed to ensure a			
		cked up from a local store			
		nount of time. [Refer to Tag 0909 Resident Rights			

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DIVISION	of Fleatill Service Regu	ialion				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ΓED
			_			
			R-C	;		
		HAL031003	B. WING		10/17	/2017
NAME OF D	DOVIDED OD SUDDUED	STREET AD	ODESS CITY STA	TE 710 CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	II E, ZIP GODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 176	Continued From page	62	D 176			
2						
	(Unabated Type A1 V	iolation)].				
	3.Based on observation	ons, interviews, and record				
	reviews, the facility fa					
	medications as ordere	ed for 3 of 4 residents (#13,				
	#16, #22) observed d	uring the medication pass				
	including errors with in	nsulin and medications for				
	heart / blood pressure	e, diabetes, prevention of				
	blood clots, and a diu	retic (#16); a medication for				
	hypothyroidism (#22);	; and prevention of heart				
		nd for 5 of 6 residents (#1,				
		ed including errors with				
		otic pain medications (#3,				
		nfection (#1, #2, #4); and a				
	I	/ (#2). [Refer to Tag D358,				
	10A NCAC 13F. 1004	· · · ·				
	Administration (Type	· ·				
	Administration (Type /	Az violation)j.				
	4 Pasad on observat	ions, interviews and a				
	record reviews, the fa					
		to 1 of 5 sampled residents				
	` ''	to wander into residents'				
	rooms, took food from	* **				
	•	o bed with another resident				
	, , , , ,	exually assaulted another				
		without her consent. [Refer				
	to Tag D270, 10A NC	AC 13F. 0901(b) Personal				
	Care and Supervision	ı (Type A1 Violation)].				
		ions, interviews and record				
		iled to report allegations of				
	abuse, neglect and dr	rug diversion to the North				
	Carolina Health Care	Personnel Registry (HCPR)				
		ations for 4 of 4 staff (A, B,				
	_	vestigate and report injuries				
		2 of 2 residents (#1, #2) to				
		Tag D438, 10A NCAC 13F.				
		rsonnel Registry (Unabated				
	Type A2 Violation)].	.coor region, (oridiated				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
	OLIMAN DV OT		E, NC 28466	DROWDERIO DI AN OF CORRECTIO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 63	D 176		
	6. Based on observat reviews, the facility fainfection control polic Centers for Disease (guidelines to assure procedures for the us diabetic residents sar #18, #19, #20, #21) with monitoring resulting in glucometers. [Refer 131D-4.4A(b)(1) Adu Prevention Requirem Violation)].	cions, interviews, and record liled to implement a written by consistent with the federal control and Prevention corper infection control are of glucometers for 9 of 9 mpled (#1, #3, #7, #16, #17, with orders for blood sugar in the shared use of to Tag D932, G.S. It Care Home Infection ents (Unabated Type B			
	7. Based on observations, interviews, and record reviews, the facility failed to assure readily retrievable records and failed to account for the use and administration of controlled substances for 2 of 2 sampled residents (#3, #17) including a resident (#3) who had some Oxycodone tablets tampered and replaced with an anti-nausea medication and a resident (#17) who had some Hydrocodone/Acetaminophen tablets tampered and replaced with a potassium supplement and a stool softener. [Refer to Tag D392, 10A NCAC 13F. 1008(a) Controlled Substances (Type B Violation)].				
	8. Based on interviews and record reviews, the facility failed to assure 3 of 5 staff sampled (B, C, E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry upon hire according to G.S. 131E-256. [Refer to Tag D137, 10A NCAC 13F. 0407(a)(5) Other Staff Qualifications (Unabated Type B Violation)]. 9. Based on observations, interviews, and record				
	reviews, the facility fa	e provider (PCP) for 4 of 4 1, #2, 3, #4) who had orders			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	E, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41 , NC 28466		
	QUILLEN/ QT		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 176	Continued From page	e 64	D 176		
	with orders for blood programmer Tag D276, 10A NCAC Care (Type B Violation	-			
	record reviews, the fatherapeutic diets were sampled (#1, #2, #4) thickened liquids (#2) (#1, #4). [Refer to Tag	e served to 3 of 3 residents			
	reviews, the facility fa medication aides (C, by a licensed health p diabetic residents pric residents. [Refer to Ta	E) sampled received training professional on the care of or to administering insulin to ag D164, 10A NCAC 13F. The of Diabetic Residents			
	staff sampled (B, C, E medications had com hour or 15 hour state administration training sampled medication awritten medication aides sam skills checklist complemedications. [Refer to 131D-4.5B(b) Adult C Training and Compete Violation)].	cility failed to assure 3 of 4 E) who administered pleted the 5 hour and 10 approved medication g courses as required; 1 of 4 aides (C) had passed the de exam; and 2 of 4 apled (B, C) had a clinical eted prior to administering o Tag D935, G.S. eare Home Medication Aides, ency Requirements (Type B			
		ations, interviews and record			

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MANE OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZP CODE 4002 SOUTH NG 41 WALLAGE, NC 24466 (PACH) DEPRICATION STATEMENT OF DEPICIENCIES 1004 ID PREPRIX ID PROVIDER'S PLAN OF CORRECTION SHOULD BE PRECEDED BY PULL PREPRIX TAQ D 176 Continued From page 65 sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times, [Refer to Tag D077, 10A NCAC 13F. 0306(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)]. 14. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 13 water fatures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed, [Refer to Tag D113, 10A NCAC 13F. 031(4)) do not 200 Halls of the facility, including 3 fixtures with steam observed, [Refer to Tag D113, 10A NCAC 13F. 031(4)) do not 200 Halls of the facility, including 3 fixtures with steam observed, [Refer to Tag D113, 10A NCAC 13F. 031(4)) do not 200 Halls of the facility, including 3 fixtures with steam observed, [Refer to Tag D113, 10A NCAC 13F. 031(4)) do not 200 Halls of the facility for the presence of controlled substances was completed upon hire for 4 of 5 staff (8, 0, 0, E) and 131D-40, [Refer to Tag D139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)]. 16. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (8, 0, 0, E) sampled who were hire after 1001/13, Refer to Tag D992, CS, 131D-45(a) Examination and Screening for the presences of controlled substances (Type B Violation)].	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER GOLDEN CARE SITERET ADDRESS, CITY, STATE, ZIP CODE 40022 SOUTH N C4 I WALLACE, NC 28468 D 10 PROVIDER'S HAN OF CORRECTION REGULATORY OR LSC DENTIFYING INFORMATION) D 176 Continued From page 65 sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation score of 85 or above at all times. [Refer to Tag D 1077, 10A NCAC 13F. 0306(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)]. 14. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 118 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed, [Refer to Tag D 113, 10A NCAC 13F. 3011(d) Other Requirements (Unabated Type B Violation)]. 15. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hire after 1001/13, [Refer to Tag D992, G.S. 131D-45(a) Examination and Screening for the presences of controlled substances (Type B Violation)]. 17. Based on observations, record reviews, and						R-C	
OLDEN CARE MALLACE, NC 2846			HAL031003	B. WING			
CALLED CARE CALLED CARE CALLED CARE CARE CARE CARE CARE CARE CARE CARE	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DAI-ID SUMMARY SIMPLEMENT OF DEFICIENCES PREFIX (EACH OPERCINENCY WIST SEPECEDED BY PULL REQULATORY OR LSC DENTIFYING INFORMATION) DECINOS-REFERENCED TO THE APPROPRIATE DATE	GOLDEN	CARE					
D 176 Continued From page 65 sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation classification at all times in the facility with a North Carolina Division of Environmental Health Sanitation core of 85 or above at all times. [Refer to Tag D077; 10A NCAC 13F. 0306(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)]. 14. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed. [Refer to Tag D113, 10A NCAC 13F. 0311(d) Other Requirements (Unabated Type B Violation)]. 15. Based on interviews and record reviews, the facility failed to assure 5 of 5 staff sampled (A, B, C, D, E) had a criminal background check in accordance with G.S. 114-19-10 and 1310-40. [Refer to Tag D139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)]. 16. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 100/11/3. [Refer to Tag D992, G.S. 1310-45(a) Examination and Screening for the presences of controlled substances (Type B Violation)].		OLIMAN DV OT			DROWDERIO DI AN OF CORRECTIO	<u>, </u>	
sanitation classification at all times in the facility with a North Carolina Division of Environmental Heatth Sanitation score of 85 or above at all times. [Refer to Tag D077, 10A NCAC 13F. 0300(a)(4) Housekeeping and Furnishings (Unabated Type B Violation)]. 14. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 110 degrees F for 7 of 13 water fixtures sampled in the residents' bathrooms and the common hall bathrooms on the 100 and 200 Halls of the facility, including 3 fixtures with steam observed. [Refer to Tag D113, 10A NCAC 13F. 0311(d) Other Requirements (Unabated Type B Violation)]. 15. Based on interviews and record reviews, the facility failed to assure 5 of 5 staff sampled (A, B, C, D, E) had a criminal background check in accordance with G.S. 114-19 10 and 131D-40. [Refer to Tag D139, 10A NCAC 13F. 0407(a)(7) Other Staff Qualifications (Unabated Type B Violation)]. 16. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 10/01/13. [Refer to Tag D992, G.S. 131D-45(a) Examination and Screening for the presence of controlled substances was completed upon hire for 4 of 5 staff (B, C, D, E) sampled who were hired after 10/01/13. [Refer to Tag D992, G.S. 131D-45(a) Examination and Screening for the presences of controlled substances (Type B Violation)].	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETE	
care in accordance with the assessed needs for 3	D 176	sanitation classification with a North Carolina Health Sanitation scotimes. [Refer to Tag D 0306(a)(4) Housekee (Unabated Type B Violation) 14. Based on observation facility failed to assure were maintained at a Fahrenheit (F) to a more for 7 of 13 water fixture bathrooms and the cotthe 100 and 200 Halls fixtures with steam of 10A NCAC 13F. 0311 (Unabated Type B Violation) 15. Based on intervier facility failed to assure C, D, E) had a criminal accordance with G.S. [Refer to Tag D139, 1 Other Staff Qualification Violation)]. 16. Based on intervier facility failed to assure for the presence of completed upon hire sampled who were hid Tag D992, G.S. 131D Screening for the presubstances (Type B Violation) 17. Based on observation interviews, the facility	on at all times in the facility Division of Environmental re of 85 or above at all 2077, 10A NCAC 13F. ping and Furnishings Diation)]. ations and interviews, the e the hot water temperatures minimum of 100 degrees aximum of 116 degrees F res sampled in the residents' common hall bathrooms on s of the facility, including 3 Deserved. [Refer to Tag D113, (d) Other Requirements Diation)]. ws and record reviews, the e 5 of 5 staff sampled (A, B, al background check in 114-19.10 and 131D-40. OA NCAC 13F. 0407(a)(7) ons (Unabated Type B ws and record reviews, the e examination and screening controlled substances was for 4 of 5 staff (B, C, D, E) red after 10/01/13. [Refer to 1-45(a) Examination and sences of controlled foliolation)].	D 176	DELIVERY)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
	OUR MARK OT	WALLACE,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 66	D 176		
	Care and Supervision	(Type B Violation)].			
	reviews, the facility fa sampled (B, E) who p residents, had succes personal care training program. [Refer to Ta 0501(c) Personal Car Competency].	-			
	19. Based on observations, interviews, and record reviews, the facility failed to assure staff documented the administration of medications immediately following the administration and observation of the resident actually taking the medications for 2 of 4 residents (#13, #22) observed during the morning medication passes on 10/12/17 and 10/17/17. [Refer to Tag D366, 10A NCAC 13F. 1004(i) Medication Administration].				
	medication administra accurate for 5 of 5 sa #4, #17) including two documentation on MA controlled substance with inaccurate docur #4), and one resident documentation for an	acility failed to assure the ation records (MARs) were impled residents (#1, #2, #3, or residents with the ARs that did not match logs (#3, #17), two residents inentation for antibiotics (#1, with inaccurate antipsychotic and an in (#2). [Refer to Tag D367,			
	facility failed to assure	ations and interviews, the e infection control measures pment and transmission of nd prevent			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
HAL031003		B. WING			R-C / 17/2017	
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GOLDEN	CARE		UTH NC 41 E, NC 28466			
(VA) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN O	DE CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLETE DATE
D 176	Continued From page	e 67	D 176			
	during the morning m	were implemented by Staff A nedication pass on 10/12/17. IOA NCAC 13F. 1004(n) ation].				
	facility failed to assur the medication room medication cart was a direct physical super-	ations and interviews, the re two medication carts and were locked when the not under the immediate or vision of the medication aide.				
	facility failed to destro to the pharmacy with or discontinuance by	ations and interviews, the by and/or return medications in 90 days of their expiration the physician. [Refer to Tag F .1007(c) Medication				
	record reviews, the far suspected drug diver substances to the ph enforcement, and the Registry for 2 of 2 sa who were prescribed Hydrocodone/Acetan	sions of controlled armacy, local law e Health Care Personnel mpled residents (#3, #17)				
	interviews, the facility medication aides san hours of continuing e medication administration observed during medications and 8 medications	lication administration ation errors were identified. IOA NCAC 13F. 0403(c)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		_		R-C	
		HAL031003	B. WING		10/17/2017
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT WALLACE,			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 176	Continued From page	68	D 176		
	interviews, the facility a restraint was current for 1 of 1 sampled rest as a restraint in a whee [Refer to Tag D485, 1 of Physical Restraints 27. Based on observation record reviews, the fat physical restraint train (A, B, C, D, E) who prestrained in a wheeled to Tag D165, 10A NC. Physical Restraints]. 28. Based on record of facility failed to provide transportation for resi appointments, the host to Tag D321, 10A NC. Resident Care and Second and Second facility failed to assure telephone to privately evidenced by resident nurses' desk without 10A NCAC 13F. 0906 and Services]. 30. Based on observation for reviews, the fakitchen, dining and foclean, orderly and free to roaches in the kitch	ations, interviews, and cility failed to provide ning for 5 of 5 staff sampled rovided care to one resident chair with a gait belt. [Refer AC 13F. 0506(a) Training on reviews and interviews, the e the provision of dents to medical spital, and shopping. [Refer AC 13F. 0906(a) Other			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CAPE	4002 SOUT	ΓH NC 41		
GOLDEN	CARE	WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 176	Continued From page 31. Based on observarecord reviews, the farounces of milk at least	ations, interviews, and cility failed to serve 8 t twice daily to the	D 176		
	0904(d)(3)(A) Nutritio	-			
	facility failed to assure kept clean and in goo bathroom/shower roo bathrooms (201, 207, (106, 108), the dayroo hallways on the 100 a	ations and interviews, the e the walls and floors were d repair for 3 common ms, 3 private resident 210), 2 resident rooms om on 100 Hall, and the and 200 Halls. [Refer to Tag F. 0306(a)(1) Housekeeping			
	in good repair, includi stands/bedside tables cabinet, headboard, a bedrooms, the dayroo dayroom on the 200 h	ations, interviews, and ility failed to have furniture ng chest of drawers, night s, dressers, chairs, television and sofas, in 8 residents' om on the 100 Hall, and the Hall. [Refer to Tag D076, t(a)(3) Housekeeping and			
	interviews, the facility was clean, uncluttered resident rooms and a the 100 Hall including facility. [Refer to Tag I	ations, record reviews, and failed to assure the facility d and free of hazards in 3 common shower room on issues with roaches in the D079, 10A NCAC 13F. ping and Furnishings].			
	facility failed to ensure towels, washcloths, a available at all times t a current census of 20	ations and interviews, the e an adequate supply of nd incontinence pads were o provide personal care for 0 residents. [Refer to Tag			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWBER.	A. BUILDING: _		COMI LETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU WALLACE	TH NC 41 E, NC 28466		
0411.15	CHMMADY CT	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTIO	N OZE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 70	D 176		
	and Furnishings].				
	record reviews, the farelectrical equipment of and operating condition fixtures not working properties and the cover with a gap around an electrical outlet coresident room. [Refer 13F. 0311(a) Other R 37. Based on interviet facility failed to assure was tested for Tubero hire according to confusion for Healt D131, 10A NCAC 13F Tuberculosis].	ws and record reviews, the e 1 of 5 staff sampled (C) culosis (TB) disease upon trol measures for the th Services. [Refer to Tag - 0406(a) Test for			
	facility failed to assure (#6, #9, #14, #19) had signed by their primal [Refer to Tag D235, 1	reviews and interviews, the e 4 of 22 residents sampled d an annual FL-2 that was ry care provider (PCP). 0A NCAC 13F. 0703(b)(c) edical Examination and			
	interviews, the facility of 14 hours of planne provided each week f	ations, record review and failed to assure a minimum d group activities were for the 20 residents currently [Refer to Tag D317, 10A Activities Program].			
	interviews, the facility records were maintain	ations, record reviews, and failed to assure resident ned in an orderly manner to medication orders, contact			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
COL DEN	CARE	4002 SOU	TH NC 41		
GOLDEN	CARE	WALLACE	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 176	Continued From page	: 71	D 176		
	hospital discharge ord sampled (#1, #2, #17 NCAC 13F. 1201(a) F	-			
	develop and maintain related emergency pr changes in resident c	ws, the facility failed to policies and procedures ocedures to include ondition. [Refer to Tag F. 1211(a) Written Policies			
	facility failed to provid staff (A, B, C, D, E) or procedures including disposition and storag physical restraints, ac procedures, supervisi and management of p	ws and record reviews, the e training to 5 of 5 sampled in the facility's policies and administration, ordering, ge of medications, use of acident and emergency on of wandering residents, obysical aggression or [Refer to Tag D449, 10A Vritten Policies and			
	to assure the manage policies of the facility the services necessal physical and mental hevidenced by the failucompliance with the radult care homes, who the Administrator/Adn failure of the Administrator were free of abuse and in Resident #18 being dug her fingernails into a skin tear, Resident bleach solution by Sta	ministrator-in-Charge failed ement, operations, and were implemented to ensure by to maintain the residents' dealth were provided as are to maintain substantial cules and statutes governing ich is the responsibility of ministrator-in-Charge. The restor to ensure residents and neglect by 3 staff resulted by Grabbed by Staff D, who so the resident's arm causing the being sprayed with a staff A, and Resident #6, #15, and by Staff B, who forced			

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	Y
					R-C	
		HAL031003	B. WING		10/17/201	17
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOL	ITH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 176	Continued From page	e 72	D 176			
	Resident #6 to sit in a	chair at the nurse's desk in				
		e resident from wetting his				
		personal and incontinence				
		and #3; to report the staff,				
	who abused 2 resider					
		h Care Personnel Registry				
		continue working in the				
	, , ,	idents at risk for further				
		provide health care referral				
		ident #10, who refused to be				
	transferred to the eme	ergency room after as and diaphoresis, and later				
		rvision of Resident #8, who				
		t on her back which resulted				
	- ·	to the resident's back; to				
		6, who had a known history				
	of wandering in other	residents' rooms, resulting				
		ng in the beds of 2 female				
		y assaulting Residents #14				
	i i	r medications as ordered,				
	•	art and blood pressure				
		diabetic medications and				
		nfection control guidelines by				
		petween residents for blood assure criminal background				
	_	ed for 5 of 5 sampled staff				
	upon hire. Interviews					
	Administrator reveale					
		ge had been on leave for 2				
		nistrator was on-site at				
	varying intervals and	worked another full-time job,				
		ous neglect of the residents				
		Residents #6, #8, #14, #15,				
		to Resident #10, which				
	constitutes an Unaba	ted Type A1 Violation.				
	The facility's Plan of F	Protection dated 10/12/17				
		available by phone and will				
	be onsite for unforese					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		R-C	
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
			, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 176	Continued From page	e 73	D 176		
D 235	check with staff and rethe daySupervisor will be in problems/concerns at to resolve any issuesSupervisor will report Administrator, one of immediately, either or issues which may arist-Administrator will be overseeing medication transportation schedureviewing documental physician regarding resolves.	t to Director/Manager or which will be available nsite or by phone, to handle se. reviewing charts and n administration, reviewing alle for appointments and tion of notification to esident condition.	D 235		
	10A NCAC 13F .0703 Examination And Imm (b) Each resident shat examination prior to a annually thereafter. (c) The results of the required in Paragraph entered on the FL-2, I Program Long Term C North Carolina Medical	B Tuberculosis Test, Medical nunizations all have a medical admission to the facility and complete examination (b) of this Rule are to be North Carolina Medicaid Care Services, or MR-2,			
	This Rule is not met a Based on record revie facility failed to assure (#6, #9, #14, #19) had	as evidenced by: ews and interviews, the e 4 of 22 residents sampled d an annual FL-2 that was ry care provider (PCP).			

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	of Health Service Regu			T		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
COLDEN	57 ti 12	WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(7.0)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
IAG	REGOLATORY OF	Lee in the in craw, then,	IAG	DEFICIENCY)	W (1)	
D 235	Continued From page	e 74	D 235			
	The findings are:					
	1. Review of Residen	t #14's Resident Register				
		was admitted to the facility				
	on 11/26/13.					
		14's most current FL-2				
		lled diagnoses included				
	coronary artery disease (CAD), hypertension,					
	osteoarthritis, and Alz	zheimer's disease.				
	D : (D :1 1//					
		14 record revealed there				
	was no FL-2 dated af	ter 06/02/16.				
	Poviou of a Modication	on Review for Resident #14				
	dated 08/31/17 revea					
		it #14's FL-2 was due.				
	documented residen	14 31 L 2 Was due.				
	Refer to interview with	h the medication				
	aide/supervisor on 10					
	•					
	Refer to interviews wi	ith the Administrator on				
	10/16/17 at 8:40 a.m.	and 10/17/17 at 11:45 a.m.				
		nt #9's Resident Register				
		was admitted to the facility				
	on 3/20/14.					
	Davidson of Davidson 111	tola access to the tolerand				
		9's current FL-2 dated				
	_	gnoses included dementia,				
	reflux disease.	and gastroesophageal				
	TOTIUN VISCASE.					
	Review of Resident #	9's record revealed there				
	was not an FL-2 date					
		2 2.13. 30, 10, 10.				
	Refer to interview with	h the medication				
	aide/supervisor on 10					

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Refer to interviews with the Administrator on

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	of Health Service Regu				<u> </u>	SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 1	(X2) MULTIPLE CONSTRUCTION			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	COMPLETED	
					,	R-C	
		HAL031003	B. WING		ı	/17/2017	
					, ,		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE			
GOLDEN	CARE		UTH NC 41				
		WALLAC	E, NC 28466				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETE DATE	
IAG			IAG	DEFICIENCY)			
D 235	Continued From page	e 75	D 235				
	10/16/17 at 8:40 a.m.	and 10/17/17 at 11:45 a.m.					
	3. Review of Residen	t #6's FL-2 dated 9/5/16					
	revealed:						
	-Diagnoses included	Congestive Heart Failure,					
	Hypertension and Hy						
	-Resident #6 was am	•					
		casionally incontinent of					
	bladder and bowel.						
		6's record revealed there					
	was no FL-2 dated af	ter 9/5/16.					
	Defeate intensions with	h tha madiantian					
	Refer to interview wit						
	aide/supervisor on 10	0/10/17 at 10.10 a.iii.					
	Refer to interviews w	ith the Administrator on					
		and 10/17/17 at 11:45 a.m.					
	10/10/17 at 0.40 a.m.	and 10/1/// at 11.40 a.m.					
	4. Review of Resider	nt #19's FL-2 dated 09/14/16					
	revealed:						
	-Diagnoses included	diabetes, hypertension,					
	_	othyroidism, mood disorders,					
	insomnia, and osteoa	arthritis.					
	-The resident was inc	continent of bladder,					
		red assistance with bathing.					
	-The date of admission	on was listed as 08/14/15.					
		19's Resident Register					
	revealed the date of a	admission was blank.					
	Deview of Deside 11	140la mandiant massad					
	Review of Resident #						
	revealed there was n	o FL-2 dated after 09/14/16.					
	Refer to interview wit	h the medication					
	aide/supervisor on 10						
	aideraupervisor on 10	,, 10, 17 at 10.10 a.III.					
	Refer to interviews w	ith the Administrator on					
		and 10/17/17 at 11:45 a.m.					

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
			B. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
			, ,	,	
GOLDEN (CARE		UTH NC 41		
		WALLAC	CE, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(7.0)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MATE DATE
				52.16.2.16.1	
D 235	Continued From page	e 76	D 235		
		dication aide/supervisor on			
	10/16/17 at 10:10 a.m				
	-She was not aware s	some of the residents' FL-2			
	forms were not currer	nt.			
	-She did not know wh	y the FL-2 forms had not			
	been done annually.				
	-The facility's Manage	er usually did the FL-2 forms			
	but she was out on m	· ·			
	Interviews with the Ac	dministrator on 10/16/17 at			
		17 at 11:45 a.m. revealed:			
		some of the residents' FL-2			
	forms were not currer				
	-The FL-2 forms shou				
		er was responsible for			
	-				
	getting the FL-2 forms				
	_	een on medical leave for			
	about 2 months and v	was unavallable for			
	interview.				
		sponsibility of the residents'			
		lager went on medical leave.			
	-There was no systen				
	Manager or to monito	or the residents' records.			
D 269	10A NCAC 13F .0901	I(a) Personal Care and	D 269		
	Supervision				
	·				
	10A NCAC 13F .0901	Personal Care and			
	Supervision				
	•	staff shall provide personal			
		ording to the residents' care			
		ny other personal care			
		be unable to attend to for			
	themselves.	be dilable to attella to loi			
	u 10111301703.				
	This Dula is a t t	an avidanced by:			
	This Rule is not met	as evidenced by:			
	TYPE B VIOLATION				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMP	LETED
					F	R-C
		HAL031003	B. WING		10	/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
			+	,		
D 269	Continued From page	e 77	D 269			
	Based on observation	ns, record reviews, and				
		failed to provide personal				
		ith the assessed needs for 3				
	of 5 residents sample					
	The findings are:					
	Confidential staff inte					
	_	checks were completed by				
	staff every two hours					
	_	en the Manager was still				
	there, the facility was					
	incontinent supplies r residents.	leeded for tolleting				
		was only extra-large adult				
		n stock and no wipes.				
		ey could with what they had.				
	-Most residents did n	-				
		olied for staff to use on				
	residents; a staff bou					
	-Staff had to wipe res	idents with toilet paper or				
	paper towels if they d	lid not have any washcloths.				
		nen the supply of adult				
		was "really, really low"; "not				
	, ,	at time the items were low.				
	I	tly" times when residents				
		g size adult protective				
	_	to wear briefs when they				
		ear pull ups (and vice versa).				
		nen residents had to wear				
	other residents' adult	-				
		r keeping the items stocked lication aide/supervisor				
		ns were running low, the				
		Manager or Administrator to				
	bring the items.	variage of Administrator to				
	_	upply disposable incontinent				
	pads for resident use					
		itinent pads, but not enough.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL031003		B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	10/11/2011
GOLDEN	CARE	4002 SOUT WALLACE	ГН NC 41 , NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 269	large (XXL) adult prote there were no smaller garments in stock. -Staff could not get in or Manager; the (name to do about the supply protective garments. -A resident's family materially member outside of the protective garments. -A few days later, the protective garments and stying the protective garments and stying the protective garments are sidents because the medium size in stock; Manager were aware. Since the Administrate facility, the supplies head in a communication note by staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the medium adult protective garments to the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 parabas (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19 pads (15 pads in each medium adult protective package) for facility under the staff brought in 19	ere were only extra, extra- ective garments in stock; sized adult protective touch with the Administrator led) MA/S did not know what y of incontinent adult ember had some extra adult and went to get them and or the facility to use. told staff to meet her family le facility ran out of adult legain. If the facility ran out of adult legain adult protective lem on the smaller female levy did not have small or the Administrator and left to started being at the lad been in stock. Inted 30 packages of adult lot the facility on 10/15/17. Inted 10/15/17 in the staff look revealed a (named) locks of disposable under left pack) and 30 packs of size left garments (16 in each left seekeeper on 10/13/17 at left ty residents who resided in protective garments (fifteen	D 269		

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Division c	<u>of Health Service Regu</u>	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	0
		1141 024002	B. WING		R-	
		HAL031003	D. VVII (U		10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STAT	TE, ZIP CODE		
		4002 SO!	UTH NC 41			
GOLDEN (CARE		E, NC 28466			
	OLIMANA DV. OT			SECURE PLAN OF CORRECTION		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 260	2 "		D 200			
D 269	Continued From page	∍ 79	D 269			
	-The facility was resp	oonsible for supplying adult				
		to eleven residents, hospice				
	supplied adult protect					
		nembers supplied adult				
	protective garments for					
	residents.	51 tilo . 5				
	-The Manager and/or	Administrator were				
		ng sure the items were in				
	stock for the residents					
		nager and/or Administrator				
	when the items were	•				
	Whom the items inc. 5	Turining low.				
	Interview with a resid	lent on 10/17/17 at 8:55am				
	revealed:	on on to the action				
	-The resident wore size	ze extra-large adult				
	protective garments.	20 OARG IGIGO GGER				
		on adult protective garments.				
	-	know there were enough				
	pulls ups in case she					
		y adult protective garments				
	in her room at that tim					
		ic.				
	Telephone interview v	with a Home Health Nurse				
	on 10/17/17 at 9:30ar					
		ilable for resident use like				
	they should be.	able to rediading deee				
		e had to go to her car to get				
	wipes to use for a res	-				
	wipoo to doo to. a	ndone.				
	Observation of the tw	o closets identified by the				
		incontinent supplies were				
	stored on 10/17/17 at	• •				
		ere was one full, unopened				
	bag of 40 count size r	•				
		same size medium pull ups				
		in the two bags, and one				
		medium size briefs with a				
	total of 36 left in the b					
	-In the second closet,					
		ze medium briefs (16 in each				
J.	anoponoa bago or oiz	.o modiam briolo (10 m odom	, ,	1		i l

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
	Г		E, NC 28466		Г
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 269	Continued From page	e 80	D 269		
	size medium briefs th	open packages of the same at were almost full, and one ups (a 12 count package) in the package.			
	Review of itemized receipts provided by the Administrator from a local department store revealed: -There was receipt dated 10/02/17 at 10:41am for the purchase of one package of small briefs (40 count) and one package of large briefs (32 count).				
	7:19pm which include	receipt dated 10/10/17 at ed the purchase of two , pull ups, one package of			
	32 count briefs, and command briefs.	ne package of 40 count			
	1:57pm for the purcha	ceipt dated 10/17/17 at ase of one package of 32 ackage of 36 count pull ups, 40 count briefs.			
	4:45pm revealed she receipts to provide rel	ninistrator on 10/13/17 at did not have any additional ated to the purchase of uch as wipes and adult			
	03/07/17 revealed:	n-ambulatory.			
	revealed: -Resident #3 was nor	3's care plan dated 03/31/17 n-ambulatory, required a device, and was a double			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMPLETED
			A. BUILDING		
		LD WING		R-C	
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOU	ΓH NC 41		
GOLDEN	CARE		, NC 28466		
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTION	l (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
			1	DEFICIENCY)	
D 269	Continued From page	2 81	D 269		
	amputee.				
	-The resident had lim	ited strength in her upper			
	extremities.				
	-The resident had dai	ly incontinence of bowel and			
	bladder.				
		ally dependent on staff for			
	_	ocumentation the aides			
		s adult protective garments			
		s) and prn (as needed)." ally dependent on staff for			
		ng; "bathed by aide and			
		air and chair/bed by aide"			
	was documented und				
	assistance needed.				
	-The resident required	d extensive assistance from			
	staff with dressing; "d	ressed by aide" was			
		e description of assistance			
	needed.				
	Interview with Reside	nt #3 on 10/11/17			
	at10:22am revealed:				
	-	I when she needed help			
	from staff.				
		elp "about a week ago" on			
		she was soiled; she needed			
	help getting her adult				
	changed, but nobody	came to assist her.			
	Confidential interview	with a resident revealed:			
		the resident that she had to			
	sit in soiled adult prot	ective garments and her			
	"butt got raw."	-			
		ell one staff that she was			
	soiled, but the staff ig	nored the resident.			
	Confidential interview	with a staff revealed			
		d bottom, but it looked better			
	last week.	2 22.0, Dat it looked better			

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Interview with a personal care aide (PCA) on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE	-
			JTH NC 41	,	
GOLDEN	CARE		E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 269	Continued From page	e 82	D 269		
	10/12/17 at 6:45pm re-Resident #3 had the breakdown on her bur-The PCA first noticed -The resident complaid Interview with a second 7:50pm revealed: -Resident #3 required	evealed: beginning of skin ttocks. d it 3-4 days ago. ined she was hurting. and PCA on 10/12/17 at I assistance with toileting,			
	was incontinent, was could tell staff when some the previous weekend. The PCA could not recomplaining of her call. She was not aware complete.	able to use her call bell, and he was wet. ne "redness" on her bottom d.			
	10/13/17 at 9:00am re-Resident #3 was incoassistance with all acc-Resident #3 was on checksA PCA told her "yeste #3 had a red bottom.	ontinent and required tivities of daily living. two hour toileting/incontinent erday" (10/12/17) Resident the resident's bottom and			
	garments and wiped the and buttocks with facing and buttocks with facing and buttocks. The skin on the left buttock and intact.	sident's adult protective the resident's perineal area al tissue.			

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Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	C
		HAL031003	B. WING		1	7/2017
		TIAL031003			1 10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
OO! DEN	0485	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACI	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
D 269	Continued From page	e 83	D 269			
	_ =	are point near the coccyx;				
	the skin was intact.					
	Intonvious with a DCA	assisting Resident #3 on				
	10/13/17 at 10:25am	•				
		e wipes to use unless the				
	resident's family supp	•				
		sholoths if residents had a				
	_	order to clean the residents.				
		f wash cloths "sometimes."				
	Interview with Reside	ent #3 on 10/17/17 at				
	10:25am revealed:					
	-She currently had a	sore on her right hip and she				
	thought the physician	was aware of it.				
	-She did not have any	y skin breakdown on her				
	bottom to her knowled	dge.				
		h a PCA on 10/12/17 at				
	8:06am.					
		h a second PCA on 10/13/17				
	at 5:30pm.					
	Defer to intensions with	h a family momber on				
		h a family member on				
	10/12/17 at 12:12pm.	•				
	Refer to interview with	h a second family member				
	on 10/12/17 at 3:45pr	· · · · · · · · · · · · · · · · · · ·				
	011 10/12/17 dt 0:10pi					
	Refer to the Interview	s with the Administrator on				
	10/13/17 at 10:30am					
	2. Review of Residen	t #6's FL-2 dated 9/5/16				
	revealed:					
	-Diagnoses included	congestive heart failure			ĺ	
	(CHF), hypertension	•				
	-Resident #6 was am					

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bladder and bowel.

-Resident #6 was occasionally incontinent in

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	•	
TVAINE OF T	NOVIDER OR OUT FEEL		UTH NC 41	, Zii GODE		
GOLDEN	CARE		E, NC 28466			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
D 269	Continued From page	e 84	D 269			
	6/8/15 revealed: -Resident #6 was ass staff; staff were to protect two hours as neededResident #6 was ass needed prompting by hygiene. Interview with a personal process of 10/12/17 at 8:06am resident be soiled in less than toileted. Confidential staff interprotective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments, put a large one on hir XL adult protective garments and large one on hir XL adult protective garments.	cisted with dressing and staff for grooming and care aide (PCA) on evealed Resident #6 would one hour after being crview revealed: sposed to wear XL adult but sometimes staff had to m, because there were no arments in the facility. The resident would get redicted the staff had to one control of the staff had to one the sta				
	Confidential interview revealed: -Staff made Resident recent as last week.	with a second staff #6 sit up on 2nd shift, most				
		ting in the dining room, and because he soiled the bed.				
	12:22pm revealed: -Staff made Resident because he would uri -He would be saturate -Staff do not toilet him	ed with urine. n like they should. medication aide (MA) on				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SO	JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 269	Continued From page	e 85	D 269		
D 269	-"All he (Resident #6) and eat." -All the resident wante-Staff assisted Residershe had to tell him to couple hours or he westaff had to get him to wet himself. -She had never told he because of incontiners. Interview with the Adr 10:30am revealed: -Resident #6 was madesk because he was -She did not interview briefly with all of the 3. Observation of the two Administrator where instored on 10/17/17 at one package of size agarments (a 12 count remaining in the pack Interview with a PCA revealed Resident #6 residents wore size agarments. Refer to interview with 8:06am.	ed to do was sleep and eat. ent #6 with toileting. o go to the restroom every ould sit there and not go. up and change him when he nim he could not go to bed nce. ministrator on 10/12/17 at de to sit in a chair at the s a "heavy wetter." the resident, but spoke spm-11pm staff. o closets identified by the ncontinent supplies were s:40am revealed there was XXL adult protective package) with only 4 rage. on 10/17/17 at 8:50am and two other (named)	D 269		
	Refer to interview witl 10/12/17 at 12:12pm.	•			
	Refer to interview with	h a second family member			

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			B. WING		R-C	
		HAL031003	B. WING		10/17	//2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
		4002 SQI	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
			·			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 000			D 000			
D 269	Continued From page	e 86	D 269			
	on 10/12/17 at 3:45pr	m.				
	oo <u>_</u> a. a					
	Refer to the Interview	s with the Administrator on				
	10/13/17 at 10:30am					
	10/10/17 at 10:00am	ана 0.00рт.				
	3 Review of Residen	it #15's current FL-2 dated				
	09/22/17 revealed:	t # 10 3 current 1 L L dated				
	-Diagnoses included	dementia and				
	hypothyroidism.	dementia and				
	-The resident was ser	mi-ambulatory and				
	incontinent of bladder					
		nstantly disoriented and was				
	"total care."	nstantily disoriented and was				
	lotal care.					
	Review of Resident #	15's current assessment				
	and care plan dated (
		ally dependent on staff for				
		ed strength in her upper				
	extremities.	ed strength in her upper				
		continent of bladder daily and				
		_				
	occasionally incontine	to provide incontinent care				
	ioi Resident #15 ever	ry 2 hours and as needed.				
	Confidential interview	with a resident revealed:				
	-Resident #15 had to	with a rediacht revealed.				
	was last weekend.	the last time it happened				
		e into Resident #15's rooms,				
	and she told the staff					
		nored her, signed the sheet				
	, ,	. 0				
	hanging on the back	or the door, and left.				
	Observation of Book	ent #15 on 10/17/17 at 9:40				
	a.m. revealed:	ent#15 011 10/1//1/ at 9.40				
		ad to the toilet by a				
	-Resident was assiste					
	medication aide (MA)					
	-The resident was we					
	protective garment pr					
	-The resident's pull-up	p was dry.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED	
			A. BOILDING			
			D WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		4002 SOUT	TH NC 41			
GOLDEN	CARE		NC 28466			
(VA) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
D 269	Continued From page	e 87	D 269			
	-The resident's buttoo	ks were not reddened and				
	did not have any sign	s of skin breakdown.				
	Based on observation	ns, record reviews, and				
	interviews, Resident #	‡15 was not interviewable.				
	Observation of the two	o closets identified by the				
		ncontinent supplies were				
		8:40am revealed there was				
	one package of size >	KXL adult protective				
	garments (a 12 count	package) with only				
	remaining in the pack	age.				
	Interview with a nerso	onal care aide on 10/17/17 at				
	·	ident #15 and two other				
	(named) residents wo					
	protective garments.					
	Observation of Reside	ent #15's room on 10/17/17				
	at 8:52am revealed th	ere were no adult protective				
	garments in her room					
	Confidential staff inter	rviow rovoglod:				
		named) resident's adult				
		supplied by his family) on				
	Resident #15.	supplied by file family) of				
		ipposed to wear pulls ups				
		If, but she could not manage				
	the briefs staff were p	•				
	·	-				
	Refer to interview with 8:06am.	n a PCA on 10/12/17 at				
	Refer to interview with at 5:30pm.	n a second PCA on 10/13/17				
	Refer to interview with 10/12/17 at 12:12pm.					

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Refer to interview with a second family member

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DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		1141 004000	B. WING		
		HAL031003			10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
		WALLAC	E, NC 20400		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG			IAG	DEFICIENCY)	
			+		
D 269	Continued From page	e 88	D 269		
	on 40/40/47 of 2:45mm				
	on 10/12/17 at 3:45pr	П.			
	D () () ()				
		s with the Administrator on			
	10/13/17 at 10:30am	and 6:55pm.			
		<u> </u>			
		on 10/12/17 at 8:06am			
	revealed:				
		e checked on and toileted			
	every two hours.				
	-The PCAs document	t incontinent care on the			
	Personal Care log.				
	-The PCA assigned to	o the hall was responsible			
	for documenting on th	ne log.			
	Interview with a secon	nd PCA on 10/13/17 at			
	5:30pm revealed:				
	-Residents were supp	posed to be checked every 2			
	hours, including toilet	ing checks.			
		e residents right then if they			
	were soiled.	,			
	Interview with a family	y member on 10/12/17 at			
	12:12pm revealed:	,			
		nen the family member came			
	in and could smell fed	-			
		in the dining room, and the			
	family member would				
	-	eral times, but most recently			
	as last week.	crai times, but most recently			
	as last week.				
	Interview with a secon	nd family member on			
	10/12/17 at 3:45pm re				
	-	doing their job; they don't			
	toilet the residents like				
		e they should. le to sit in soiled adult			
	protective garments a	and dotnes.			
	linda miliano, colletta dia a. A. I.				
		ministrator on 10/13/17 at			
	10:30am revealed:				

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-Medicaid was supposed to supply adult

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED	
			A. BOILDING.			
			D WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
OO! DEN	0485	4002 SOL	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE COMPLETE	
				DEFICIENCY)		
D 269	Continued From page	e 89	D 269			
	protective garments for	or the residents, but the				
		ad been a "mix up with a				
	number" so the facility	y had not been getting the				
	adult protective garm	ents from Medicaid.				
	-The facility had been	buying the items in order to				
	provide them for resid	dent use.				
		w long the mix up had been				
	-	nager had done anything to				
		der to get Medicaid to				
	provide the items for					
	-She purchased wipe					
		orning (10/13/17) they were				
	currently out of wipes					
		shcloths if they ran out of				
	wipes.	to notify her when the items				
	were running short or					
	_	of staff using wipes or adult				
		provided by family members				
		e did not know staff were				
		idents who were supposed				
		plied by Medicaid and/or the				
	, -	of the facility ever running				
	out of adult protective					
	· ·	of any resident having to				
		adult protective garments				
	_	ns being kept stocked for				
		of any resident having to				
		y wear supposed to wear				
		sa due to lack of the correct				
	items being in stock.					
		e wipes, adult protective				
		protective garments were				
		ents' personal care needs.				
	A second interview w	ith the Administrator on				
		evealed she expected all				
		lents with personal care as				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILBING		D C	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COLDEN.	CADE	4002 SOUT	H NC 41			
GOLDEN	CARE	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 269	Continued From page	90	D 269			
	needed.					
	needed.					
	#6, and Resident #15 personal care in acco needs resulting in Re her perineal area afte incontinence care. Th disposable adult prote were maintained in st assessed needs of m to include Residents a failed to maintain eace evidenced by multiple correct size of adult p having wipes to clean incontinent care; and by family members fo residents. The facility the health and welfare	ssure Resident #3, Resident received assistance with rdance with their assessed sident #3 having redness to r not being provided with refacility failed to assure rective garments and wipes ock to accommodate the residents residents residents dignity as residents rot having the rotective garments; staff not residents when providing staff using items purchased respecific residents on other is failure was detrimental to residents. This titutes a Type B Violation.				
	10/13/17 revealed: -Incontinence supplie	s Plan of Protection dated s would be available at all				
		nswered in a timely manner. be documented on the				
	-All staff who provided re-inserviced by 10/1 documenting personal be documented.	d personal care would be 6/17 on providing and al care; the in-service would				
	and interviewThe supply closet for would be monitored w	ould be responsible for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		TED
			B. WING		R-0	-
		HAL031003			10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA J TH NC 41	TE, ZIP CODE		
GOLDEN	CARE		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	91	D 269			
	THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.					
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
	· ·	e supervision of residents in resident's assessed needs,				
	This Rule is not met a					
	reviews, the facility fa supervision to 1 of 5 s was known to wander food from a resident (into bed with another	ns, interviews and a record iled to provide adequate sampled residents (#6), who into residents' rooms, took #12), attempted to climb resident (#15) and allegedly other female resident (#14)				
	The findings are:					
	9/5/16 revealed: -Diagnoses included of Hypertension and Hypertension and Hypertensident #6 was ami-Resident #6 was occibladder and bowel.	bulatory asionally incontinent of				
	Review of Resident #	6's most recent Care Plan				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
0411.45	CLIMMADVCT		E, NC 28466	PROVIDER'S PLAN OF CORRECTION	1 000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 92	D 270			
	staff; staff were to pro two hours as needed. -Resident #6 was ass needed prompting by hygiene.	sisted to the bathroom by ovide incontinent care every . sisted with dressing and staff for grooming and				
	Review of Resident #6's primary care provider (PCP) progress notes revealed that he had last been seen by his PCP on 8/16/17.					
	06/02/16 revealed: -Diagnoses included (CAD), hypertension, Alzheimer's diseaseHer orientation level	t #14's current FL-2 dated coronary artery disease osteoarthritis, and was not documented. n-ambulatory and had a				
	11:45am revealed:	ent #14 on 10/11/17 at g room in her Geri-chair. self and situation.				
	Interview with Resident #14 on 10/11/17 at 11:45am revealed she received assistance from staff with bathing, dressing, and getting in her chair.					
	Interview with the Administrator on 10/13/17 at 6:55pm revealed she had not been there enough to tell what Resident #14's orientation level was.					
	-Resident #6 went in	with a third staff revealed: other residents' rooms. I Resident #6 "tried to mess the past."				

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<u>Division</u> of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017
NAME OF D		etheet as	DDESS CITY STA	TE ZID CODE	,
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA JTH NC 41	TE, ZIP CODE	
GOLDEN	CARE		E, NC 28466		
(VA) ID	SLIMMARY ST.			PROVIDER'S PLAN OF CORRECTION	d (VE)
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	93	D 270		
	-The staff was not sur "it was in the past."	re if she reported it because			
	family member said F bed with Resident #1 -"Nothing was done to	s ago, " Resident #14's Resident #6 tried to get in 4.			
	p.m. revealed: -Resident #6 tried to g -Resident #6 tried to g -Resident #6 tried to g because she fought h -She did not tell anyo because she did not g -The incident happen -She had not seen Re but saw him yesterda	rape her, but he did not nim off. ne about the incident want to get in trouble. ed about 3 months ago. esident #6 today (10/13/17), y. uld be discharged from the			
	at 5:52 p.m. revealed -Resident #6 came ar -She was not a friend want him in her room -He attempted to "fee (private area)It happened every ni -She told the "nurses" her; they said there w -Resident #6 normally in the dining room. (S	nd visited her room. of the resident and did not . I on her important parts" ght. and they did not believe			

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that way to her family."

-She had not reported Resident #6 coming into her room to her family because she did not "talk

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MULTIDUE	CONSTRUCTION	(Y3) DATE SLIDVEV	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL031003	B. WING		R-C 10/17/2017
A145.=	20/4252 65 51/55				1 10/1//2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	IE, ZIP CODE	
GOLDEN	CARE		UTH NC 41 CE, NC 28466		
0/4) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
D 270	Continued From page	e 94	D 270		
	from talking that way now. -It was a matter of research was telling it now protected. Interview with a person 10/13/17 at 6:50pm rewish it" (oriented). Interview with a second 2:50pm revealed Research was in the 6:02pm revealed: -Resident #14 was in	w because she wanted to be onal care aide (PCA) on evealed Resident #14 was and PCA on 10/16/17 at sident #14 was oriented. e dining room on 10/13/17at the dining room. into the dining room and			
	Refer to confidential s	staff interview.			
	member of a resident				
	Refer to Interview wit resident on 10/13/17	h a family member of a third at 10:10 a.m.			
	Refer to Interview wit member on 10/13/17	h Resident #6's family at 12:522 p.m.			
	Refer to Interview wit 10/17/17 at 8:38 a.m.	h Resident #6's guardian on			
	Refer to Interview wit at 5:33 p.m.	h Resident #6 on 10/13/17			
	Refer to Interview wit on 10/16/17 at 4:08 p	h the PCP for Resident #6 .m.			

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AND BLAN OF CORRECTION INDENTIFICATION NUMBER		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CADE	4002 SOUT	'H NC 41		
GOLDLIA	CARE	WALLACE,	NC 28466		1
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 270	Continued From page	95	D 270		
	Refer to Interview with the Administrator on 10/12/17 at 9:55 a.m.				
	reviews, the facility fa #6, who was known to by Resident #14's fan attempted to get into Resident #14 also rep #6 had attempted to t	ns, interviews and record iled to supervise Resident o wander, and was reported nily member to have the bed with Resident #14; ported to staff that Resident ouch her, but nothing was t #6 from coming into her			
	2. Review of Residen 09/22/17 revealed: -Diagnoses included of hypothyroidismThe resident was serum and the resident's orient documented.	mi-ambulatory.			
	Review of Resident # and care plan dated 0 resident was sometim				
		onal care aide (PCA) on evealed Resident #15 was ed."			
	p.m. revealed: -She felt that the residencare." -She felt that Residenstaff or residentsA resident informed head into another resident and tried to "me -Resident #6 did not the state of the state o				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
COLDEN	CADE	4002 SOL	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	96	D 270		
	or not.				
	or not.				
	Confidential staff inte				
		to Resident #15's room.			
	other residents' bed.	observed Resident #6 in any			
	other redicente bea.				
	I	y member of a resident on			
	10/13/17 at 10:10 a.m	n. revealed: Resident #6 went into a			
		m and attempted to get in			
	the bed with that resid				
	_	biggest concern was that			
	Resident #6 wandere	d.			
	Interview with a seco	nd shift PCA on 10/12/17 at			
	6:46 p.m. revealed:				
	-Resident #6 was ver				
		nt when Resident #6 had , and went in Resident #15's			
	room and pulled the o	•			
	-The PCA found Resi	•			
	1	Resident #15 was in the bed.			
	#15's body and "knee	nding midway over Resident			
	-She reported this to	•			
		S); the MA/S did not do			
	anything and just gav				
	-Resident #6 had a bahimself" while walking	•			
	_	nts were afraid of Resident			
	#6.				
		w if Resident #6's PCP was			
	aware of his wandering aware that Resident #	ng, but the Administrator was #6 wandered.			
		nt #15's roommate on			
	10/12/17 at 6:25pm re	evealed: her room and stole items			
	so she had to "padloo				

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DIVISION OF Flearth Service Regulation		1		ı		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR\	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	:ט
					50	
		1141 024000	B. WING		R-C	
		HAL031003	D. WING		10/17/2	2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
0. 11				,		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	SIATE	DATE
				22.16.2.16.1		
D 270	Continued From page	97	D 270			
	. •					
		nt #6 being in her room				
	-	o and also two weeks ago.				
	•	sident #6 tried to get in bed				
	with her roommate, R					
	-Resident #15 could r	not tell what was going on.				
	-She "cussed him out	" and he left.				
	-She told the (named)) staff that was on duty; the				
	staff did not do anythi	ng.				
		" Resident #6 went into				
	• • •	s and nothing had been				
	done.					
	dono.					
	Second interview with	n Resident #15's roommate				
	on 10/13/17 at 5:35 p					
		the resident's room and				
	stole her cake off her					
		A saw Resident #6 with the				
		empting to "crawl" in the bed				
	with the other residen					
	-The PCA told her tha	at Resident #6 was				
	completely dressed.	1 1 1/0 1 1 1 1 1				
	-The PCA made Resi	dent #6 get out of the				
	resident's room.					
		en Resident #6 walking				
		rbating," but this had been a				
	long time ago.					
	-The resident felt that	Resident #6 knew what he				
	was doing.					
	-The resident told Res	sident #6's family member				
	about the incident.					
	Telephone interview v	vith Resident #15's family				
	•	at 2:21pm revealed the				
		d any concerns related to				
	Resident #15's care.	•				
	Interview with the Adr	ministrator on 10/13/17 at				
	6:55pm revealed she	had not been there long				
		esident #15's orientation				

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level was.

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	of Health Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		UAL 024002	B. WING			
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ΓΕ, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN	CARE		CE, NC 28466			
		WALLAC	JE, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		
17.0		,	17.0	DEFICIENCY)		
D 270	Continued From page	e 98	D 270			
	Daged on observation	ns, record reviews, and				
		#15 was not interviewable.				
	interviews, Resident	#15 was not interviewable.				
	Dagod on about stice	as interviews and record				
		ns, interviews and record				
		illed to supervise Resident				
		o wander, and was reported				
		observed kneeling over				
		he was lying in her bed.				
		able to verbalize her needs				
		e to communicate to staff if				
		mpted to assault her or get				
	into her bed.					
	D-ft	-t-#:-t:				
	Refer to confidential s	stan interview.				
	Defer to confidential I	ntoniou with a family				
		nterview with a family				
	member of a resident					
	Defeate Interview vit	h a family manulage of a third				
		h a family member of a third				
	resident on 10/13/17	at 10:10 a.m.				
	D () 1 1 1 1 1 1 1 1 1					
		h Resident #6's family				
	member on 10/13/17	at 12:522 p.m.				
	Defeate later decrease	b Danidant #Ola mandian an				
		h Resident #6's guardian on				
	10/17/17 at 8:38 a.m.					
	Defeate Interview vit	h Daoident #C an 40/42/47				
		h Resident #6 on 10/13/17				
	at 5:33 p.m.					
	Defer to Interviewe	h the DCD for Desident #0				
		h the PCP for Resident #6				
	on 10/16/17 at 4:08 p	.т.				
	Defeate laterates 19	h tha Advainiateat				
		h the Administrator on				
	10/12/17 at 9:55 a.m.					
		t #12's current FL2 dated				
	4/6/17 revealed:		1			

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-Diagnoses included Hypertension, Anemia,

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
				R-C		
		HAL031003	B. WING		10/17/	
NAME OF D		CTDEET AS	ADDECC CITY CTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
GOLDEN	CARE		TH NC 41			
			E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 270	Continued From page	. 00	D 270			
D 210	Continued From page	: 99	D 210			
	Dementia, Depression	n and Hyperlipidemia				
	-The resident was ser	•				
	-The resident was inc	continent of bladder and				
	bowel.					
		nt #12 on 10/13/17 at				
	8:45am revealed:	4- b				
	-Resident #6 came in snacks.	to her room and took her				
		no. Decident #6 was in her				
	-One to two weeks ago, Resident #6 was in her room at 1:30am "scaring me to death."					
		lesident #6, but she was				
		h because it would just				
	make it hard on her.	i because it would just				
		ain pill, I would not know if				
	he got in bed with me					
	no got in bod with me	of medded with me.				
	Confidential staff inte	rview revealed Resident #12				
	said that Resident #6	came into her room "often;"				
	nothing had been dor	ne to stop him.				
	Confidential interview	with a second staff				
	revealed:					
		Resident #12's room "all the				
	time."					
	-Resident #12 was "te	errified" of Resident #6.				
	1.6	1.1.6				
		and shift personal care aide				
	(PCA) on 10/12/17 at					
	-Resident #6 was ver	teal all the food he could				
	see.	icai all the 1000 He could				
		ed in other residents' rooms				
	all the time.	ed in other residents rooms				
	-He stole snacks from	n Resident #12.				
	otolo oridono mon					
	Interview with a secon	nd PCA on 10/12/17 at 7:49				
	p.m. revealed:					
	•	dent needed "one on one				

care." Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 100 of 419

Division of Health Service Regulation

STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41 E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		
D 270	Continued From page	e 100	D 270			
	-Resident #6 would steal food; the resident did not know it was wrongResident #6 went in other residents' rooms looking for foodShe felt that Resident #6 meant no harm toward staff or residents. Confidential interview with a third staff revealed Resident #12 got scared when Resident #6 went into her room. Confidential interview with a family member of a resident revealed Resident #6 would go into other residents' rooms to take their food.					
		ent #12 on 10/13/17 at resident alert and oriented,				
	Based on observations, interviews and record reviews, the facility failed to supervise Resident #6, who was known to wander into residents' rooms. Staff were aware that Resident #6 wandered into residents' rooms looking for food, and were also aware that he wandered into Resident #12's room frequently in search of food. Resident #12 was afraid of Resident #6, and nothing had been done to prevent Resident #6 from continuing to wander into other residents' rooms.					
	Refer to confidential staff interview.					
	Refer to confidential I member of a resident	nterview with a family				
	Refer to Interview with resident on 10/13/17	h a family member of a third at 10:10 a.m.				
	Refer to Interview with	h Resident #6's family				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION OF Fleature Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			1	_	5,	
			B. WING		R-C	
		HAL031003	D. WING		10/17/	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	TH NC 41			
GOLDEN	CARE		E, NC 28466			
			z, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE
iAO		,	IAG	DEFICIENCY)		
			+			
D 270	Continued From page	e 101	D 270			
	member on 10/13/17	at 12:522 n m				
	member on 10/15/17	at 12.522 p.111.				
	Pofor to Interview with	h Resident #6's guardian on				
	10/17/17 at 8:38 a.m.					
	10/17/17 at 8:38 a.m.					
	Defends later decords	L D:				
		h Resident #6 on 10/13/17				
	at 5:33 p.m.					
	5					
		h the PCP for Resident #6				
	on 10/16/17 at 4:08 p	.m.				
		h the Administrator on				
	10/12/17 at 9:55 a.m.					
						
	Confidential staff inter					
	-Resident #6 was sma	art and knew right from				
	wrong.					
		at staff and peek to see if				
	-	ore he went in or came out				
	of a resident's room.					
		him, but it did not work.				
	-Staff had been told to	o watch him 24/7, and staff				
	"tried their best."					
		with a family member of a				
	resident revealed:					
	-She described Resid	lent #6 and said he				
	wandered into other r	esidents' rooms.				
	-She was informed by	another resident's family				
	member that Residen	it #6 went into a female				
	resident's room who v	was not able to get out of				
	bed and had his penis	s out.				
	-	e female resident's name,				
	but her room was loca					
	-She received the info	ormation one month ago, but				
		e incident had occurred.				
	-"I am very concerned					
	_	sident #6 to go into her				
	loved one's room and	-				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMP	COMPLETED	
0.14410	R-C	
HAL031003 B. WING 10/	17/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
4002 SOUTH NC 41		
GOLDEN CARE WALLACE, NC 28466		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE	
DEFICIENCY)		
D 070		
D 270 Continued From page 102 D 270		
Interview with a family member of a third resident		
on 10/13/17 at 10:10 a.m.		
-Resident #6 came in her family member's room,		
and wanted to see what the resident had in her		
refrigerator.		
-The family member reported the incident to the		
Administrator on the day that it occurred (unable		
to recall exact date).		
-The Administrator told the family member that		
she would have staff keep a closer watch on him.		
-The family member was informed by staff and		
other residents that Resident #6 went in other		
residents' rooms all the time looking for food.		
-The family member's biggest concern was that		
Resident #6 was a wanderer.		
Interview with Resident #6's family member on		
10/13/17 at 12:52 p.m. revealed:		
-He had not seen any serious concerns at the		
facility.		
-Staff had told him that Resident #6 wandered.		
-Resident #6 had brain damage that occurred in		
2007.		
-Resident #6 was enticed by food; if food was		
kept out for Resident #6 to see, he would take it.		
-Resident #6 was like a three or four year old		
child at times.		
-He was smart with a great IQ but his mind came		
and went.		
-Resident #6 was put in the facility so he could be		
observed 24 hours a day, 7 days a week.		
-The family member felt that Resident #6 needed		
increased supervision.		
Interview with Resident #6's guardian on 10/17/17		
at 8:38 a.m. revealed:		
-Resident #6 was not competent enough to tell		
the guardian if the resident was being harmed.		
-Staff had not told the guardian about anything		

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sexual related to Resident #6.

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
					10/11/2011
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SO	OUTH NC 41		
		WALLAG	CE, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG		,	IAG	DEFICIENCY)	
D 270	Continued From page	2 103	D 270		
	-The guardian felt the	e staff would have told her			
		naviors regarding Resident			
	#6.				
		ent #6 on 10/13/17 at 5:33			
	p.m. revealed:				
	-He stayed in his roor				
	_	ne dayroom until staff made			
	him go to bed.	t to so in other regidents!			
	rooms.	t to go in other residents'			
		esidents' rooms, it was to talk			
	to them or watch telev				
		VISIOIT.			
	Interview with the PC	P for Resident #6 on			
	10/16/17 at 4:08 p.m.	. revealed:			
	-Resident #6 had rece	ently become her patient			
	around July or Augus				
		documentation for years that			
		d; there was no updated			
	documentation about	•			
	_	ecessarily need to report to			
	be easily redirected.	andering if the resident could			
	_	tation in the resident's			
		er 2016 about inappropriate			
	sexual behavior.	71 ZO TO about mappropriate			
		nentation as to what type of			
		esident was exhibiting.			
		tation that the PCP at that			
	time increased his ps	ychiatric medication.			
		nentation of any recent			
	inappropriate sexual I				
	-Resident #6 did not r	receive mental health			
	treatment.				
		ped to handle all of the			
	resident's medical ne				
	She saw Resident #6	6 at least once a month.			

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Interview with the Administrator on 10/12/17 at

STATE FORM 6899 DBPR11 If continuation sheet 104 of 419

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (N OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COLDEN.	CADE	4002 SOUT	'H NC 41		
GOLDEN	CARE	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 104	D 270		
	9:55 a.m. revealed: -There had been no reany inappropriate sex-She was aware that the resident was only drinksResident #6 did not bodyIf things happened, if The facility failed to so was known to wander resulting in the reside	eports from any staff about ual acts by Resident #6. Resident #6 wandered, but looking for snacks and nave a harmful bone in his t needed to be documented. upervise a resident, who into other residents' rooms, nt sexually assaulting two			
	female residents, one of which was disoriented and unable to verbalize her needs. This failure resulted in serious physical harm and serious neglect of the residents, and constitutes a Type A1 Violation. Review of the facility's Plan of Protection dated 10/13/17 revealed: -Staff will monitor residents at least every two hours to ensure they are dry and not showing any adverse signs and symptoms which need to be addressed or reported. -The Administrator will ensure no use of heating pad unless specifically ordered by the physician, and if ordered, staff will supervise according to resident's needs. -Will monitor residents who wander every thirty minutes, including Resident #6. -In-service staff regarding monitoring and redirecting wandering residents. -Every two hour checks and interaction with residents to ensure no problems exist and they remain dry. -Documentation of every 30 minute checks for wandering residents. -The Administrator will check log on evening visits and observe staff who are monitoring residents.				

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, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. BOILBING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
		WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE COMPLETE
D 270	Continued From page	e 105	D 270		
	-Monitor Resident #4, patient safety.	#12, #14, and #15 for			
	CORRECTION DATE VIOLATION SHALL N 16, 2017.	FOR THE TYPE A1 IOT EXCEED NOVEMBER			
D 273	10A NCAC 13F .0902	2(b) Health Care	D 273		
	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. Based on these findings, the previous Type A1 Violation was not abated.				
	Based on observations, record reviews, and interviews, the facility failed to assure the acute and routine health care needs were met for 6 of 8 residents sampled (#1, #2, #3, #6, #10, #11) as related to failing to notify the primary care physician (PCP) of elevated blood sugars over 400 as ordered for a diabetic resident (#3) on 14 of 15 occasions; of unexplained injuries of skin tears and bruising for two residents (#1, #2); of inappropriate sexual behaviors from a resident (#6); of a resident's (#3) complaints of a prosthetic leg being uncomfortable and refusing to wear it; of a resident complaints of not feeling well, burning upon urination, decreased appetite and increased confusion prior to a hospitalization for diagnosis of sepsis (#11); of a resident (#10)				

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Division of	<u>of Health Service Regu</u>	ilation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETE	ED	
				R-C		
		HAL031003	B. WING		10/17/	2017
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
				DEFICIENCY)		
D 273	Continued From page	- 100	D 273			
D 213	Continued From page	2 106	02/3			
	with a change in statu	us and complained of				
		weating, altered mental				
		be sent to the hospital for				
		aluation, who was later				
		s bed; failing to assure				
		Ith services was completed				
		eral wound (#2); and failing (#1) was sent to the hospital				
	,	oulder abscess and a head				
	injury of unknown orig					
	injury or armatown one	9				
	The findings are:					
		t #11's current FL-2 dated				
	10/05/16 revealed:					
		congestive heart failure				
		m, anxiety disorder, and				
	hypertension.	of orientation was not				
	documented.	or orientation was not				
		n-ambulatory, incontinent of				
	bladder and bowel, a	•				
	,					
		ency Department (ED)				
	•	ed from the local hospital)				
	for Resident #11 date					
		aluated and discharged on				
	-	s of urinary tract infection				
	(UTI).	e to the ED by emergency				
		IS) and was therefore				
		by a family member.				
		ted to the ED after being				
	•	and loss of appetite for one				
	day.	• •				
	-	en treated "recently" for a				
	UTI and delirium.	•				
	-She denied any urina	ary symptoms of UTI.				
			1		[

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Interview with a medication aide (MA) on

STATE FORM 6899 DBPR11 If continuation sheet 107 of 419

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						0
		1141 004000	B. WING		R-0	
		HAL031003			10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
	OLIMANA DV OT		·	TOO WEEDIN DIAM OF CORRECTION		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
5,070	- " IF		15.070			
D 273	Continued From page	e 107	D 273			
	08/18/17 at 2:00pm re	evealed:				
		ot feeling well on Tuesday				ļ
	night (08/15/17).	, , , , , , , , , , , , , , , , , , , ,				
		gitated the night before				
	according to the note					
	_	and how she was talking was				
	not right.					
		wanted Resident #11 sent				
	,	cause the family member				
	felt she had a urinary	,				
	•	e and the resident was				
	having the same sym	iptoms.				
	-The MA called 911.					
	-The Manager told he	er that she was not supposed				
	_	anagement services (EMS)				
	without going through	-				
		er to call EMS back and				
	cancel the call.					
	-The Manager would	get a urine sample on				
		next morning if she could				
	remember.	-				
	-The Manager stated	she did not know who would				
		rom the hospital if she was				
	sent out.					
	-Resident #11's family	y member called to see				
	which hospital Reside					
	-The MA informed the	-				
		t going to the hospital.				
	-	/ member called EMS about				
		at was how the resident got				
	sent to the hospital.					
		ne Manager a lot of the times				
		would not get an answer, so				
	she would not know v	what to do.				
		jer on 08/18/17 at 8:20am				
	revealed:					
		t the complaint was, if a				
	resident was sent to t	•				
	-The emergency roon	m was abused by a lot of				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
HAL031003			B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
OOLDEN		WALLACI	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 273	(ER) staff that staff no residents before send- If a resident always of thing, she would not so would consult with the (PCP). A second interview what 10:15am revealed: She knew how Resident and a UTI. She had it worked or urine sample to the Porthe first shift MA had specimen. The Manager had no with the family member to the family member to the family member to the family member to the family member sesident #11. Resident #11. Resident #11 had betime. The family member is Resident #11 should.	by the emergency room eeded to learn to assess ding them to the ER. complained on the same send that resident out, but e primary care provider	D 273	DEFICIENCY)	
	-The family member s				

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1				
				R-C		
		HAL031003	B. WING		10/17/2017	
			<u> </u>			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
		WALLACE	, NC 20400			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
D 070	0 " 15	100	D 070			
D 273	Continued From page	9 109	D 273			
	Booldont #11 (rossiya	od from the legal begnital)				
	•	ed from the local hospital)				
	dated 09/26/16 revea					
		ought to the hospital ED by				
	EMS after the facility	reported she was				
	unresponsive.	•				
	-Resident #11 presen	ited to the FD with				
	•	awake, alert, and oriented.				
	-"This patient has a h	• .				
		oration in conditions, at the				
	initial presentation or	during the ED course				
	related to: urinary trac	ct infection				
		epsis due to urinary tract				
		s an infection of the blood				
		ood pressure, altered mental				
	and respiratory status	s, kidney damage, and in				
	some instances, deat	h).				
	Review of a hospital F	Progress Note for Resident				
	#11 dated 09/26/17 re					
		ed 09/26/17 for "severe				
		sion on admission-identified				
	source thus far as uri	nary tract infection"				
	-Resident #11 also ha	ad "acute renal failure				
	superimposed on stag					
	disease."	ge o emonie Maney				
	uisease.					
	Review of a hospital [Discharge Summary for				
	Resident #11 dated 0	9/29/17 revealed:				
	-The resident was add	mitted on 09/26/17 into the				
	intensive care unit (IC					
		ation, Resident #11 was				
	treated with intraveno					
	antibiotics for diagnos	•				
	-Resident #11 was dis	scharged on 09/29/17.				
		-				
	Confidential staff inter	rview revealed:				
		sually oriented and often				
	complained that she					
	-Resident #11 went of	ut to the hospital sometime	1			

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near the end of September 2017, had not

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		D WING		R-C	
HAL031003			B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AI	DDRESS, CITY, STA	TE ZID CODE	
NAIVIE OF FI	NOVIDER OR SUFFLIER			II E, ZIF CODE	
GOLDEN	CARE	4002 SOI	JTH NC 41		
00222.1	o,	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	110	D 273		
D 213	Continued From page	: 110	5273		
	returned to the facility	<i>'</i> .			
	-Prior to being sent or				
	•	sident #11 was "congested"			
	•	on and off for about one			
		of feel good" and it "burned			
		_			
	when she went to the				
		see her doctor for her			
	complaints.				
	-"They ignored her."				
	-"They should have g	ot her checked out. They			
	finally sent her out" (to	o the hospital), but she did			
	not return to the facilit	ty and died in rehab a short			
	time later (date of dea	ath unknown).			
	· ·	•			
	Confidential interview	with a second staff			
	revealed:	mar a cocom cian			
		otal care" and required staff			
	assistance with all ac				
	-The staff was on duty				
	Resident #11 was ser	nt to the nospital on			
	09/26/17.				
		at Resident #1 was "a little			
		nd complained she did not			
	feel good.				
	-Resident #11 did not	have any specific			
	complaints, just that s	she did not feel good.			
	-The staff recalled Re	sident #11 had a poor			
	appetite for two week	s before that.			
		esident #11's complaints to			
	the Medication Aide (
		w if Resident #11's PCP was			
	notified of her compla				
	responsible for notifyi				
		all changes in Resident			
	-	uch as odor or increase in			
		resident being sent to the			
	hospital in September	r 2017.			
	Confidential interview	with a third staff revealed:			

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-Resident #11 would say she did not feel good "a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R-C	
HAL031003		B. WING		10/17/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOUT	'H NC 41			
GOLDEN	CARE	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	#11 in late Septembe did not feel good and -The staff reported Rethe MA; the MA said s-Resident #11 went to that; she was told by had a urinary tract inf Confidential interview -Prior to the resident last time (in Septemb "help, me, where am in her buttocks, and voconstantly. Review of the staff corevealed: -On 09/21/17 on secondocumentation Resid on stomach and hurti -On 09/21/17 on third documentation Resid "pain and discomfort -There were no notes -There was an undate shifts that Resident # -On 09/27/17 on third documentation Resid hospital." -There was no docum 09/27/17 in the staff or related to Resident #	e last time she saw Resident r 2017, she complained she her "legs hurt real bad." esident #11's complaints to she had medication for that. In the hospital sometime after another staff Resident #11 ection and "sepsis." If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the er 2017), she would said I," complained of her of pain would holler for staff If with a fourth staff revealed: going out to the hospital the erton out to the hospital th	D 273			
		o, Resident #11 had a UTI,				

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
		HAL031003	B. WING		R- 10/1	C 7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•	
COLDEN	CARE	4002 SOU	TH NC 41			
GOLDEN	JARE	WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 112	D 273			
D 2/3	her son called 911 an she came back the sa-Resident #11 would '-"That was her norma-She was off work two went back to the hosp septicResident #11 went to hospitalization and su-In the past when Reswould get confusedIn September 2017, like she did when she was not confused)Resident #11 complate few days' before her shospitalization, but it in just did not feel wellWhen staff observed staff were supposed to provider (PCP)The staff who observed staff were supposed to she did not think any PCP that she was not Interview with a second 9:00am revealed: -Resident #11 had no a week or so." -She sent Resident # shift on 09/26/17 becare of breath; the shortned day (09/26/17)Resident #11 had no and staff had to feed the same shift on declaration of the shortned day (19/26/17)Resident #11 had no and staff had to feed the same shift had to feed the same shift on declaration of the same shift on on and staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on on a staff had to feed the same shift on the same shift on on a same shift on the same shift	Indicate the second of the second of the primary care of the change was the one of call the primary care of the change was the one of call the PCP. The change was the one of call the PCP. The change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the change was the one of call the primary care of the primary c	D 2/3			
	and staff had to feed l -There had not been a Resident #11 prior to	any other changes in				

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Division of Health Service Regulation					_
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		P WING		R-C	
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	NOVIDEN ON OUT FIEN		, ,	12, 211 0002	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
				DETIGIENCY)	
D 273	Continued From page	e 113	D 273		
		/s said 'I don't feel good'."			
	-Her family was aware	e she did not feel well			
	because she told ther	m.			
	-Resident #11's PCP	was not notified at all during			
	the week she did not	feel good before she went to			
	the hospital on 09/26/	/17.			
	-The only physician n	otification was when she			
	was sent to the hospi	tal.			
	-Changes in resident's				
	•	documented anywhere			
	except the staff communication shift report				
	notebook.				
	A second interview or	n 10/16/17 at 1:00pm with			
		esident #11 to the hospital			
	revealed:	coldent # 11 to the hoopital			
		any change in Resident			
		day she was sent to the			
	hospital (09/26/17).	day sile was sell to the			
		ent #11 was in the dining			
		•			
	room when she starte				
	respirations were not				
		#11's family member then			
	she called 911.				
		rehab (skilled nursing			
	* *	oital stay in September 2017.			
		nt #11 got pneumonia and			
		ile at rehab and passed			
	away.				
		ange in residents' status			
		oing on but the PCP was			
	"usually" called by the				
		not always documented in			
	the resident's record I	but it was supposed to be			
	documented in the sh	ift communication notebook.			
	-Nobody called Resid	ent #11's PCP before her			
	_	pitalization because "she did			
	not have any complai				
	, ,				

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Review of Resident #11's record revealed:

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MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX REGULATORY OR LSC DENTIFYING INFORMATION) D 273 Continued From page 114 -There was no documentation of any recent ED visits for UT1, change in status, or her complaints of not feeling well. -There was no documentation of Resident #11's PCP being notified of her complaintsThere were no staff communication notesThere were no staff communication of Resident #11's PCP being notified of her complaintsThere were no documentation the resident was sent to the hospital 2017, Resident #11 went to the hospital 2017, Resident #11 went to the hospital for UT1 and was treated with antibioticsIn September 2017, Resident #11 went to the hospital for UT1 and was treated with antibioticsIn September 2017, Resident #11 was bent back to the hospital anglain because she was disoriented and did not want to eat or drink anythingWhen she got to the hospital on 09/26/17, she was septicThe family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anythingShe was saying over and over again "I'm	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 4002 SOUTH NC 41 WALLACE, NC 28466 MALLACE, NC 28466				A. BOILDING			
CALIDER CARE CALIDER CONTROL CALIDER CONTR	HAL031003			B. WING			
MALLACE, NC 28466 (X41)D PROVIDERS PLAN OF CORRECTION PROFIDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 114 There was no documentation of any recent ED visits for UTI, change in status, or her complaints of not feeling well. There were no staff communication notes. There were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalization. There was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: In August 2017, Resident #11 went to the hospital oral of not to eat or drink anything. -When she got to the hospital on 09/26/17, she was septic. The family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disorierted and smalled like urine, she was "not herself," and did not want eat anything. -She was saying over and over again "I'm	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WALLACE, NC 28466 (CA) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 114 -There was no documentation of any recent ED visits for UTI, change in status, or her complaints of not feeling well. -There was no documentation of Resident #11's PCP being notified of her complaints. -There was no documentation of Resident #11's PCP being notified of her complaints. -There were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalization. -There was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: -In August 2017, Resident #11 want to the hospital for a UTI and was treated with antibiotics. -In September 2017, Resident #11 was sent back to the hospital again because she was disoriented and did not want to eat or drink anything. -When she got to the hospital on 09/26/17, she was septic. -The family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anything. -She was saying over and over again "I'm	COLDEN	CADE	4002 SOU	TH NC 41			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 114 -There was no documentation of any recent ED visits for UTI, change in status, or her complaints of not feeling well. -There were no staff communication notesThere was no documentation of Resident #11's PCP being notified of her complaintsThere were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalizationThere was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: -In August 2017, Resident #11 was sent back to the hospital for a UTI and was treated with antibioticsIn September 2017, Resident #11 was sent back to the hospital pagain because she was disoriented and did not want to eat or drink anythingWhen she got to the hospital on 09/26/17, she was septicThe family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anythingShe was saying over and over again "I'm	GOLDEN	CARE	WALLACE	, NC 28466			
-There was no documentation of any recent ED visits for UTI, change in status, or her complaints of not feeling well. -There were no staff communication notesThere were no staff communication notesThere was no documentation of Resident #11's PCP being notified of her complaintsThere were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalizationThere was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: -In August 2017, Resident #11 went to the hospital for a UTI and was treated with antibioticsIn September 2017, Resident #11 was sent back to the hospital again because she was disoriented and did not want to eat or drink anythingWhen she got to the hospital on 09/26/17, she was septicThe family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anythingShe was saying over and over again "I'm	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE COMPLETE	
visits for UTI, change in status, or her complaints of not feeling well. -There were no staff communication notes. -There was no documentation of Resident #11's PCP being notified of her complaints. -There were no faxes or physician orders related to Resident #11's complaints in September 2017 prior to her 09/26/17 hospitalization. -There was no documentation the resident was sent to the hospital ED by EMS on 09/26/17 for unresponsiveness. Telephone interview with Resident #11's family member on 10/17/17 at revealed: -In August 2017, Resident #11 went to the hospital for a UTI and was treated with antibioticsIn September 2017, Resident #11 was sent back to the hospital again because she was disoriented and did not want to eat or drink anything. -When she got to the hospital on 09/26/17, she was septic. -The family had last visited Resident #11 on 09/24/17 between 2:00pm and 4:00pm and noticed she was disoriented and smelled like urine, she was "not herself," and did not want eat anything. -She was saying over and over again "I'm	D 273	Continued From page	e 114	D 273			
hurting." -The family talked to a (named) MA on 09/24/17 and was told she been like that all day and had not wanted to eat or drink for a few daysIn the past when the resident had a UTI, she would get confused; the family told the (named) staff this information on 09/24/16On 09/26/17, a (named) staff member contacted him to report her respirations were not good and her blood pressure was low; he told staff to send	D 2/3	-There was no docum visits for UTI, change of not feeling wellThere were no staff on the was no docum PCP being notified of the were no faxes to Resident #11's comprior to her 09/26/17 on the hospital European to the hospital European to the hospital European to the hospital European to 10/17/17 on August 2017, Responsiveness. Telephone interview was member on 10/17/17 on August 2017, Responsital for a UTI and on the hospital again to the hospital again to the hospital again to the was septicThe family had last wo 09/24/17 between 2:00 noticed she was disorurine, she was "not heanythingShe was saying over hurting." -The family talked to and was told she been to wanted to eat or colon the past when the would get confused; the staff this information colon 09/26/17, a (name him to report her response).	in status, or her complaints communication notes. her complaints. her complaints. her complaints. her complaints. her complaints. hor physician orders related hiplaints in September 2017 hospitalization. hentation the resident was D by EMS on 09/26/17 for with Resident #11's family at revealed: ident #11 went to the d was treated with antibiotics. Resident #11 was sent back because she was of want to eat or drink hospital on 09/26/17, she histed Resident #11 on 00pm and 4:00pm and riented and smelled like erself," and did not want eat and over again "I'm a (named) MA on 09/24/17 an like that all day and had drink for a few days. resident had a UTI, she the family told the (named) on 09/24/16. hed) staff member contacted birations were not good and	D 2/3			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C		
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
			E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 115	D 273			
	-When the family got told Resident #11 was -He did not think Resishe was confused or 09/24/17The PCP should hav Attempted telephone #11's PCP on 10/16/1 at 10:58am was unsuffication for a was to monitor the respectation for a was to monitor the respected procedureThe Medication Aide physicianShe was "unsure" if expected procedureThe facility currently place for changes in sphysician was notified she would implement possible and assure a she did not have spenotification of Resider Refer to interview with Aide/Supervisor on 10 Refer to interview with 10/16/17 at 9:45 a.m.	to the hospital, they were is septic. Ident #11's PCP was notified had any complaints on the been notified. Interview with Resident 7 at 10:15am and 10/17/17 ccessful. Ininistrator on 10/16/17 at a change in resident's status sident frequently, notify the had document the changes as should be notifying the staff were following the did not have a system in status to assure the did not have assure the did staff were trained. Secific information regarding the material staff were trained to the mat				
	dementia, uncontrolle	d Type II diabetes,				

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Division o	<u>if Health Service Regu</u>	lation				
AND DIAM OF CODDECTION		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				R-C		
		HAL031003	B. WING		10/17/2017	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
GOLDEN (CARE	4002 SO	JTH NC 41			
OOLDEN		WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	Έ
D 273	Continued From page	e 116	D 273			
	and on the right side of ear and extended down hairline. -He had a yellowish/lifthe right front and right about 2.5 by 2.5 inchedented in the right front and right about 2.5 by 2.5 inchedented in the had a skin tear of elbow that was oval supproximately 1 by 1. -He had two dime size arm; one above the effect the underside of the fect the underside of the fect the had a linear scab of his right forearm the 2.5 inches long and well-helbox and the had a reddish collinear and	sitting in a recliner. ned and his clothing ed scaly rash on his nose of his face /head above his wn below his ear and into his ght green colored bruise on nt side of his head that was es in size. n his right arm near the haped and measured 5 inches in size. ed circular scabs on his right lbow and the second one on				
	10/11/17 at 11:05am in She was not sure, but fell on 2nd shift about "just skin tears" on his	ut she thought Resident #1 two weeks ago and got				
	4:10pm revealed: -She did not know how "bruises" on his arm.	nd PCA on 10/11/17 at w Resident #1 got the s has some kind of bruise."				

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Interview with a third PCA on 10/12/17 at 1:45pm revealed Resident #1's arms "always" had

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Division of Health Service Regulation

Division C	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		_			
				R-C	
		HAL031003	B. WING		10/17/2017
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NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	I E, ZIP CODE	
GOLDEN	^ADE	4002 SO	UTH NC 41		
GOLDLIN	DAIL	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	\ · -/
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 273	Continued From page	e 117	D 273		
	coratabas and bruisse	a: the regident "rung into			
		s; the resident "runs into			
	stuff."				
	Interview with a fourth	n PCA on 10/12/17 at			
	6:45pm revealed:				
	-Four or five days ago	o, Resident #1 fell in the			
	dining room and "gas	hed open" his right elbow			
	and it bled.				
		w he got the other arm			
	injuries.	w no got the other ann			
	injunes.				
	Intonious with a modi	action aido/aunom/icar			
		cation aide/supervisor			
	(MA/S) on 10/11/17 a				
		ver oriented, was a "brittle			
		'very heavy care resident."			
	-Resident #1 got bruis	sed "often."			
	-Resident #1 had a hi	story of falls but had not			
	fallen within the last tl	hree months.			
		w Resident #1 got the			
		m or how long they had			
		es were probably from him			
	hitting his arm agains				
		he PCP was aware of the			
	arm injuries.				
		as checked on his shower			
	days, which was Mon	day, Wednesday, and			
	Friday.				
	A second interview wi	ith the MA/S on 10/13/17 at			
	9:00am revealed:				
		xplained injuries was to			
		ometimes send pictures by			
	phone.	samos sona piotaros by			
	•	n hospica or home health			
		n hospice or home health			
	` '	juries were reported to the			
	nurse.				
		urse was supposed to call			
	the PCP and also let	the Manager know; the			
	Manager would make	a decision on what to do			

next.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				R-C	
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
0/0/15	STIMMADA ST	ATEMENT OF DEFICIENCIES	E, NC 28466	PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 118	D 273		
		rocess was to clean them otic cream on it, and put a			
	Review of Resident #1's record to include Nursing/Progress notes and physician orders revealed:				
	-There was no staff documentation related to the arm injuriesThere was no documentation made by staff that				
	his current arm injuries were reported to the PCP, family, or HH.				
	-There were no physician orders, notifications, or faxes related to the arm injuries.				
	Review of the staff communication notebook revealed there was no documentation related to Resident #1's arm injuries.				
	Review of the Interdisciplinary HH notes for Resident #1 revealed:				
	-On 10/03/17: A HH visit was made for wound care. All wounds were healed except for a right heel wound. "Staff aware to contact [HH agency name] for questions or concerns."				
	-On 10/11/17: A HH visit was made for wound care. All wounds were noted to be healed. Resident #1 had "scabbed abrasions" to his right forearm, Contact was made with the PCP office				
	were aware to contact with questions on cor	of the new findings. Staff It the home health agency Incerns. It is a Registered Nurse			
	(RN).				
	#1 dated 10/11/17 rev				
	 -Resident #1 was eva assessment and treat were noted as healed 	tment; all previous wounds			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R-C		
HAL031003			B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
			E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 119	D 273			
	forearm and elbow. -The HH RN notified in photos to the PCP upThe note was electron. Telephone interview wat 9:30am revealed: -She last saw Reside his arm injuriesThe injuries on Residunexplained and she themThe facility was supplied new open areas in Resconcerns.	Resident #1's PCP and sent on request. Onically signed by an RN. with the HH RN on 10/17/17 and noted dent #1's right arm were did not know how he got cosed to notify her of any esident #1's skin or any notified her of Resident #1's				
		ns, records review, and #1 was not interviewable.				
	Telephone interview with a Nurse Practitioner (NP) at Resident #1's PCP office on 10/16/17 at 3:31pm revealed: -The NP was aware of the injuries to his arm; it looked like he fell. -The office wanted to be notified anytime the resident was injured. -Nobody could tell her how Resident #1 got the arm injuries.					
	10:30am revealed: -The facility did not ha injuries of unknown o of any specific proces followed for injuries o					

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the MA/S to send the resident to the hospital

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 120	D 273		
	and/or notify the PCP				
		nterview revealed if a d or was injured, they were to the hospital emergency			
	10/11/17 at 11:05am	onal care aide (PCA) on revealed she did not know the bruise on his head; she			
	4:10pm revealed she when she returned to Monday (10/09/17), s Resident #1's head; s happened or how he Interview with a third revealed: -She first noticed the head on Sunday (10/how he got the bruise-She had not reported	PCA on 10/12/17 at 1:45pm bruise on Resident #1's 08/17); she did not know			
	on his head; she thou -She did not really kn resident had an unex was never trained, bu unexplained injuries t aide/supervisor (MA/S -She did not really kn	w Resident #1 got the bruise aght he fell. ow what to do when a plained injury because she at the would report of a medication			

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Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
INAME OF T	TO VIDER OR GOLT LIER		, ,	(I, Zii GGBE		
GOLDEN	CARE		ITH NC 41			
		WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		E
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DEI IOIENOT)		
D 273	Continued From page	e 121	D 273			
	never trained.					
	-She would report it to	o a MA/S.				
	-The MA/S called 911	when needed, but she did				
	not know the actual p					
	Interview with a MA/S	S on 10/11/17 at 11:12am				
	revealed:	5 611 167 117 17 dt 111 12dill				
	-She had first noticed	the vellow bruise on				
		n Monday (10/09/17); the				
		* *				
		there the last time she				
	worked on Friday (10	· · · · · · · · · · · · · · · · · · ·				
		w Resident #1 got the bruise				
	on his head.					
	-Resident #1's primar	ry care provider (PCP) had				
	not been into the facil	lity since the bruise was				
	noticed and had not b	peen notified about the				
	bruise on his head.					
	Interview with a secon	nd MA/S on 10/12/17 at				
	3:30pm revealed:					
	•	e bruise on Resident #1's				
	head.	o braide on reducine n re				
		ry, he should have been				
	sent to the hospital.	y, no snould have been				
	•	was sent to the hospital for				
	the head bruise; the l					
		the hospital was for low				
	blood sugar.					
		ith a MA/S on 10/13/17 at				
	9:00am revealed:					
		posed to be sent to the				
	hospital if they had a	head injury or suspected				
	head injury.					
		sent to the hospital for the				
		ecause the bruise looked old.				
		nt #1's HH RN called the				
	doctor about the bruis					
	מטטנטו מטטענ נווכ טועוג	on his head.				

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Interview with a third MA/S on 10/13/17 at 5:30pm

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		5.0
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•
		4002 SOUT	'H NC 41		
GOLDEN	CARE	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 122	D 273		
	revealed: -The process for a head injury was to send the resident to the hospitalThe resident may have a "concussion." -She did not know anything about the bruise on Resident #1's head. Review of Resident #1's record to include Nursing/Progress notes and physician orders revealed: -There was no staff documentation by facility staff related to the bruise on his head -There was no documentation made by staff related to the bruise being reported to the PCP, family, or home health (HH)There were no physician orders, notifications, or faxes related to the bruise.				
		mmunication notebook of documentation related to nt #1's head.			
	Review of an electronic HH visit note for Resident #1 dated 10/11/17 revealed: -Resident #1 was evaluated for wound assessment and treatment; all previous wounds were noted as healedResident #1 had a "bruise that is healing to right side of head." -Staff told the HH RN Resident #1 "fell the other night, but no ER (emergency room) visit was made when he hit his head." -The HH Registered Nurse (RN) notified Resident #1's PCP and sent pictures to the PCP by email, at the PCP's requestThe note was electronically signed by a RN. Telephone interview with the HH RN on 10/17/17 at 9:30am revealed:				
		nt #11 on 10/11/17 and			

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STATE FORM 6899 DBPR11 If continuation sheet 123 of 419

Division of Health Service Regulation

Division	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	•
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		HAL031003	B. WING	B. WING		7
		TIAE031003			10/17/201	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
	CUMMADV CT		<u> </u>	DDOVIDEDIC DI ANI CE CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) MPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 070	0 " 15	100	D 070			
D 273	Continued From page	e 123	D 273			
	observed the bruise of	on his head.				
		nt #1 fell at the nurses'				
		sure of the date of his fall.				
	· · · · · · · · · · · · · · · · · · ·	notified her of Resident #1's				
	head injury/bruise.	otified fier of resident #13				
	ricad irijai y/braisc.					
	Based on observation	ns, records reviews, and				
		#1 was not interviewable.				
	interviews, Resident +	T was not interviewable.				
	Tolophono intonviou v	vith Resident #1's family				
	member on 10/13/17	•				
	l	family updated with Resident				
	#1's status.					
		acted the family the previous				
		o the hospital for low blood				
	sugar.					
		711 - N - D - 675				
		vith a Nurse Practitioner				
		PCP office on 10/16/17 at				
	3:31pm revealed:					
		be notified anytime the				
	resident was injured.					
		r how Resident #1 got the				
	bruise on his head.					
	, ,	ected to notify the PCP office				
	of the bruise when it v					
		PCP office about the bruise				
	on Resident #1's head					
	-	otified the office of the				
	bruise on his head.					
		ent #1 should have been				
		bruise on his head, the NP				
	said she expected the	e facility to follow their policy				
	for emergencies or he	ead injuries for the bruise.				
	Interview with the Adr	ministrator on 10/13/17 at				
	10:30am revealed:					
	-The procedure for a	head injury or suspected				
		nd the resident to the ER.				
	-All staff should know					

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-	C
		HAL031003	B. WING	B. WING		7/2017
		HALUS 1003			10/1	112011
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
OOL DEN	0485	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	CE, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IGIENCI)		
D 273	Continued From page	e 124	D 273			
	. •					
		ave a written policy for				
	-	rigin and she was not aware				
	of any specific proces	•				
	followed for injuries of					
		inexplained injuries was for				
		resident to the hospital				
	and/or notify the PCP					
		on Resident #1's head a few				
	days ago.	ected Resident #1 to have				
	•	ER for the bruise on his				
	head.	ER for the bruise of this				
	-Resident #1 was not	sent to the FR				
	-i Coldent #1 Was not	Sent to the Liv.				
	C. Interview with a pe	ersonal care aide (PCA) on				
	10/16/17 at 3:00pm re					
	•	Resident #1 had a "sore" on				
	the back of his left sh					
	-The sore was little, b	ut then it got big (maybe the				
	size of a quarter).					
	-The sore kept drainir	ng "blood" and what looked				
	like "pus."					
	-She kept a pad unde	rneath the resident when he				
	was in bed because it					
		sident #1 to grimace and				
	say "ouch."					
		nedication aide/Supervisor				
	,	e "several times" (unsure				
	over what period of til	•				
	somebody would com					
		re was there a week or two.				
		nis PCP was aware of the				
	sore.					
		Resident #1 was sent to the				
	hospital for the sore.					
	Deview of1	sia hamaa haalkh (LUD) siisiit				
		nic home health (HH) visit				
	note for Resident #1 (dated 08/07/17 revealed:	- 1			

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-A scheduled HH visit was completed for wound

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUI COMPLET	
			A. BOILDING.	74 551EBINO.		
		HAL031003	B. WING		R-C 10/17	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT	'H NC 41			
GOLDLIA	CAIL	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 125	D 273			
	-Resident #1 was not wounds to the left mid shoulder"Abscess noted to le instructed to have part (emergency departmeter -The PCP was made -Staff were "encourage with any questions or -The note was electron Registered Nurse (RN Review of a second et Resident #1 dated 08 -A scheduled HH visities -Resident #1 "continus shoulder. Staff did not (incision and drainage -A telephone call was (named) who stated so area and would contain Review of a third elect Resident #1 dated 08 reported Resident #1 the abscess on his left Resident #1 dated 08 -Resident #1 dated 08 -Resident #1 was evaluble abscessThe diagnosis was did (A carbuncle is a seve skin, usually caused it	ed with two new skin d back and the left upper fit upper shoulder staff tient taken to the ED ent) to have area treated." aware of the findings. ged" to call the HH agency concerns. onically signed by a N). electronic HH visit note for //11/17 revealed: was made for wound care. es to have abscess on left take patient to ER for I & D e) as recommended" made to the Manager she needed to look at the fort Resident #1's PCP. etronic HH visit note for //14/17 revealed staff was currently at the ER for ft shoulder. After Visit Summary for //14/17 revealed: aluated and treated for an occumented as "carbuncle." ere boil/abscess under the by a bacterial infection). charged with a prescription				
	Telephone interview vat 9:30am revealed:	vith the HH RN on 10/17/17				

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Division of	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
					R-C		
		HAL031003	B. WING		10/17/2017		
					10/11/2011		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN	CARE	4002 SOI	JTH NC 41				
		WALLAC	E, NC 28466				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /		
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR			
IAG	1,2002 11 01 11 01 11		IAG	DEFICIENCY)			
D 0=0			D 070				
D 273	Continued From page	e 126	D 273				
	-She and another hor	ne health staff member					
	were at the facility to						
	08/07/17 for wound ca						
	-Resident #1 had and	l abscess on his left					
	shoulder that was dra	ining yellowish purulent					
	drainage.						
	-She told the (named)) MA/S to send Resident #1					
	to the ER and the MA						
		of the abscess and the					
		end Resident #1 to the ER					
	per her recommendat						
		scheduled visit on 08/11/17					
		not been to the ER about					
	the abscess.	and the district of the second					
	-On 08/11/17, the abs						
	ER.	dent still needed to go to the					
	 She contacted the M abscess. 	anger on 08/11/17 about the					
	-The Manager said sh	ne would need to look at the					
	abscess before sendi	ng the resident to the ER					
	and she would call Re						
		er next scheduled visit on					
		1 was at the hospital for the					
	abscess.						
	-	ocol for the HH agency to					
	notify the PCP of cha						
	evaluation when need	a resident to the ER for					
	-The carbuncle was n						
	- i ile carbullcie was il	iow ricalcu.					
	Based on observation	ns, records reviews, and					
		#1 was not interviewable.					
	Telephone interviews	with a Nurse Practitioner					
	•						
	3:31pm revealed:	PCP office on 10/16/17 at					
	•	ency notified the office about					
		ident #1's shoulder on					

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08/07/17 and recommended it be lanced and

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
					R-	C
		HAL031003	B. WING		1	7/2017
					10/1	772011
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOL	JTH NC 41			
COLDEN		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEOCEMONI S.C.	200 IDENTIFICATION OF CHARACTERS	TAG	DEFICIENCY)	NAIL	
2.070			+			
D 273	Continued From page	e 127	D 273			
	drained.					ı
	-The NP did not have	documentation of a delay in				ı
	treatment for the carb					ı !
	08/07/17-08/14/17.					ı .
	-If the carbuncle was	causing the resident				ı ,
		vorse, the PCP office would				ı ,
	want to be notified.					ı .
	-The PCP office had r	-				ı !
		facility about the carbuncle				ı .
	other than by the HH	RN.				
		10/10/17 10:00				
		S on 10/13/17 at 9:00am				ı .
	revealed:					ı !
	Resident #1's carbun	nurse notified his PCP about				ı
						ı
	carbuncle.	otify the PCP about the				
	-Resident #1 went to					ı
	carbuncle; that was a	all she really knew about it.				
	Refer to interview with	h a MA/S on 10/12/17 at				
	3:30 p.m.	11 4 11 10 011 10 12 17 40				ı
						ı
	Refer to interview with	h the Administrator on				ı
	10/16/17 at 9:45 a.m.					ı
						ı
		t #10's current FL-2 dated				ı
	9/1/17 revealed:	· · · · · · · · · · · · · · · · · · ·				ı
		anemia, history of Non-ST				ı
		infarction, bipolar affective				ı
	disorder, traumatic Br hypertension, and sei					ı
	-The resident was am					ı
		ntinent of bladder and				ı
	bowel.	Titille II of bladder and				ı
	DOWCI.					ı
	Review of an Acciden	nt/Incident Report dated				ı
	8/29/17 revealed:					ı
	-Resident #10 fell at a	around 8:20 p.m.				ı
		dication aide (MA) was				ı

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUITIPI F	CONSTRUCTION	(X3) DATE SU	JRVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 1	A. BUILDING:		TED
			7 20.25 10			_
		UAL 024002	B. WING	B WING		2/0047
		HAL031003			1 10/17	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOL	JTH NC 41			
COLDLIN	OAIL	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 128	D 273			
	passing out medication Resident #10 was lying of his head bleedingPressure was applied #10's head to stop the resident's family where we have a substituted in the resident for the resident #10 was according to a fall from the resident #10 was discretured back to the form the resident #10's follow to follow up with primary week to check basic in that measures kidney fluid balance and gluc with orthostatic, and he	ons, turned around and and ong on the floor with the back of to the back of Resident e bleeding. The ment Services (EMS) and overe contacted. 10's hospital records In ground level. Scharged on 9/1/17, and				
	revealed: -Resident #10 had be of a fallResident #10 returne evening of 9/1/17, after few daysThe first shift person on 9/2/17 at around 6 to Resident #10She started work around yet had a chance roomThe PCA stopped at thought something was	een in the hospital because ed from the hospital on the er being in the hospital for a all care aide (PCA) came in :55 a.m. and went to speak bund 6:40 a.m. but she had to go to Resident #10's				

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HAL031003 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	C 7/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. ZIP CODE	
COUDEN CARE 4002 SOUTH NC 41	
GOLDEN CARE WALLACE, NC 28466	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273 Continued From page 129 D 273	
She knew the resident was dead as soon as she saw the resident. -The cook/PCA contacted EMSShe and the third shift PCA performed Cardio-Pulmonary Resuscitation (CPR) until EMS arrivedShe was unsure how long the resident had been dead. Interview with second shift PCA on 9/27/17 at 12:10 p.m. revealed: -She had been working at the facility for two monthsResident #10 had sat outside the night before he died for a while with another residentResident #10 came in from outside around 9:30 p.m., and when he got to the nurse's desk, he was sweating and not breathing rightThe second shift MA/S kept asking Resident #10 if he wanted to be transported to the hospital, but the resident kept refusing; the resident said he had just gotten out of the hospital and did not want to go backThe PCA did not know if the MA/S contacted the resident's PCPThe MA/S took Resident #10's vital signs and the resident's Blood pressure was low, but it came back up; the PCA did not know where the MA documented the vital signsThe PCA notified the MA/S of any issues with a resident, and the MA would contact the PCP and family memberThe MA/S were responsible for calling 911Resident #10 sat at the nurse's desk until around 10:45 p.m.; then, the MA/S waked the resident to his roomThe MA/S informed the third shift MA/S about Resident #10 and told her to keep a check on him.	

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMIT LETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		4002 SOUT	'H NC 41		
GOLDEN	CARE	WALLACE	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	the facility at 11:00 p. Resident #10 came of resident wanted to go the staff wouldn't allow. She left the facility at after, and Resident # Second interview with 9/26/17 at 12:20 p.m. Resident #10's call li arrived to work at aro not go to the resident. No other call lights wight. The PCA came in to and went to Resident. The PCA called the froom. Resident #10 was lay arm and leg hanging. Resident #10's call be of the bed like it had for the call lights used thappened, because the buzzed in a couple of the call lights could desk from both halls. Staff could see that they did not buzz. Interview with a first sp.m. revealed: Resident #10 came to the staff call to the staff call they did not buzz.	the PCA and the MA/S left m. when their shift ended. but of his room, because the back outside to smoke, but w him to. t around 11:00 p.m. or a little 10 was still alive. In the first shift MA/S on revealed: ght was on when the MA/S und 6:40 a.m. but she did 's room. Were on but Resident #10's work at around 6:55 a.m. #10's room. MA/S to Resident #10's ying on his back with his left off the bed. bell was hanging off the side fallen off the bed. to buzz, but something the call lights have not	D 273	DETICIENCE!)	
	work at around 7:00 a check on the resident	light was on when I got to a.m. I decided to go and a.m. I because I had not seen a resident returned from the			

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DIVISION	of Health Service Regu	lation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STA	TE ZID CODE	
NAIVIE OF F	ROVIDER OR SUFFLIER			TE, ZIF CODE	
GOLDEN	CARE	4002 SO	UTH NC 41		
00151.1	O, ((L	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 070	0 " 15	404	D 070		
D 273	Continued From page	9 131	D 273		
	-Resident #10's door	was closed so the PCA			
		ne resident's name and got			
		ie resident's name and got			
	no response.				
	_	as wrong with the resident			
	as soon as I entered	the room."			
	-The PCA called the I	MA/S to Resident #10's			
	room.				
	-The MA/S and the th	ird shift PCA took Resident			
	#10 off the bed and s	tarted doing CPR.			
		ong Resident #1 had been			
	dead."	ong reoleone with the boom			
		it #10's call light was on			
		_			
		e corner at the nurse's desk			
	around 7:00 a.m.				
		siad she did not know that			
	Resident #10's call lig	ght was on.			
	A second interview w	ith the first shift PCA on			
	9/27/17 at 11:45 a.m.	revealed:			
	-"I knocked on reside	nt's door, called the			
		got no answer. I opened the			
		s soon as I saw Resident			
		ent was dead, because he			
	was pale and not brea	•			
		oot and arm was hanging off			
	,	ave tried to get off the bed.			
		y called the first shift MA/S			
	to Resident #10's roo	m.			
	Interview with a house	ekeeper on 9/14/17 at 11:46			
	a.m. revealed:				
	-Resident #10 had go	one to the hospital on the			
	Wednesday before he				
	-A family member car				
		t the doctor was keeping			
		cause of his blood pressure.			
					
	_	in the hospital for three			
	days.				
		ed to the facility on the			
	Friday evening before	e he died.			

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-She was told that Resident #10 died between the

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		D.C.
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOL	ITH NC 41		
COLDLIN	OAIL	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 132	D 273		
	on first shiftStaff were supposed incontinence care chadid not know why he	d 4:00 a.m. und dead by a staff person to do two hour checks and anges, so the housekeeper was not found until first shift. ent on 9/26/17 at 3:05 p.m.			
	-Resident #10 was a -Resident #10 came I being in the hospital a before he diedResident #10 and the watched the lightenin around 8:30 p.m. or 8 diedResident #10 acted t familyThe resident was tole	good friend of the resident. back to the facility from at around 3:30 p.m. the day e resident sat outside and g show in the sky until 8:45 p.m. the night before he fine and talked about his d by staff that when he nurse's desk, Resident			
	#10 started sweating, and he was not thinki	his coordination was gone,			
	at 3:45 p.m. revealed -Resident #10 arrived being in the hospital v -Resident #10 was ha smoke and stayed un was around 10:00 p.r -Resident #10 came i medicationsResident #10 becam -She asked Resident nurse's deskShe checked Reside	I back at the facility from well after supper time. appy; he went outside to til his normal time, which n.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C 10/17/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		ulation	Division of Health Service Regul
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 133 -The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to go to the hospitalShe was ready to send him to the hospital, but he did not want to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.	COMPLETED	(X1) PROVIDER/SUPPLIER/CLIA	STATEMENT OF DEFICIENCIES
NAME OF PROVIDER OR SUPPLIER GOLDEN CARE A002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 133 -The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.		HAL031003	
GOLDEN CARE ### WALLACE, NC 28466 CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 D 273 Continued From page 133 D 273 The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad was. She did not contact the resident's PCP or family member. Resident #10 did not want to go to the hospital. She was ready to send him to the hospital, but he did not want to go. The resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him out. Resident #10 said he would be alright after using his inhaler and getting his medications. Summary STATEMENT OF CRRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 D			
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 133 -The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to go to the hospitalShe was ready to send him to the hospital, but he did not wan to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.			NAME OF PROVIDER OR SUPPLIER
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 133 -The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to go to the hospitalShe was ready to send him to the hospital, but he did not want to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.			GOLDEN CARE
-The vital signs were written on a note pad that was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to go to the hospitalShe was ready to send him to the hospital, but he did not want to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE N) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH DEFICIENC)
was at the desk at the time; she did not know where the pad wasShe did not contact the resident's PCP or family memberResident #10 did not want to go to the hospitalShe was ready to send him to the hospital, but he did not want to goThe resident was able to communicate what he wanted; if he would not have been able to communicate, she would have sent him outResident #10 said he would be alright after using his inhaler and getting his medications.	D 273	- је 133	D 273 Continued From page
(being sweaty and unstable), but was all right after using his inhaler. -Resident #10 was a smoker and was on medication related to his breathing; Resident #10 was given his inhaler and he began to feel better. -Resident #10 went to his room. -Resident #10's symptoms were not ignored. -She informed the third shift MA/S about Resident #10's vital signs. -She made rounds before getting off work at 11:00 p.m., and Resident #10 was still alive. Interview with the third shift MA/S on 9/27/17 at 3:08 p.m. revealed: -The MA/S had been working at the facility for a couple of months on third shift. -She monitored the 200 hall at the facility. -She was responsible for making rounds to check on resident's every 1 ½ -2 hours to make sure residents were breathing, folleting residents if they were soiled, and changing bed linen if needed. -If a resident put on a call light, staff had to go and check on the resident. -She was working the night Resident #10 died. -He was in good spirits and did not complain.	al. at the sing sing to ter. dent at a eck	e written on a note pad that he time; she did not know the time; she did not know the the resident's PCP or family of want to go to the hospital. Send him to the hospital, but too. ble to communicate what he not have been able to would have sent him out. The would be alright after using the medications. The would be alright after using the medications. The would be alright after using the would have symptoms unstable), but was all right the er. a smoker and was on the began to feel better. The his room. The promise were not ignored. The his room was still alive. The working at the facility for a third shift. The working at the facility. The for making rounds to check the formaking rounds to check the formaking residents if the changing bed linen if the a call light, staff had to go sident. The night Resident #10 died.	-The vital signs were was at the desk at the where the pad wasShe did not contact to memberResident #10 did not she was ready to see he did not want to goThe resident was able wanted; if he would not communicate, she was gestingResident #10 previous (being sweaty and unafter using his inhaler -Resident #10 was a smedication related to was given his inhaler -Resident #10 went to was given his inhaler

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
		1141 024002	B. WING		R-C
		HAL031003	B. W. C		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
			·		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 070	0 (15	404	D 072		
D 273	Continued From page	e 134	D 273		
	-She talked with Resi	dent #10 before he went to			
	sleep.				
	-Resident #10 wanted	d to go outside around 11:30			
	p.m. or 12:15 a.m. to	•			
		th Resident #10, so he could			
	smoke a cigarette.				
	-Resident #10 was no	ot pale, clammy or			
	complaining; he was				
	, ,,	bed once he came back in			
	from smoking.				
	•	sident #10 every two hours.			
	-She checked on resi				
		did not turn on the room light			
	because she was able	e to see the resident from			
	the hall light.				
	-She got up next to th	e resident's bed to make			
	sure they were okay a	and still breathing, but she			
	did not touch or bothe	er the resident.			
	-She felt it would be r	ude to wake the residents if			
	they were sleeping.				
	-She did not remember	er Resident #10's call light			
	being on.				
	-When staff were wall	king up and down the halls			
	checking on residents	s, they could not help but			
	see when a resident's				
	-She could look up ar				
		as on and switch position to			
	•	both halls when sitting at the			
	nurse's desk.				
		s supposed to be at the			
	nurse's desk monitori	•			
	-On 9/2/17, she got o	# work at 7:01 a.m.			
		0/07/47			
		on 9/27/17 at 3:41 p.m.			
	revealed:	41-1-1-1-14 11			
	•	third shift on the 100 hall at			
	the facility.	- 000 h - 11 - f 41 f - 111			
		e 200 hall of the facility			
	unless the MA/S aske	ea tor help.			[

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-Resident #10 was at the nurse's desk looking for

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D.C
			B. WING		R-C
		HAL031003	B. WC		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOU	TH NC 41		
GOLDEN	CARE		, NC 28466		
			., 140 20400	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
			 		
D 273	Continued From page	e 135	D 273		
	the MA/S at 11:00 p.n	n			
		ident #10 anymore after			
	that.	dent # 10 difymore after			
		o be checked on every 1 ½			
		ney were not wet and to help			
	those that could walk				
		monitored while walking up			
	and down the halls.	nonitored write watking up			
		f the call lights were on while			
	walking the halls or fr	•			
	walking the halls of th	om the nurse's desk.			
	Intonvious with the Adr	ministrator on 9/26/17 at			
		Tillistrator on 9/20/17 at			
	9:35 p.m. revealed:	do a alacar abady of the			
		do a closer check of the			
	residents.	d b b - d, d - d & d d			
	_	d be scheduled to address			
	all the facility concern				
		ld be put behind each			
		signed by staff once a full			
	room check had beer	i completed.			
	A	:th. A durinintantan an 40/40/47			
		ith Administrator on 10/13/17			
	at 10:54 a.m. reveale				
		the hospital because of a			
	fall.				
		t returned to the facility on			
	the night that he died				
		told her that she took a			
	break with him and he				
		rmed her that Resident #10			
		s sick that evening when			
	she spoke with the re				
		hat Resident #10 had			
	complained.				
	•	sident had any complaints			
	that it be documented				
	-The facility had no w	ritten policies on an			
	emergency.				
		responsible for sending a			
	resident to the hospita	al, if an emergency.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		D.0
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41 , NC 28466		
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 136	D 273		
	a resident refused to -She did not know of refused to go to the h -If a resident refused documented in the re -She expected the PC Refer to interview with 3:30 p.m. Refer to interview with	any resident that has ospital. medical care, it should be sident's record. CP to be notified. h a MA/S on 10/12/17 at			
	9/5/16 revealed: -Diagnoses included hypertension and hyp-Resident #6 was am	t #6's current FL-2 dated congestive heart failure, perlipidemia.			
	6/8/15 revealed: -Resident #6 was ass staff; staff were to protwo hours as neededResident #6 was ass needed prompting by hygiene. Review of Resident # (PCP) progress notes been seen by his PCI Interview with a secon (PCA) on 10/12/17 at -Resident #6 would state.	sisted with dressing and staff for grooming and 6's primary care provider revealed that he had last P on 8/16/17.			

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DIVISION C	of Health Service Regu	lation				
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D 0	
		1141 024002	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
		4002 SOI	UTH NC 41			
GOLDEN (CARE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	\ · · /	ΓE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
D 273	Continued From page	<u>-</u> 137	D 273			
		, 101				
	all the time.					
ļ	-He stole snacks from					
		nt when Resident #6 had				
	_	n, and went in Resident #4's				
ļ	room and pulled the o					
		ident #6 kneeing over				
ļ	Resident #4's roomm	ate, Resident #15, while she				
	was in the bed.					
		dway Resident #15's body				
	kneeling over her.					
	-She reported this to	the medication				
	aide/supervisor (MA/S					
	-Resident #6 had a ba	ad habit of "feeling of				
ļ	himself" while walking					
	-All the female reside	ents were afraid of Resident				
	#6.					
	-Resident #6 was ver	y intelligent.				
		ow if Resident #6's PCP was				
		ng, but the Administrator was				
	aware that Resident #	•				
	Interview with a secon	nd shift PCA on 10/12/17 at				
	7:49 p.m. revealed:					
	-She felt that the resid	dent needed increased				
	supervision.					
	-Resident #6 would s	teal food; the resident did				
	not know it was wrong					
		other residents' rooms				
ļ	looking for food.					
		nt #6 meant no harm toward				
	staff or residents.					
	-A (named) resident t	old her Resident #6 had				
		luring the night and tried to				
	"mess with her sexua	•				
		Resident #6 would do that.				
		the incident was reported to				
		e it was in the past, Resident				
	_	lly, and she did not know				
		attempted to have sexual				
,		attomptod to make contact				

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contact with the resident or not.

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STATEMENT	of Health Service Regul FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
GOLDEN	CARE		JTH NC 41 E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	2 138	D 273		
	revealed: -Resident #6's family had to talk to Resider -Resident #6 wander -Resident #6's PCP win residents' rooms lo Interview with a family 10:10 a.m. revealed: -Resident #6 came in and wanted to see wherefrigeratorThe family member in Administrator on the control of the Administrator on the control of the would have staffThe family member in the residents that Reside residents' rooms all the Astaff told her that in Female resident's room the bed with that residents are sident #6 wandere. Interview with Reside 10/13/17 at 12:52 p.mHe had not seen any facilityStaff had told him that	member told them that they at #6 like he was a child. ed. vas aware that he wandered oking for food. y member on 10/13/17 at her family member's room, nat the resident had in the reported the incident to the day that it occurred. Id the family member that keep a closer watch on him. heard from staff and other in #6 went in other the time looking food. Resident #6 went into a m and attempted to get in dent. be biggest concern was that d. nt #6's family member on			
	kept out for Resident	iced by food; if food was #6 to see, he would take it. a three or four year old			

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child at times.

-He was smart with a great IQ but his mind came

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Division (of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			-		_	_
			D. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 EIEN			KIL, ZII GODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 273	Continued From page	e 139	D 273			
	Continuou i rom page					
	and went.					
	-Resident #6 was in t	he facility to receive				
	increased supervision	rather than being left at				
	home.	Ğ				
	-The family member f	elt that Resident #6 needed				
	increased supervision					
	moreacea capervioler					
	Interview with Reside	nt #6's guardian on 10/17/17				
	at 8:38 a.m. revealed					
		competent enough to tell				
		sident was being harmed.				
		guardian about anything				
	sexual relating to Res					
		Resident #6 wandered in				
	residents' rooms look	ing food.				
	-Resident #6 was alm	nost 500 pounds, at one				
	time, and would eat a	ıll day, if allowed.				
	-The guardian felt the	staff would have told her				
		aviors regarding Resident				
	# 6.					
	Interview with Reside	nt #6 on 10/13/17 at 5:33				
	p.m. revealed:					
	-He stayed in his roor	m most of the time				
		e dayroom until staff made				
		c dayroom until stall made				
	him go to bed.	t to go in other regidents!				
		t to go in other residents'				
	rooms.					
		sidents' rooms, it was to talk				
	to them or watch telev					
		y food from any residents or				
	staff.					
	Interview with a resid	ent on 10/13/17 at 4:30 p.m.				
	revealed:					
	-Resident #6 tried to	get in bed with her.				
		but he did not because she				
	fought him off.					
	-She did not tell anyo	ne about the incident				[
	because she did not					
	because sile did 110t	want to get in trouble.	1			

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
OOLDEN		WALLACI	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 140	D 273		
	-She had not seen Re the resident yesterda -She did not want it to	old because it would get her at she would be discharged			
	5:52 p.m. revealed: -Resident #6 came at -She was not a friend want the resident in h -He attempted to "fee (private area)It happened every ni -She told the "nurses her; they told her thet -Resident #6 normally in the dining room. (S front of her indicating Resident #6 came int he left, she stated "th -She had not told any the resident was com because she did not toll -When growing up, st talking that way and of -"It was a matter of resident af resident r	ght. " and they did not believe re was nothing to the table in where the resident sat; to the dining area and when at is the one".) "one, including her family, ing into her room to her, talk that way to her family. The was restricted from did not talk that way now.			
	protected. Interview with a seco 5:35 p.m. revealed: -Resident #6 "steals" -Resident #6 went in stole her cake off her -The second shift PC	the resident's room and dresser. A saw Resident #6 with the empting to "crawl" in the bed it in the room.			

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1 _	
			D WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TVAIVIL OF T	TOVIDER OR OUT FEIER		, ,	(12, 211 00BE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	NAIE	DAIL
D 273	Continued From page	e 141	D 273			
	. •					
	completely dressed.					
	-The PCA made Resi	dent #6 get out of the				
	resident's room.					
	-The resident had see	en Resident #6 walking				
		rbating" but this had been a				
	long time ago.	3				
		what he is doing;" he has				
	plenty of sense.	what he is doing, he has				
		sident #6's family member				
	about the incident.	Sident #03 family member				
		t afraid of Resident #6.				
	- The resident was no	t alraid of Resident #6.				
	Interview with the De	sident #Clanninson, sons				
		sident #6's primary care				
	provider (PCP) on 10	/16/17 at 4:08 p.m.				
	revealed:					
		ently become her patient				
	around July or Augus					
		locumentation for years that				
	the resident wandere	d; there was no updated				
	documentation about	recent wandering.				
	-The facility did not no	ecessarily need to report to				
	the PCP about the wa	andering if the resident could				
	be easily redirected.	•				
	•	tation in the resident's				
		er 2016 about inappropriate				
	sexual behavior.					
		ication as to what type of				
	·	esident was exhibiting.				
		tation that the PCP at that				
	time increased his ps					
		=				
		nentation of any recent				
	inappropriate sexual I					
	-Resident #6 did not r	eceive mentai nealth				
	treatment.					
		ped to handle all of the				
	resident's medical ne	- · · ·				
	-She saw Resident #6	6 at least once a month.				
	Interview with the Adr	ministrator on 10/13/17 at				

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6:36 p.m. revealed:

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
			E, NC 28466		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 142	D 273		
D 273	-There had been no rany inappropriate sexIf things happened, to documentedStaff were supposed her but she did not know report the incidentsShe was aware that the resident was only drinksResident #6 did not he body. Refer to interview with 3:30 p.m. Refer to interview with 10/16/17 at 9:45 a.m. 5. Review of Resident 4/6/17 revealed: -The diagnoses included HypertensionThe resident was note that the resident was incomposed. A .Review of Resident dated 4/6/17 revealed: -The resident was incomposed. A .Review of Resident dated 4/6/17 revealed: -The resident was alwed the resident was alwed the resident was alwed the resident was alwed the resident was total for eating, bathing, driver and the resident was total for eating, bathing, driver and the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver and the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, bathing, driver all the resident was total for eating, and the resident was total for eating the resident was total for eati	eports from any staff about rual acts by Resident #6. hey needed to be to report any incidents to row if staff were aware to Resident #6 wandered, but looking for snacks and mave a harmful bone in his a MA/S on 10/12/17 at the Administrator on the #2's current FL-2 dated ded Alzheimer's and n-ambulatory. dia geriatric chair (Geri ontinent of bladder and the #2's current Care Plants it ways disoriented. ally dependent on the staff essing and grooming. ally dependent on the staff	D 273		
	a.m. revealed:	ent #2 on 10/12/17 at 8:10 the dining room sitting in a			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.1.2.2.1.1		152.11.11.10.11.10.11.10.11.52.11.	A. BUILDING: _		
		HAL031003	B. WING		R-C 10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		ITH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 143	D 273		
	Aide (PCA). -The resident had a d arm and a dressing of writing on either of the been applied. -The resident had a 2 scab below her right k-The resident had a 1 below her left knee. -The resident had mu and both legs. Based on observation interviews, Resident # Interview with a PCA revealed: -She did not know how tears or bruises. -She had been off wo does not recall that R tears prior being off we	.0 by 1.0 inches in size scab Itiple bruises on both arms as, record reviews, and #2 was not interviewable. on 10/12/17 at 8:15 a.m. w Resident #2 got the skin rk for a few days prior and esident #2 had the skin			
	a.m. revealed: -The Medication Aide.	ent #2 on 10/12/17 at 9:30 /Supervisor (MA/S) and a			
	resident's right upper	oved the dressings on the arm and her left forearm. upper arm had two skin tears			
	1.0 by 0.50 inches in blood tinged clear dra	-			
	tear on the right uppe	r was just under the first skin r arm, and was 0.50 by 0.50 color and had blood tinged			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, boilbii(0		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
			E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 144	D 273			
	clear drainage.					
	a.m. revealed:-She did not know ho tears or bruises.-She did not rememb put on the resident's a	nd PCA on 10/12/17 at 9:35 w Resident #2 got the skin er when the dressings were arms. he physician or family had				
	Interview with MA/S on 10/12/17 at 9:40 a.m. revealed: -She did not know what caused the skin tears on Resident #2's armsThere were no physician orders (or standing orders) for dressing changesShe did not know if the physician was aware of the skin tearsShe would contact the physician immediately.					
	Review of Resident #2's record revealed: -There was no documentation by the facility staff related to the injuries such as nursing or progress notes. -There was no documentation that the resident's current arm skin tears, scabs on both knees or bruises on arms and legs were reported to the PCP, family or hospice. Second interview with MA/S on 10/12/17 at 9:55 a.m. revealed: -She had just informed the physician's medical assistant of Resident #2's skin tearsThe physician's medical assistant informed her to call hospice for cleaning/dressing the skin					
		uld call the physician to eaning/dressing the skin				

tears.

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STATE FORM 6899 DBPR11 If continuation sheet 145 of 419

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					R-C	
		1141 024002	B. WING		1	
		HAL031003			10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	ITH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IGIENCI)		
D 273	Continued From page	e 145	D 273			
	-The hospice RN told	the MA/S to leave the				1
	dressings off the skin					1
		ald arrive later that day to				1
	clean/dress the skin t					I
	Cican/dic33 the 3kin t	cars.				1
	Interview with the hos	spice RN on 10/12/17 at				I
	12:07 p.m. revealed:					1
	-This was the first tim	e she had seen Resident #2				1
	since her discharge fr	rom hospice in June 2017.				I
	-She was waiting on a physician order to					1
	clean/dress the skin t					I
	T = 1	n performed dressing				I
	_	s on Resident #2 prior to her				I
	discharge from hospid	ce in June 1017.				
	Review of hospice ph	ysician order for Resident				
		12:50 p.m. revealed a				I
	telephone order for "S	Skin tears, clean with soap				I
	and water and apply a	antibiotic ointment and cover				1
	with opsite (transpare	ent adhesive film dressing).				1
		days. Okay for facility staff				I
	to change in absence	of hospice nurse."				I
	Ob					
		ent #2 on 10/12/17 at 12:50				I
	dressed the skin tears	spice RN cleansed and				1
	diessed the skill tears	s on both anns.				1
	Interview with MA/S of	on 10/13/17 at 9:10 a.m.				
	revealed:					1
	-The process for injur	ies of unknown origin was to				1
	contact the physician	and send pictures by phone				1
	if requested.					1
		tears was the Med Aide				
		n saline and put a dressing				1
	or band aid on it and					
		on the dressing the date				
	when it was changed					
		ge the dressing each day.				
		a verbal report at shift				
	change about any res	sident with skin tears.				I

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
		1141 024002	B. WING		R-	
		HAL031003			10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
0(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 273	Continued From page	146	D 273			
		report given to the MA/S for				
	the current skin tears					
	-"The first time I knew	of Resident #2's current				
	skin tears was yester	day 10/12/17."				
		strator on 10/13/17 at 10:55				
	a.m. revealed:					
	-"I am not sure what t	o do with an injury of				
	unknown origin."					
		ritten policy on injuries of				
	unknown origin."					
		s is the Supervisor makes a				
	decision of whether o					
	_ ·	s a question they can call				
	the Administrator."					
		staff have been formally				
	trained on emergenci					
		ny delays in delays in 911				
	care."					
	·	ysician on 10/13/17 at 2:15				
	p.m. revealed:	i any akin taona an Daaidant				
	#2.	any skin tears on Resident				
		communicated with the				
		xpectation was that they				
	_	r issues/requests pertaining				
		to their office, and follow-up				
		ne office alerting them.				
		on 10/12/17 and spoke with				
	•	if there were any issues he				
	needed to be aware of	-				
		o the physician on 10/12/17				
	that there were no iss					
		ut the communication				
	issues with the facility					
	issues with the facility	•				
	Interview with family r	member on 10/17/17 at 8:50				

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a.m. revealed:

-He was aware of the skin tears that are now

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	of Health Service Regu		1		(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOI	JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
IAG	REGOLATORY OF	Lee Berrii Fiive II wa Gravii (11614)	IAG	DEFICIENCY)	1000	
			-			
D 273	Continued From page 147		D 273			
	scabs on Resident #2	2's lower leas.				
		der skin tears on her legs				
	~	the Geri chair because she				
	moves her legs const					
	•	v she got the current skin				
	tears on each arm.					
	-"The skin tears have	been on and off with her for				
	the last one year."					
	-The staff previously called him and told him about skin tears and often apologize for "calling					
	too much".					
	Interview with Admini	strator on 10/17/17 at 11:10				
	a.m. revealed:					
		are of (Resident #2's) skin				
	tears during this surv	• •				
		they would follow for skin				
		uld contact the physician and				
	the home health/ hos	pice nurse for plan of care.				
	D. Dovious of physicia	on orders for Decident #2				
	revealed:	n orders for Resident #2				
		dated 9/6/17 for home				
	health to evaluate an					
		older with other residents'				
		ation Administration Records				
	(MARs) laying at the					
	, , , ,					
	Review of Resident #	2's record revealed:				
	-The physician's orde	er dated 9/6/17 for home				
	health to evaluate and	d treat sacral ulcer was not				
	filed in the resident's					
		nentation by the facility staff				
		ade to home health such as				
	nursing or progress n					
		nentation made by facility				
	staff regarding a nota					
		nentation made by home				
	health regarding a ref	ferral being received to				

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evaluate and treat a sacral ulcer.

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Division of	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					D 0		
		1141 004000	B. WING		R-C		
		HAL031003	B: Will 5		10/17/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
		4002 SOI	JTH NC 41				
GOLDEN	CARE		E, NC 28466				
	OUR MAR DV OT		·				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD			
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR			
				DEFICIENCY)			
D 070	0 " 15	440	D 070				
D 273	Continued From page	2 148	D 273				
	-There was no docum	nentation made by home					
		uation and treatment of a					
	sacral ulcer.						
	Interview with a PCA	on 10/13/17 at 11:30 a.m.					
	revealed:						
	-She was not aware o	of a physician's order for					
	home health to evalua	ate and treat sacral ulcer for					
	Resident #2.						
	-She was not aware t	hat Resident #2 had a					
	sacral ulcer.						
	-She bathes Resident	t #2 routinely and has not					
	seen any skin breakd	own on sacral area.					
	Interview with MA/S of	on 10/13/17 at 11:40 a.m.					
	revealed:						
		of a physician's order for					
		ate and treat sacral ulcer for					
	Resident #2.						
		hat Resident #2 had a					
	sacral ulcer.						
		ent #2 on 10/13/17 at 12:40					
	revealed:	a bathing the goaldest in					
		s bathing the resident in					
	bed.	ks and sacral area had no					
	signs of skin breakdo						
	signs of skill breakdo	wit of feditess.					
	Interview with the has	spice aide on 10/13/17 at					
		as not aware of any referral					
	for Resident #2 regar	•					
	121 1 100.00111 112 10901	g					
	Interview with the Phy	sician on 10/13/17 at 2:15					
	p.m. revealed:	, <u> </u>					
	•	at the order dated 9/6/17 for					
		ate and treat sacral ulcer					
	was not completed.						
		that all orders are carried					

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out immediately after the order is written.

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DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			1	_	5.	<u> </u>
			B. WING		R-C	
		HAL031003	B. WING		10/17	/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	-		JTH NC 41			
GOLDEN	CARE		E, NC 28466			
		WALLAC	E, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG	REGOLATORI ORE	100 IDENTIF TING IN CINIMATION)	IAG	DEFICIENCY)	WATE	
D 273	Continued From page	e 149	D 273			
	"I am vangunaat aha	ut the communication				
	-"I am very upset abo					
	issues with the facility					
		g the Administrator to follow				
	up on his concerns.					
		nt #2's family member on				
	10/17/17 at 8:50 a.m.					
	 He was not aware of 	Resident #2 having an				
		referral for a sacral ulcer.				
	-He was only aware o	of the skin tears.				
	Interview with Adminis	strator on 10/17/17 at 11:10				
	a.m. revealed:					
	-She was not aware t	hat Resident #2 had an				
	order for home health	referral for a sacral ulcer.				
	-The normal process	was the supervisor should				
		he order for the referral.				
	•	that the order was missed".				
	Refer to interview with	h a Medication				
	Aide/Supervisor on 10					
	Refer to interview with	h the Administrator on				
	10/16/17 at 9:45 a.m.					
	15/15/17 at 0.40 d.m.					
	6 Review of Resider	nt #3's current FL-2 dated				
		agnoses included diabetes				
		_				
	and muscle weakness	ascular disease, pneumonia,				
	and muscle weakness	S.				
	A Povious of Posidos	nt #3's current FL-2 dated				
	A. Review of Resider 03/07/17 revealed:	nt #3 S current FL-2 dated				
		for Noveley Flavores intent				
		for Novolog Flexpen inject				
		nes a day: 200 - 250 = 2				
		nits; 301 - 350 = 6 units; 351				
		reater than (>) 400 = call				
	physician.					
	-There was an order f	for Levemir 60 units twice a				
	day. (Levemir is long	-acting insulin used to lower				

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blood sugar.)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
		HAL031003 B. WING			R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOI	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 273	Continued From page	e 150	D 273		
	-There was an order for fingerstick blood sugars (FSBS) 4 times daily. Review of Resident #3's October 2017 medication administration record (MAR) revealed there was no documentation of any FSBS on the MAR.				
	Review of Resident #3's October 2017 FSBS log revealed: -The resident's FSBS were to be checked 4 times a day. -The FSBS was 420 on 10/06/17 at 5:00 p.m. -The FSBS was 416 on 10/16/17 at 8:00 p.m. -There was no documentation the physician was contacted about the 2 FSBS over 400 as ordered. -The FSBS ranged from 50 - 420 from 10/01/17 - 10/13/17.				

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
INAME OF T	NOVIDEN ON OUT LIEN		, ,	III., ZII OOBE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	151	D 273		
D 210	Continued i Tom page	: 151	5270		
	509 on 09/14/17 at 11	1:45 a.m.; 416 on 09/15/17			
	at 11:45 a.m.; 437 on	09/15/17 at 8:30 p.m.; 478			
		p.m.; 466 on 09/18/17 at			
		21/17 at 4:45 p.m.; 434 on			
		; and 484 on 09/23/17 at			
	8:00 p.m.	, 4114 10 1 011 00/20/17 41			
		nentation the physician was			
	contacted on any of the				
	•	om 62 - 600 from 09/01/17 -			
	09/30/17.				
	Interview with the me	, ,			
	10/13/17 at 9:07 a.m.	revealed:			
	-	cument insulin administration			
	and FSBS on the FSB	BS log instead of the MARs.			
	-The MAs were support	osed to call the physician to			
	find out how much SS	I to administer if Resident			
	#3's FSBS was over 4	400.			
	-If they called the phy				
		1AR or the FSBS log or they			
	would have a fax fron				
	resident's record.	The physician in the			
	resident s record.				
	Intonvious with a soco	nd MA on 10/13/17 at 12:55			
	p.m. revealed:	110 10/10/17 at 12.00			
	•	on accord shift as a			
	-She usually worked	on second shint as a			
	MA/supervisor.				
		osed to call the physician to			
		SI to administer to Resident			
	#3 if her FSBS was o				
	-	hysician's office on 09/12/17			
		SBS was 600 and got a			
	verbal order to admin	ister 10 units of Novolog			
	SSI.				
	-She documented it o	n the back of the FSBS log.			
		SBS on 09/12/17 at 7:00			
	p.m.				
	· ·	ed the physician's office			
	_	k of 445 and there were no			
	pack after the recited	K OF TTO AND WILL WELL IN	1	1	

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further orders.

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Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					_	•
			B. WING		R-(
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE					
	Г	WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGOLATORI ORT	EGO IDENTIL TING INI GRAMATIGN)	TAG	DEFICIENCY)	WALL	1
			+			
D 273	Continued From page	e 152	D 273			1
	Sho was not sure ab	yout calling the physician's				1
	-She was not sure about calling the physician's office back since she did not document it.					ı
						1
		nted on the MAR or FSBS				ı
	log if she called the p					ı
		the physician for other				ı
	FSBS that were over					ı
	documented it on the	_				1
		ntacting the physician on				ı
	any other occasion.					1
	<u></u>					I
		ent #3 on 10/17/17 at 10:25				1
	a.m. revealed:					I
		and FSBS checks about 3				1
	or 4 times a day.					ı
	-She got SSI about 3	times a day and a different				ı
	kind of insulin once o	r twice a day.				1
	-Her FSBS ran so hig	h sometimes she would				1
	have to get 60 units of	of insulin at night.				I
	-She usually felt "ner	vous" when her FSBS was				I
	high.					1
	-Her FSBS sometime	s ran low and she would get				1
	"nervous and shaky".					1
	-Her FSBS got so hig	h in September 2017 that				I
	she had to go to the h	nospital.				I
						I
	Telephone interview v	with Resident #3's primary				1
	care provider (PCP) of	on 10/13/17 at 2:00 p.m.				1
	revealed:					1
	-He was not aware R	esident #3's FSBS had been				1
	running over 400.					1
	-His office was contact	cted on one occasion in				ı
	September 2017 abo	ut a high FSBS for Resident				1
	#3.					
	-If he had been conta	cted regarding the multiple				1
	FSBS over 400, he w	ould have changed the				
	resident's insulin dosa					
		phone number and his				
	assistant's phone nur					
	available 24 hours a					
		ve called him anytime				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.11 .	5. GG.W.EG.1.G.1	ISENTINO IN TOTAL CONTROL IN	A. BUILDING:			
		HAL031003	B. WING		R- 10/1	C 7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN CARE 4002 SOUT						
		WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	273 Continued From page 153		D 273			
	regarding the FSBS.					
	Care Plan dated 03/3 -The resident was a conon-ambulatory, and -The resident had limextremitiesThe resident was incompleted by the resident was originated by the resident was originated by the resident was too to bathing, and transferred by the resident required dressing and limited a substantial ambulation. Review of a physician for Resident #3 reveaused of the bilatered by the resident would be because of the bilatered by the resident would be because of the bilatered by the resident was a handwrest for right leg prosthesis hours, check for skinelt was scheduled to be 10:00 a.m., on at 12:00 at 4:00 p.m., off at 6:00 off at 10:00 p.mThe prosthetic leg was a resident was resident was scheduled to be 10:00 a.m., on at 12:00 p.m.	louble amputee, used a wheelchair. ited strength in upper continent of bowel and ented and had adequate ally dependent for toileting, ing. d extensive assistance with assistance with grooming. lependent with eating and a's visit form dated 08/09/17 alled: teral below the knee benefit from a prosthesis ral amputations. d be safer, increase mobility avoid falls. 3's August 2017 medication				

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	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 1	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1		R-C	
		HAL031003	B. WING		10/17/2017	
		1			,	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		
IAG	REGOLATORY OF	LOG IDENTIFICATION OF CONTROL OF	IAG	DEFICIENCY)	10/112	
D 273	Continued From page	e 154	D 273			
	08/31/17.					
	-The prosthetic leg wa	as documented as being on				
		at 2:00 p.m. from 08/10/17 -				
	08/18/17, 0820/17 - 0)8/26/17, and 08/28/17 -				
	08/31/17.					
	-The prosthetic leg wa	as not documented as being				
	on at 4:00 p.m. or 8:0	00 p.m. from 08/10/17 -				
	08/31/17.					
	-It was documented as refused at 4:00 p.m. and 8:00 p.m. from 08/10/17 - 08/12/17.					
		:00 p.m. and 8:00 p.m. was				
	blank from 08/13/17 -	- 08/31/17.				
		3's September 2017 and				
		revealed no entry for the				
		nd no documentation it was				
	being worn.					
	Observations of Posi	dent #3 from 10/11/17 -				
		7 - 10/17/17 revealed:				
		wear the prosthetic leg.				
		as in a chair next to the				
	resident's bed	as in a snail next to the				
	Telephone interview v	with a medication aide (MA)				
	on 10/16/17 at 2:40 p	.m. revealed:				
	-Resident #3 did not	wear her prosthetic leg like				
	she was supposed to	wear it.				
	-If staff helped Reside	ent #3 put on the prosthesis,				
		nly wear it a short period of				
	time and then pull it of					
		t complained of pain from				
		that it was uncomfortable.				
		reakdown on the resident's				
	stumps.					
		the physician that the				
	resident was not wea	-				
		anyone had notified the				
	physician.		1			

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL031003	B. WING		R-	C 7/2017
NAME OF D	POVIDED OD SLIDDI IED		DRESS, CITY, STA	TE ZID CODE	1 10/1	172011
NAIVIE OF PI	ROVIDER OR SUPPLIER		JTH NC 41	TE, ZIP CODE		
GOLDEN (CARE		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 155	D 273			
D 2/3	Interview with a media 10/17/17 at 9:01 a.mBoth of Resident #3's -The resident only hawas for her right legStaff tried to get the prosthetic leg but the hurtingThe resident already services to help her was not sure if the notified the resident was prosthetic leg or comparthere were no sores resident's amputated. Interview with Reside a.m. revealed: -She had one prosthes stopped coming becamaking any progress -Facility staff offered the prosthetic leg but som wearing itShe was supposed to 2 hours and off 2 ho	cation aide (MA) on revealed: s legs had been amputated. d one prosthetic leg and it resident to use the resident complained about it had physical therapy with the use of the leg. The physician had been was not wearing the plaining about it hurting. For opens areas on the leg stumps. The #3 on 10/17/17 at 10:25 betic leg and physical therapy muse they said she was not with it. To help her with the ne days she did not feel like of owear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of wear the prosthetic leg on lins. In the her with the ne days she did not feel like of the her	D 273			
	the resident's refusal	lity had contacted him about to wear the prosthesis. hone number and his				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, , ,	SURVEY PLETED	
						R-C
		HAL031003	B. WING			/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
COL DEN	CADE	4002 SOI	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 156	D 273			
	assistant's phone nur hours a day 7 days a	nber and could reach him 24 week.				
	Refer to interview with Aide/Supervisor on 10					
	Refer to interview with 10/16/17 at 9:45 a.m.	h the Administrator on				
	10/12/17 at 3:30 p.m. -When staff observed staff were supposed t	a change in a resident, the to call the PCP. The determinant the change was the one				
	9:45 a.m. revealed: -The expectation for a was to monitor the re PCP by telephone, an and notificationShe was "unsure" if expected procedureThe facility currently place for changes in a physician was notifiedShe would implement possible and assure a lin an emergency, sta 911.	d. It a policy as soon as all staff were trained. If were supposed to call and a policy or system in called 911 or for				
	residents sampled (# received health care maintain their mental	oordinate and assure 6 of 8 1, #2, #3, #6, #10, #11) services necessary to and physical health and otify the PCP of Resident				

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	or riealth Service Regu				(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAI 034003	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE					
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IAIE BAIL	-
				,		\dashv
D 273	Continued From page	e 157	D 273			
	. •					
		sugar results, ranging from				
	406 - 537 on fourteen	occasions; a resident with				
	a change in status, re	sulting in a delay in				
	Resident #11 being e	valuated for signs and				
	symptoms of a urinary	y tract infection before being				
	sent to the hospital fo	r unresponsiveness,				
	•	respiratory status, and				
		spitalization for intravenous				
		or sepsis; and Resident				
		ot feeling well, dizziness,				
	=	tus, and refusal of emergent				
		sulting in the resident being				
		deceased in his bed. The				
		lure resulted in serious				
	-					
	physical harm, death,	-				
	constitutes an Unaba	ted Type A1 Violation.				
	D : (0 (20 I					
	-	s Plan of Protection dated				
	10/13/17 revealed:					
		on survey will be reported to				
		opriate referral source.				
		one by Administrator to				
	ensure that all health	care orders have been				
	followed and health n	eeds met.				
	-Administrator will mo	nitor by auditing random				
	charts and observation	on with residents.				
	-All communication w	ith health care providers will				
	be documented in res	sident records.				
	-Facility will develop p					
		when to send residents out				
		vill be in-serviced on new				
	policy.					
		view transportation log to				
	ensure appointments	,				
	chadic appointments	аго корт.				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	10A NCAC 13F .0902	2 Health Care				
	(c) The facility shall a	ssure documentation of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
	I	WALLACE	, NC 28466		T .
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 158	D 276		
	following in the reside (3) written procedures a physician or other li and (4) implementation of				
	This Rule is not met TYPE B VIOLATION	as evidenced by:			
	reviews, the facility fa from the primary care residents sampled (#	ns, interviews, and record hilled to implement orders provider (PCP) for 4 of 4 1, #2, 3, 4) who had orders residents sampled (#2, #3) pressure checks.			
	The findings are:				
	04/06/17 revealed: -Diagnoses included a HypertensionThere was an order				
	form on 10/12/17 at 1 -Resident #2's weight pounds (lbs.) in Marc -Resident #2's weight in April 2017Resident #2's weight in May 2017.	t was documented as 112			

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Division (of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
			D WING		R-C	
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	KIE, ZII CODE		
GOLDEN	CARE	4002 SOU				
		WALLACI	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V .	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 276	Continued From page	150	D 276			
22.0	Continued From page	2 100	52.0			
	-Resident #2's weight	t was not documented in				
	July, August, Septem	ber or October 2017.				
	,					
	Review of the 100 Ha	all Monthly Weights 2017				
		ent #2 was not listed on the				
	form.	me me was not noted on the				
	ioiii.					
	Davious of Davidant #	tala Ostobar 2017				
	Review of Resident #					
	medication administra	ation records (MARS)				
	revealed:					
		er generated entry to check				
	weight every month.					
	-There was no weight					
	-There was a comput	er generated entry to check				
	blood pressure every	month.				
	-There was no blood	pressure documented.				
	Review of Resident #	2's September 2017 MARs				
	revealed:	·				
	-There was a comput	er generated entry to check				
	weight every month.	g ,				
	-There was no weight	t documented				
	_	er generated entry to check				
	blood pressure every					
		pressure documented.				
	-Triefe was no blood	pressure documented.				
	Davious of Davidant #	tale August 2017 MADs				
		2's August 2017 MARs				
	revealed:					
		er generated entry to check				
	weight every month.					
	-There was no weight					
		er generated entry to check				
	blood pressure every					
	-There was one blood					
	documented on 08/08	3/17.				
	Interview with a medi	cation aide/supervisor				
		at 12:05 p.m. revealed:				
		have been weighed monthly.				
		ost likely not been weighed				
			I	1		1

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 160 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B 14/14/0		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE	
NAIVIE OF F	ROVIDER OR SUFFLIER		, ,	II E, ZIF CODE	
GOLDEN	CARE	4002 SOL	JTH NC 41		
00151.1	O, ((L	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 070	0 " 15	100	D 070		
D 276	Continued From page	e 160	D 276		
	after lune 2017 heca	use she moved to the 100			
		as not transferred to the 100			
		2017 form at that time".			
	-She was not sure if F	Resident #2 had lost weight			
	since June 2017.				
	-Resident #2 should h	nave had her blood pressure			
	checked monthly.				
	-She was not sure wh	ny Resident #2's blood			
		cked in September and			
	October 2017.	oned in Coptomber and			
	October 2017.				
	Tolonhono intonvious	with Decident #2's Drimon			
	•	vith Resident #2's Primary			
		13/17 at 2:15 p.m. revealed:			
		lent #2 for four years, and			
	"she has gone downh	nill ever since".			
	-He was not aware th	at the facility had not			
	weighed Resident #2	since June 2017.			
	-He expected Reside	nt #2 to be weighed monthly			
	as ordered.	g ,			
	-He was not aware th	at the facility had not			
		's blood pressure since			
	August 2017.	3 blood pressure since			
	_	nt #0 to have blood nacon			
	T	nt #2 to have blood pressure			
	checks monthly as or				
		#2 at the facility each month			
	and expected all orde	ers to be carried out			
	immediately after the	order was written.			
	-He was going to con	tact the Administrator			
	because he was cond	cerned that physician orders			
	were not being carrie				
	Based on interviews a	and record reviews			
		peen weighed for 4 of the			
		•			
		ered and had not had blood			
		of the last 3 months as			
	ordered.				
	Refer to the schedule	for blood pressure (BP)			
	checks.				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 161 of 419

Division of Health Service Regulation

DIVISION	of Fleatill Service Regu	ialion				_
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-			
		HAL031003	B. WING		10/17/2017	
			•			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES		DROVIDER'S DI ANI OF CORRECTION	0.50	_
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	-
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
		,		DEFICIENCY)		
						\dashv
D 276	Continued From page	e 161	D 276			
	Refer to the schedule	for resident weight checks.				
	Refer to interview with	h a first shift medication aide				
	(MA) on 10/17/17 at 8	3:45 a.m.				
	Refer to interview with	h a second shift personal				
	care aide (PCA) on 10					
	() ()					
	Refer to interview with	h the Administrator on				
	10/17/17 at 11:45 a.m					
	10/17/17 at 11.43 a.ii	1.				
		nt #3's current FL-2 dated				
		agnoses included diabetes				
	mellitus, peripheral va	ascular disease, pneumonia,				
	and muscle weakness	S.				
	Review of physician's	orders dated 04/06/17 for				
	Resident #3 revealed					
		to check weights monthly.				
		to check blood pressure				
		to check blood pressure				
	(BP) monthly.					
		0047 0 4 4 0047 4				
		2017, September 2017, and				
		tion administration records				
	(MARs) revealed:					
	-There was an entry e	each month for the weight to				
	be checked monthly.					
	-There was an entry e	each month for the BP to be				
	checked monthly.					
	_	for the weights and BPs to				
		a.m 3:00 p.m. (first shift).				
		nts or BPs documented on				
	_					
	the MARs from 08/01	/17 - 10/13/17.				
	-	s monthly weight book				
	revealed:					
	-Resident #3 weighed	d 110 pounds in April 2017.				
	-Resident #3 weighed	d 116 pounds in June 2017.				
		weights documented for				

Division of Health Service Regulation

Resident #3.

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Division of Health Service Regulation

	of Health Service Regu		1		1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AIND FLAIN (J. GORREGHON	IDENTIFICATION NOWIBER.	A. BUILDING: _		COWII LL IED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
OO! DEN	0405	4002 SOU	TH NC 41		
GOLDEN	CARE	WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 162	D 276		
	Review of a physiciar revealed the resident	n's visit form dated 09/06/17 's BP was 100/63.			
	10/17/17 at 8:45 a.m.	been done.			
	a.m. revealed:-The facility staff had months.-They facility staff "ha	not weighed her in a few ardly ever" checked her BP. nber the last time her BP ty staff.			
	Refer to the schedule	for blood pressure checks.			
	Refer to the schedule	for resident weight checks.			
	Refer to interview with (MA) on 10/17/17 at 8	h a first shift medication aide 3:45 a.m.			
	Refer to interview with care aide (PCA) on 1	h a second shift personal 0/17/17 at 9:08 a.m.			
	Refer to interview witl 10/17/17 at 11:45 a.m	h the Administrator on า.			
	02/20/17 revealed: -Diagnoses included :	liabetes, hypertension, ion.			

Division of Health Service Regulation

Review of the 100 Hall Monthly Weights 2017

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		
		HAL031003			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
			·		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(/
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
5.050			D.070		
D 276	Continued From page	e 163	D 276		
	form revealed:				
		t was documented as 110			
	pounds (lbs.) in April				
	. , , .	t was not documented in			
	June, July, or August				
		Resident #1's weight was			
	documented as 100 l				
		* • •			
	documented as 104 l	sident #1's weight was			
	documented as 104 ii	08			
	Daview of Decident #	Ale Avenuet 2017 medication			
		1's August 2017 medication			
	administration record	•			
		itten entry to check weight			
	every month.	1 16 D : 1 1//4:			
	_	mented for Resident #1 in			
	August 2017.				
		1's September 2017 MARs			
	revealed:				
	·	er generated entry to check			
	weight every month.				
	_	t was documented as 100			
	pounds lbs. on 09/03/	/17.			
		n order for Resident #1 dated			
	10/02/17 revealed:				
		tation of a seven pound			
	weight loss over 6 we				
	-There was an order	to check weight once weekly			
	and record				
		1's October 2017 revealed:			
		er generated entry to check			
	weigh every month.				
	-There was no entry t	o check weight weekly.			
	-Resident #1's weight	was documented as 103			
	lbs. on 10/01/17.				
		weights documented.			
		-			

Division of Health Service Regulation

Interview with a medication aide/supervisor

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
			DE00 0171/ 074	TE 310 0005	10/1//2017
NAME OF P	ROVIDER OR SUPPLIER	4002 SOU	ORESS, CITY, STA	ILE, ZIP CODE	
GOLDEN	CARE		, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 164	D 276		
	(MA/S) on 10/12/17 a -She did not think Res weightNo residents were or residents were weigh	t 11:56 a.m. revealed: sident #1 had lost any n weekly weight; all ed monthly.			
	10/12/17 at 7:50 p.m.	onal care aide (PCA) on revealed Resident #1 st weight over the last few			
	p.m. revealed: -All residents were weResident #1 was alw weightThe last time she we	eighed monthly. ays "skinny", but he had lost ighed Resident #1 was this and he weighed 104 lbs.			
	member on 10/13/17 -Resident #1 had lost -The family member of weight he had lost or but the family had to provide the sweat pants for the residual process.	did not know how much over what period of time, ourchase a smaller size esident. did not know if or when			
	(NP) at Resident #1's office on 10/16/17 at a Resident #1 had son be expectedShe expected Reside ordered (weekly).	ne weight loss, which was to ent #1 to be weighed as			
		eight Resident #1 on n.; however the weight was f were not observed to weigh			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
	HAL031003 B. WING		R-C 10/17/2017			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLI	ETE
D 276	Continued From page	165	D 276			
	the resident.					
	, ,					
		s, records reviews, and \$1 was not interviewable.				
	Refer to the schedule	for resident weight checks.				
	Refer to interview with (MA) on 10/17/17 at 8	n a first shift medication aide 3:45 a.m.				
	Refer to interview with care aide (PCA) on 10	n a second shift personal 0/17/17 at 9:08 a.m.				
	Refer to interview with 10/17/17 at 11:45 a.m					
	06/05/17 revealed: -Diagnoses included t seizures, and bi-polar					
	p.m. revealed: -She had lost 21 lbs. shospitalization (unsure-She had lost so much plate did not fit and show oneAll of her clothes were lost weight.					

Division of Health Service Regulation

A second interview with Resident #4 on 10/13/17

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAI 024002	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA JTH NC 41	TE, ZIP CODE		
GOLDEN	CARE		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	e 166	D 276			
	at 4:50 p.m. revealed -Every resident was sonce a monthShe was supposed to Sunday of each montoweigh herThe last time she was PCP was at the facilities. She did not recall her Review of a Provider dated 10/02/17 revea -There was document lb. weight loss over twe resident #4's weight lbs. Review of Resident ## revealed there was not found. Interview with a medic (MA/S) on 10/13/17 are record became in her record became weighed monthlyShe would look for the to Resident #4's weighed resident #4's weighed resident #4 had son couple of months. Interview with a second p.m. revealed: -All residents were well-she did not think Resident.	supposed to be weighed to be weighed on the first th, but staff did not always as weighed was when the y (unsure of date). r last weight. Visit Form for Resident #4 led: tation Resident #4 had a 4 wo weeks. It was documented as 119 4's physician orders to orders for weight checks cation aide/supervisor at 10:15 a.m. revealed: for monthly weights should use all residents were the physician orders related thts. The weight loss over the last and MA/S on 10/13/17 at 5:30				
	Review of the 100 Ha form revealed:	all Monthly Weights 2017				

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-Resident #4's weight was not documented in

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT	ГН NC 41 , NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 276	Continued From page	e 167	D 276			
	lbs. in September 201	was documented as 122 4's October 2017				
	-There was a computer generated entry to check weigh every monthResident #4's weight was not documented in October 2017.					
	revealed: -There was a compute weigh every month.	4's September 2017 MARs er generated entry to check was documented as 117				
	revealed: -There was a handwrievery month.	4's August 2017 MARs itten entry to check weigh mented for Resident #4 in				
	(NP) at Resident #4's 3:31 p.m. revealed: -She last evaluated R noted she had recent -Resident #4 was supmonthlyShe expected Reside ordered.	posed to be weighed ent #4 to be weighed as				
	A copy of Resident #4	1's physician order for				

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weights was not provider by the end of the

STATE FORM 6899 DBPR11 If continuation sheet 168 of 419

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL031003	B. WING		l l	R-C 0/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	,	
GOLDEN	CARE	4002 SO	UTH NC 41			
		WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 168	D 276			
	survey.					
	per physician and factor no physician order for for monthly weights a locate the weight order was not completed for Refer to the schedule Refer to interview with (MA) on 10/17/17 at 8	ered to be weighed monthly, illity procedure. There was und in Resident #4's record nd staff were not able to er. Resident #4's weight r August 2017. If for resident weight checks. In a first shift medication aide 8:45 a.m. In a second shift personal				
	Refer to interview with 10/17/17 at 11:45 a.m	h the Administrator on				
	checks posted at the -BPs were to be taken beginning of the shiftThe BP schedule wa week with 3 room nur of the week except fo	s broken down to 7 days a mbers listed under each day				
	at the nurses' station -Second shift was to since there were no buildThe weight schedule Sundays of the month for the 1st, 3rd, and 4	weigh residents on Sundays paths. was broken down to 4 on with 5 room numbers each with Sundays of the month. numbers scheduled for the				

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DIVISION	n Health Service Regu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					_{BC}
		1141 004000	B. WING		R-C
		HAL031003	D. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
			JTH NC 41		
GOLDEN	CARE				
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(713)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MATE
			+	,	
D 276	Continued From page 169		D 276		
	1 0				
		shift medication aide (MA) on			
	10/17/17 at 8:45 a.m.				
	-Weights and vital sig	ns should be documented			
	on the MARs.				
	-Second shift MAs an	d personal care aides			
	(PCAs) were respons	sible for checking and			
	documenting vital sign	ns and weights.			
	-There was an assign				
		eights and vital signs should			
	be checked.				
		ny the weights and vital signs			
	were not being done.	iy the weights and vital signs			
	were not being done.				
	Intonvious with a access	nd shift PCA on 10/17/17 at			
		nd Siliit PCA oii 10/1//1/ at			
	9:08 a.m. revealed:	NA			
		As usually did vital signs			
		ays during second shift.			
		ented the results on scratch			
	pieces of paper.				
		nere the scratch pieces of			
	paper were kept.				
		nen the vital signs or weights			
	were last checked.				
		ministrator on 10/17/17 at			
	11:45 a.m. revealed:				
		nts should be documented			
	on the MARs or the lo	og books.			
	-She was not aware v	vital signs and weights were			
	not being done as ord				
		osed to do the vital signs			
	and weights.	-			
		veights could be done on			
	any shift.	3			
	·				
	The facility failed to o	btain weights as ordered for			
	4 of 4 residents samp	_			
		ts with documented weight			
	moluding two residen	ıs willi documented welgiri	1		

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loss (#1, #4) and failed to obtain blood pressures

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
	OLIMANA DV. OT	WALLACE,		DROWDERIO DI AN OF CORRECTIO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 170	D 276		
	as ordered for 2 of 2 residents (#2, #3) including one resident with a diagnosis of hypertension. The facility's failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation.				
	10/17/17 revealed: -Charts will be audite care orders, including -Staff on all shifts will -Supervisor / medicat for implementation of implementation on MAdministrator to mor -Supervisor / medicat orders as soon as it co	cion aide will be responsible orders, documentation of ARs, and follow-up. nitor orders daily. cion aide will implement comes in on all shifts. onitor orders and MARs daily ex.			
	VIOLATION SHALL N 1, 2017.	NOT EXCEED DECEMBER			
D 282	10A NCAC 13F .0904 Service	(a)(1) Nutrition and Food	D 282		
	(a) Food Procurement Homes: (1) The kitchen, dining shall be clean, orderly contamination. This Rule is not met Based on observation				
		ge areas were kept clean, contamination related to			

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Division of Health Service Regulation

Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		
		HALU31003			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
		4002 SOI	UTH NC 41		
GOLDEN	CARE		E, NC 28466		
			L, NO 20400		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
		,		DEFICIENCY)	
D 282	282 Continued From page 171		D 282		
	roaches in the kitchen and dining room.				
	TOUCHCS III the kitcher	Tana aning room.			
	The findings are:				
	The illiulitys are.				
	Review of a kitchen in	agnostics report from			
		Services dated 08/01/17			
		1 Services dated 08/01/17			
	revealed:				
		ion grade was 87.0 on			
	08/01/17.				
		ere observed on the prep			
	tables and drawers.				
		nation needed every 2			
	-	t the severity of the problem.			
		hat spraying was completed			
		re was no documentation			
	from July 2017.				
	-This documentation	should be kept in a secure			
	location for viewing.				
	-A follow-up visit will I	be made to access			
	extermination attemp	ts.			
	Review of a kitchen re	evisit report from			
	Environmental Health	Services dated 08/29/17			
	revealed:				
	-A visit was made to	verify correction of items			
	noted on the last kitch	,			
		ed an exterminator company			
		day and she thought they			
	were spraying every				
		ation in the kitchen indicated			
		rminator company came was			
	in June 2017.	The state of the s			
		was observed on the prep			
	sink drainboards.	That observed on the prop			
		es were observed on a sticky			
		-			
	pad that was not char	-			
	exterminator compan				
		pads get changed to verify if			
	current actions are w	orking to eradicate the roach			

Division of Health Service Regulation

population.

STATE FORM 6899 DBPR11 If continuation sheet 172 of 419

Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
						c l
		HAL031003	B. WING	B. WING		7/2017
		11AE031003			10/1	1/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	<u> </u>	2/5
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 202	92 Continued From page 172		D 282			
D 282	Continued From page	e 1/2	D 202			
	the prep tables and o	drawers.				
	Interview with the me	dication aide/supervisor				
	(MA/S) on 10/11/17 a					
	,	mpany came to the facility				
	about once a month.	, , , , , , , , , , , , , , , , , , , ,				
	-She saw a roach in t	he kitchen in the ice box				
	yesterday (10/10/17).					
		oach out of the ice box but it				
	•	ne ice in the ice box and she				
	could not get the road	ch.				
		or 12 roaches every day in				
	the kitchen or dining i					
	•	nad gotten better about 2				
	weeks ago.	g				
	•	ld flip a light on and the				
	roaches were everyw	. •				
	Interview with a cook	/MA on 10/11/17 at 8:20 a.m.				
	revealed:					
	-She had not seen an	ny roaches recently; the last				
	time was 3 weeks age					
	-The exterminator's la	ast treatment was one month				
	ago.					
	Observation of the kit	tchen on 10/16/17 at 9:50				
	a.m. revealed:					
	-There was one roach	n crawling on the floor near				
	the hand sink.					
	-There was a roach c	rawling on the trash can				
	near the hand sink.					
	Interview with a cook	on 10/16/17 at 9:50 a.m.				
	revealed she still saw	roaches in the kitchen but it				
	was better.					
	Interview with the Adr	ministrator on 10/12/17 at				
	10:02 a.m. revealed:					
	-She thought the exte	erminator company came to				
		eeks and targeted treatment				

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Division of Health Service Regulation

Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		
		HAL031003			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SO	UTH NC 41		
GOLDEN	CARE		E, NC 28466		
	OLIMANA DV OT		,	DDOWDEDIO DI ANI OF CODDECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 282	Continued From page	172	D 282		
D 202	Continued From page	e 173	D 202		
	for the roaches.				
	-She did not think the	ey left invoices when they			
	came but she would o				
	-There had been an i				
	roaches but they were	•			
	•	hes in the kitchen last week.			
	Review of invoices from	om the exterminator			
	company revealed:				
		doors and dining/cafeteria			
	were treated for roac	<u> </u>			
		ol (roaches) for room 106 -			
		oom, janitor closet, and			
	emergency closet.	oom, jamen olooot, and			
		doors, dining/cafeteria, and			
	bathrooms were treat				
		doors and dining/cafeteria			
	were treated for roacl	_			
		doors and dining/cafeteria			
	were treated for roach	_			
		preparation areas, entry			
		nd a couple of resident			
	rooms were treated for	•			
		n, dining area, and a couple			
		re treated for roaches.			
	-There were no invoice				
	- There were no involu	Les for October 2017.			
5 00-	404 NOAG 107 577	4/1/0//4/ 11 / 12 - 1 - 1			
D 299		4(d)(3)(A) Nutrition And Food	D 299		
	Service				
	404 NOAC 40E 666	4 N 4 W A 15 10 1			
		Nutrition And Food Service			
	. ,	nts in Adult Care Homes:			
	· ·	egular diets shall include the			
	following:				
		ole milk, low fat milk, skim			
	milk or buttermilk: Or				
	pasteurized milk at le				
		k or diluted evaporated milk			
	may be used in cooki	ng only and not for drinking			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		TH NC 41			
			E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 299	Continued From page	e 174	D 299			
	during mixing and the the product if too muc This Rule is not met Based on observation reviews, the facility fa	as evidenced by: ns, interviews, and record iled to serve 8 ounces of				
	milk at least twice dai	ly to the residents.				
	The findings are:					
	Review of the Resident Roster provided by the medication aide/supervisor on 10/11/17 revealed there were 20 residents currently residing in the facility.					
	Review of the "Cycle 1, Week 2" menu posted in the kitchen on 10/11/17 at 11:41 a.m. revealed: -The posted menu did not include the current week for October 2017Milk was listed to be served daily at breakfast, lunch and dinner; the serving size of milk was not documented on the menuBased on the census, the facility required 3.75					
	gallons of milk daily.					
	Observation of the milk on hand on 10/11/17 at 11:41 a.m. revealed there were three full gallons of 2% reduced fat milk and one gallon of 2% reduced fat milk that had approximately ¼ of the milk remaining.					
	· · · · · · · · · · · · · · · · · · ·	nch meal service on n. revealed the residents es which included 4oz of				
	8:19 a.m. revealed:	ilk on hand on 10/12/17 at				

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-	C
		HAL031003	B. WING		1	7/2017
		TIALOUTOUS	1		1 10/1	772017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDLIN	CAIL	WALLACE	, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/ (L
D 299	Continued From page 175		D 299			
	milk and one gallon o	f 2% reduced fat milk that				
		of the milk remaining.				
		on of 1% reduced fat milk				
		ly ¼ of the milk remaining.				
	and mad approximate	., ,,, e. a.e				
	Observation of the mi	ilk on hand on 10/13/17 at				
	8:34 a.m. revealed:					
	-There were four full of	gallons of whole milk.				
	-There was one gallo	n of 2% reduced fat milk that				
	had approximately 1/4	of the milk remaining.				
	-There was one gallo	n of 1% reduced fat milk that				
	had approximately 1/4	of the milk remaining.				
		ilk on hand on 10/17/17 at				
	8:25 a.m. revealed:					
		allons of 2% reduced fat				
	_	of 2% reduced fat milk that				
		3 of the milk remaining.				
	_	gallons of 1% reduced fat				
	milk.					
	Observation of the lur	ach moal sorvice on				
		n. revealed residents were				
		at included 6oz of milk.				
	301 VCd DC VClages the	at included 662 of fillik.				
	Review of the posted	menu in the kitchen for				
		18, Week 3" on 10/17/17 at				
	8:26 a.m. revealed:	, , , , , , , , , , , , , , , , , , , ,				
		cluded the current week for				
	October 2017.					
		served daily at breakfast,				
		serving size of milk was not				
	documented on the m	nenu.				
		ent on 10/12/17 at 12:15				
	p.m. revealed the res	ident did not usually get milk				
	at meals.					
	Intendance 10	nd resident on 10/12/17 at				
	INTERVIEW WITH A CECO	na regident on 10/17/1/ at	1	1		

Division of Health Service Regulation

5:10 p.m. revealed:

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Division o	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	0
		1141 004000	B. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE. ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENOT)		
D 299	Continued From page	176	D 299			
2 200	Continued i form page	. 170	2 200			
	-"We never get milk."					
	-The resident would li	ke to have milk every day.				
	-"I love it."					
	Interview with a family	y member on 10/12/17 at				
	12:22 p.m. revealed:	, mombor on 10, 12, 17 at				
	-The residents never	had milk				
		is only served at breakfast				
	(with cereal).					
		visited at least once daily				
	and never saw milk be	eing served at meals.				
	Interview with a secon	nd family member on				
	10/12/17 at 3:45 p.m.	revealed milk was not				
	served at lunch or din	ner.				
	Confidential staff inter	rviews revealed:				
	-The first time the star	ff had ever seen milk served				
	was that day (date wi					
	confidentiality).					
	-The residents were "	nover" served milk				
	-THE TESIDENTS WEIE	never served milk.				
	Interview with a Cool	/Madication Aida (MAA) on				
		/Medication Aide (MA) on				
	10/11/17 at 8:20 a.m.					
		milk every other day.				
	-They usually kept 4-	5 gallons of milk on hand all				
	the time.					
	Interview with a secon	nd Cook on 10/13/17 at 8:30				
	a.m. revealed:					
	-Milk was bought at a	local store.				
	-They kept 4-6 gallon					
		e (oz.) of milk at each meal.				
		y residents would say they				
	were not being served					
	•	ilk, she turned the receipt in				
	to the Manager.					
	-The only receipt she	had was from 10/11/17.				

Division of Health Service Regulation

Review of an itemized receipt from a local

STATE FORM 6899 DBPR11 If continuation sheet 177 of 419

Division of Health Service Regulation

DIVISION OF RESIDENCE REGULATION		0(0) 14111 7151 5	CONCERNATION	1000 5475 0	110,45,4	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING: _	A. BUILDING:		
					R-	c
		HAL031003	B. WING		1	7/2017
NAME OF T	201/IDED OD 61/251/155		DDDE00 0:T/ 6=:	TE 7/D 000E	-	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ILE, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGOLATORI ORT	EGO IDENTIL PING IN ORMATION)	TAG	DEFICIENCY)	WATE.	
D 299	Continued From page 177		D 299			
	department store date	ed 10/11/17 revealed three				
	gallons of milk were li					
	9					
	Interview with the Adr	ministrator on 10/13/17 at				
	10:30 a.m. revealed:					
	-The Manager bought	t milk from a local store for				
	the facility.					
		d not have any receipts for				
	milk purchases.					
	-They were supposed	d to have milk in stock.				
	Daniel an abanesation	:-t:				
		ns, interviews, and review of				
		d menu, the facility failed to				
		maintain enough milk on				
		es of milk at least twice daily				
	to a census of 20 resi	-				
	10 4 0011343 01 20 1031	dente.				
D 210	10 A NO A O 12 E 000 A	1/a)/4) Nivitain and Food	D 310			
טונט	Service	4(e)(4) Nutrition and Food	0310			
	Service					
	104 NCAC 13F 0904	Nutrition and Food Service				
		s in Adult Care Homes:				
	• •	ets, including nutritional				
	. ,	kened liquids, shall be				
		the resident's physician.				
	ŕ	. ,				
	This Rule is not met as evidenced by:					
	TYPE B VIOLATION					
		ns, interviews, and record				
		illed to assure therapeutic				
		3 of 3 residents sampled				
	• • • •	orders for thickened liquids				
	(#2) and nutritional su	upplements (#1, #4).				
	The findings					
	The findings are:					

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVIP	LETED
		HAL031003	B. WING		I	-C 17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 310	O 310 Continued From page 178		D 310			
	Review of Resider 04/06/17 revealed dia Alzheimer's and hype					
		orders for Resident #2 dated order for honey thickened				
	a.m. revealed: -There was a handwi posted on the freeze	list did not list residents with				
	revealed: -Resident #2 was on -She had been mixing years."	on 10/11/17 at 11:30 a.m. honey thickened liquids. g and using thickener "for ections on the thickener ident #2's liquids.				
	revealed: (Thickener liquids to achieve ner consistency for indiviproblems to prevent liquids into the lungs). For honey consistent teaspoons of thickenwaterFor honey consistent "5-5.5" teaspoons of glass of supplementFor honey consistent	as belonging to Resident #2 is a powder added to thin ctar, honey, or pudding duals with swallowing choking or aspiration of the b.				

Division of Health Service Regulation

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	2 179	D 310		
	-Let stand for 30 secondieve desired consumble and stirred with mile stirred by let stand 5 and	onds to one minute to istency and serve. k or nutritional supplement, is-10 minutes, stir and serve. Issume within 30 minutes of uring device found inside the issume that is a Geri-chair in the dining staff member. Is so of honey thickened water iney thickened milk sitting at etting. It is feeding Resident #2 a pudding thickened iz glass. Exhibit any signs and			
	-Resident #2 did not exhibit any signs and symptoms of choking. Interview with Resident #2's hospice physician on 10/11/17 at 4:47 p.m. revealed: -Resident #2 had previously been on hospice, but she stabilized and was removed from hospice (he did not recall the dates right off hand)Resident #2's family member requested she be re-evaluated for hospice because she was having swallowing difficulty and poor appetiteHe recalled it being mentioned at a care meeting that Resident #1 was on nutritional supplements and honey thickened liquids -Resident #2 would have been at risk for aspiration on any consistency of liquids due to her end stage dementiaResident #2 should not receive liquids thinner than honey consistency. Interview with a cook on 10/12/17 at 8:20 a.m.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 180	D 310		
	for breakfast.	ted Resident #2's beverages			
	resident's water and o	of thickener powder in the orange juice.			
	the cook pointed to a that was what she ha	2/17 at 8:20 a.m. revealed regular teaspoon indicating d used to measure the			
	orange juice.	Resident #2's water and			
	Observation on 10/12 -Resident #2 had 4oz thickened.	2/17 at 8:38 a.m. revealed: c of milk that was not			
	-Resident #2 had hor orange juice served.	ney thickened water and			
		on 10/12/17 at 8:38 a.m. not esident #2 because it was stency.			
	(MA/S) and cook on 1 revealed:				
	not honey thickened	that Resident #2's milk was consistency. ne cook not to thicken			
		old the cook not to thicken			
		thought it was a nutritional supplement was already			
	-The cook began to d thickened Resident #	2's liquids.			
	glass (without use of	onal supplement into a 4oz a measuring device). ular teaspoon to measure			

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Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL031003	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
24.0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N 0.50	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
				DEFICIENCY)		
D 310	Continued From page	. 191	D 310			
D 310	Continued From page	5 101	5010			
	the thickener powder	•				
	-She was prompted to	o stop the process (because				
	she was not using ap	propriate measuring				
	devices, so as not to	waste the nutritional				
	supplement).					
	Interview with the coo	ok on 10/12/17 at 8:45 a.m.				
	revealed:					
	-She was trained a lo	ng time ago with a different				
	type of thickener.					
	-She had not had any	training on how to mix				
	Resident #2's thicken	ier.				
	Observation of the lui	nch meal service on				
	10/12/17 at 12:07 p.n	n. revealed:				
	-Resident #2 was in a	a Geri-chair in the dining				
	room being fed by a h	nospice Registered Nurse				
	(RN).					
		ss of honey thickened water				
	_	oney thickened tea sitting at				
	Resident #2's place s					
	•	Resident #2 a spoon of				
		hickened substance out of a				
	4oz glass.					
	-Resident #2 did not					
	symptoms of choking					
	154555 90 0 2					
		spice RN on 10/12/17 at				
	12:07 p.m. revealed:	and the best seen Book 1992				
		e she had seen Resident #2				
		rom hospice in June 2017.				
		propriately responding to				
		noney thickened beverage.				
	-Resident #2 did not					
	symptoms of choking					
	Talanhana istassi	with Decident #01- DOD				
		with Resident #2's PCP on				
	10/13/17 at 2:15 p.m.					
		a facility staff member on				
	10/9/17 that Resident	t #2 was having difficulty	1			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
		WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 182	D 310			
	Interview with a MA/S	red honey thickened liquids. S on 10/16/17 at 12:30 p.m.				
	revealed Resident #2 thick liquids well.	was tolerating the honey				
	Interview with the hospice RN on 10/16/17 at 12:35 p.m. revealed Resident #2 has had no issues with swallowing the honey thick liquids.					
	Interview with Resident #2's family member on 10/17/17 at 8:55 a.m. revealed: -Prior to the resident's emergency room (ER) visit for coughing on 10/7/17, she was on a regular diet and had no problems swallowing that he was aware ofHe was informed by the ER physician that "she may need to be considered for a liquid diet".					
		edical records for Resident did not show any physician				
	Interview with the Administrator on 10/17/17 at 10:19 a.m. revealed she would make sure staff were trained to mix thickened liquids.					
	2. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.					
	Review of physician's orders for Resident #1 dated 02/21/17 revealed an order for a (named type/brand) nutritional supplement one carton every six hours while awake "no stop date."					
	Observation of the kit a.m. revealed:	chen on 10/11/17 at 11:30				

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Division of Health Service Regulation

	of Health Service Regu				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D 0	
			B. WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATURY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	
D 310	Continued From page	e 183	D 310			
		the type/brand of nutritional				
	supplements Resider	nt #1 was ordered stocked in				
	the refrigerator or free	ezer.				
	-There was a handwr	itten therapeutic diet list				
	posted on the freezer	door.				
	-The therapeutic diet	list did not contain a list of				
		for dietary supplements.				
		,				
	Observation of the lui	nch meal service on				
		a.m12:00 p.m. revealed				
	Resident #1 was not					
	supplement.	Screed a natificinal				
	supplement.					
	Observation of the kit	chen on 10/12/17 at 8:18				
		nd and type of nutritional				
		#1 was ordered was not				
	stocked in the refrige	rator or freezer.				
		eakfast meal service on				
		.m8:30 a.m. revealed:				
	-Resident #1 was ser	ved orange and water for				
	beverages.					
	-Resident #1 was not	served a nutritional				
	supplement.					
	Observation of the lui	nch meal service on				
	10/12/17 from 11:30 a	a.m 12:07 p.m. revealed:				
	-Resident #1 was ser	ved water, tea, and 4oz milk				
	for beverages.					
	-Resident #1 was not	served a nutritional				
	supplement.	 -				
	Observation of the kit	chen on 10/17/17 at 8:25				
		ered brand of nutritional				
		dent #1 was not stocked in				
	the refrigerator or free	52 6 1.				
	Deview of Deside 1."	idle October 2017				
	Review of Resident #					
	medication administra	ation records (MARs)	1			

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revealed:

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED
					D 0
		1141 004000	B. WING		R-C
		HAL031003	B: Will		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	ITH NC 41		
GOLDEN	CARE		E, NC 28466		
			L, NO 20400	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 310	Continued From page	e 184	D 310		
	-There was a comput	er generated entry for the			
		ritional supplement one			
	carton every 6 hours				
	,	of 8:00 a.m., 2:00 p.m., and			
	8:00 p.m.	o. 0.00 a.m., 2.00 p.m., and			
		amont was decumented as			
		ement was documented as			
	•	10/01/17 and 10/02/17.			
		ement was documented as			
		y from 10/03/17-10/06/17.			
		ement was documented as			
	•	10/07/17 and 10/08/17.			
		ement was documented as			
	•	y from 10/09/17-10/10/17.			
		ement was documented as			
	_	d 2:00 p.m. on 10/11/17 (it			
	was not in stock).				
		ement was documented as			
	given at 8:00 a.m. on	10/13/17 (it was not in			
	stock).				
		cation aide/supervisor			
	(MA/S) on 10/12/17 a				
	Resident #1 was not	on a nutritional supplement.			
	Interview with a cook	on 10/12/17 at 12:17 p.m.			
	revealed:				
	_	nt #1 was on nutritional			
		nes a day unless the order			
	changed.				
	-They were out of Res	sident #4's brand/type of			
	nutritional supplemen	ts right now.			
		ith the cook on 10/12/17 at			
	3:30 p.m. revealed:				
	-She recalled taking t	he last of the brand/type of			
	nutritional supplemen	t Resident #1 was ordered			
	out of the refrigerator	on Tuesday (10/10/17); she			
	_	upplement to Resident #1.			
	-She was told by a (n				
		nal supplement three times			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251110		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
		WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 185	D 310			
	a day with meals but order for the nutrition	did not know if he had an al supplements.				
	10/12/17 at 7:50 p.mShe thought Resider supplement at one tin getting the supplement	onal care aide (PCA) on revealed: at #1 was on a nutritional ne, but he had not been nt "recently" (over a month). sike he had lost weight over				
	Interview with a second cook on 10/13/17 at 8:30 a.m. revealed Resident #1 was the only resident on the specific brand of nutritional supplements.					
	revealed she had nev	on 10/16/17 at 3:00 p.m. rer observed Resident #1 onal supplement at meals.				
	Telephone interview with Resident #1's family member on 10/13/17 at 7:06 a.m. revealed: -Resident #1 had lost weightThe family member did not know how much weight he had lost or over what period of time, but the family had to purchase a smaller size sweat pants for the residentThe family member did not know if or when Resident #1 was weighedResident #1 was not on a nutritional supplement.					
	dated 10/02/17 revea	Visit form for Resident #1 led there was even pound weight loss in 6				
	(NP) at Resident #1's office on 10/16/17 at	vith a Nurse Practitioner Primary Care Provider's 3:31 p.m. revealed: ne weight loss, which was to				

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
					1 10////2011	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
		,		DEFICIENCY)		
D 210	Oti	- 400	D 310			
D 310	Continued From page	2 186	0310			
		ent #1 receive his (named				
		ll supplement as ordered.				
		he facility was out of the				
		nutritional supplements or				
	that Resident #1 had					
	nutritional supplemen	ns. notification that the facility				
	•	supplements depended on				
		nent had been out of stock.				
	now long the supplem	none had been eat or eteck.				
	Staff was asked to we	eight Resident #1 on				
		n.; however the weight was				
	not provided and staf	f were not observed to weigh				
	the resident.					
		ee months of receipts from				
		rs was requested from the				
	Administrator on 10/1	•				
	however, the receipts	s were not provided.				
	Observation of the kit	tchen on 10/17/17 at 8:15				
		vas a handwritten diet list				
		which had Resident #1's				
	name documented to					
	supplements.					
		tchen on 10/17/17 at 8:25				
	a.m. revealed the typ					
		nt #1 was ordered was not				
	stocked in the refrige	TAILUI UI IIEEZEI.				
	Based on observation	ns, records reviews, and				
		#1 was not interviewable.				
	Refer to the interview	with a cook on 10/12/17 at				
	11:30 a.m.					
	Refer to the interview					
	aide/supervisor (MA/S	S) on 10/12/17 at 12:15 p.m.				

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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R-C	
		HAL031003	B. WING		10/17/201	7
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
001.5511		4002 SO	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COM	(5) PLETE ATE
D 310	Continued From page	e 187	D 310			
	Refer to the second in 10/12/17 at 3:30 p.m.	nterview with a cook on				
	Refer to the interview 10/13/17 at 8:30 a.m.	with a second cook on				
	Refer to the interview 10/13/17 at 10:30 a.m	with the Administrator on n.				
	Refer to the second in Administrator on 10/1					
	06/05/17 revealed dia	t #4's current FL-2 dated agnoses included traumatic and bi-polar disorder.				
	dated 10/02/17 revea -There was documen lb. weight loss over tv	tation Resident #4 had a 4 vo weeks.				
	lbs.	was documented as 119 for a (named type/brand) t with each meal				
		nt #4 on 10/11/17 at 4:20				
	-She had lost 21 lbs. hospitalization (unsur					
	plate did not fit and sh new one.	ne was going to be getting a				
	lost weight.	re baggy because she had o be weighed once a month.				
		nt #4 on 10/13/17 at 4:50 d never received a (named) t.				

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Division of	Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D 0	
		1141 024002	B. WING		R-C	
		HAL031003	B: Willo		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	ΓH NC 41			
GOLDEN	CARE		, NC 28466			
0411.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 310	Continued From page	100	D 310			
D 310	Continued From page	5 100	D 010			
	Observation of the kit	chen area on 10/11/17 at				
	11:30 a.m. revealed:					
	-There were none of t	the type/brand of nutritional				
	supplements Resider	nt #4 was ordered stocked in				
	the refrigerator or free	ezer.				
	-There was a handwr	itten therapeutic diet list				
	posted on the freezer	door.				
	-The therapeutic diet	list did not list the residents				
	with orders for nutrition	onal supplements.				
		chen area on 10/12/17 at				
		e type/brand of nutritional				
		nt #4 was ordered was not				
	stocked in the refriger	rator or freezer.				
	Observation of the su					
	10/13/17 at 5:10 p.m.					
		ved milk, water, and tea as				
	beverages.					
	-She was not served	a nutritional supplement.				
	01 (11 1					
		eakfast meal service on				
	10/16/17 at 8:15 a.m.					
		ved milk, water, and orange				
	juice as beverages.					
	-She was not served	a nutritional supplement.				
	Davious of Davidant #	Ma October 2017				
	Review of Resident #					
	medication administrate revealed:	ation records (WARS)				
	-There was not an en	try for the nutritional				
	supplements.	ay ior the numborial				
		nentation of Resident #4				
		upplements on the October				
	MAR.	applements on the October				
	IVII/ALX.					
	Interview with a media	cation aide/supervisor				
	(MA/S) on 10/12/17 a	· ·				
		on a (named) nutritional				

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supplement

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	HAL031003 B. WING			R-C 10/17/2017		
NAME OF P	ROVIDER OR SUPPLIER			TE, ZIP CODE	10/11/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 310	Continued From page	e 189	D 310			
	1:00 p.m. revealed: -She did not know Re the (named type/bran -She would check on nutritional supplemen -She did not think Re; nutritional supplemen -All she could say was order for Resident #4 Interview with a Perso 10/16/17 at 3:00 p.m. observed Resident #4 nutritional supplemen A copy of the last thre the vendor food order Administrator on 10/1 however, the receipts Telephone interview w (NP) at Resident #1's office on 10/16/17 at 3 -She expected Reside nutritional supplemen -She was not aware to nutritional supplemen not been getting the re -Her expectation on re was out of nutritional how long the supplemen Observation of the kit 8:15 a.m. revealed the	sident #4 had been getting ts. s they probably missed the s nutritional supplements. In all Care Aide (PCA) on revealed she had never to being served any type of that at meals. It is months of receipts from the swas requested from the 3/17 at 10:30 a.m.; In were not provided. In a Nurse Practitioner Primary Care Provider's 3:31 p.m. revealed: I ent #4 receive her (named) that as ordered. I he facility was out of the facility was out of the facility was out of the facility supplements. I otification that the facility supplements depended on the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		A. BUILDING:				
		HAL031003	B. WING			R-C)/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
COLDEN	CARE	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 310	Continued From page	e 190	D 310			
	a.m. revealed the typ	nt #4 was ordered was not				
	Refer to the interview 11:30 a.m.	with a cook on 10/12/17 at				
	Refer to the interview with a medication aide/supervisor (MA/S) on 10/12/17 at 12:15 p.m. Refer to the second interview with a cook on 10/12/17 at 3:30 p.m.					
	Refer to the interview 10/13/17 at 8:30 a.m.	with a second cook on				
	Refer to the interview 10/13/17 at 10:30 a.n	with the Administrator on n.				
	Refer to the second in Administrator on 10/1					
	revealed:	on 10/12/17 at 11:30 a.m.				
		(named) residents who supplement (not Resident				
		n list for staff on who was nutritional supplements; staff em.				
	(MA/S) on 10/12/17 a -The (named brand/ty were kept in the kitch -The cooks served th supplements.	cation aide/supervisor It 12:15 p.m. revealed: It p.m. revealed: I				
		ts Resident #1 and Resident				

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Division of	of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					R-	-C
		HAL031003	B. WING		1	17/2017
			-		1 10/1	172011
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		WALLACI	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
D 210	O	- 101	D 210			
D 310	Continued From page	e 191	D 310			
	#4 were ordered in st	ock.				
	-The Manager ordere	ed the (named brand/type)				
	nutritional supplemen	its.				
		ith a cook on 10/12/17 at				
	3:30 p.m. revealed:					
	_	y ordered the nutritional				
		sident #1 and Resident #4				
		different (named) staff				
		may have forgotten to order				
	the nutritional suppler	e last time the facility had				
		ed) nutritional supplements				
	ordered for Resident					
	ordered for resident	#1 and resident #4.				
	Interview with a secon	nd cook on 10/13/17 at 8:30				
	a.m. revealed:					
	-The Manager usually	y ordered the type/brand of				
	-	its that Resident #1 and				
	Resident #4 were ord	lered.				
	-She (the cook) order	red the (named brand/type)				
	• • • • • • • • • • • • • • • • • • • •	its the last time, but the				
		them because she (the				
	• ,	k there were any residents				
	who were supposed t					
		osed to give the residents				
		ements; if the MA/S forgot,				
		utritional supplements.				
		ss in place to make sure tritional supplements as				
	ordered.	unional supplements as				
		e there was a process in				
		esidents got their nutritional				
	supplements.	coldenie get their Hathtenian				
	- -					
	Interview with the Adr	ministrator on 10/13/17 at				
	10:30 a.m. revealed:					
	-Nutritional suppleme	ents were usually given at				
		as working in the kitchen.				
	-Resident #1 and Res	sident #4's type/brand of				

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Division C	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_		_	_
					R-(
		HAL031003	B. WING		10/1	7/2017
NAME OF D		STREET A	DDRESS, CITY, STA	TE 710 CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		, ,	II E, ZIP CODE		
GOLDEN	CARE	4002 SOI	JTH NC 41			
00252.11	57 ti t =	WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 310	Continued From page	102	D 310			
D 310	Continued From page	5 192	5010			
	nutritional supplemen	its were ordered from a				
		may have forgotten to order				
	them.	, ,				
		run out of the (named)				
	nutritional supplemen					
	• • • • • • • • • • • • • • • • • • • •	nal supplements were				
	supposed to be kept i					
	ordered.	in stock and given as				
		he facility was out of the				
	• •	nal supplements Resident #1				
	and Resident #4 were	•				
	_	nutritional supplements.				
		dietary staff would let the				
	MA/S know if they we					
	nutritional supplemen					
	-The PCP would not be	be aware that the facility was				
	out of the (named) nu	ıtritional supplements.				
	A second interview wi	ith the Administrator on				
	10/17/17 at 10:19 a.m	n. revealed:				
	-The specified brand/	type of nutritional				
		be routinely ordered from the				
	vendor every two wee					
	•	vendor to try to get the				
		s delivered last week, but				
	could not get them.					
		nutritional supplements				
	would be back in stoc					
		been giving the nutritional				
	supplements, but the					
		· Francisco de la companya del companya del companya de la company				
	~	S would give them now and				
	document on the MAI					
		t kept with orders of who				
	was supposed to get	nutritional supplements.				
	TI 6 99 6 9 11					
	The facility failed to a					
		pt in stock and served as				
	ordered to two reside	• •				
		oss and failed to assure				
	Resident #2, who had	d swallowing difficulty, was				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:	
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
COLDEN		WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 193	D 310		
	served honey thicken facility's failure was d	ed liquids, as ordered. The etrimental to the health and its which constitutes a Type			
	10/12/17 revealed: -Facility will provide in physician and ensure availableStaff will be in-service to correct thickeners and thickeners and thickeners and thickeners and thickeners and the supplements and thickenersDietary Manager will supplementsAdministrator will audenties and thickeners and thickeners and thickeners.	ed on how to mix thickener ordered. d in the kitchen for keners. be responsible for ordering dit charts for diet orders. ntory food supply to ensure ent supply at all times.			
	supplements and doc -Food supply will be r -Administrator will comixing thickener and documentation weekl	monitored weekly. Induct observation weekly of review MAR for y.			
	1, 2017.				
D 317	10A NCAC 13F .0905	5 (d) Activities Program	D 317		
	10A NCAC 13F .0905	5 Activities Program			
	variety of planned gro include activities that physical interaction, g	minimum of 14 hours of a bup activities per week that promote socialization, group accomplishment, ncreased knowledge and			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			R-C	
		HAL031003	B. WING		I	/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN	CARE		JTH NC 41				
			E, NC 28466				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 317	Continued From page	e 194	D 317				
	learning of new skills exclusively for reside exempt from this required facility can demonstrate resident's involvement Examples of group and dancing, games, exemparties, discussion grouncil meetings, both appreciation, review of spelling bees. This Rule is not met Based on observation interviews, the facility of 14 hours of planners.	Homes that care ints with HIV disease are uirement as long as the ate planning for each it in a variety of activities. ctivities are group singing, rcise classes, seasonal oups, drama, resident ok reviews, music of current events and as evidenced by: as, record review and failed to assure a minimum d group activities were for the 20 residents currently					
	The findings are:						
	10/12/17, 10/13/17, 1 revealed: -There were no activi 2017.	calendar on 10/11/17, 0/16/17 and 10/17/17 ties posted for October showed only those for					
		/17 from 9:15 a.m5:15 vere no activities being					
	p.m. revealed: -At 10:25 a.m., there	•					

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DIVISION	n nealth Service Regu	iation			1
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE. ZIP CODE	
			JTH NC 41	,	
GOLDEN	CARE				
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIL BALL
				,	
D 317	Continued From page	e 195	D 317		
	F- 3 -				
	Observation on 10/13	3/17 from 7:45 a.m7:00			
	p.m. revealed there w	ere no activities being			
	conducted.				
	Observation on 10/16	5/17 from 9:00 a.m5:45			
	p.m. revealed there w	ere no activities being			
	conducted.				
	Conductou.				
	Observation on 10/17	7/17 from 8:15 a.m8:00			
		vere no activities being			
	conducted.				
	1. (0/44/47 - 1.44-45			
		ent on 9/14/17 at 11:15 a.m.			
	revealed:				
		tivity calendar was "a lie."			
		ties at the facility, other than			
	when the preacher ca	ame on Saturday; the			
	preacher did not com-	e every Saturday.			
	Interview with a perso	onal care aide (PCA) on			
	8/15/17 at 3:38 p.m. r	evealed she had never			
	done activities with th	e residents.			
	Interview with a secon	nd PCA on 10/17/17 at 5:20			
	p.m. revealed:				
	-The activity calendar	was "for show "			
	-None of the activities				
	_	en changed the calendar.			
		ng to do but sit around; no			
	activities were done v	vitn the residents.			
		dication aide/supervisor on			
	10/11/17 at 9:20 a.m.				
		or" were responsible for			
	doing the activities wi	th the residents.			
	-She and one other e	mployee had taken the			
	activities course in the				
	specified).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		CO EL 1ED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 317	Continued From page	e 196	D 317			
	Confidential interview -The resident did not activities other than c sometimesThe resident did thei Confidential interview revealed: -They did not have er -They needed to have facilityThey did not take the Interview with the Adr 10:50 a.m. revealed: -The Manager was re everything at the facil activitiesThe Manager had be about 2 months and v interviewNo one took over res	with a resident revealed: think the facility had hurch and preaching r own activities. with a second resident hough activities at the facility. e more activities at the e residents on outings. ministrator on 10/13/17 at esponsible for doing lity including overseeing the een out on medical leave for				
D 321	10A NCAC 13F .0906 And Services	6(a) Other Resident Care	D 321			
	Services (a) Transportation. The assure the provision of residents of adult care resources and activities to the nearest appropagations agencies, shadilities, and religious	Other Resident Care And The administrator shall of transportation for the e homes to necessary es, including transportation priate health facilities, social hopping and recreational s activities of the resident's shall not be charged any service. Sources of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 321	Continued From page	e 197	D 321		
	transportation may inc public systems, volun members as well as f				
	This Rule is not met Based on record revie facility failed to provid transportation for resi appointments, the hos	ews and interviews, the le the provision of dents to medical			
	The findings are:				
	revealed: -She had no transpor up from the hospital.	er on 08/18/17 at 8:20 a.m. t staff just to pick a resident e transport person to pick a the emergency room.			
	08/18/17 at 5:13 p.mShe had been at the -A resident was sent of member could pick the -If the family member resident, the Manage bed and go pick up the -That had been the re- not want to send resident.	facility since October 2016. but to the hospital if a family e resident up. could not pick up the r would have to get out of le resident. eason why the Manager did			
	when the resident wa someone from the fac up. Confidential interview member revealed:	s sent to the hospital, cility would pick the resident with a resident's family			
	-The family member I	ived close by, and visited			

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	С
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE 710 CODE		
INAIVIE OF F	ROVIDER OR SUFFLIER		, ,	KIE, ZIF GODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIATE	DATE
				DETICIENCY)		
D 321	Continued From page	e 198	D 321			
	often.					
	-The family member h	nad been told there was			ľ	
	nobody to drive the fa	cility van, so the family			ļ	
	member took the resi	dent to medical				
	appointments.					
	-Staff used their person	onal cars to pick up				
		spital, but not since the				
	Manager had been ou					
	a.a.goaa boon o					
	Interview with a reside	ent on 10/17/17 at 8:55 a.m.				
	revealed:					
		gh staff to take residents to				
	appointments.	gri stail to take residents to				
		ere was no staff available to				
	_				ļ	
	carry or transport resi	idents to the doctor.				
	1 Interview with Desi	dont #4 on 10/12/17 of 4:50				
		dent #4 on 10/13/17 at 4:50				
	p.m. revealed:					
	-The Manager did not					
		ound clinic because "it's so			ļ	
	far away."					
	• •	n Aide/Supervisor (MA/S)			ļ	
	-	d not have enough staff to				
	transport her to the w	ound clinic appointments.				
	-The Manager told the	e resident that she had to				
	directly ask for her for	r transportation to the wound				
	clinic.					
					ĺ	
	Interview with a medi-	cation aide/supervisor				
	(MA/S) on 10/12/17 a	t 1:40 p.m. revealed:				
	-The home health age	ency wanted Resident #4 to				
	•	nearby (named) city about				
	her head wound, but					
		a different physician in a				
	different (named) city					
	-"Somebody" (not fac					
		pointments, but then the				
	facility started transpo					
		nung ner to the				
	appointments.	ally know what have a				
	- ine MA/S did not rea	ally know what happened,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			R-C		
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 321	Continued From page	e 199	D 321		
		we wouldn't take her"; to try to go to a specific			
	Social Worker (SW) or revealed:	with Resident #4's previous on 10/16/17 at 4:48 p.m. ned because Resident #4			
	-The SW was concerned because Resident #4 had multiple medical appointments and the resident expressed concerns about lack of				
		appointments.			
	appointmentsThe facility was not a any documentation of	able to provide the SW with fany missed appointments.			
		ent #4 to multiple medical nfected head wound (in July			
		the Manager about her esident #4's transportation to			
	-The Manager said R any medical appointn	esident #4 had not missed nents and would not provide related to transportation.			
		clinic visit history revealed an appointment on 10/02/17 ason cancelled" was			
	(RN) at Resident #4's 10/16/17 at 10:55 a.n -Resident #4 was sch clinic appointments fo -Resident #4 missed	neduled for weekly wound or an open skull wound. an appointment scheduled ck of transportation; the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
				R-C
	HAL031003	B. WING		10/17/2017
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		UTH NC 41	,	
GOLDEN CARE		CE, NC 28466		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 321 Continued From page	200	D 321		
4:00 p.m. revealed: -She did not know what Resident #4's wound of appointments because -The Manager was not about the matter. Refer to the interview with 8/24/17 at 10:15am. Refer to the interview with 10/17/17 at 10:10am. 2. Review of Resident revealed: -Diagnoses included Hober Dementia, Depression -The resident was sem -The resident had bladed Interview with Resident p.m. revealed: -Resident #12 had been yearThe doctor had stated resident #12 only too -The Manager took he her at the store for two -She had to call the fact they had forgotten her. Interview with the Mana 8/22/17 at 6:00 p.m. recon 07/24/17, Resident the store.	clinic transportation or a she was not here then. It available for interview with the Manager on with the Administrator on #12's FL-2 dated 4/6/17 Rypertension, Anemia, and Hyperlipidemia ni-ambulatory. Ider and bowel continence. In #12 on 8/22/17 at 3:01 en at the facility for one is that her "mind is sharp". It is a heart pill and ibuprofen. In to the local store, and left is hours. In cility because she thought in ager of the local store on			

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	<u>of Health Service Regu</u> FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION	(X3) DATE SI	JRVFY
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLE	
			_		R-0	_
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF T	NOVIBER OR GOLF EIER		JTH NC 41	12, 211 0002		
GOLDEN	CARE		E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	XIAIE	DAIL
D 221	0	- 004	D 321			
D 321	Continued From page	201	D 321			
	store.					
		ld to sit outside on the				
	lt was 98 degrees ou	finished her shopping.				
		nt #12 to remain in the store				
	outside of her office in					
	-She called the facility	y several times about				
	someone picking up F					
		ed at the store for 2 hours				
	before being picked u	ıp.				
	Interview with the Ma	nager on 8/24/17 at 10:15				
	a.m. revealed:					
	-Resident #12 did her	own shopping at the local				
	store.					
	-She took Resident # dropped her off.	12 shopping at the store and				
	• •	month but she could not				
	remember the date.					
		ompetent to leave because				
	•	oing her own shopping and				
	paying.					
	to the store.	ed "forever" when she went				
		street from the store at an				
	appointment.					
		as full so the Manager had				
	to wait.					
	-The Manager of the shad forgotten Resider	store called to see if she				
		ily been at the store for one				
	hour when she got the	•				
	-After she got the cal	ll, she picked Resident #12				
		inutes after she received the				
	call from the store Ma	anager.				
	Refer to the interview	with the Manager on				
	8/24/17 at 10:15 a.m.					

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Refer to the interview with the Administrator on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		HAL031003	B. WING		R-0 10/1	C 7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 321	Continued From page	202	D 321			
	10/17/17 at 10:10 a.m	1.				
	a.m. revealed: -The facility had no space was the transportThe facility had one for the facility had no space with the facility had one for the facilit	ransportation van. ministrator on 10/17/17 at sport a resident, the				
	Housekeeper would; she would not pull an aide off the floor. If it was after hours or if the Housekeeper was not there, she would transport residents to appointments or the hospital. There was supposed to be transportation available when residents needed it.					
D 324	10A NCAC 13F .0906 And Services	(d) Other Resident Care	D 324			
	10A NCAC 13F .0906 Services	Other Resident Care And				
	providing privacy for receive calls. (2) A pay station telelocal calls; and	I be available in a location residents to make and ephone is not acceptable for nome's obligation to pay for a				
	failed to assure reside	ns and interviews, the facility				

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
					R-	С
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	II E, ZIP GODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
D 324	Continued From page	e 203	D 324			
		ts using the telephone at the				
	nurses' desk without	privacy.				
	The findings are:					
	Observation on 10/13	3/17 at 10:19 a.m. revealed:				
	-A resident came to the	ne nurses' station to use the				
	telephone.					
	-There were 3 staff pr	resent at the nurses' station				
	during the resident's t	telephone conversation.				
	-	•				
	Interview with the me	dication aide (MA) on				
	10/13/17 at 10:20 a.m	n. revealed:				
	-The phone at the nui	rses' station was the only				
	phone the residents of					
	· ·	or privacy, she would leave				
	the nurses' station.	pasy, ss meana leave				
	are ridress station.					
	Interview with the first	t shift medication				
	aide/supervisor on 10					
	revealed:	, 10/17 at 0.00 a.m.				
		ss to a phone; the phone				
	was kept at the nurse	·				
	-She would have to a					
	-Sile would have to a	ssist some residents.				
	Observation on 10/16	5/17 at 4:00 p.m. at the				
	nurses' station reveal					
		eu. ling next to the nurses'				
		phone (landline that the				
	nurses use).	regidente etendina errord				
		residents standing around				
	the resident while he	was taiking.				
	Intonious with a marri	anal care aide (DCA)				
	•	onal care aide (PCA) on				
	10/17/17 at 5:15 p.m.					
		none at the nurses' station to				
	make personal calls.					
	_	next to them when they are				
	talking."					
	-"Sometimes I let ther	m use my cell phone to				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_B c		
		HAL031003	B. WING		R-C 10/17		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN	CARE		JTH NC 41				
			E, NC 28466				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 324	Continued From page	e 204	D 324				
	make personal calls."	,					
	revealed: -The only phone they calls was at the nurseThey could not use to distance calls"I have no calls to modistance, so I can't medistance, so I can't	hat phone to make long ake locally, only long ake any calls." ne." r resident on 10/17/17 at so I use that." e phone at the desk, but					
D 000	at the nurses' station.		D 000				
D 338	all residents guarante	Resident Rights hall assure that the rights of ed under G.S. 131D-21, ents' Rights, are maintained	D 338				
	This Rule is not met	as evidenced by:					

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					R-C	`
		HAL031003	B. WING		1	
		HALUSTUUS	1		10/1/	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
			., 110 20400			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			 			
D 338	Continued From page	e 205	D 338			
	FOLLOW-UP TO TYP	PE A1 VIOLATION				
	TOLLOW OF TO TH	Z/// VIOZ/MION				
	Based on these finding	ngs, the previous Type A1				
	Violation was not aba	- · · · · · · · · · · · · · · · · · · ·				
	violation was not aba	ilica.				
	Rased on observation	ns, record reviews, and				
		failed to assure three				
		#15) were protected from				
	, , ,	sault from Resident #6 who				
		nts' rooms, stole a resident's				
		et into bed with a resident resident in a sexual manner				
	without consent (#14)					
	• • • • •	ere free from physical abuse				
	-	nd Staff D); failed to assure				
) were free of neglect by				
	_	's (#6) personal care needs				
		rced to sit at the nurse's				
	- ·	B), and personal care was				
	=	t (#8), who was left lying on				
		and received burns and				
	blisters to her back; a					
	. ,	cked up from a local store				
	after a reasonable am	nount of time.				
	The findings are:					
		t #8's FL-2 dated 7/8/16				
	revealed:					
	•	hypertension, presbycusis				
	and dementia.					
	-Resident #8 was sen	_				
	-Resident #8 was con	ntinent of bladder and bowel.				
		Care Plan dated 9/11/15				
		dent required assistance				
	with incontinent care	as needed daily and bathing				
	by staff.					
	Review of an Acciden	t/Incident report dated				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or Connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETED	
			R WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
			E, NC 28466		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	206	D 338			
		Resident #8 was found on with blisters on the resident's back was red.				
	9/25/17 revealed:	cords for Resident #8 dated				
	EMS at 10:38 a.m. af	to the emergency room via				
	_	ity, at which she resides, sident #8 had been left on a				
	heating pad all night a her back.	and that she was burned on				
	thermal burn; she had	ed to the hospital with a d a burn from the mid back				
	area down to the mid -The resident had sev some that had erupte	veral blisters noted and				
	revealed:	S) on 9/28/17 at 3:45 p.m.				
	9/1/17. -Resident #8's family	working at the facility since member came to the facility				
	between 7:00 p.m8: -She was in the middle medications and was	•				
	-She remembered Re	esident #8's family member led the heating pad on and				
	requested that staff to hours.	ırn the heating pad off in two				
	-She did not know wh	CA) about the heating pad. y the family member would				
	-	on and leave. y member had used the d turn it off before leaving				
	•	nat Resident #8 still had the				

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heating pad.

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Division of	<u>of Health Service Regu</u>	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-	C
		HAL031003	B. WING		1	7/2017
		TIALUS 1003			10/1	//201/
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN (CADE	4002 SOI	UTH NC 41			
GOLDEN	JARE	WALLAC	E, NC 28466			
(X4) ID PREFIX	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
D 338	Continued From page	e 207	D 338			
	-She and the second	shift PCA did rounds				
	together on the nights					
	-The PCA put Reside	ent #8 in the bed around 9:00				
	p.m.					ı İ
		heating pad when she went				
	into Resident #8's roo					
	-	y were made every two		ĺ		
	hours.					
	Intonuiow with a first s	shift personal care aide				
	(PCA) on 9/26/17 at 1					
		nt #8's room to get her up.				
		Inderneath Resident #8.				
	• .	on top of the heating pad; the				
		ctly on her skin and was on				
	high.			ĺ		
	-Resident #8 was lyin	ng on her right side.				ı
	-She had never know	n Resident #8 to use a				ı
	heating pad.					
		esident #8's family member				
	brought the heating p	ad in that evening.				
	Interview with the firs	st shift MA/S on 9/26/17 at				
	8:40 a.m. revealed:					
		vent to Resident #8's room to				
	get resident up and d					
		at Resident #8's back was				
	red and blistered.	aying on Resident #8's bed.				
	~ .	eating pad in the past, but				ı
		en taken out of the facility.				
		ow long the heating pad had				
	been under Resident					ı
		ust lay there because the		ĺ		
	resident could not get	•				I
	_	upposed to be checked on				I
	every 1 to 2 hours.					
	Interview with a Socia	al Worker (SW) from the				
	mitor viola mitir a coole	ar trontor (ott) nom are		i		1

Division of Health Service Regulation

local Department of Social Services on 9/29/17 at

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						0
		1141 024 002	B. WING		R-	
		HAL031003			10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		E, NC 28466			
1	OLIMANA DV. OT		1	DESCRIPTION DI AN OF CORRECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 220	IE		D 000			
D 338	Continued From page	∍ 208	D 338			
	10:00 a.m. revealed:		1			
		second shift PCA on 9/25/17.				
	•	he checked on Resident #8				
	all the time.	To officiation and it is a second and				
		nat Resident #8's family				
	· ·	heating pad to the facility the				
	previous night.	riculing pad to the lacinty the				
	, ·	ent #8 down on the heating				
	pad at around 9:00 p.	g .				
	-The PCA reported th					
	Resident #8 was havi					
		ing back pain.				
	Interview with second	d shift PCA on 9/29/17 at				
	10:55 a.m. revealed:	1311111 0/1011 3/20/11 41				
		at Resident #8 had the				
	heating pad.	At Resident no flee and				
	-She put Resident #8	to hed hetween 8:00				
	p.m9:00 p.m on the					
	(9/24/17).	Thight of the moldon	1			
		do with heating pad and no				
		ing to her about a heating				
	pad.	ing to not about a nearing				
	-She did not see a he	eating had				
		esident #8's family member				
		family member had spoken				
	_	the heating pad and the				
		ught in for warming Resident				
	#8's hands.	ight in for warming recordence				
		e MA/S was the one that put				
	the heating pad unde					
		esident #8's family member				
	about what happened		1			
	• • •	irn, so the resident probably				
	pulled the heating page					
	ı ·	a resident that will remain				
	still.	a reducite that will remain				
	Juli.					
	Interview with a third	shift MA/S on 9/27/17 at				
	3:08 p.m. revealed:	51111 1VII V 5 511 5/27/17 Gt				
		ng at the facility for a couple				
	One had been working	ig at the lacinty for a couple	1			1

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STATE FORM 6899 DBPR11 If continuation sheet 209 of 419

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STATEMENT	of Health Service Regul FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	,
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP	LETE
D 338	Continued From page	e 209	D 338			
	heating pad since she facility. -Resident #8 was soil night that night (9/24/ -The one time she was the third shift PCA, be another resident's rocShe walked in Resid of hours to check on she did not documen was something the Pu-When she checked on ext to Resident #8's breathing; she did nor resident. -No one on second sheating pad because -She did not see the lighted up the covbrief was and touched soiled, but she did nor resident because it work with a third 11:25 a.m. revealed: -She heard Resident the incident occurred check on the resident the incident occurred check on the resident -The PCA was not wowent to check on resi was normally quietShe went into Reside a.m12:30 a.m on 9/2	as soiled, she was toileted by ecause the MA/S was in om. ent #8's room every couple Resident #8. Int the checks because that CA knew to do. on Resident #8, she got up bed to make sure she was touch or bother the iff told her about the she would have checked it. heating pad when she ent. er where the incontinent do it to see if the resident was tould disturb her. shift PCA on 9/29/17 at #8 mumbling, on the night (9/24/17), so she went to it. orking on the second hall but dent, because Resident #8 ent #8's room between 12:00				

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-Resident #8 was soiled so she provided

incontinent care to the resident.

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Division of Health Service Regulation

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					R-	C
		HAL031003	B. WING		1	7/2017
					1 .07.	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
iAG		,	IAG	DEFICIENCY)		
D 000						
D 338	Continued From page	210	D 338			
	-Resident #8's body v	was warm but the resident				
	kept two or three blar	nkets on her bed.				
	-She removed the bla	inkets and left one sheet on				
	Resident #8.					
		g pad was there because				
		x lying beside the bed.				
		ite blanket on top of the				
	heating pad.					
	-Sne did not see wha set on.	t temperature the pad was				
	Set on.					
	Interview with the phy	sical therapist on 10/4/17 at				
	2:59 p.m. revealed:	yolodi tilorapiot oli 10/1/1/ di				
	-	eiving physical therapy due				
	to being non-ambulat					
	-She had been seen	five times since 9/5/17 for				
	physical therapy serv	ices for transferring and				
	strengthening.					
	 She was receiving st transfer. 	trengthening and learning to				
	-She was informed by	y the first shift Supervisor on				
	9/25/17 that staff wer	nt to get Resident #8 out of				
	bed and found her ba	ick blistered and red.				
		esident #8 was found lying				
	on a heating pad.					
		s lying on Resident #8's bed				
	and it was on high.	olisters intact on Resident				
	#8's back.	Sisters intact on resident				
		had busted, and some were				
	curved-shaped like th				ĺ	
		lent's #8's family member,				
	emergency managem	nent services (EMS) and			ĺ	
		e primary care provider			ľ	
	(PCP).					
		1.401-16-11				
	Interview with Reside	nt #8's family member on			ĺ	
	9/20/1/ at 2'20 n m r	evesied.	1	I .		i l

Division of Health Service Regulation

-The first shift MA/S on duty contacted her on 9/25/17 between 8:00 a.m. and 9:00 a.m. about

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Division c	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					_	_
			B. WING		R-	
		HAL031003	D. 11110		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN (CARE		E, NC 28466			
	OLIMANA DV. OT		·	SECURE PLAN OF CORRECTION		
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
,,				DEFICIENCY)		ı
7.000	. <u></u>		+			
D 338	Continued From page	e 211	D 338			ı .
	coming to the facility	regarding blisters on				ı .
	Resident #8's back.	regarding bilatera ari				ı
		went directly to the facility				ı ,
	after receiving the cal					ı .
		ii. looked at Resident #8's				ı
	_					ı
ļ	back, and it was burn				ļ	ı .
		cal therapist was at the				ı ,
	-	nat Resident #8 needed to be			ļ	ı ,
	taken to the hospital.	ident to the beautel				ı
ļ	_ = -	e resident to the hospital.			ļ	ı !
		s brought into the facility by				ı
		help keep Resident #8's				ı .
	hands warm.					ı .
		e heating pad last winter to				ı .
ļ	keep her hands warm				ļ	ı !
		informed the second shift				ı
	•	member had left the heating				ı
	•	ould warm Resident #8's				ı
	hands.					ı
ļ		turned the heating pad on			ļ	ı
	and left it hanging on					ı
	_	told the second shift MA/S to				ı
	unplug the heating pa					ı
	•	did not know why she said				ı
	turn it off in two hours					ı
		was never told by staff that				ı
		t have the heating pad.				ı
		was unsure as to how the				ı
	heating pad got on Re					ı
		f and unable to grip so there				ı
		t #8 could have moved the				ı
	heating pad.					ı
		transported Resident #8				1
	back to the facility.					1
						1
	Interview with the PC	A/housekeeper on 9/26/17				1
	at 2:41 p.m. revealed	i.				1
	-She was asked to tra	ansport Resident #8 back to				1
	the facility from the ho	ospital.				1
	-That was when she I	learned that Resident #8 had				1

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Division of Health Service Regulation

Division C	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					5.0
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	TO VIDER OR OUT FEET		, ,		
GOLDEN (CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
				DEI IOIENOT)	
D 338	Continued From page	212	D 338		
	Continuou i rom page	2.2			
	gotten burned.				
	-Staff should have do	ne the 2 hours checks like			
	staff were supposed t	to do; then staff would have			
	seen the heating pad				
	3 P				
	Interview with the Adr	ministrator on 9/26/17 at			
	9:35 p.m. revealed:	111110trator 011 0/20/17 at			
	-No heating pads sho	auld be at the facility			
		do a closer check of the			
	residents.				
	_	d be scheduled to address			
	all the facility concern				
		ld be put behind each			
	resident's door to be	signed by staff once a full			
	room check had been	n completed.			
	-Resident #8 had bee	en moved to another facility.			
		·			
	Second interview with	n the Administrator on			
	10/16/17 at 9:45am re				
		a change in resident's status			
		sident frequently, notify the			
		nd document the changes			
	•	id document the changes			
	and notification.	stoff ware fallowing the			
		staff were following the			
	expected procedure.				
	-She would implemen				
	possible and assure a				
	-In an emergency, sta	aff were supposed to call			
	911.				
	-The facility had not h	nad a policy or system in			
	place to assure staff of	called 911 or for			
	documentation related				
		-			
	2. Review of Residen	t #18's FL2 dated 5/4/17			
	revealed:				
		siabetes, hyperlipidemia,			
		obstructive pulmonary			
	disease (COPD), and				
	-The resident was ser	mı-ambulatory			

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PRINTED: 11/12/2017

Division of Health Service Regulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL031003	B. WING		R-C 10/17/2017
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN CARE	4002 SO	UTH NC 41		
- GOEDEN GARE	WALLAG	CE, NC 28466		
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338 Continued From pa	ge 213	D 338		
Interview with Resip.m. revealed: -Resident #18 had monthsThe resident show right armAnother resident rather resident rather resident slapp armShe took off her bestaff D (personal carm and Staff D's firesident's arm and The incident happer 8/22/17. Interview with Staff revealed: -Resident #18 was -Resident #18 picket to stab the other residentStaff D grabbed Resident 18's arm ther nails when she Interview with Resident 10/12/17 at 3:45pm The incident between resident occurred, I Resident #18.	dent #18 on 8/22/17 at 4:40 been at the facility for 2 ed agency representative her an into her with the wheelchair. ed the other resident on the elt to hit the other resident. eare aide, PCA) grabbed her nger nails dug into the hand. ened on the morning of D on 10/17/17 at 8:55 a.m. fussing at another resident. ed up a fork like she was going sident. took off her belt off to hit the esident #18's arm, and must have gotten bruised by grabbed her arm. dent #18's family member on			

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-A staff grabbed Resident #18, and dug her fingernails into Resident #18's arm.

There were three areas on the arm."

-"You could see the nail imprints in the resident's right forearm; the staff broke the skin and it bled.

-The next day, the staff came up to the family

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Division of	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
			B. WING		R-C	
		HAL031003	D. (III)		10/1/	//2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
	CUMMARY CT			PROVIDERIO DI ANI DE CORRECTION		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	ı			DEFICIENCY)		
D 220	O ()		D 220			
D 338	Continued From page	e 214	D 338			
	member and said, "I a	am the one that dug my				
	fingers into [name of	Resident #18].				
	-The family member of	did not know the staff's				
	name, but knew she	worked different shifts.				
	-The family member a	asked the staff, "Do you				
	know that's abuse an	id you could go to jail?"				
		ged Resident #18's arm.				
	_	did not know if the physician				I
	was notified.	- -				
	ı					
	Interview with a medi	ication aide/supervisor				
	(MA/S) on 8/22/17 at					
		y member told her that Staff				
		he resident's arm and hand.				
		I the Manager after speaking				
	with the family memb					
	-The Manager was av					
		nat Staff D grabbed Resident				
	#18 with too much for					
	-The Manger stated the	hat Resident #18 started the				
	incident.					
	ı					
	Interview with a media	cation aide (MA) on				
	10/13/17 at 10:25am	revealed:				
	-All she knew was Sta	aff D was giving meds and				
	heard the residents ta					
	-Staff D went to check	k on the residents, and the				
	residents had "got int					
		sident #18's arm and tore her				
	skin.					
	-Staff called the Mana	ager, and the Manager				
	looked at the resident	t's arm.				
	-Staff called Resident	t #18's family member; the				
	staff did not call her d	loctor.				
	1					
		nager on 8/24/17 at 10:15				
	a.m. revealed:					
		re of the incident on the				
	morning that it occurr					
	-Staff D did not intent	tionally hurt Resident #18.				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	X3) DATE SURVEY COMPLETED	
				R-C	
	HAL031003	B. WING		10/17/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN CARE	4002 SOL	JTH NC 41			
GOLDEN GARE	WALLAC	E, NC 28466			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 338 Continued From page 2	15	D 338			
-Staff D thought that Reshurt the other residentStaff D was protecting the Resident #18 had taken other residentThe other resident burn walker with her wheelched #18 offResident #18 could get gotten aggressiveShe had spoken to Staff and Staff D said that she the belt instead of Resident #18 offShe did not feel that Staff Ported to the Health Control (HCPR), because she was resident. Interview with the Admin 10:30am revealed: -The Administrator had reform anyone related to a she she was to her when the Meased on observations,	he other resident. In her belt off to hit the ped into Resident #18's air and it set Resident agitated but had never if D about the incident, e should have gone for ent #18's arm. aff D needed to be are Personnel Registry as protecting another iistrator on 10/12/17 at not gotten any reports allegations of abuse. eport any allegations of alanager was out. iinterviews, and record d to assure Resident #18 se by Staff D, and failed the incident to HCPR. continue to work at the Resident #18 to further er residents residing in 6's current FL-2 dated agestive heart failure				

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-Resident #6 was occasionally incontinent of

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	i Health Service Regu				T	_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R-C		
		HAL031003	B. WING		1		
		TALUS TUUS			10/17/2017	-	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		4002 SOL	JTH NC 41				
GOLDEN	CARE		E, NC 28466				
						\dashv	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(7.0)		
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR			
				DEFICIENCY)			
D 000			D 000			┪	
D 338	Continued From page	216	D 338				
	bladder and bowel.						
	D.Gador and Dowol.						
	Review of Resident #	6's most recent Care Plan					
	dated 6/8/15 revealed						
		sisted to the bathroom by					
		ovide incontinent care every					
	two hours as needed.						
		sisted with dressing and					
		staff for grooming and					
	hygiene.						
	Interview with Deside	nt #Cla famili, manual av av					
		nt #6's family member on					
	10/13/17 at 12:52 p.m						
		serious concerns at the					
	facility.						
		at Resident #6 wandered.					
		in damage that occurred in					
	2007.						
		iced by food; if food was					
	kept out for Resident	#6 to see, he would take it.					
	-Resident #6 was like	a three or four year old					
	child at times.						
	-He was smart with a	great IQ but his mind came					
	and went.						
	-Resident #6 was put	in the facility so he could be					
	observed 24 hours a	-					
	Interview with Reside	nt #6's guardian on 10/17/17					
	at 8:38 a.m. revealed						
		tell the guardian if the					
	resident was being ha						
	TOSIGOTIC WGG DOING HE						
	Interview with Reside	nt #6 on 10/13/17 at 5:33					
		f the time, he stayed in his					
	room until staff made						
	room unu stan made	mm go to bea.					
	Δ Interview with a po	ersonal care aide (PCA) on				J	
	10/12/17 at 8:06am re						
	-Resident #6 Would b	e wet in less than one hour					

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after changing him.

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PRINTED: 11/12/2017

Division of	of Health Service Regu	lation			FURIV	IAPPROVED	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI		
		HAL031003	B 14/11/0			R-C)/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN	CARE		JTH NC 41				
	I	WALLAC	E, NC 28466				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE	
D 338	Continued From page	217	D 338				
	-Residents were to be every two hours.	e checked on and toileted					
	Interview with a second PCA on 10/12/17 at 11:35 a.m. revealed: -She was concerned about Resident #6 being						
	T	ide/personal care aide)					
		up because he was a raff B did not want to have to					
	-The resident had been cor	en made to sit up until Staff npleted at 11:00 p.m.					
	nurse's desk or in the	•					
	-He had a right to go - -Staff were at the faci residents.	to bed when he wanted to. lity to take care of the					
	p.m. revealed:	PCA on 10/13/17 at 5:30					
	 -Residents were supp hours, including toilet 	oosed to be checked every 2 ing checks.					
		the residents right then if					
	at 8:57 a.m. revealed	=""					
	-Resident #6 was like -He had to be assiste	a child. d with bathing, and needed					
l	to be prompted to go	to the bathroom.					
	and not in the bed all	vanted Resident #6 to be up day.					

Division of Health Service Regulation

made to stay up.

-The resident would wet himself.
-He wore incontinent briefs all the time.
-She never heard anything about second shift staff; she did not know how late Resident #6 was

Interview with a first shift medication aide (MA) on

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Division of	Division of Health Service Regulation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D C
		1141 024002	B. WING		R-C
		HAL031003	B. W. C		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOU	TH NC 41		
GOLDEN	CARE		, NC 28466		
	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 338	Continued From page	218	D 338		
D 330	Continued From page	210	D 330		
	10/12/17 at 12:05 p.m	n. revealed:			
	-She was informed by	y staff that Staff B would not			
	allow Resident #6 to	go to bed one evening last			
	week.				
	-The resident had not	t been allowed to go to bed			
	because of "wetting the	he bed."			
	-Staff B made Reside	ent #6 sit in the dining room.			
	-Staff B would make I	Resident #6 sit in the chair			
	at the nurse's desk ur	ntil she wanted him to go to			
	bed.				
	Interview with the hou	usekeeper/MA on 10/12/17			
	at 12:30 p.m. reveale	d:			
		n first and second shift, and			
	also a MA and PCA.				
	-	rious Saturday, 10/7/17, and			
		Resident #6 because he			
	wanted to lay down a				
		going to change Resident			
	#6 when he pisses up				
		Staff B had to because it			
	was her job.				
		en made to sit up until 9:00			
		would not let him go to bed,			
		ed her that Staff B would put			
		desk and made Resident #6			
	sit until she wanted hi	•			
	-The Administrator ha	id been made aware.			
	Confidential interview	with a second staff			
		e Resident #6 sit up on 2nd			
		ast week; Staff B had him om, and she told him to set			
	up because "he wet the				
	up because he well	ne bed.			
	Interview with a family	y member on 10/12/17 at			
	12:22pm revealed:	y member on 10/12/1/ at			
	•	#6 sit in a leather chair,			
	hecause he would uri				

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-He would be saturated with urine.

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Division of Health Service Regulation

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF FI	NOVIDER OR SUFFLIER		, ,	KIE, ZIF GODE		
GOLDEN	CARE		UTH NC 41 E, NC 28466			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU	(- /	Ε
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR		
				DEFICIENCY)		
D 338	Continued From page	e 219	D 338			
	-Staff did not change	nim like they should.				
	Interview with a secon	nd family member on				
	10/12/17 at 3:45pm re					
		doing their job; they don't				
	change the residents					
	-The residents were r	made to sit in wet briefs and				
	clothes.					
		ent on 10/11/17 at 4:20 p.m.				
	revealed:	a racidanta				
	-Staff B won't help the-Staff B stayed on the					
	-	d second shift now, and				
	some third shift.	a second shift now, and				
	-Residents asked for	help and Staff B ignored				
		ne in every two hours and				
	sign the door."					
		nd resident on 10/12/17 at				
	8:30 a.m. revealed:	d at the feedble of least time.				
		d at the facility a long time. desident #6 nice, and some				
	did not.	esident #0 filce, and some				
		t Resident #6 was being				
	treated better lately.					
		en Resident #6 being made				
	to sit in a chair in the	hall.				
	•	t it was punishment for				
		omething since he would				
	steal other residents'	food				
	Intonious with Staff D	on 10/12/17 at 2:12 n m				
	revealed:	on 10/12/17 at 3:12 p.m.				
		had been for two years.				
		ng all three shifts at the				
	facility.	5				
	-Resident #6 loved to	eat.				
		questions over and over.				

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-Resident #6 could not recall what day of the

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Division of Health Service Regulation

Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
OOL DEN	0485	4002 SO	UTH NC 41		
GOLDEN	CARE	WALLAG	CE, NC 28466		
			·		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	· - /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG		,	IAG	DEFICIENCY)	
D 338	Continued From page	e 220	D 338		
	week it was.				
	-He had to be told all	the time to go to the			
	bathroom.	•			
	-The resident wore in	continent briefs			
		e awake, but that did not			
	mean he knew to go t				
	_	on" Resident #6 about			
	stealing and going to				
	-The staff would move	e him from the dining hall			
	after he finished eatin	ng, because he would steal			
	other residents' food.				
	-When Resident #6 w	et the bed, Staff B would			
		to sit up a little longer once			
	she made the bed.	to oit up a little longer office			
		an made to sit in a shair at			
		en made to sit in a chair at			
		der to keep an eye on him			
	_	another resident's room.			
	-He had not sat at the	e desk that long during the			
	times he had sat at th	ne desk.			
	Interview with Staff B	on 10/12/17 at 7:50pm			
	revealed:				
		does is sit and get in bed			
	and eat."	does is sit and get in bed			
		ad to do was alson and ast			
		ed to do was sleep and eat.			
	-Staff assisted Reside				
		go to the restroom every			
	couple hours or he we	ould sit there and not go.			
	-Staff had to get him	up and change him when he			
	wet himself.				
	-She had never told h	nim he could not go to bed			
	because of toileting.	· · · · · · · · · · · · · · · · · · ·			
	2000000 or tollothing.				
	Intorvious with the Ad-	ministrator on 10/10/17 at			
		ministrator on 10/10/17 at			
	12:30 p.m. revealed:				
		aware of staff making			
	Resident #6 sit at the				
	-She had been told th	nat Staff B was making			
	Resident #6 sit at the				

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-She had spoken with Staff B and told her that

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Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAG	CE, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
				DEFICIENCY)		
D 338	Continued From page	221	D 338			
	Resident #6 had the r	ight to lay down when he				
	wanted to.					
	latamiaith tha Ada	ministrator on 10/10/17 of				
	10:30am revealed:	ninistrator on 10/12/17 at				
		ade to sit in a chair at the				
	desk because he was					
	somebody called the county before she could					
	address the report (unable to recall which staff					
	reported it to her).					
		the resident, but spoke				
	briefly with all of the 3	•				
	-She addressed the c	oncerns with Stair B. a formal investigation into				
	the allegation, but had					
	groundwork.	a completed the				
	0	stand the rationale behind				
	make Resident #6 sit	up.				
	B. Interview with a me	edication aide/supervisor				
	(MA/S) on 8/7/17 at 9					
	-On 8/4/17, Resident	#6 was sitting in the dining				
	hall and asked for a p					
		the nurse's desk to get the				
	gum that was kept on					
	-Resident #6's pants	were wet in the front. er the nurse's desk as if he				
	wanted to reach behi					
		pray bottle and sprayed				
	Resident #6 in the fac					
		uid in the bottle that the				
	· · · · · · · · · · · · · · · · · · ·	water and bleach mixture.				
		esident #6 to get his "nasty				
	self" to his room and	•				
	-The MA/S went to as	_				

Division of Health Service Regulation

-Resident #6 asked the MA/S if she was going to

-The MA/S did not report the incident to the Manger, because "the Manager was not going to

do anything about the incident."

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 338	Continued From page	. 222	D 338		
D 330	Continued From page	5 222	5550		
		ith the MA/PCA, who was			
		sprayed the bleach at			
		2/17 at 3:30pm revealed:			
	-Staff A was "meaner				
	_	e MA/PCA remembered a			
	new girl was in trainin	and asked for her pay			
	check, which was in t	. ,			
		he dining room, sitting			
	against the wall.				
		nd the MA/PCA told him			
	there was some on th				
	-He walked behind th	e nurse's desk. Staff A			
	picked up a bottle of t	oleach water and sprayed			
	him; his pants in the f	•			
		nd said, "Look at you."			
	-Staff A got loud with				
	-He ducked and put h				
	-"It's sad how Staff A	treats nim."			
	Intorvious with a porce	onal care aide (PCA) on			
		revealed Staff A sprayed			
		ce (don't recall date) with			
	some kind of bleach s				
	Interview with Staff A	on 8/7/17 at 3:40 p.m.			
	revealed:				
	-Staff A would never of				
		w "who the vicious person			
	was that had told this				
		embers there that were			
	"handicapped."	tham to be mistrested if the			
	had to be placed in a	them to be mistreated if they			
	-Residents should be	•			
	-ivesidellis slindid be	icated like faililly.			
	Interview with the Ma	nager on 8/7/17 at 3:00 p.m.			
	revealed:	g.: 0 0 at 0.00 p			

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-She was not aware of any resident being

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Division of	Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D C	
		HAL031003	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(VA) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTION	l (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
D 338	Continued From page	223	D 338			
2 000	. •	, 220				
	sprayed in the face.					
	-No incident had beer	n reported to her.				
		n the Manager on 8/15/17 at				
	2:30 p.m. revealed:					
		reat the residents like their				
	_	ff could not do that then staff				
	needed to go and wor					
		at Staff A sprayed Resident				
	#6 in the face.					
		nything about the spray				
	bottle.					
		ent had reported anything to				
	her about the spray b					
		ne medication desk and had				
	not seen a spray bottl					
		es they had were disinfectant				
		were kept in the janitor				
	closet.					
	_	s close to the nursing desk.				
	-Resident #6 had too	have done something.				
		Managar an 0/22/47 at				
	10:15 a.m. revealed:	ne Manager on 8/22/17 at				
		e of the spray bottle, but had				
	been looking for it.	e of the spray bottle, but had				
	_	d Staff A to the Health Care				
		HCPR), because she did not				
	believe Staff A had do					
		acility and did not see Staff A				
	do it.	, a a.a				
		eported the incident to her.				
		report to HCPR unless she				
	knew who Staff A's ac					
	-She did not know wh					
						
	C. Interview with a me	edication aide/supervisor				
	(MA/S) on 9/12/17 at	· · · · · · · · · · · · · · · · · · ·				
		he facility earlier in the				

week. Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	\ -7
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
iAG		,	IAG	DEFICIENCY)	
D 220	0 " 15	004	D 220		
D 338	Continued From page	224	D 338		
	-The donuts were at t	he nurse's desk.			
	-Resident #6 saw the	donuts and went behind the			
	desk and got one.				
		out of the kitchen, and saw			
	Resident #6 with the				
		nt #6 in the back and pushed			
	him down the hall.	""			
		#6 that the donut had			
		Resident #6 would die. aid to swallow the donut.			
	to eat the donut.	esident #6 that it was okay			
		Il therapist at the facility			
	when the incident occ	· · · · · · · · · · · · · · · · · · ·			
	Whom the melaent eet	, and a			
	Second interview with	n the MA/S working at the			
	time of the incident or				
	revealed:				
	-Staff A was "meaner	than a snake".			
	-There were donuts a	t the desk, and Resident #6			
	took a donut to eat.				
		#6 there was rat poison on			
	them.				
	Interview with a perce	onal care aide (PCA) on			
	9/12/17 at 4:30 p.m. r				
		it the facility for 3 months.			
	-	reated horrible, and she no			
	longer wanted to work	·			
	_	e donuts behind the nurse's			
		6 had gotten a donut.			
		he kitchen and started			
	shoving Resident #6				
		#6 that there was poison in			
	the donut and that he	•			
	-Resident #6 had star				
	-Resident #6 looked I	ike he was scared to finish			

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eating the donut.

Interview with a second PCA on 10/12/17 at

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DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	RRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMPLI	ETED	
						C
		UAL 024002	B. WING		R-	_
		HAL031003			10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
			, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG		,	1/40	DEFICIENCY)		
			+			
D 338	Continued From page	e 225	D 338			
	2,20,000,000,000,000					
	3:30pm revealed:	44 /DOA				
		MA/PCA were at the desk				
		lked around and got a donut				
	hole to eat.					
		nut out of Resident #6's				
		s rat poison. I guess you will				
	die tonight."					
		ent #6 it was not rat poison.				
	-Staff A talked hateful	to Resident #6 all the time.				
		on 9/14/17 at 8:20 a.m.				
	revealed:					
		have wanted a donut, she				
	would have given him					
	-"Gosh, that never wa					
	-She knew where this	was coming from and she				
	was going to speak w	vith a lawyer.				
	-It was a bunch of lies	S.				
	-If she would have do	ne it, she would had taken				
	the blame for it.					
	-Staff A did not know	why anyone would say that				
	-She knew who she	worked with during the day.				
	-She would work on S	Saturday, and, then she				
	would quit.					
	Interview with the Ma	nager on 9/14/17 at 8:30				
	a.m. revealed:					
	-The Manager was "v	ery angry."				
	-She knew that there	were donuts at the facility,				
	because it was assist	ed living appreciation week.				
		Staff A would have said that.			ľ	
	-If she found out who	told this, she would fire				
	them on the spot.	·			ľ	
	•	ven the 24 hour and 5 day				
	working forms to repo					
	Personnel Registry (F					
		t Staff A to HCPR because				
	Staff A would quit.	Can A to Hor A because				
	Stall A Would quit.				ľ	

Division of Health Service Regulation

Based on observations, interviews and record

STATE FORM 6899 DBPR11 If continuation sheet 226 of 419

Division of	<u>of Health Service Regu</u>	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ΓED
		HAL031003	B. WING		R-C	
		HALUSTUUS			10/17	//2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CORRECTION	<u></u>	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 338	Continued From page	e 226	D 338			
		ailed to protect Resident #6				
		ect from Staff A and B. Both				
		continue to work at the				
		d Resident #6 to further				
		om these staff as well as the				
	othe residents residin	g in the racility.				
	4 Refer to Tag D270	, 10A NCAC 13F. 0901(b)				
	Personal Care and Su					
		uper vision.				
	5. Review of Residen	nt #12's FL-2 dated 4/6/17				
	revealed:					
		Hypertension, Anemia,				
	Dementia, Depression					
	-The resident was ser					
		adder and bowel continence.				
		ent #12 on 8/22/17 at 3:01				
	p.m. revealed:					
		een at the facility for one				
	year.	ad the at he are linesimal in the area!!				
		ed that her "mind is sharp".				
		ook a heart pill and ibuprofen. er to the local store, and left				
	her at the store for tw	•				
		acility because she thought				
	they had forgotten he	-				
		1.				
	Interview with the Ma	nager of the local store on				
	8/22/17 at 6:00 p.m. r	_				
	-	ent #12 was dropped off at				
	the store.	тип така и тарран ан ан				
		esident #12 in a while at the				
	store.					
	-Resident #12 loved t	to come and shop at the				
	store.	·				
	-Resident #12 was to	ld to sit outside on the				
	bench once she had f	finished her shopping.				
	-It was 98 degrees ou	utside on that day.				
	-She allowed Resider	nt #12 to remain in the store				

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STATE FORM 6899 DBPR11 If continuation sheet 227 of 419

Division of Health Service Regulation

DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						_
			D WING		R-	_
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN			TE, ZII GODE		
GOLDEN	CARE		ITH NC 41			
		WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
D 338	Continued From page	227	D 338			
2 000	Continued From page	,				
	outside of her office in	n a chair.				
	-She called the facility	y several times about				
	someone picking up F	Resident #12.				
		ed at the store for 2 hours				
	before being picked u					
	before being plotted a	φ.				
	Interview with the Ma	nager on 8/24/17 at 10:15				
	a.m. revealed:	nager on 6/24/17 at 10.10				
		sown shanning at the lead				
		own shopping at the local				
	store.					
		12 shopping at the store and				
	dropped her off.					
	-It was sometime last	month but she could not				
	remember the date.					
	-Resident # 12 was co	ompetent to leave because				
	she was capable of d	oing her own shopping and				
	paying.	0 11 0				
		ed "forever" when she went				
	to the store.	ou lorovor whom one work				
		street from the store at an				
	appointment.	succe from the store at an				
		es full so the Manager had				
		as full so the Manager had				
	to wait.					
	-	store called to see if she				
	had forgotten Resider					
		lly been at the store for one				
	hour when she got the					
	•	II, she picked Resident #12				
	up; it was about 15 m	inutes after she received the				
	call from the store Ma	nnager.				
	The facility failed to p	rotect a resident from				
	physical and verbal a					
		ution on the resident and				
		ame resident and allowed				
	-					
		work in the facility after				
		rom another staff were				
		ger; a second resident from				
	physical abuse from S	Staff D, who grabbed the				

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resident's arm and dug her fingernails in the

STATE FORM 6899 DBPR11 If continuation sheet 228 of 419

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
						_
			B. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE		
				,		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			,
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR L	230 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MATE	D/IIL
				,		
D 338	Continued From page	e 228	D 338			
	. •					
		created a skin tear, by				
	_	ntinue to work in the facility				
		use were reported to the				
	Administrator; a resid	ent from neglect by Staff B,				
	who refused to provid	le incontinent care to the				
	resident and forced th	ne resident to sit at the				
	nurse's station and we	ould not change the				
	resident's incontinent	brief. Staff B was also				
	allowed to continue to	work in the facility after				
	allegations of neglect					
		esident from neglect by				
		re, who was left lying on a				
		ived thermal burns to her				
		lure resulted in serious				
	physical harm and se					
		ted Type A1 Violation.				
	constitutes an onaba	ted Type AT Violation.				
	Poviou of the facility's	s Plan of Protection dated				
	10/12/17 revealed:	S Flair of Frotection dated				
		alth Care Registry followed				
	•	• .				
	by investigation and 5					
	_	ten warning or immediate				
	termination.	D. LIODD: II. L				
		D to HCPR immediately				
	and conduct investiga					
	-Any future allegation	s will be reported as				
	required.					
		service staff on Resident				
	Rights immediately.					
		r and be aware of signs of				
	• • • • • • • • • • • • • • • • • • • •	ghts) and report immediately				
	to Manager/Administr					
	-In-service to ensure	staff of their responsibility to				
	report.					
	-Contact Ombudsmar	n for in-service.				
	-Administrator to do ra	andom observations and				
	resident interviews wi	th interactions with staff.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			551251110.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		ITH NC 41 E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	229	D 358		
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	(a) An adult care horn preparation and admit prescription and non-by staff are in accordated (1) orders by a license which are maintained	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies			
	This Rule is not met TYPE A2 VIOLATION	•			
	Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#13, #16, #22) observed during the medication pass including errors with insulin and medications for heart / blood pressure, diabetes, prevention of blood clots, and a diuretic (#16); a medication for hypothyroidism (#22); and prevention of heart disease (#13, #22), and for 5 of 6 residents (#1, #2, #3, #4, #5) sampled including errors with insulin (#1, #3); narcotic pain medications (#3, #5); medications for infection (#1, #2, #4); and a medication for anxiety (#2).				
	The findings are:				
	opportunities during to medication passes or	ror rate was 27% as ervation of 8 errors out of 29 he 7:30 a.m. / 8:00 a.m. n 10/12/17 and 10/17/17. ht #16's current FL-2 dated			

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		<u> </u>	COMPLETED	-
					R-C	
		HAI 024002	B. WING	B. WING		. 7
		HAL031003	1		10/17/201	1 /
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOL	ITH NC 41			
		WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 358	Continued From page	e 230	D 358			
	06/10/17 revealed diabetes mellitus with stage 3, hypertension sepsis, and moderate a. Review of Resider 06/10/17 revealed an insulin, 4 units twice of a mixture of a rapid-a	agnoses included type II chronic kidney disease - a, gram negative pneumonia, e protein malnutrition. ht #16's current FL-2 dated order for Novolog Mix 70/30 daily. (Novolog Mix 70/30 is				
	06/13/17 for Resident -The resident was add pneumonia and acute -The resident was dis -There was an order to insulin 4 units twice defined.	mitted on 06/07/17 for e respiratory insufficiency. ccharged on 06/13/17. for Novolog Mix 70/30				
	pass on 10/12/17 revi-Resident #16 had a lithe table in front of hir-The resident had eath drank his milk. -The medication aide #16's blood sugar and -The MA administered insulin to Resident #1 resident had finished 70/30 insulin is a mixt and an intermediate a insulin is not the same	ealed: breakfast tray in his room on m. ten all of his cereal and (MA) checked Resident d it was 123 at 8:11 a.m. d 4 units of Novolin 70/30 6 at 8:13 a.m. after the eating breakfast. (Novolin ture of a short-acting insulin acting insulin. Novolin 70/30 e as Novolog Mix 70/30.)				
	-There was a handwr 70/30" inject 4 units u	16's October 2017 ation record (MAR) revealed: itten entry for "Insulin Nov inder skin every morning ry night for diabetes and it				

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STATE FORM 6899 DBPR11 If continuation sheet 231 of 419

Division c	<u>of Health Service Regu</u>	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
					R-C	c
		HAL031003	B. WING			7/2017
		070557.45		T. 70.000		
NAME OF Pr	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE		
GOLDEN (CARE		JTH NC 41			
-			E, NC 28466	1		
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	e 231	D 358			
	was scheduled for 8:0	00 a.m. and 8:00 p.m.				
		3 ranged from 104 - 213 from				
	10/01/17 - 10/12/17.	3				
	Review of Resident #	t16's September 2017 MAR				
	revealed:					
	-There was a handwr					
		4 units under skin every				
	and it was scheduled	units every night for diabetes				
	-The 8:00 a.m. dose					
		nistered on 09/03/17 or				
		sons for the omissions.				
	-There was no time n	oted for a night time dose of				
		mented on 5 of 30 days on a				
	second row below the					
	· ·	hat no night time dose of				
	insulin was document					
	09/01/17 - 09/30/17.	3 ranged from 88 - 233 from				
	00/01/17 00/00/					
		t16's August 2017 MAR				
	revealed:					
		ritten entry for "Novolin				
	•	n the morning and inject 2 and it was scheduled for 8:00				
	a.m. and 8:00 p.m.	and it was scrieduled for 6.00				
		of insulin for 08/06/17 was				
		dministered with no reason				
	for the omission.					
	-The 8:00 p.m. dose of					
	documented as admir					
		08/14/17, 08/17/17, 08/19/17,				
	and 08/24/17 - 08/28/	717. 3 ranged from 81 - 224 from				
	08/01/17 - 08/31/17.	ranged nom 61 - 224 nom				
	00/01/17 - 00/01/17.					
	Observation of Resid	ent #16's medications on				
	10/12/17 revealed:					

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-There was 1 opened vial of Novolin 70/30 insulin

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DIVISION	i Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D 0
			B. WING		R-C
		HAL031003	B. WC		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOU	TH NC 41		
GOLDEN	CARE		, NC 28466		
	OLUMBA DV OT		1	DD0//DEDI0 D/ 44/ 05 00DD507/04	.
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 250	0 (15	000	D 250		
D 358	Continued From page	232	D 358		
	dispensed on 03/07/1	7 with no open date.			
	-It could not be detern	nined when the vial would			
	have expired with no	open date. (According to			
		volin 70/30 vials that have			
		kept at room temperature			
	for up to 42 days.)				
	• • •	vial of Novolin 70/30 insulin			
		7 that had not been opened.			
		ensed by the veteran's			
	•	ctions for 4 units in the			
	morning and 2 units a				
	morning and 2 units a	it night.			
	Interview with the MA	on 10/12/17 at 12:40 p.m.			
	revealed:				
	-The facility policy wa	s to administer insulin			
	before a meal.				
	-She usually administ	ered Resident #16's insulin			
	•	was running late that			
	morning on 10/12/17.				
		osed to document the open			
	date on all insulin.	•			
		en Resident #16's insulin			
		but it lasted a while because			
	he only took a small a				
	•	the insulin order was for			
	Novolog Mix 70/30.				
	~	had Novolin 70/30 insulin to			
	her knowledge.				
	•	cations came in the mail			
	from a veteran's phar				
	· ·	here had been any order			
	changes for the reside				
		the insulin information on			
	the MARs.	are modification on			
		on from the prescription			
	•	cribed it onto the MARs.			
		y there were blanks on the			
	MARs or why the nigh	nt time dose was not pented on the Sentember			

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2017 MAR.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING	B. WING		C 7/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10/1	772011
GOLDEN	CARE	4002 SOUT	ΓH NC 41			
OOLDEN		WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	know if the resident reinsulin in September 2-She would call Reside provider (PCP) and the insulin. Interviews with the Ad 8:40 a.m. and 10/17/2-The facility's Manage getting the FL-2 forms -The Manager had be about 2 months and vinterview. -No one took over resembles of the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Manager or to monito interview with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Adr 11:45 a.m. revealed: -Staff should date the -The facility's policy with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility with the Adr 11:45 a.m. revealed: -Staff should date the -The facility	cond shift so she did not eceived the evening dose of 2017. Itent #16's primary care he veteran's pharmacy about diministrator on 10/16/17 at 17 at 11:45 a.m. revealed: er was responsible for so completed. Here out on medical leave for exas unavailable for exponsibility of the residents' dianager went on medical	D 358			
	p.m. revealed: -He usually got his mealsHe got his blood sug and it "runs good".	nt #16 on 10/17/17 at 2:20 edications after eat ate his ar checked in the evenings v often he got insulin or what				

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-His medication came from the veteran's

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	234	D 358		
	pharmacy.				
	revealed:	on 10/12/17 at 2:50 p.m. nurse at Resident #16's			
	-	eran's provider and they told			
	-	acy would fax a list of			
	Attempts to contact R pharmacy on 10/17/1 unsuccessful.	esident #16's PCP and 7 at 10:52 a.m. were			
	No further information insulin was provided.	n regarding Resident #16's			
	06/10/17 revealed an	nt #16's current FL-2 dated order for Lasix 40mg once etic used to treat swelling ion.)			
	06/13/17 for Resident -The resident was ad- pneumonia and acute -The resident was dis	discharge summary dated #16 revealed: mitted on 06/07/17 for respiratory insufficiency. charged from the hospital			
	fluid overload.	rited on Lasix due to some			
	Observation during the pass on 10/12/17 revealministered one Last instead of 40mg as on				
	Review of Resident # medication administra	16's October 2017 ation record (MAR) revealed			

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STATE FORM 6899 DBPR11 If continuation sheet 235 of 419

Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
				_		
	HAI 031003 B. WING			R-		
		HAL031003	D. WING		<u> 10/1</u>	7/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU				
GOLDEN (CARE		, NC 28466			
			, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
IAO		,	IAG	DEFICIENCY)		
D 358	Continued From page	e 235	D 358			
	there was an entry for	r Lasix 40mg 1 tablet daily				
	and it was scheduled	•				
	and it was scrieduled	101 0.00 a.111.				
	Paview of Pacident #	16's September 2017 MAR				
		n entry for Lasix 40mg 1				
	tablet daily and it was	-				
		8:00 a.m. from 09/01/17 -				
	•	6.00 a.m. nom 09/01/17 -				
	09/30/17.					
	Davious of Davidant #	16's August 2017 MAD				
		16's August 2017 MAR				
		n entry for Lasix 40mg 1				
	tablet daily and it was					
	•	8:00 a.m. from 08/01/17 -				
	08/31/17.					
	D : (D ::	401 1 1 0047 1445				
	Review of Resident #	16'S July 2017 MAR				
	revealed:					
		er printed entry for Lasix				
		nd it was scheduled at 8:00				
	a.m.					
		ed as administered on				
	07/01/17 and from 07					
		nented as administered from				
		nd 07/31/17 with no reason				
	noted.					
		itten marked through 40mg				
		was written above the Lasix				
	entry.					
		o indicate when the change				
	was made for Lasix.					
		ent #16's medications on				
	10/12/17 revealed:					
		e of Lasix 20mg tablets with				
	90 tablets dispensed	on 09/08/17.				
		he label were to take 1				
	tablet (20mg) daily for	r blood pressure and fluid				
	control.					
	-There were 102 Lasi	x 20mg tablets in the bottle.				

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Division of	<u>of Health Service Regu</u>	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED	
						C	
		HAL031003	B. WING		1	R-C 10/17/2017	
					1 10/1	172017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN	CARE		UTH NC 41				
		WALLAC	E, NC 28466		_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	 e 236	D 358				
2 000	. •						
		on 10/12/17 at 12:40 p.m.					
	revealed:	- h l 40 t-blat-					
		o have Lasix 40mg tablets. of the Lasix 20mg tablets but					
	, 0	ng, 10/12/17, and only gave					
	1 tablet.	ig, 10/12/17, and only gave					
		ny there were 102 tablets in					
		neone poured the previous					
	supply into the new b						
	117	cations came in the mail					
	from a veteran's phar	macy.					
		here had been any order					
	changes for the resident						
		dent #16's primary care					
	provider (PCP) and the Lasix.	ne veteran's pharmacy about					
	Interview with the Adr 11:45 a.m. revealed:	ministrator on 10/17/17 at					
		responsible for clarifying					
		abels did not match, the MA					
		o and contact the physician					
	to clarify the orders.	Turid correct tric projection.					
	Interview with Reside	ent #16 on 10/17/17 at 2:20					
	p.m. revealed:						
	 -He was not sure aboreceived. 	out which medications he					
	-His medication came	from the veteran's					
	pharmacy.	, nom the veterane					
		swelling in his feet or legs.					
	Interview with the MA revealed:	on 10/12/17 at 2:50 p.m.					
	-She had spoken to a	nurse at Resident #16's					
	-	eran's provider and they told					
	her to call the pharma						
	-The veteran's pharm	nacy would fax a list of					

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Resident #16's medication orders.

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Division of Health Service Regulation

	of Health Service Regu		(V2) MULTIPLE	CONSTRUCTION	(V2) DATE CUDVEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
			B. WING		R-C
		HAL031003	D. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
COLDEN	CARE	4002 SO	UTH NC 41		
GOLDEN	CARE	WALLAC	CE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 237	D 358		
	Attempts to contact R pharmacy on 10/17/1 unsuccessful.	Resident #16's PCP and 7 at 10:52 a.m. were			
	No further information regarding Resident #16's Lasix was provided.				
	06/10/17 revealed an	nt #16's current FL-2 dated order for Plavix 75mg once to prevent blood clots.)			
	Review of a hospital discharge summary dated 06/13/17 for Resident #16 revealed: -The resident was admitted on 06/07/17 for pneumonia and acute respiratory insufficiency. -The resident was discharged on 06/13/17. -There was an order for Plavix 75mg once daily. Observation during the 8:00 a.m. medication pass on 10/12/17 revealed: -Resident #1 was not administered Plavix 75mg at 8:10 a.m. when he received his other morning medications. -The MA initialed the Plavix on the MAR as being administered.				
	-There was an entry f and it was scheduled	ation record (MAR) revealed: for Plavix 75mg 1 tablet daily			
	revealed there was a tablet daily and it was	e16's September 2017 MAR n entry for Plavix 75mg 1 s documented as 8:00 a.m. from 09/01/17 -			

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
			B. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU				
GOLDEN (CARE					
		WALLACE	, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOLATORT OR I	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	II/II	57.1.2
D 358	Continued From page	238	D 358			
	Review of Resident #	16's August 2017 MAR				
		n entry for Plavix 75mg 1				
	tablet daily and it was	-				
		nistered and no reason for				
	the omissions for the					
	the omissions for the	entire month.				
	Pavious of Pacidont #	16'o July 2017 MAD				
	Review of Resident #	105 July 2017 WAR				
	revealed:	in Din in 75 and 4 to be to delive				
	•	for Plavix 75mg 1 tablet daily				
		at 8:00 a.m. but none was				
	documented as admir					
		itten note beside the entry				
		discontinued but no date was				
	documented and no in	nitials.				
	Observation of Reside	ent #16's medications on				
		erit #10 s medications on ere was no Plavix on hand				
		ere was no Plavix on nano				
	for the resident.					
	Interview with the MA	on 10/12/17 at 12:40 p.m.				
	revealed:					
	-She gave the last do	se of Plavix yesterday on				
	10/11/17.	•				
	-She needed to order	the Plavix because it had				
	not been ordered to h					
		d medications when there				
	was one week supply					
		cations came in the mail				
	from a veteran's phar					
	•	back-up pharmacy for				
		e his medications came				
	from the veteran's pha					
		here had been any order				
	changes for the reside					
		lent #16's primary care				
		ne veteran's pharmacy about				
	the Plavix.					
	Interview with the Adr	ministrator on 10/17/17 at	1			1

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11:45 a.m. revealed:

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		URVEY ETED
			A. BUILDING: _			
		HAL031003	B. WING		R-0 10/1	C 7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
OO! DEN	0.4.0.5	4002 SOL	ITH NC 41			
GOLDEN (CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	239	D 358			
	-The MA on duty was discrepancies with me-If orders, MARs or la was supposed to stop to clarify the ordersMedications should be out of the medications. Interview with Reside p.m. revealed: -He was not sure aboreceivedHis medication came pharmacyHe did not think he withinners and he had not thinner to his knowled. Interview with the MA revealed: -She had spoken to a PCP office at the veter her to call the pharmatical theorem and the pharmatical that the pharmatical ending the series of the pharmatical ending the series of the series o	responsible for clarifying edications. bels did not match, the MA and contact the physician of eordered before they run is. Int #16 on 10/17/17 at 2:20 Int which medications here is from the veteran's was getting any blood hever been on a blood lige. Int which medications here is from the veteran's was getting any blood hever been on a blood lige. Int which medications here is from the veteran's provider and they told hever been on a blood lige. Int which medications here is from the veteran's provider and they told hever been on a blood lige. Int which medications here is from the veteran's provider and they told hever been on a blood lige. Int which medications here is from the veteran's provider and they told hever been on a blood lige. Int which medications here is from the veteran's provider and they told here. In regarding Resident #16's provider and they told here. In regarding Resident #16's provider and they told here. In regarding Resident #16's provider point is for heart / blood				
		discharge summary dated				

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06/13/17 for Resident #16 revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		D.0
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
	QUILLEN OT		, NC 28466	DD0//DDD0 D/ AV 05 00DD507/0	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 240	D 358		
	-The resident was ad pneumonia and acute -The resident was dis	mitted on 06/07/17 for e respiratory insufficiency. scharged on 06/13/17. for Diltiazem ER 180mg			
	pass on 10/12/17 rev	ne 8:00 a.m. medication ealed Resident #16 was m ER 240mg at 8:10 a.m. ordered.			
	there was an entry fo	ation record (MAR) revealed r Diltiazem ER 180mg 1 ras scheduled for 8:00 a.m.			
	Review of Resident #16's September 2017 MAR revealed there was an entry for Diltiazem ER 180mg 1 capsule daily and it was documented as administered daily at 8:00 a.m. from 09/01/17 - 09/30/17.				
	revealed there was a 180mg 1 capsule dail	16's August 2017 MAR n entry for Diltiazem ER ly and it was documented as 8:00 a.m. from 08/01/17 -			
	capsule daily and it w administered on 07/0 07/30/17. -Diltiazem ER was no administered from 07 07/31/17 with no reas	for Diltiazem ER 180mg 1 vas documented as 1/17 and from 07/17/17 - ot documented as 1/02/17 - 07/16/17 and			
	10/12/17 revealed:	-			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
	OLIMANA DV. OT		E, NC 28466	DROWNERIO DI ANI OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	.ETE
D 358	Continued From page	e 241	D 358			
	-There was one supp 90 capsules dispense supply)The instructions on t capsule dailyThere were 14 Diltia: remaining. Interview with the MA revealed: -She had not noticed the MAR was 180mg administered an on h-Resident #16's medi from a veteran's phare-She did not know if t changes for the resid-She would call Resid provider (PCP) and the Diltiazem. Interview with the Adri 11:45 a.m. revealed: -The MA on duty was medication ordersIf orders, MARs or later the supplementary of the	ly of Diltiazem 240mg with ed on 07/27/17 (a 3 month) he label were to take 1 zem 240mg capsules on 10/12/17 at 12:40 p.m. the dosage of Diltiazem on and the dosage she and was 240mg. cations came in the mail macy. here had been any order				
		onsible for transcribing				
	-The MAs were support make sure it matches medications on handThe Manager was re MARs but she had be months.	osed to read the MARs and the orders and the esponsible for monitoring the een on medical leave for two				
		ve to check the MARs.				
	Interview with Reside	nt #16 on 10/17/17 at 2:20				

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p.m. revealed:

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AND PLAN OF CORRECTION IN IDENTIFICATION NUMBER:	(3) DATE SURVEY	
AND PLAN OF CORRECTION I IDENTIFICATION NUMBER: I I	(X3) DATE SURVEY	
A. BUILDING:	COMPLETED	
	5 0	
HAI 034003 B. WING	R-C	
HAL031003 B. WING	10/17/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
4002 SOUTH NC 41		
GOLDEN CARE WALLACE, NC 28466		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE		
DEFICIENCY)		
D 358 Continued From page 242 D 358		
-He was not sure about which medications he		
received.		
-His medication came from the veteran's		
pharmacy.		
Interview with the MA on 40/40/47 at 0.50 mm		
Interview with the MA on 10/12/17 at 2:50 p.m.		
revealed:		
-She had spoken to a nurse at Resident #16's		
PCP office at the veteran's provider and they told		
her to call the pharmacy.		
-The veteran's pharmacy would fax a list of		
Resident #16's medication orders.		
Attempts to contact Resident #16's PCP and		
pharmacy on 10/17/17 at 10:52 a.m. were		
unsuccessful.		
No further information regarding Resident #16's		
Diltiazem was provided.		
e. Review of Resident #16's current FL-2 dated		
06/10/17 revealed an order for Glipizide 5mg		
twice daily. (Glipizide lowers blood sugar.)		
Review of a hospital discharge summary dated		
06/13/17 for Resident #16 revealed:		
-The resident was admitted on 06/07/17 for		
pneumonia and acute respiratory insufficiency.		
-The resident was discharged on 06/13/17.		
-There was an order for Glipizide ER 5mg twice		
daily. (Glipizide ER lowers blood sugar and is an		
extended-released medication. Glipizide ER is		
longer acting than immediate-released Glipizide.)		
Observation during the 8:00 a.m. medication		
pass on 10/12/17 revealed Resident #16 was		
administered Glipizide 5mg at 8:10 a.m. instead		
of Glipizide ER 5mg as ordered on 06/13/17.		

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Review of Resident #16's October 2017

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		LETED
	HAL031003	B. WING			R-C / 17/2017
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, ZIP CODE		
GOLDEN CARE	4002 SOL	JTH NC 41			
GOLDEN CARE	WALLAC	E, NC 28466			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
-There was an entwice a day 30 min scheduled for 8:00 -The resident's FS 10/01/17 - 10/12/1 Review of Reside revealed: -There was an entwice a day 30 min documented as aca.m. and 5:00 p.mThe resident's FS 09/01/17 - 09/30/1 Review of Reside revealed: -There was an entwice a day 30 min documented as aca.m. and 5:00 p.mThe resident's FS 08/01/17 - 08/31/1 Observation of Re 10/12/17 revealed: -There was one since Glipizide 5mg table. The instructions of 30 minutes before. There was no Gliffor the resident. Interview with the revealed: -She had not notice the hospital dischere.	istration record (MAR) revealed: try for Glipizide 5mg 1 tablet nutes before meals and it was 0 a.m. and 5:00 p.m. 6BS ranged from 104 - 213 from 17. Int #16's September 2017 MAR try for Glipizide 5mg 1 tablet nutes before meals and it was dministered twice daily at 8:00 1. from 09/01/17 - 09/30/17. 6BS ranged from 88 - 233 from 17. Int #16's August 2017 MAR try for Glipizide 5mg 1 tablet nutes before meals and it was dministered twice daily at 8:00 1. from 08/01/17 - 08/31/17. 6BS ranged from 81 - 224 from 17. BBS ranged from 81 - 224 from 18. BBS ranged from 81 - 224 from 19. BBS ranged from 82 - 233 from 19. BBS ranged from 82 - 230 from 19. BBS ranged from 82	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION	(X3) DATE SI	
		A. E				_
		HAL031003	B. WING	B. WING		C 7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	•	
001.5511		4002 SOL	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 244	D 358			
D 336	-Resident #16's medifrom a veteran's pharShe did not know if t changes for the residShe would call Resid- provider (PCP) and the Glipizide. Interview with the Adr 11:45 a.m. revealed: -The MA on duty was medication ordersIf orders, MARs or lawas supposed to stop to clarify the ordersThe MAs were responders onto the MARsThe MAs were support make sure it matches medications on handThe Manager was remarks but she had be monthsShe was going to ha Interview with Reside p.m. revealed: -He usually got his mimealsHe got his blood sugand it "runs good".	cations came in the mail macy. here had been any order ent. dent #16's primary care ne veteran's pharmacy about ministrator on 10/17/17 at responsible for clarifying abels did not match, the MA or and contact the physician consible for transcribing as. assed to read the MARs and at the orders and the desponsible for monitoring the ene on medical leave for two ve to check the MARs. ant #16 on 10/17/17 at 2:20 dedications after eat ate his ar checked in the evenings and which medications he	D 336			
	pharmacy. Interview with the MA revealed:	on 10/12/17 at 2:50 p.m. nurse at Resident #16's				

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PCP office at the veteran's provider and they told

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL031003	B. WING		R-C 10/17/2017	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	10/11/2017	
GOLDEN CARE		JTH NC 41 E, NC 28466			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
Resident #16's med Attempts to contact pharmacy on 10/1' unsuccessful. No further informated Glipizide was provided and a series of the serie	macy. rmacy would fax a list of dication orders. It Resident #16's PCP and 7/17 at 10:52 a.m. were ion regarding Resident #16's ded. dent #13's current FL-2 dated ed atrial fibrillation, peripheral chest pain, and elevated INR alized ration - for Coumadin cician's orders for Resident #13 an order dated 06/27/17 for edaily, mix in 8 ounces of juice (Miralax is a laxative used to the MAR included by for Miralax, mix 1 capful as of liquid and drink once daily medication aide (MA) on	D 358			

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DIVISION	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1141 024002	B. WING		R-C	
		HAL031003	B. W(0		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
			-, NC 20400			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	те
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		'-
				DEFICIENCY)		
5.050			T			
D 358	Continued From page	e 246	D 358			
	the orange juice.					
	and draingd jaidd.					
	Observation of the Ma	A on 10/12/17 at 7:44 a.m.				
	revealed:	7 (5) 12) 17 dt 7 11 d.iii.				
	-She was at the nurse	es' station preparing				
	medications at the me					
		side the dining room from				
	her location.	olde the diffing room from				
	nor location.					
	Observation of the me	edication pass on 10/12/17				
	at 7:46 a.m. revealed					
		tting at a dining room table				
	eating breakfast, feed					
	•	nale residents sitting at the				
	same table.	naie residents sitting at the				
	-There was a cup of c	orange juice (about 6				
		table beside the resident's				
	plate.	table beside the residents				
	•	resident the cup of orange				
	juice to take his morn	· · · · · · · · · · · · · · · · · · ·				
	=	bout 2/3rds of the orange				
		nd sat the cup back down.				
		ourage the resident to finish				
	drinking the orange ju					
		g room and went back to the				
	medication cart at the					
		Miralax as administered and				
	stated, "he got that".	Wildiax do dariii ilotoroa dila				
	otatoa, 110 got that .					
	Observation of the dir	ning room on 10/12/17 at				
	8:17 a.m. revealed:	<u> </u>				
	-Resident #13 left the	dining room.				
		ately 15ml (1/2 ounce) of				
		alax left in the resident's cup				
	on the table.					
	J 110 table.					
	Interview with the MA	on 10/12/17 at 12:18 p.m.				
	revealed:					
		e Miralax in Resident #13's				
		reakfast and left it at the				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1		
			D WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF DE	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE	
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE	
GOLDEN (CARE		JTH NC 41		
00111		WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
				DETICIENCY)	
D 358	Continued From page	247	D 358		
	dining room table with				
	-She thought other sta	aff helped feed the resident			
	and they would make	sure he drank the orange			
	juice.	· ·			
	-She had not asked o	ther staff to watch the			
	resident drink the ora	nge juice.			
		er staff there was medication			
	in the resident's orang				
		o back to see how much			
		Irank because she thought			
	he probably drank all				
		Resident #13 did not drink all			
	of the Miralax today,				
		n why she documented the			
		ered when she did not know			
	how much he drank.				
	Intervious with the Adr	ministrator on 10/17/17 at			
		ministrator on 10/17/17 at			
	11:45 a.m. revealed:				
		rained to actually watch the			
	residents take their m				
		leave the medications			
	unattended.				
		ns, interviews, and record			
	reviews, Resident #13	3 was not interviewable.			
		nt #13's family member on			
	10/12/17 at 12:12 p.m				
	-The resident was sup	pposed to get Miralax every			
	day.				
	-She did not think he	had been getting the			
		ause she helped toilet him			
		een constipated on and off.			
		en to the hospital in the past			
		was concerned that he not			
	get another impaction				
	Jac Sallor Impublior				
	b. Review of Resider	nt #13's current FL-2 dated			

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03/20/17 revealed there was an order for Aspirin

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	248	D 358			
	81mg once daily. (As heart disease.)	spirin is used to prevent				
	Review of Resident # medication administra	13's October 2017 ation record (MAR) revealed:				
	-There was an entry f at 8:00 a.m.	or Aspirin 81mg once daily				
	-Aspirin was documer 10/01/17 - 10/12/17.	nted as administered from				
	10/12/17 revealed:	orning medication pass on				
		ot administered Aspirin 81mg er other scheduled morning .m.				
		the Aspirin as administered				
	Interview with the me 10/12/17 at 12:18 p.m	1.				
	-She usually administ resident's other morn	ing medications.				
	10/12/17 but should h	Aspirin that morning on nave administered it.				
	Interview with the Adr 11:45 a.m. revealed:	ministrator on 10/17/17 at				
		rained to read the MARs. ninister medications when to be administered.				
		nt #22's current FL-2 dated				
	01/24/17 revealed:	alamania dia atalia lat				
	•	chronic diastolic heart / disease - stage 3, chronic				
	obstructive pulmonary					
	hypertension, bilatera	ll leg pain, pure				
		, Raynaud's phenomenon,				
		and Vitamin D deficiency. for Levothyroxine 50mcg 1				

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
						0	
		1141 004000	B. WING		R-		
		HAL031003			<u>ı 10/1</u>	7/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE			
		4002 SQL	JTH NC 41				
GOLDEN	CARE		E, NC 28466				
			20400			Ī	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE	
				DEFICIENCY)			
D 358	Continued From page	249	D 358				
	tablet daily in the mor	ning. (Levothyroxine is for					
	hypothyroidism.)	g. (==:==:,:=::::=:=:=:=					
	, p						
	Review of Resident #	22's October 2017					
		ation record (MAR) revealed:					
		for Levothyroxine 50mcg					
		orning and it was scheduled					
	to be administered at	_					
		ocumented as administered					
	daily from 10/01/17 -						
	daily ironii 10/01/11	10/12/17.					
	Interview with the me	dication aide (MA) on					
	10/17/17 at 9:13 a.m.						
		he housekeeper reported					
		opped pills on the floor in the					
	resident's room.	opped pins on the noor in the					
		d up from the floor in the					
	resident's room and p						
		not take all of her morning					
	pills at one time.	taka tha Lavathymavina finat					
		take the Levothyroxine first					
	and then the other pil						
	-Resident #22 ate bre						
		e the morning medications					
		so she could take the					
	Levothyroxine before						
		other pills when she ate					
	breakfast.						
	-The resident did not	have an order to					
	self-administer.						
		she was not supposed to					
		s in the resident's room.					
	-	er had told the MAs to do it					
	•	lanager was out on medical					
	leave.						
	-She usually checked						
	mornings to see if it w	vas empty.					
	Observation of the Ma	A on 10/17/17 at 9:35 a.m.					
	revealed she was sta	nding at the medication cart					

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 250 of 419

<u>Division c</u>	<u>of Health Service Regu</u>	ilation				_
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	
					10/11/2017	-
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN (CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
IAG		is being in ordination,	IAG	DEFICIENCY)		
2.050	, _					┪
D 358	Continued From page	e 250	D 358			
	holding the medicatio	on cup with 5 pills found on				
	Resident #22's floor.	•				
	I					
		A on 10/17/17 at 9:35 a.m.				
	revealed:					
		hich pills were in the cup.				
	-They only found 5 pil					
		epare and administer				
		ing medications since the				
	resident dropped ther	n on the moor earlier.				
	Observation on 10/17	7/17 at 9:35 a.m. revealed:				
	-The 5 pills in the cup					
	comparing the medica					
		o were Sotalol 80mg (for				
		e); Lasix 40mg (a diuretic),				
	-	ts (a supplement); Diltiazem				
	30mg (for heart / bloo					
		g (for hypothyroidism).				
	- 					
		7/17 at 9:45 a.m. revealed				
		ot administered when the				
	resident received her	other morning medications.				
		40/47/47 -+ 0/40				
		ent #22 on 10/17/17 at 9:46				
	a.m. revealed:	marning modications in her				
	room for her to take.	morning medications in her				
		Levothyroxine tablet first				
	then the others a little					
	-She dropped the cup					
	(10/17/17) by acciden					
		k the Levothyroxine that				
	morning before she d	lropped the cup.				
		A on 10/17/17 at 10:15 a.m.				
	revealed:					
		the Levothyroxine was one of				
	the pills found on the	floor.				

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-She was aware the resident did not get any

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Division of Health Service Regulation

	or riealth Service Regu				T		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COWIFE	ETED	
					R-	.c	
		HAL031003	B. WING		I	7/2017	
		TIALOGIOGO			1 10/1	772017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
OOL DEN	0.4.DE	4002 SOL	JTH NC 41				
GOLDEN	CARE	WALLAC	E, NC 28466				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE	
				DEFICIENCY)			
D 358	Continued From page	251	D 358				
D 000	Continued From page	5 20 1	5 330				
	Levothyroxine today,	10/17/17.					
	-The resident would n	not get any Levothyroxine					
		use the resident did not like					
	to take Levothyroxine						
	to take Levelly textile	and broamad.					
	Interview with the Adr	ministrator on 10/17/17 at					
	11:45 a.m. revealed:						
		rained to actually observe					
	the residents take the	-					
		he Manager had told staff to					
		morning medications in the					
		morning medications in the					
	resident's room.						
	2 Poviou of Posidor	nt #3's current FL-2 dated					
		agnoses included diabetes					
		_					
		ascular disease, pneumonia,					
	and muscle weakness	S.					
	A Poviou of Posidor	nt #3's current FL-2 dated					
	03/07/17 revealed:	iii #3 3 cuiteiii i L-2 dated					
		for Novolog Flexpen inject					
		•					
		nes a day: 200 - 250 = 2					
		nits; 301 - 350 = 6 units; 351					
	_	reater than (>) 400 = call					
		s a rapid-acting insulin used					
	to lower blood sugar.)						
		for fingerstick blood sugars					
	(FSBS) 4 times daily.						
	D . (D	01.0.1.1.0047					
	Review of Resident #						
		ation record (MAR) revealed:					
	_	or the Novolog Flexpen					
	sliding scale that mate						
	-There was no docum	nentation of any FSBS or					
	insulin administration	for Novolog on the MAR.					
	Review of Resident #	3's October 2017 FSBS log					
	revealed:						
	-Novolog sliding scale	e insulin (SSI) was not					

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administered as ordered on 7 occasions from

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,	
		4002 SOUT	H NC 41			
GOLDEN	CARE	WALLACE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 252	D 358			
	10/01/17 - 10/13/17The FSBS was 256 on SSI was documen units were requiredThe FSBS was 420 a p.m. on 10/06/17 and as administered but the physicianThe FSBS was 208 on SSI was documen units were requiredThe FSBS was 323 on SSI was documen units were requiredThe FSBS was 344 of 2 units of SSI were do requiredThe FSBS was 253 on SSI was documen units were required.	on 10/03/17 at 8:00 p.m. and ted as administered but 4 at 5:00 p.m. and 416 at 8:00 8 units were documented ne order was to call the on 10/07/17 at 8:30 p.m. and ted as administered but 2 on 10/08/17 at 8:00 p.m. and ted as administered but 6 on 10/09/17 at 4:45 p.m. and ocumented but 6 units were on 10/09/17 at 8:30 p.m. and ted as administered but 4 om 50 - 420 from 10/01/17 -				
	log revealed: -Novolog sliding scale administered as order 09/01/17 - 09/30/17On 12 occasions, the 391 and would have runits but none was do-For example, the FS 7:50 a.m. and 2 units none was documente a.m. on 09/25/17 was -On 9 occasions, the staff documented the units of insulin but the they contacted the ph	a's September 2017 FSBS e insulin (SSI) was not red on 21 occasions from e FSBS ranged from 200 - required SSI from 2 to 8 ocumented as administered. BS was 257 on 09/25/17 at of SSI were required but d. (The next FSBS at 11:30 s 311.) FSBS was over 400 and y either administered 6 or 8 or was no documentation sysician to get an order. BS was 537 on 09/13/17 at				

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DIVIDIOIT	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
					1 10
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
1710		,	,,,,,	DEFICIENCY)	
D 250	Continued From page	- 050	D 358		
D 358	Continued From page	253	D 336		
	7:40 p.m. and 8 units	was documented as			
		contact with the physician to			
	get an order was doc				
		g ranged from 62 - 600 from			
	09/01/17 - 09/30/17.				
	lasta mui avvu vuitla tla a maa	diaction side (MAX) an			
	10/13/17 at 9:07 a.m.	dication aide (MA) on			
		cument insulin administration			
	-	BS log instead of the MARs.			
		red, it would be documented			
	on the FSBS log.				
		ny some of Resident #3's SSI			
		as administered when			
	required.				
		osed to call the physician to			
		SI to administer if Resident			
	#3's FSBS was over				
	-If they called the phy				
		MAR or the FSBS log or they			
	would have a fax fron	n the physician.			
	Interview with a seco	nd MA on 10/13/17 at 12:55			
	p.m. revealed:	11d W/ COT 10/10/17 dt 12.00			
	-She usually worked	on second shift as a			
	medication aide / sup				
		osed to call the physician to			
	find out how much SS	SI to administer to Resident			
	#3 if her FSBS was o				
		hysician's office on 09/12/17			
		SBS was 600 and go a			
		ister 10 units of Novolog			
	SSI.	on the healt of the ECDC les			
		on the back of the FSBS log.			
	FSBS that were over	the physician for other			
	documented it on the	•			
		ntacting the physician on			
	any other occasion.	industry the physician on			

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STATE FORM 6899 DBPR11 If continuation sheet 254 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	_
			D 14/11/0		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				DEFICIENCY)		
D 358	Continued From page	254	D 358			
D 000	Continued i form page	204				
	Telephone interview v	with Resident #3's primary				
	care provider (PCP) of	on 10/13/17 at 2:00 p.m.				
	revealed:	·				
	-He was not aware Re	esident #3's FSBS had been				
	running over 400.					
	-His office was contact	cted on 1 occasion in				
		ut a high FSBS for Resident				
	#3.	at a flight obe for resident				
		be getting Novolog SSI and				
	Levemir insulin as ord					
		esident #3 had missed any				
	doses of insulin.					
		nt #3 on 10/17/17 at 10:25				
	a.m. revealed:					
		and FSBS checks about 3				
	or 4 times a day.					
	-She got SSI about 3	times a day and a different				
	kind of insulin once of					
	-Her FSBS ran so hig	h sometimes she would				
	have to get 60 units of	of insulin at night.				
	-She usually felt "nerv	vous" when her FSBS was				
	high.					
	-Her FSBS sometime	s ran low and she would get				
	"nervous and shaky".	•				
	-Her FSBS got so hig	h in September 2017 that				
	she had to go to the h	•				
	B Review of Resider	nt #3's current FL-2 dated				
	03/07/17 revealed:					
		for Levemir 60 units twice a				
		-acting insulin used to lower				
	blood sugar.)	adding indumination to lower				
	• ,	for fingerstick blood sugars				
	(FSBS) 4 times daily.				ľ	
	Davious of Danielant #	321a October 2017			ľ	
	Review of Resident #					
		ation record (MAR) revealed:				
		for the Levemir inject 60				
	units twice a day at 8	:00 a.m. and 8:00 p.m.				

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		R-C
		HAL031003	b. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET VI	DDRESS, CITY, STA	TE ZIR CODE	
IVAIVIL OF T	NOVIDEN ON OUT LIEN		, ,	12, 211 0002	
GOLDEN	CARE		JTH NC 41		
00		WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 358	Continued From page	255	D 358		
2 000					
	-Levemir was not doo	cumented as administered at			
	8:00 a.m. on 10/07/17	7 and 10/08/17.			
	-There was no reasor	n for the omissions			
	documented on the M	IAR.			
	Review of Resident #	3's October 2017 FSBS log			
	revealed:	00 00.000. 2011 1 020 10g			
	-There was no Lever	air documented as			
	administered at 8:00	a.iii. 0ii 10/07/17 aiiu			
	10/08/17.				
		e through the area used to			
		nd amount of insulin on both			
	occasions.				
	-The FSBS ranged from	om 50 - 420 from 10/01/17 -			
	10/13/17.				
	Review of Resident #	3's September 2017 MAR			
	revealed:				
	-There was an entry f	for the Levemir inject 60			
		:00 a.m. and 8:00 p.m.			
	•	umented as administered			
	from 09/01/17 - 09/30				
	-There was a handwr				
	sheet".	itteri flote to 'See flow			
	SHEEL.				
	Davious of Davidant #	2's Contombor 2017 ESPS			
		3's September 2017 FSBS			
	log revealed:				
	-Levemir insulin was				
	administered on 30 of	f 60 occasions from			
	09/01/17 - 09/30/17.				
		was not documented as			
	administered on 09/0	1/17 - 09/06/17, 09/08/17,			
	09/10/17 - 09/12/17, 0	09/16/17, 09/18/17,			
	09/19/17, 09/21/17 - 0	09/23/17, 09/27/17 -			
	09/30/17.				
		BS was 146 at 8:00 a.m. on			
	·	emir was documented as			
		BS on 09/12/17 at 5:00 p.m.			
		50 011 09/12/17 at 0.00 p.111.			
	was 600).				

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-The 8:00 p.m. dose was not documented as

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DIVISION OF HEAlth Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		(X3) DATE SUBVEY				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, 2012Bii (0:		D C	
		HAL031003	B. WING		R-C 10/17/2017	7
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	•	
			UTH NC 41	-		
GOLDEN	CARE	WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMI	(5) PLETE ATE
D 358	Continued From page	e 256	D 358			
	administered on 09/0 09/12/17, and 09/17/- On 4 occasions, staf Novolog insulin was a units of Levemir. (Th sliding scale insulin.) -For example, the FS 8:00 p.m. and 60 unit documented as admi 09/22/17 at 7:20 a.mThe FSBS was 391 66 units of Levemir wadministered instead -The FSBS on the log 09/01/17 - 09/30/17. Review of Resident # revealed: -There was an entry funits twice a day at 8 -Levemir was initialed - 08/05/17 but there warking through the inference was a handwrighter was a handwrighter. Review of Resident # revealed: -There was a handwrighter	1/17, 09/03/17 - 09/09/17, 17. If documented 60 units of administered instead of 60 e resident used Novolog for BS was 325 on 09/21/17 at s of Novolog were nistered (the next FSBS on was 91). In 09/19/17 at 8:00 p.m. and lere documented as of 60 units as ordered. If ranged from 62 - 600 from If at 8:00 p.m. from 08/02/17 was a handwritten line nitials. Levemir doses initialed. itten note to "see flow If a see flow If a				
	•	BS was 66 at 8:00 a.m. on				

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p.m. was 396).

administered (the FSBS on 08/06/17 at 12:00

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT WALLACE,				
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	257	D 358			
	administered on 08/0 08/24/17 - 08/31/17.	was not documented as 1/17, 08/12/17 - 08/15/17, granged from 61 - 439 from				
	Resident #3 dated 04 -There were 12 Lever supply) dispensed on -There were 12 Lever supply) dispensed on -No Levemir was dispos/2017.	mir Flexpens (36ml = 30 day 06/28/17. pensed in 07/2017 or mir Flexpens (36ml = 30 day				
	hand on 10/13/17 rev -There was one Leve drawer of the medicat 09/15/17 with no open would be 2.5 day sup -There were 6 unopen medication refrigerate which was a 15 day s -If administered as or Flexpens dispensed of daysThere should have b day supply) remaining had been administered 09/15/17.	mir Flexpen in the top tion cart dispensed on n date documented (1 pen ply). ned Levemir Flexpens in the or dispensed on 09/15/17 upply. dered, the 12 Levemir on 09/15/17 would last 30 een 1 Levemir Flexpen (2.5 g on 10/13/17 if the Levemir ed as ordered since				
		revealed: cument insulin administration 3S log instead of the MARs. nistered, it would be				

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	1
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/201	17
		Incorpor	_l		10/11/20	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	l	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		MPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE	DATE
				,		
D 358	Continued From page	e 258	D 358			
	documented on the M	1AB				
		ny some of Resident #3's				
		umented as administered				
	when required.	intented as administered				
	when required.					
	Interview with a seco	nd MA on 10/13/17 at 12:55				
	p.m. revealed:	110 W/X 011 10/10/17 at 12:00				
	-She usually worked	on second shift as a				
	medication aide / sup					
		y Resident #3's Levemir				
	was not documented	-				
		nted on the FSBS log if it				
	was administered.					
	Telephone interview v	vith Resident #3's primary				
	care provider (PCP) of	on 10/13/17 at 2:00 p.m.				
	revealed:	·				
	-He was not aware Re	esident #3's FSBS had been				
	running over 400.					
	-His office was contact	cted on 1 occasion in				
	September 2017 about	ut a high FSBS for Resident				
	#3.					
		be getting Novolog SSI and				
	Levemir insulin as ord					
		esident #3 had missed any				
	doses of insulin.					
	1. () () () () () () () () () (1.110 40/47/47 1.40.05				
		nt #3 on 10/17/17 at 10:25				
	a.m. revealed:	and ESDS about about 2				
		and FSBS checks about 3				
	or 4 times a day.	times a day and a different				
		times a day and a different				
	twice a day.	t know the name) once or				
		h sometimes she would				
	have to get 60 units of					
		or insulin at night. vous" when her FSBS was				
	-	vous when her rodo was				
	high.		1			

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"nervous and shaky".

-Her FSBS sometimes ran low and she would get

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
AND FLAIN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	A. BUILDING:		FLETED
						R-C
		HAL031003	B. WING		10	/17/2017
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN	CARE		E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	DE CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 259	D 358			
	-Her FSBS got so hig she had to go to the I	h in September 2017 that nospital.				
	3. Review of Resident #1's current FL-2 dated 02/20/17 revealed diagnoses included senile dementia, uncontrolled Type II diabetes, hypertension, anemia, and depression.					
	Resident #1 dated 08 -Resident #1 was evaluabscessThe diagnosis was diagnosis dia	locumented as "carbuncle." ere boil/abscess under the by a bacterial infection). charged with an order for our times daily for ten days.				
	revealed: -There was a handwr 300mg four times a d of 8:00 a.m., 12:00 pClindamycin was do on fourteen days (fro -Clindamycin was firs administered on 08/1 dose was documente 08/28/17 at 8:00 a.m. days; the final dose s days from 08/15/17, v -On 08/15/17, the me as administered only 12:00 p.m.; the 4:00 p	itten entry for Clindamycin ay with administration times .m., 4:00 p.m., and 8:00 p.m. cumented as administered m 08/15/17 and 08/28/17). It documented as being 5/17 at 8:00 a.m.; the last as administered on (The order was for ten hould have been given 10 which was 08/24/17). It dication was documented twice, at 8:00 a.m. and p.m. and 8:00 p.m. doses				
	skin, usually caused -Resident #1 was dis Clindamycin 300mg f (Clindamycin is an ar infection). Review of Resident # administration record revealed: -There was a handwr 300mg four times a dof 8:00 a.m., 12:00 pClindamycin was do on fourteen days (froight -Clindamycin was first administered on 08/1 dose was documented 08/28/17 at 8:00 a.m. days; the final dose sidays from 08/15/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas administered only 12:00 p.m.; the 4:00 p. were not documented -On 08/17/17, the meas	by a bacterial infection). charged with an order for four times daily for ten days. atibiotic used to treat et 's medication (MAR) for August 2017 witten entry for Clindamycin ay with administration times am., 4:00 p.m., and 8:00 p.m. cumented as administered an 08/15/17 and 08/28/17). at documented as being 5/17 at 8:00 a.m.; the last at as administered on and (The order was for ten althould have been given 10 and hould have been given 10 and and 8:00 p.m. doses at as administered.				

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DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	:TED
			1		n/	_
			B. WING		R-(
		HAL031003	1 2. 7,,5		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN (CARE		E, NC 28466			
			-, 140 20400	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
iAO		,	IAG	DEFICIENCY)		
			+			
D 358	Continued From page	e 260	D 358			
	12:00 n m and 4:00	p.m.; the fourth daily dose,				
	•	m., was not documented as				
	administered.	iii., was not documented as				
		disation was decomposited				
		dication was documented				
		e times, at 8:00 a.m., 12:00				
	· · · · · · · · · · · · · · · · · · ·	the dose scheduled for 4:00				
	• •	ented as administered.				
		26/17, the medication was				
		nistered three times a day at				
	8:00 a.m., 4:00 p.m.,					
		28/17, the medication was				
	documented as admir	nistered once a day at 8:00				
	a.m.					
	-There was no docum	nentation on the MAR				
	related to any of the r	missed doses.				
	Telephone interview v	with the Pharmacist from the				
	facility's pharmacy pro	ovider on 10/16/17 at 2:30				
	p.m. revealed:					
	•	ved the order dated 08/14/17				
	for Clindamycin 300m					
	-	0 Clindamycin (a ten day				
	supply) for Resident #					
		not received any returns for				
	•	facility for Resident #1.				
	Omidamyon nom the	radinty for reorderit in 1.				
	Observation of Reside	ent #1's medications on				
		11:15 a.m. revealed there				
	was no Clindamycin o	JII HAHU.				
	Intonvious with a madi-	eation aido/supor ricor				
		cation aide/supervisor				
	,	t 10:15 a.m. revealed with				
		RS, you would not know				
	whether the medication	on was given or not.				
		ith a MA/S on 10/16/17 at				
		ne did not recall Resident #1				
	missing any antibiotic	s or refusing any				
	medications.					

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Division of	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						0
			B. WING		R-	
		HAL031003	B. WING		10/1	17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		E, NC 28466			
		WALLACI	E, NC 20400			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
iAO		,	IAG	DEFICIENCY)		
			+			
D 358	Continued From page	e 261	D 358			
	Rased on observation	as record reviews and				
	Based on observations, record reviews, and interviews, Resident #1 was not interviewable.					
	interviews, ixesident	#1 was not interviewable.				
	Daviou of Homo Hoa	olth (HH) Visit notes for				
	Resident #1 revealed	alth (HH) Visit notes for				
	-On 08/29/17 and 08/					
	-	e HH Registered Nurse (RN)				
	that the left shoulder	caruncie wound was				
	healing.	/40/47 the LULDN				
	-On 09/05/17 and 09/					
		nd was healing and had no				
	signs and symptoms					
		I RN documented the wound				
	was healed.					
		–				
	•	with a Nurse Practitioner				
	` '	s PCP office on 10/16/17 at				
	•	edications were expected to				
	be administered to Re	esident #1 as ordered.				
		ministrator on 10/16/17 at				
	9:35 a.m. revealed:					
		I to initial the MAR when				
	medications were give					
		if a resident got medications				
	or not if the entry was					
		nitialed, they did not get the				
	medication.					
		nt #1's physician orders				
		0/09/17 revealed an order				
		nits subcutaneously every				
		long-acting insulin used to				
	treat and control high	blood sugar).				
	Review of Resident #					
		ation record (MAR) revealed:				
		ter generated entry for				
		utaneously every morning.				
	"Prime pen with 3 uni	its prior to each use-Do not				

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DIVISION (<u>of Health Service Regu</u>	ilation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
						0
		1141 024002	B. WING		R-0	
		HAL031003	D. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
	0.11.11.4.5.4.5.4		<u>, </u>	T		
(X4) ID		TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 250	2 " 15		D 250			
D 358	Continued From page	e 262	D 358			
ļ	mix with other insulin-	-use within 42 davs."				
ļ		nted as administered every				
	day from 10/01/17-10					
ļ	day	,, 10, 11.				
	Review of Resident #	t1's October 2017 FSBS log				
ļ	revealed:					
ļ		S was checked 93 times from				
ļ	10/01/17 - 10/16/17.					
ļ		g ranged from 20 - "HI"				
		cording to the manufacturer				
	of the glucometer).	70.4				
ļ	J. 1.10 g. 1.1.1.1.					
	Review of the Toujeo	"Highlights of Prescribing				
	_	manufacturer included in				
		evealed opened (used)				
		oujeo pens should be stored				
		and "must be discarded 42				
	days after being open					
	day 5 a					
	Observation of Resid	lent #1's medications on				
	hand on 10/12/17 at					
		ed, disposable, prefilled				
		th a pharmacy dispense date				
	of 08/03/17.					
		attached to the pen with				
		ntation which read the Toujeo				
		d on 08/24/17 (42 days from				
	08/24/17 was 10/05/1					
		opened Toujeo insulin pens				
	for Resident #1.	•				
	Interview with a medi-	cation aide/supervisor				
		at 11:35 a.m. revealed:				
	-When insulin was op	pened, the medication aides				
	put a sticker on it as	documentation of the date it				
	was opened.					
	-Insulin was kept for 2	28 days, then it was				
	disposed of.	•				
	-Insulin was re-ordere	ed before it ran out or				
	expired so they medic	cation was kept in stock.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
		WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 263	D 358			
	was not on the medic -The Toujeo with the of 08/24/17 should had a now because it was " -The MA/S did not ac	open date documented as been disposed of before				
	-The MA/S disposed 08/24/17 open date in	n the sharps container. Toujeo pen for Resident #1				
	06/05/17 revealed dia	t #4's current FL-2 dated agnoses included traumatic and bi-polar disorder.				
	revealed; -There was an order of	dated 09/11/17 for Duricef				
	used to treat bacteria	dated 09/25/17 for Duricef				
	facility's pharmacy proposed p.m. revealed the pharmacy prescription for Durice 09/13/17 at 11:11 a.m.	with the Pharmacist from the ovider on 10/16/17 at 2:30 armacy did not receive the ef dated 09/11/17 until n.; twenty Duricef capsules are dispensed/delivered to 7.				
	-For the 09/11/17 Dur handwritten entry for	4's September 2017 ation record (MAR) revealed: ricef order, there was a Cefadroxil (generic for one capsule twice daily for				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU	TH NC 41			
OOLDEN		WALLACI	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 264	D 358			
	and 5:00 p.m. -The first dose of Durgiven on twelve dates with the first dose do 8:00 a.m. and the last administered on 09/2 was for only ten days -Duricef was documedaily from 09/13/17 -Duricef was documedaily from 09/25/17 Duricef was documedated by the conduction of the first dose was doon 09/25/17 at 5:30 purchase one capsule twice administration times of the first dose was doon 09/25/17 at 5:30 purchase of the first dose was doon 09/25/17 at 5:30	nited as administered twice 09/23/17; on 09/24/17, ated as administered at 5:00 ricef order, there was a antry for Cefadroxil 500mg be daily for "30" days with of 8:00 a.m. and 5:30 p.m.; cumented as administered .m.				
	revealed:	4's October 2017 MAR for Cefadroxil 500mg twice				
	-There were a total of 20 doses documented as administered from 10/01/17 - 10/13/17Cefadroxil was documented as administered only once daily on 6 dates: 10/01/17, 10/08/17, 10/09/17 and 10/11/17-10/13/17 (The order was for twice daily).					
	facility's pharmacy proposed p.m. revealed: -The pharmacy received dated 09/25/17 on 09	vith the Pharmacist from the ovider on 10/16/17 at 2:30 ved the order for Duricef /25/17 at 1:48 p.m.; there "somebody" at the facility				

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included with the prescription asking the

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DIVISION	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D C	
		UAL 024002	B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
	OLIMANA DV OT			DDOV/DEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
D 358	Continued From page	265	D 358			
D 330	Continued From page	200	D 330			
	pharmacy not to send	the medication then.				
	-The pharmacy receiv	ved the order for Duricef				
	dated 09/25/17 a sec	ond time on 10/03/17 at				
	10:11 a.m., but withou	ut the note requesting the				
	medication not to be	sent; thirty Duricef were				
	dispensed and delive	red to the facility on				
	10/03/17 (a fifteen da	y supply).				
	-There had not been	any Duricef returned to the				
	pharmacy for Resider					
	Review of Resident #	4's medications on hand on				
	the medication cart of	n 10/13/17 at 10:15 a.m.				
	revealed:					
	-There was one card	of Duricef on hand with a				
	dispense date of 10/0	03/17.				
	-There was a total of	11 Duricef left on the card.				
	Interview with a medi	cation aide/supervisor				
	(MA/S) on 10/13/17 a	at 10:15 a.m. revealed with				
	the "holes" in the MAI	RS, you would not know				
	whether the medication	on was given or not.				
		_				
	A second interview w	ith the MA/S on 10/17/17 at				
	12:10 p.m. revealed:					
	-As far as she knew,	Resident #4 had not missed				
	any doses of antibioti	cs.				
	-Se did not recall Res	sident #4 ever refusing or				
	having any left-over a	antibiotics.				
	Interview with a secon	nd MA/S on 10/13/17 at 5:30				
	p.m. revealed:					
	-Staff put their initials					
	medications were give	en.				
	-If there was no initial	l, the medication was not				
	given.					
	-If a medication was r	not given, the MA was				
	supposed to write the	reason on the back of the				
	MAR.					
			1			

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Interview with Resident #4 on 10/13/17 at 4:50

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Division of Health Service Regulation

	or Regulation		0/0) 14111 7101 5	CONTRICTION	Lava BATE OURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
D I LAN			A. BUILDING: _		
					R-C
	HAL031003 B. WING		10/17/2017		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
COLDLIN		WALLACE	, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAIE
				,	
D 358	Continued From page	e 266	D 358		
	n na vasta aladi				
	p.m. revealed:	al and introverse (NA)			
		al and intravenous (IV)			
	antibiotics for her sku				
		iotics gave her diarrhea and			
	did not help; she thou				
		rently taking (Duricef).			
		she had missed any doses of			
	oral antibiotics.				
	Tolonhono intonvious v	with a Degistered Nurse			
		vith a Registered Nurse			
	, ,	wound clinic on 10/16/17 at			
	10:55 a.m. revealed:	receribed Decident #4			
		rescribed Resident #4			
	•	ntibiotics for an infection and			
	necrosis of the skull b				
	-	pected to take all antibiotics			
	as ordered.	t and the mutibilities as			
		t get the antibiotics as			
		uild up a resistance and			
	require stronger antib				
		scribed IV antibiotics for			
		oone tissue; the need for IV			
		ecessarily related to any			
	missed oral antibiotics	S.			
	Intonvious with the A-I-	ministrator on 10/10/17 -t			
		ministrator on 10/16/17 at			
	9:35 a.m. revealed:	nitialed no one would know			
		nitialed, no one would know			
	if a resident got the m				
		nitialed, they did not get the			
	medication.				
	5 Review of Pecidor	nt #2's current FL-2 dated			
	04/06/17 revealed dia				
	Alzheimer's and Hype				
	Aizneimei s and Hype	51 (C1131U11.			
	A. Review of Emerge	ncy Department (FD)			
		ed from local hospital) for			
	Resident #2 dated 10	• •			

Division of Health Service Regulation

-The resident was evaluated for complaint of

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Division of Health Service Regulation

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
OO! DEN	0485	4002 SOU	TH NC 41		
GOLDEN	CARE	WALLACE	, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 358	Continued From page	e 267	D 358		
	coughing up blood.				
	-Chest x-ray was con	npleted with no acute			
	findings.				
		scharged back to facility on			
		agnosis was: Encounter for			
	medical screening ex				
	Review of the physici	ian orders for Resident #2			
	revealed an order dat				
		in) (medication used to treat			
		s) 500 mg, take one tab by			
	mouth two times a da				
	-Portable chest x-ray	(Diagnosis: pneumonia).			
	-Hospice consult (Dia	agnosis: failure to thrive).			
	Review of an ED Pro	vider note (received from			
	local hospital) for a se	econd visit for Resident #2			
	dated 10/07/17 revea	ıled:			
		aluated for complaint of			
	coughing up blood.				
		member reported that she			
		congestion and that her			
	prescription for an an	er (PCP) had ordered a			
		nented (family member)			
		nurse practitioner felt as if			
		I pneumonia and reported to			
	·	patient (resident) would be			
		(family member) was unsure			
	if patient had received	` '			
	-The ED nurse docum	nented (family member)			
	reported "facility staff	told him that they were			
		dent) to ED to be evaluated			
	due to her breathing	-			
		oses were: Bronchitis and			
	Cellulitis of right ante	•			
		scribed were: Cephalexin			
	, , ,	used to treat infections			
	caused by bacteria) 5	500mg oral capsule; take			

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	268	D 358		
	one cap by mouth fou	r times a day for 7 days. rged back to facility on			
	revealed an order dat	an orders for Resident #2 red 10/07/17 for Cephalexin capsule, take one cap by ay for 7 days.			
	hospital) from a third dated 10/10/17 revea -The resident was eva status. -Resident's ED diagnamedical screening ex	aluated for altered mental osis was: Encounter for			
	Clarithromycin 500 m for 10 days. -On 10/09/17 there w Cephalexin 500 mg, 1 times daily for 7 days -The first dose for Cla	ation records (MARs) as a handwritten order for g, 1 tab by mouth twice daily as a handwritten order for I capsule by mouth four			
	Interviews, Resident # Interview with a medic (MA/S) on 10/13/17 a -She did not know wh	ns, record reviews, and #2 was not interviewable. cation aide/supervisor t 12:55 p.m. revealed: y the Cephalexin and the not given to Resident #2 until			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 269 of 419

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
						`
		HAL031003	B. WING		R-C	7/2017
					1 10/11	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLACI	E, NC 28466			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL I SO IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
TAG	REGULATORT ON	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DAIL
D 358	Continued From page	≥ 269	D 358			
		nember may put medication				
	in the back room and arrived."	not tell anyone that it had				
		cian's office on 10/09/17 at				
	10:30 a.m. to verify th	nat both antibiotics should be				
	given.	Conferent the continuous				
	office to give both the	nation from the physician's				
	Clarithromycin as ord					
	_	armacy on 10/09/17 at				
	approximately 10:35	a.m. that both Cephalexin				
	_	hould be given as ordered.				
		re was to write the new				
	facility, and then give	AR once it arrived to the				
	acility, and then give	as ordered.				
	Interview with the Phyp.m. revealed:	ysician on 10/13/17 at 2:15				
	•	nat Resident #2 did not				
	receive the first dose dose of Clarithromyci	of Cephalexin and the first				
		for new medication orders				
		ould fax the order to the				
	pharmacy immediatel					
	•	that all orders are carried				
	out immediately after					
		hat "some infections could				
	started immediately".	24 hours if antibiotics are not				
	Interview with the Dh	armanist at the facility's				
		armacist at the facility's y on 10/16/17 at 9:45 a.m.				
	revealed:	611 10/10/17 at 5.45 a.m.				
		romycin was received via fax				
	from the facility on 10					
	-The main pharmacy					
	Clarithromycin on 10/					
	from the facility on 10	lexin was received via fax 0/07/17 at 7:53 p.m.				

Division of Health Service Regulation

-The order for Cephalexin was sent from the main

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
			•		-
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	_	4002 SOL	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
			20400	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	NEGOLATORT OR I	LOCIDEIVIII TIIVO INI OKMATION)	TAG	DEFICIENCY)	JAIL SALE
				,	
D 358	Continued From page	270	D 358		
	Communa Trom page	2.0			
	pharmacy to the back	cup pharmacy on 10/09/17.			
		les) were dispensed to the			
		up pharmacy on 10/09/17 at			
	11:51 a.m.	priarriady on rordor ir at			
		loo) were dispensed to the			
		les) were dispensed to the			
		pharmacy on 10/09/17 at			
	9:37 p.m. and the ren	- ·			
	10/10/17 at 9:41 p.m.				
	-The two prescriptions	s were received after hours			
	on Saturday 10/07/17	,			
	<u> </u>	on Saturday (10/07/17)			
	were 8:00 a.m12:00				
		macy requests after hours			
	-	ed to call their after hours			
	_				
		know that a prescription was			
		be delivered to the backup			
	pharmacy.				
	-"If they were not call	ed, they would not know that			
	a prescription was fax	red and sitting in que."			
	-On 10/07/17 at 8:31	p.m. the backup pharmacy			
	technician called the	facility and spoke with the			
		on if Resident #2 should be			
	•	romycin and Cephalexin.			
		p.m. the MA/S was going to			
		ian and call the pharmacy			
	back.				
		3 a.m. the pharmacy called			
	the facility for follow-u	ıp.			
	-On 10/09/17 at 10:35	5 a.m. the pharmacy			
	received a call from the	ne MA/S confirming that the			
	physician wants Resi				
	medications as order				
	modications as order	O4.			
	Davious of aboves	dianonaina roporda rayaalad			
	•	dispensing records revealed			
	the following:				
		ng capsules were dispensed			
	for Resident #2 on 10)/09/17.			
	-Cephalexin 500 mg	capsules were dispensed for			
	Resident #2 on 10/07				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 271 of 419

Division of	<u>of Health Service Regu</u>	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL031003	B. WING	B. WING		7/2017
		TIALOGIOGO	1		1 10/1/	172017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDLIN	DAIL	WALLACE	, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIE	BATE
D 358	Continued From page	e 271	D 358			
	Interview with a family	y member on 10/17/17 at				
	8:50 a.m. revealed:	,				
		he facility nurse practitioner				
		tic for Resident #2 for				
	•	pneumonia after her first				
	ER visit on 10/06/17.					
	-He was aware that the	ne ED prescribed another				
	antibiotic for Residen	t #2 for bronchitis and				
	cellulitis.					
		vare that the antibiotics were				
	•	sident #2 did not receive her				
	first dose of either an	tibiotic until 10/09/17.				
	Cocond intensions with	n the MA/S on 10/17/17 at				
	10:00 a.m. revealed:	Title MA/S off To/T//17 at				
		d for pharmacy requests				
		acility would call the backup				
		e prescription to them.				
		e prescription to the main				
		cility would call them and				
	speak with their after	hours service and tell them				
	the fax was sent.					
		ce would send the fax to the				
	backup pharmacy to					
		cation arrived to the facility,				
		vrite it on the MAR and give				
	as ordered.					
	Interview with the Adr	ministrator on 10/17/17 at				
	11:10 a.m. revealed:	ministrator on 10/11/11 at				
		hat Resident #2 had a delay				
	in receiving the Ceph					
	Clarithromycin.					
		rmacy requests after hours				
		ed to call the pharmacy				
		d let them know that a				
	prescription was faxe					
	delivered to the back	up pharmacy.				

Division of Health Service Regulation

B. Review of the physician orders for Resident #2

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Division of Health Service Regulation

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF PROVIDE	ER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	10/11/2011	
GOLDEN CARE		4002 SOU ⁻ WALLACE	ГН NC 41 , NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
reversible constitute of the c	azepam 0.5mg ondere was an order of continue Ativan throan 0.5 mg, take or as a day. Bere was an order of azepam (Ativan) (ruptoms of anxiety) mouth three times are was a compute azepam 0.5mg takes a day. Bere was a handwrid of p.m. dose. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day. Bere was a compute azepam 0.5mg takes a day.	dated 06/13/17 to give e tab three times a day. dated 08/09/17 to ee times per day. Start he tablet by mouth two dated 09/06/17 to give medication used to treat the tab 0.5 mg, take one tablet	D 358			

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION C	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-(C
		HAL031003	B. WING		10/1	7/2017
NAME OF D	20//DED OD OUDDUED	OTDEET A	DDEGG OITY OTA	TE 7/D 00DE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SO	JTH NC 41			
COLDEN		WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 358	Continued From nego	272	D 358			
D 330	Continued From page	273	D 336			
	0.5mg; take one table	et by mouth two times a day.				
		of Lorazepam documented				
		from 08/01/17 - 08/05/17				
	and 08/07/17 - 08/08/					
		of Lorazepam documented				
		from 08/06/17, 08/09/17 -				
	-					
		08/26/17, and 08/29/17 -				
	08/30/17.					
		Lorazepam documented as				
	•	m 08/14/17 - 08/15/17 and				
	08/27/17 -08/28/17.					
		s of Lorazepam documented				
	as administered on 08	8/31/17.				
	Based on observation	ns, record reviews, and				
	interviews, Resident #	#2 was not interviewable.				
	Interview with a MA/S	on 10/13/17 at 1:55 p.m.				
	revealed:	·				
	-She was not aware t	here was an order dated				
		zepam 0.5 mg, take one				
	tablet by mouth three					
	•	no drew the handwritten line				
		dose on the September				
	2017 MAR.	doce on the coptember				
		Il the physician to clarify the				
	correct order for the L					
	correct order for the L	Lorazeparri.				
	Interview with the Dhe	armacist from the facility's				
		on 10/16/17 at 9:45 a.m.				
		7 Ativan order for 0.5 mg,				
		outh three times a day was				
	most current.					
	5					
		dispensing records revealed				
	the following:					
		bs; 60 were dispensed for				
	Resident #2 on 08/29					
	-Lorazepam 0.5mg ta	bs; 90 were dispensed for				
	Resident #2 on 09/13	/17.				

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	iation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (λ		' '	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			D WING	D 144110		-C	
		HAL031003	B. WING		10/1	7/2017	
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZID CODE			
NAME OF T	NOVIDEN ON 3011 LIEN			TE, ZII GODE			
GOLDEN	CARE	4002 SOUT					
		WALLACE	, NC 28466				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DATE	
				DEI IOIEROT)			
D 358	Continued From page	274	D 358				
	communication page						
	Interview with the Adr	ministrator on 10/17/17 at					
	11:10 a.m. revealed:						
	-She was not aware t	hat the Ativan was not given					
	according to physicial	n's order.					
	-The normal process	for medication errors was to					
	report it to the physici	ian immediately.					
	-The MA/S should har	ve clarified the Ativan order					
	with the physician and	d the pharmacy.					
		•					
	6. Review of Resider	nt #5's FL-2 dated 03/22/17					
	in the closed record re	evealed:					
	-Diagnoses included I	hypertension, chronic					
		nic kidney disease, atrial					
	fibrillation, sepsis, hyp	· · · · · · · · · · · · · · · · · · ·					
	hypokalemia.	oomationia, and					
	• •	for Norco 5/325mg 1 tablet 3					
		s a narcotic pain reliever.)					
	unies a day. (Noico i	s a narcolic pain reliever.)					
	Poviow of a physician	n's order for Resident #5					
		led an order to discontinue					
		ied an order to discontinue					
	Norco 5/325mg.						
	Daview of Decident #	Fla Ameil 2017 madiantian					
		5's April 2017 medication					
	administration record	•					
		for Norco 5/325mg 1 tablet 3					
		.m., 2:00 p.m., and 8:00					
	p.m.						
		nented as administered was					
	on 04/21/17 at 8:00 a						
		ted to be in the hospital from					
	04/21/17 (2:00 p.m. d						
		ted as discontinued on					
	04/25/17.						
	Review of Resident #	5's May 2017 MAR					
	revealed:						
		or Norco 5/325mg 1 tablet 3					
	times a day at 8:00 a.	.m., 4:00 p.m., and 8:00					

p.m.

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
			B. WING		R-C
		HAL031003	B: Wille		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	ITH NC 41		
GOLDEN	CARE		E, NC 28466		
			·		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 250	0 (15	075	D 250		
D 358	Continued From page	275	D 358		
	-No Norco was docum	nented as administered and			
		n documentation the order			
	was "d/c" (discontinue				
	(,			
	Review of the control	led substance (CS) log for			
	Resident #5's Norco	· · · · · · · · · · · · · · · · · · ·			
	-The CS log started w	_			
	04/06/17 at 8:00 a.m.				
	-The last dose docum	nented for April 2017 was			
		(prior to the order being			
	discontinued on 04/2				
		documented after the order			
	was discontinued on				
		umented as administered			
	on 05/16/17 at 2:00 p				
	r	P			
	Interview with the me	dication aide (MA) on			
	10/17/17 at 12:52 p.m				
	-	ospice resident who passed			
	away a few months a	go (not sure of date).			
		e resident's Norco being			
	discontinued.	•			
	-She was not aware t	he Norco was administered			
	to the resident after it	was discontinued.			
	-The Norco should ha	ave been pulled out of the			
	medication cart when	it was discontinued.			
	-She would check for	any return records to the			
	pharmacy.				
	Review of a certificate	e of death for Resident #5			
	revealed:				
	-The date of death wa				
		listed was cardiac arrest,			
	respiratory insufficien	cy, and end stage dementia.			
		dminister sliding scale			
		g insulin as ordered to			
		diabetic and had multiple			
		0 and as high as 600. The			
	facility failed to admin	ister two courses of an oral			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A. BOILDING.		
			B WING	R	
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
OO! DEN	0405	4002 SOL	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	276	D 358		
	antibiotic as ordered to infection and necrosis facility failed to admin ordered to Resident # and diagnoses including the right lower leg. The expired insulin to Resuncontrolled diabetes ranging from 20 - "HI" facility failed to admin for 3 of 4 residents ob passes with 27% mederrors with insulin, a content / blood pressure blood clots, hypothyroheart disease. The famedications as ordere in substantial risk of significant insuling risk of significant insuling as ordered in substantial risk of significant insuling as ordered in substantial risk of significant disease.	to Resident #4 who had softhe skull bone. The sister two antibiotics as the standard properties and the standard properties and cellulities of the facility administered.			
	10/12/17 revealed: -Review with all Medimedication administra medication accuracyCharts will be audited medication errors repimmediatelySupervisor and Admiphysician for medication-service with Mediceach to ensure properior chart per Supervisor-Audits will include or medications on hand.	d by Administrator and any orted to physician inistrator will contact ion clarifications. Cation Aides and monitor redication administration. In immediately and organized or and Administrator. Inistrator will do random ekly.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED	
					R-C
	HAL031003 B. WING		10/17/2017		
					10/11/2011
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
		WALLACE	, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 277	D 358		
	Administrator monthly	y.			
	CORRECTION DATE VIOLATION SHALL N 16, 2017.	FOR THE TYPE A2 NOT EXCEED NOVEMBER			
D 366	10A NCAC 13F .1004 Administration	4 (i) Medication	D 366		
	10A NCAC 13F .1004	4 Medication Administration			
	medication administra staff person who adm immediately following medication to the res				
	reviews, the facility fadocumented the admimmediately following observation of the resmedications for 2 of 4	ns, interviews, and record alled to assure staff inistration of medications the administration and sident actually taking the residents (#13, #22) morning medication passes			
	The findings are:				
	01/24/17 revealed: -Diagnoses included	=			

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Division (of Health Service Regu	ilation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPL	ETED	
					R-C	
			B. WING		1	
		HAL031003	b. WING		10/1	17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
			., NC 20466	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
iAG		,	IAG	DEFICIENCY)		
D 366	Continued From page	e 278	D 366			
	hyporcholoctorolomia	a, Raynaud's phenomenon,				
		, and Vitamin D deficiency.				
		•				
		for Levothyroxine 50mcg 1				
		rning. (Levothyroxine is for				
	hypothyroidism.)	fant asia 10an ann a daibh in				
		for Lasix 40mg once daily in				
	the morning. (Lasix is	The state of the s				
		for Sotalol 80mg once daily.				
	(Sotalol is for heart / I					
		for Diltiazem 30mg 3 times a				
	, ,	heart / blood pressure.)				
		for Vitamin D3 1000 units 1				
	tablet daily in the mor					
	supplement for Vitam	in D deficiency.)				
	Review of physician's	s orders for Resident #22				
	revealed:					
	-There was an order	dated 06/26/17 for				
	Prednisone 5mg 1 tal	blet daily with breakfast.				
	(Prednisone is a corti	icosteroid used to treat				
	inflammation.)					
	-There was an order	dated 08/15/17 to start				
	Aspirin 81mg once da	aily. (Aspirin may be used to				
	help prevent heart dis	sease.)				
	Review of Resident #	22's October 2017				
	medication administra	ation record (MAR) revealed:				
	-There was an entry f	for Levothyroxine 50mcg 1				
		and it was scheduled to be				
	administered at 7:30					
		for Lasix 40mg 1 tablet every				
		cheduled to be administered				
	at 7:30 a.m.					
		for Sotalol 80mg 1 tablet				
	every day and it was					
	administered at 7:30					
		for Diltiazem 30mg 1 tablet 3				
		heduled to be administered				[
	at 8:00 a.m., 12:00 p.					
		for Vitamin D3 1000 units 1				
	- mere was an entry i	ioi vitailiili Do 1000 ullito I	1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPL	ETED I	
	COMPLETED	
	•	
R-		
HAL031003 B. WING 10/1	7/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN CARE 4002 SOUTH NC 41		
WALLACE, NC 28466		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE	
DEFICIENCY)		
D 000		
D 366 Continued From page 279 D 366		
tablet every morning and it was scheduled to be		
administered at 7:30 a.m.		
-There was an entry for Prednisone 5mg 1 tablet		
every other day and it was scheduled to be		
administered at 8:00 a.m.		
-There was an entry for Aspirin 81mg 1 tablet		
every day and it was scheduled to be		
administered at 8:00 a.m.		
-All seven of these medications were		
documented as administered in the morning on		
10/17/17.		
Observation on the 100 Hall and Resident #22's		
room on 10/17/17 at 8:45 a.m. revealed:		
-Resident #22 called the Housekeeper (who was		
in the hall) into her room and told her she		
dropped her medicine.		
-There were 5 pills on the resident's floor to the		
left of her recliner.		
-The resident was holding an empty disposable		
soufflé cup in her hand.		
-The Housekeeper swept up the pills and told		
Resident #22 she would tell the medication aide		
to get her some more medication.		
Interview with the medication aide (MA) on		
10/17/17 at 9:13 a.m. revealed:		
-A few minutes ago, the housekeeper reported		
Resident #22 had dropped pills on the floor in the		
resident's room.		
-The pills were picked up from the floor in the		
resident's room and put in a pill cup.		
-Resident #22 would not take all of her morning		
pills at one time.		
-Resident #22 liked to take the Levothyroxine first		
and then the other pills.		
-Resident #22 ate breakfast in her room.		
-The MAs would leave the morning medications		
in the resident's room so she could take the		

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Levothyroxine before she ate breakfast.

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R-C	
		HAL031003			10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE					
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		
IAG	REGOEMONT ON	100 IBENTII TINO INI GIAWATIGIN	TAG	DEFICIENCY)		
			+			
D 366	Continued From page	e 280	D 366			
		other pills when she ate				
	breakfast.					
	-The resident did not	have an order to				
	self-administer.					
	-The MA was aware s	she was not supposed to				
	leave the medications	s in the resident's room.				
	-The Manager had to	ld the MAs to do it that way.				
	-She usually checked	the cup later in the				
	mornings to see if it w					
	-					
	Observation of the Ma	A on 10/17/17 at 9:35 a.m.				
	revealed she was sta	nding at the medication cart				
		n cup with 5 pills found on				
	Resident #22's floor.					
	Interview with the MA	on 10/17/17 at 9:35 a.m.				
	revealed:					
		nich pills were in the cup.				
	-They only found 5 pil					
	-She was going to pre					
		ng medications since the				
	resident dropped ther	ii on the noor earlier.				
	Observation on 40/47	7/47 of 0:25 o m. moveded:				
		//17 at 9:35 a.m. revealed:				
	-The 5 pills in the cup	-				
	comparing the medica					
	T	were Sotalol 80mg; Lasix				
	•	00 units; Diltiazem 30mg,				
	and Levothyroxine 50	mcg.				
		7/17 at 9:45 a.m. revealed:				
		d Vitamin D3 1000 units,				
	Lasix 40mg, Sotalol 8					
	Prednisone 5mg, and	Diltiazem 30mg.				
	-Levothyroxine was n	ot administered when the				
	resident received her	other morning medications.				
		-				
	Interview with Reside	nt #22 on 10/17/17 at 9:46				
	a m. rayaalad:					

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-Staff always left her morning medications in her

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARF	4002 SOU	TH NC 41		
		WALLACI	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 366	Continued From page	e 281	D 366		
D 366	room for her to takeShe usually took the then the others a little-She dropped the cup (10/17/17) by accider-She thought she too morning before she do not morning before she was not sure if the value of the value of the value of the value of the resident would resident to take Levothyroxine lotterview with the Adn 11:45 a.m. revealed: -The MAs had been to the residents take the	Levothyroxine tablet first e later. of of pills that morning ont. k the Levothyroxine that lropped the cup. If on 10/17/17 at 10:15 a.m. Ills on the floor. Origin or Prednisone on the one or if the pills were on the end they could not find them. In of the pills found on the one of the pills found on the o	D 366		
	03/20/17 revealed dia fibrillation, peripheral	nt #13's current FL-2 dated agnoses included atrial vascular disease, chest IR (international normalized the blood thinner,			
	Review of physician's	orders for Resident #13			

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Division (of Health Service Regu	liation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	· '		COMPL	ETED
			7 50.25			
					R-	·C
		HAL031003	B. WING		10/1	7/2017
NAME 05 B		077557.40	DDE00 01TV 0T4	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ALE, ZIP CODE		
GOLDEN	CARE	4002 SOU	TH NC 41			
COLDLIN	OAKE	WALLACI	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	≀IATE	DATE
				DEFICIENCY)		
D 366	Cantinuad Frame name	- 202	D 366			
D 300	Continued From page	202	5 300			
	revealed there was a	n order dated 06/27/17 for				
	Miralax 17gm once da	aily, mix in 8 ounces of juice				
		Miralax is a laxative used to				
	treat constipation.)	villatax to a taxative acca to				
	ticat constipation.)					
	Review of Resident #	13's October 2017				
		ation record (MAR) revealed:				
	-Diagnoses printed or	ii the war included				
	confusion.	r Maria da Cara				
	_	for Miralax, mix 1 capful				
		f liquid and drink once daily				
	at 8:00 a.m.					
		dication aide (MA) on				
	10/12/17 at 7:44 a.m.					
	-She was preparing F	Resident #13's morning				
	medications.					
	-She had already pre	pared and mixed Resident				
	#13's Miralax in orang	ge juice and put on the				
	dining room table with	n the resident's breakfast.				
	-She mixed 1 capful ((17gms) of Miralax powder in				
	the orange juice.	3 -,				
	and onemge junear					
	Observation of the Ma	A on 10/12/17 at 7:44 a.m.				
	revealed:					
	-She was at the nurse	es' station preparing				
	medications at the me					
		side the dining room from				
	her location.	side the diffing room from				
	Her location.					
	Observation of the m	edication pass on 10/12/17				
	at 7:46 a.m. revealed	-				
		tting at a dining room table				
	eating breakfast, feed					
		nale residents sitting at the				
	same table.					
	-There was a cup of o					
	ounces) sitting on the	table beside the resident's				
	plate.					
	-The MA handed the	resident the cup of orange				

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DIVISION	n nealth Service Regu	ialion	_				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	` '	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
			_				
					R-C		
		HAL031003	B. WING		10/17/2017	7	
NAME OF D		STDEET ADI	DRESS, CITY, STA	ATE ZID CODE			
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	AIE, ZIP GODE			
GOLDEN	CARE	4002 SOU					
		WALLACE	, NC 28466				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (>	X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL)		PLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE DA	ATE	
				DEI IGIENGT)			
D 366	Continued From page	283	D 366				
	. •						
	juice to take his morn						
	-The resident drank a	bout 2/3rds of the orange					
	juice (with Miralax) ar	nd sat the cup back down.					
	-The MA did not enco	urage the resident to finish					
	drinking the orange ju	-					
		g room and went back to the					
	medication cart at the	_					
		Miralax as administered and					
	stated, "he got that".	Will did X do dariii liotorod dira					
		ack to the dining room to					
	check on the resident	-					
	Check on the resident						
	Observation of the dir	ning room on 10/12/17 at					
	8:17 a.m. revealed:	mig 100m on 10/12/17 at					
	-Resident #13 left the	dining room					
		ately 15ml (1/2 ounce) of					
		alax left in the resident's cup					
	on the table.						
	Intorvious with the MA	on 10/12/17 at 12:18 p.m.					
	revealed:	1011 10/12/17 at 12.10 p.m.					
		e Miralax in Resident #13's					
	•						
		reakfast and left it at the					
	dining room table with						
	•	aff helped feed the resident					
	-	sure he drank the orange					
	juice.						
		ther staff to watch the					
	resident drink the ora						
		er staff there was medication					
	in the resident's orang	ge juice.					
	-She did no usually go	o back to see how much					
	Miralax the resident d	Irank because she thought					
	he probably drank all						
		Resident #13 did not drink all					
	of the Miralax today,						
	_	n why she documented the					
		ered when she did not know					
	how much he drank.	ord whom one did not know					

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Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE	
NAIVIE OF F	NOVIDER OR SUFFLIER			II E, ZIF CODE	
GOLDEN	CARE	4002 SO	JTH NC 41		
00222.1	o,	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 000	0 " 15	22.4	D 000		
D 366	Continued From page	284	D 366		
	Interview with the Adr	ministrator on 10/17/17 at			
	11:45 a.m. revealed:	ministrator on 10/17/17 at			
		rained to actually watch the			
	residents take their m				
	-The MAs should not	leave the medications			
	unattended.				
	Based on observation	ns, interviews, and record			
		3 was not interviewable.			
	Total of the state				
5.00-					
D 367	10A NCAC 13F .1004	I(j) Medication	D 367		
	Administration				
	10A NCAC 13F .1004	Medication Administration			
	(i) The resident's me	dication administration			
		e accurate and include the			
	following:				
	(1) resident's name;				
	• •	cation or treatment order;			
	. ,				
		ge or quantity of medication			
	administered;				
	* *	ministering the medication			
	or treatment;				
	(5) reason or justificat	tion for the administration of			
	medications or treatm	nents as needed (PRN) and			
	documenting the resu	Ilting effect on the resident;			
	(6) date and time of a				
	(7) documentation of	The state of the s			
	` '	nents and the reason for the			
	omission, including re				
		the person administering			
		atment. If initials are used, a			
	•	to those initials is to be			
	documented and mai	ntained with the medication			
	administration record	(MAR).			
	This Rule is not met	as evidenced by:			
		ns, interviews, and record			
	reviews, the facility fa				

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Division of Health Service Regulation

ADDIENTO FORRECTION HALD31003 STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 GROUDEN CARE 4002 SOUTH NC 41 WALLACE, NC 28466 PROVIDERS PLAN OF CORRECTION PRICE TAG REQUIZION OF RECEIVED TO THE APPROPRIATE (EACH DEPTICIANT OR LISC DESTITIVING INTORNATION) D 367 Continued From page 285 medication administration records (MARs) were accurate for 5 of 5 sampled residents (#1, #2, #3, #4, #17) including two residents with documentation or market that of commentation or market that of the controlled substance logs (#3, #17), two residents with documentation or market that on mainsychotic and an antianxiety medication (#2). The findings are: 1. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness. Review of Resident #3's physician's orders revealed: -There was an order dated 06/07/17 for Oxycodone 10mg 1 tablet 3 times a day. (Oxycodone 10mg 1 tablet 3 times a day. (Oxycodone 10mg 1 tablet wice a day. -There was an order dated 08/23/17 for Oxycodone 10mg 1 tablet twice a day. -There was an order dated often day. -The review of the controlled substance (CS) log for Resident #3's Oxycodone 1 tablet substance and 109/18/17 with instructions to tablet sweet a day. -The medication aide signed that 60 Oxycodone 1 tablet were a day. -The medication aide signed that 60 Oxycodone 1 tablet were a day. -The medication aide signed that 60 Oxycodone 1 tablets were received on 09/18/17 with instructions to tablet were a day. -The first entry on the CS log was 1 Oxycodone 1 tablets were received on 09/18/17 at 18/18/18/18/18/18/18/18/18/18/18/18/18/1		TOE DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
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Oxycodone 10mg 1 tablet twice a dayThere was an order dated 09/18/17 for Oxycodone 10mg 1 tablet twice a day. Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
-There was an order dated 09/18/17 for Oxycodone 10mg 1 tablet twice a day. Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
Oxycodone 10mg 1 tablet twice a day. Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a day. -The medication aide signed that 60 Oxycodone tablets were received on 09/18/17. -The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at			-			
Review of the controlled substance (CS) log for Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a day. -The medication aide signed that 60 Oxycodone tablets were received on 09/18/17. -The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at		Oxycodone 10mg 1 to	ablet twice a day.			
Resident #3's Oxycodone tablets dispensed on 09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at		Deview of the second of	lad substance (CC) last fact			
09/18/17 revealed: -The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
-The prescription label on the CS log matched the label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at			done tablets dispetised off			
label on the bubble card dispensed on 09/18/17 with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at			al on the CS log matched the			
with instructions to take 1 tablet twice a dayThe medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
-The medication aide signed that 60 Oxycodone tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at			•			
tablets were received on 09/18/17The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at			· · · · · · · · · · · · · · · · · · ·			
-The first entry on the CS log was 1 Oxycodone 10mg tablets was administered on 09/19/17 at						
10mg tablets was administered on 09/19/17 at		10.0.0.010				
4:00 p.m. and the last entry was on 10/11/17 at						
8:00 p.m.		· · · · · · · · · · · · · · · · · · ·	condy was on for the at			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 286 of 419

Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
				_	_	
			B. WING		R-	
		HAL031003	D. WING		10/1	7/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU				
GOLDEN (CARE		I NC 41			
		WALLACE	., NC 20466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR E	100 IDENTIFY TING IN ONWATION)	TAG	DEFICIENCY)	WAI L	
				·		
D 367	Continued From page	e 286	D 367			
	The meaning date fo	= 40/40/47 was not				
	-The morning dose fo					
	documented on the C	-				
	•	umented as administered 3				
	•	/17 - 09/24/17, 10/02/17,				
	10/03/17, 10/07/17, a	nd 10/09/17 instead of twice				
	a day.					
	Review of Resident #					
	medication administra	ation record (MAR) revealed:				
	-There was a compute	er printed entry for				
	Oxycodone 10mg tak	e 1 tablet 3 times a day at				
	8:00 a.m., 4:00 p.m.,	and 8:00 p.m.				
	-There was no Oxyco	done documented as				
	administered beside t					
	documented the orde	•				
		itten entry for Oxycodone				
		rice daily at 8:00 a.m. and				
	8:00 p.m.	ios daily at 5.55 a.m. and				
	-Staff documented Ox	vycodone 10mg was				
	administered twice a					
	09/30/17.	day iroin 09/01/17 -				
	-A total of 24 doses w	vora dagumentad sa				
	administered on the N					
		s were documented as				
		CS log during this time				
	period.	4-b 4b - 00 la				
	-The MAR did not ma	itch the CS log.				
	Deview of Deside 17	21a Ootobor 2017 MAD				
		3's October 2017 MAR				
	revealed:	an animta di antoni fi				
	-There was a comput	•				
	,	e 1 tablet twice a day at				
	8:00 a.m. and 8:00 p.					
		umented as administered				
	•	I/17 - 10/12/17 (8:00 a.m.)				
	for a total of 21 tablets	s but 26 tablets were				
	documented on the C	S log during this time				
	period.	-				
	-The MAR did not ma	tch the CS log.				

Division of Health Service Regulation

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Division of Health Service Regulation

Division C	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						0
			B. WING		R-	
		HAL031003	D: 111110		10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU				
GOLDEN (CARE					
		WALLACE	, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEODEATORT OR I	EGO IDENTIF TING IN ONWATION	TAG	DEFICIENCY)	WAIL	
D 367	Continued From page	e 287	D 367			
		ent #3's medication on hand				
	on 10/12/17 revealed					
		Oxycodone 10mg tablets				
	dispensed on 09/18/1					
		ts dispensed and 5 pink,				
	round tablets left in th	ne bubble card.				
	-Bubbles #1-5 still had	d tablets but bubble #3 was				
	the only one with an u	unbroken seal.				
	-Bubbles #1, 2, 4, and	d 5 had transparent tape				
	over the broken seals	s holding the tablets in place.				
	-The tablet in bubble	#3 was Oxycodone 10mg.				
	-The tablets in the oth	ner 4 bubbles were				
	Promethazine 12.5mg	g tablets.				
		or #11-15 and #20-21 had				
		ent tape peeling from the				
	bubbles.	and the beaming mean and				
		cycodone 10mg tablet in the				
	bubble card.	dyoddone forng tablet in the				
	bubble cara.					
	Interview with the me	dication aide on 10/12/17 at				
	6:48 p.m. revealed:	dication aide on 10/12/17 at				
		5/17), she noticed a problem				
	with Resident #3's Ox					
	-She noticed the Oxy	-				
	·	on the bubble card and the				
	•					
		not match the controlled				
	substance (CS) log.	U MAD I				
		y the MAR documentation				
	did not match the CS	log.				
		nt #3 on 10/17/17 at 10:25				
	a.m. revealed:					
		Oxycodone twice a day, in				
	the morning and at ni					
		pain from her right leg				
	amputation.					
	-The pain medication	helped but it made her				
	sleepy.				ĺ	

Division of Health Service Regulation

Refer to interview with the Administrator on

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Division of Health Service Regulation

Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
					1
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		UTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	
IAG			IAG	DEFICIENCY)	
D 367	Continued From page 288		D 367		
	10/17/17 at 11:45 a.m	1.			
	2. Review of Resider	nt #17's current FL-2 dated			
	09/25/17 revealed:				
	-Diagnoses included	diabetes mellitus with			
	diabetic neuropathy,	coronary artery disease,			
	atherosclerotic heart	disease, hyperlipidemia, iron			
	deficiency, chronic ob	ostructive pulmonary			
	disease, constipation	, insomnia, pain, rash,			
		ntion, seasonal allergic			
	rhinitis, wheezing, ma	ajor depressive disorder,			
	hypomagnesemia, ga	astroesophageal reflux			
	disease, and pressure	e ulcer of right heel.			
		n's order dated 07/17/17 for			
	Resident #17 reveale				
	_	ninophen 5/325mg take 1			
	tablet every 4 hours a				
		minophen is a controlled			
		eat moderate to severe			
	pain.)				
	Paview of Pasident #	17's controlled substance			
	(CS) log for Hydrocod				
	revealed:	done, rectaminophen			
		ription label on the CS log.			
	-	handwritten at the top of the			
		s name, prescription number			
	•	17), name of the medication,			
	` .	ke 1 pill every 4 hours by			
	mouth.	. , , ,			
		tablets were received on			
	10/07/17.				
		nented on the log was on			
	10/07/17 at 8:00 p.m.				
	-	10/11/17 at 9:00 p.m. with 22			
	tablets remaining.	•			
	-A total of 7 tablets w	ere documented as			
	administered on the 0	CS log.			

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURV COMPLETED	
		HAL031003	B. WING		R-C 10/17/20	017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
GOLDEN	CARE		UTH NC 41 CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) OMPLETE DATE
D 367	Continued From page	e 289	D 367			
	for all medications state. There was no entry for Hydrocodone/Acetam therefore none was doin October 2017. The MAR did not refl Hydrocodone/Acetam documented as admined as admined as admined to the MAR did not material	ation records (MARs) adwritten and documentation arted on 10/04/17. for ninophen on the MAR and documented as administered lect any of the 7 doses of ninophen that were nistered on the CS log. atch the CS log. lent #3's medication on hand literal of ninophen 5/325mg tablets on pensed on 07/17/17 for a lensed with 60 tablets and the polets. Is seed with 60 tablets had 8 pubbles #1-7 and #11. Indicate any of the 7 doses of ninophen 5/325mg tablets. In on bubbles #1, 6, and 11 the bubbles were Docusate its. In pensed with 15 tablets had in bubbles #1-14. Is sealed with ninophen 5/325mg tablets. It will be the company tablets and the pensed with 15 tablets had in bubbles #1-14. It is sealed with ninophen 5/325mg tablets. It will be the company tablets and the pensed with 15 tablets had in bubbles #1-14. It is sealed with ninophen 5/325mg tablets. It will be the company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14. It is a company tablets had in bubbles #1-14.				

Division of Health Service Regulation

-Bubble #15 was empty but had tape stuck on it.

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	of Health Service Regu					
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE S	
		HAL031003	B. WING			-C I7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
GOLDEN	CARE	4002 SO	UTH NC 41			
		WALLAG	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 367	Continued From page	e 290	D 367			
	hand. Interview with a medi 6:48 p.m. revealed: -She noticed a proble Hydrocodone/Acetan (10/11/17)She had not reported. She noticed the bub Hydrocodone/Acetan the back of the card a card were not the sard -She had not noticed Hydrocodone/Acetan the October 2017 MAI Interview with a seco p.m. revealed:	ication aide on 10/12/17 at em with Resident #17's ninophen tablets yesterday d it to anyone. ble card for the ninophen tablets had tape on and some of the pills in the me.				

-She documented it on the CS log.

-She thought it may have been left off of the MAR since it was handwritten.

Hydrocodone/Acetaminophen was not on the

-She did not know why Resident #17's October 2017 MAR was handwritten instead of printed by the pharmacy.

-She could not locate any other October 2017 MARs for Resident #17.

Interview with Resident #17 on 10/12/17 at 8:04 p.m. revealed:

-His pain medication sometimes helped and sometimes it did not.

-He did not know the name of his pain medication or if he got more than one kind.

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MAR.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
			A. BUILDING		
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SO	UTH NC 41		
GOLDEN	CARE		E, NC 28466		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 367	Continued From page	e 291	D 367		
		n medication every 4 to 6			
	hours if he needed it.				
	l .	nedication 3 or 4 times a			
	day.				
	Defer to intensious with	h the Administrator on			
	10/17/17 at 11:45 a.m				
	10/17/17 at 11.45 a.ii	1.			
	3 Review of Residen	t #1's current FL-2 dated			
		agnoses included senile			
	dementia, uncontrolle	_			
	hypertension, anemia				
	Tryportonoion, anomic	a, and depression.			
	Review of a hospital A	After Visit Summary for			
	Resident #1 dated 08	-			
	-The diagnosis was d	ocumented as "carbuncle."			
	(A carbuncle is a seve	ere boil/abscess under the			
	skin, usually caused b	by a bacterial infection).			
	-Resident #1 was disc	charged with a prescription			
	for Clindamycin 300m	ng four times daily for ten			
	days. (Clindamycin is	an antibiotic used to treat			
	infection).				
	Review of Resident #				
		(MAR) for August 2017			
	revealed:				
		itten entry for Clindamycin			
		ay with administration times			
		m., 4:00 p.m., and 8:00 p.m.			
	· ·	t documented as being			
		5/17 at 8:00 a.m. (The final			
		en given 10 days from			
	08/15/17, which was	•			
	l '	dication was documented			
	-	twice, at 8:00 a.m. and			
		o.m. and 8:00 p.m. doses			
	were not documented				
		dication was documented			
		three times, at 8:00 a.m.,			
	12:00 p.m., and 4:00	p.m.; the fourth daily dose,			

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				S 111110		С
		HAL031003	B. WING		10/1	7/2017
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN CA	ARE	4002 SOU				
		WALLACE	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	292	D 367			
s a r r r c c c c c c c c c c c c c c c c	scheduled for 8:00 p.r. administered. On 08/19/17, the med as administered three o.m., and 8:00 p.m.; the comment of the comme	dication was documented as dication was documented times, at 8:00 a.m., 12:00 he dose scheduled for 4:00 ented as administered. 26/17, the medication was histered three times a day m., and 8:00 p.m.). 28/17, the medication was histered once a day at 8:00 hentation on the MAR hissed doses. 42 doses documented as 17 and 08/28/17. with the Pharmacist from the ovider on 10/16/17 at 2:30 hed the order dated 08/14/17 and 00 capsules of Clindamycin /14/17. For received any returns for facility for Resident #1. Ininistrator on 10/16/17 at to initial the MAR when en. y 42 doses of medication given when only 40 were				

Division of Health Service Regulation

Review of physician's orders for Resident #4

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X2)		
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
			_		D.C.
		HAL031003	B. WING		R-C 10/17/2017
			DDD500 0ITV 0TV	TE 7/0 0005	1 10/11/2011
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE	
GOLDEN	CARE		UTH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 367	Continued From page	293	D 367		
	revealed;	ation dated 09/07/17 for			
		otion dated 08/07/17 for daily, #14. (Duricef is an			
	antibiotic used to trea	•			
		prescription dated 09/11/17			
	for Duricef 500mg twi				
		escription dated 09/25/17 for			
	Duricef 500mg twice				
	Review of Resident #				
		(MAR) for August 2017			
		o entry for the Duricef			
	ordered 08/07/17 on t	the MAR.			
	Review of Resident #	4's September 2017 MAR			
	revealed:				
		itten entry for Cefadroxil			
		500mg take one capsule			
		s" with administration times			
	of 8:00 a.m. and 5:00	p.m er, there were 23 doses of			
		as administered with the first			
		administered on 09/13/17 at			
		t dose was documented as			
		4/17 at 5:00 p.m There			
	was no dose docume	•			
	administered on 09/24	4/17 at 8:00 a.m			
	-There was a second	,			
	Cefadroxil 500mg tak	e one capsule twice daily for			
	"30" days (from the 0				
		of 8:00 a.m. and 5:30 p.m.;			
		cumented as administered			
	on 09/25/17 at 5:30 p				
		er, there were 11 doses			
	09/30/17.	nistered from 09/25/17-			
	Review of Resident #	4's October 2017 MAR			
		or Cefadroxil 500mg twice			

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Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					D 0	
			B. WING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			TH NC 41	,		
GOLDEN	CARE					
		WALLACI	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
TAG	REGOEMONT ON E	is in the initial in the initial in the initial in the initial initial in the initial initial in the initial initial initial in the initial in	TAG	DEFICIENCY)	W (1 L	
D 367	Continued From page	e 294	D 367			
	-l-:l /f	47				
	daily (from the 09/25/	,				
		20 doses documented as				
	administered from 10	/01/17-10/13/17.				
		vith the Pharmacist from the				
		ovider on 10/16/17 at 2:30				
	p.m. revealed:					
		ved the prescription dated				
		via fax at 3:22 p.m. and				
	dispensed/delivered 1	14 capsules that same day				
	to the facility.					
	-The pharmacy did no	ot receive the prescription for				
	Duricef dated 09/11/1	7 until 09/13/17 at 11:11				
	a.m.; twenty capsules	were dispensed/delivered				
	to the facility on 09/13	3/17.				
	-The pharmacy receiv	ved the prescription for				
	Duricef dated 09/25/1	7 on 09/25/17 at 1:48 p.m.;				
		en by somebody at the				
		he prescription asking the				
	pharmacy not to send					
		ved the prescription for				
	Duricef dated 09/25/1					
		n., but without the note				
		ation not to be sent; 30				
		dispensed and delivered to				
	the facility on 10/03/1	· ·				
		any Duricef returned to the				
	pharmacy for Resider					
	priarriacy for records.					
	Observation of Reside	ent #4's medications on				
		on cart on 10/13/17 at 10:15				
	a.m. revealed:	5 52 51. 15. 15. 17 at 15.15				
		of Duricef on hand with a				
	dispense date of 10/0					
	-	11 Duricef left on the card.				
	THEIC Was a lotal Of	The Dunice left of the Card.				
	Based on chaorieties	es interviews and record				
		ns, interviews and record				
		total of 54 doses of Duricef				
	documented as admir	nistered to Resident #4.				

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There were 11 doses of Duricef on hand, for a

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DIVISION	of Health Service Regu	lation •				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
						_
			B. WING	B WING		C
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			JTH NC 41	,		
GOLDEN	CARE					
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	MAIL	DATE
				,		
D 367	Continued From page	e 295	D 367			
		e pharmacy dispensed a				
		Resident #4 in August,				
	September, and Octo	ber 2017.				
	Interview with the Adr	ministrator on 10/16/17 at				
	9:35 a.m. revealed:					
	-Staff were supposed	to initial the MAR when				
	medications were give	en.				
	-She did not know wh	ny more doses of medication				
		an were actually dispensed				
	by the pharmacy.	, ,				
	Refer to interview with	h the Administrator on				
	10/17/17 at 11:45 a.m					
	5 Review of Residen	t #2's current FL-2 dated				
		noses included Alzheimer's				
		10363 ITCIUGEU AIZITEITTEI 3				
	and hypertension.					
	Pacod on observation	ns, record reviews, and				
		· ·				
	interviews, Resident 7	#2 was not interviewable.				
	A D : (1)					
	· ·	sician orders for Resident #2				
	revealed:	1.1.1040471				
	-There was an order	U				
		e tab three times a day.				
		dated 8/9/17 to discontinue				
		r day. Start Ativan tab 0.5				
		y mouth two times a day.				
	-There was an order	dated 9/6/17 to give				
		medication used to treat the				
	symptoms of anxiety)	tab 0.5 mg, take one tablet				
	by mouth three times	a day.				
	Review of Resident #	2's October 2017				
	medication administra	ation record (MAR) revealed:				
		er-generated entry for				
	-	ke one tablet by mouth three				
	times a day.					
		itten line drawn through the				
	was a manawi	a. a. a a. a. a. a. a. a				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 367	Continued From page	296	D 367		
	4:00 p.m. doseThere were 2 doses of Lorazepam documented as administered daily from 10/1-10/9/17 and 10/11-10/15/17 and 1 dose documented as administered on 10/10/17 with no reason noted for the omitted dose.				
	Review of Resident #2's September 2017 MAR revealed: -There was a computer-generated entry for Lorazepam 0.5mg take one tablet by mouth three times a dayThere were 3 doses of Lorazepam documented as administered daily from 9/1-9/30/17				
	as administered daily from 9/1-9/30/17 Review of Resident #2's August 2017 MAR revealed: -There was a computer-generated entry for Lorazepam tab 0.5mg take one tablet by mouth three times a day that was rewritten by the medication aide/supervisor (MA/S) on 8/9/17. -On 8/9/17, there was a handwritten entry by the MA/S for Ativan 0.5mg; take one tablet by mouth two times a day. -There were 3 doses of Lorazepam documented as administered daily from 8/1-8/5 and 8/7-8/8/17. -There were 2 doses of Lorazepam documented as administered daily from 8/6/17, 8/9-8/13/17, 8/16-8/26/17, and 8/29-8/30/17. -There was 1 dose of Lorazepam documented as administered daily from 8/14-8/15/17 and 8/27-8/28/17. -There were no doses of Lorazepam documented as administered on 8/31/17.				
		here was an order dated pam tab 0.5 mg, take one times a day.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE S	URVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
						С
		HAL031003	B. WING		1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
001 551	CADE	4002 SOI	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	297	D 367			
	through the 4:00 p.m. MAR.	no drew the handwritten line dose on the September If the physician to clarify the corazepam.				
	Interview with Pharmacist on 10/16/17 at 9:45 a.m. revealed: -The 9/6/17 Ativan order for 0.5 mg, take one tablet by mouth three times a day was most current.					
	Review of pharmacy dispensing records revealed the following: -Lorazepam 0.5mg tabs; 60 were dispensed for Resident #2 on 8/29/17Lorazepam 0.5mg tabs; 90 were dispensed for Resident #2 on 9/13/17.					
	11:10 a.m. revealed:	ministrator on 10/17/17 at hat the Ativan was not given				

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Division c	<u>of Health Service Regu</u>	lation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	l				R-C
		HAL031003	B. WING		10/17/2017
					10/11/2011
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	.TE, ZIP CODE	
GOLDEN (CARE		UTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
,, .=		•		DEFICIENCY)	
D 367	Continued From page	200	D 367		
D 307	Continued From page	3 298	D 307		
	according to physiciar				
		ere to be reported to the			
	physician immediately				
		ive clarified the Ativan order			
	with the physician and	d the pharmacy.			
	R Review of the phys	sician orders for Resident #2			
	revealed:	Moder of dois to Trostacity //2			
		7 for Haloperidol (Haldol)			
		reat certain mental or mood			
	`	outh three times daily.			
	, <u>-</u> .	-			
		2's October 2017 MAR			
	revealed:				
	-	ter-generated entry for			
	_	one tablet by mouth three			
	times a day.	of Haldol documented as			
	administered daily fro				
	10/11-10/12/17.	111 10/2 10/0/17 and			
		of Haldol documented as			
	administered on 10/1/				
	-There was 1 dose of	Haldol documented as			
	administered on 10/10				
		s of Haldol documented as			
	administered on 10/13	3-10/15/17.			
	Daview of Docident #	401- Cantamban 2017 MAD			
	revealed:	2's September 2017 MAR			
		ter-generated entry for			
		one tablet by mouth three			
	times a day.	taz.o. 2,a a			
		of Haldol documented as			
	administered daily fro	m 9/1-9/30/17.			
	Boylow of Booldont #	tota August 2017 MAD			
	revealed:	² 's August 2017 MAR			
		ter-generated entry for			
		one tablet by mouth three			

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times a day.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED			
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOWII EI	-120
	HAL031003 B. WING_		B. WING		R- 10/1	C 7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 367	Continued From page	299	D 367			
D 367	-There were 3 doses administered daily fro -There were 2 doses administered on 8/16-There was 1 dose of administered on 8/15/-There were no doses administered on 8/31/ Based on review of M 2017 the following err were revealed: -The August 2017 MA were not documented was no reason noted each day), 8/28-8/30/8/15/17 (2 doses) and -The October 2017 M were not documented was no reason noted 10/10/17 (2 doses)The October 2017 M were not documented 10/13-10/15/17 (3 dos that medication was no Interview with a MA/S revealed: -The MAs initialed the the medicationsIf there was no initial was not administered -If a medication was rewas to be documented Interview with MA/S on-She knew on 10/13/1	of Haldol documented as m 8/1-8/14/17 and 8/27/17. of Haldol documented as e8/26/17 and 8/28-8/30/17. Haldol documented as e17. If a of Haldol documented as e17. If a soft and the end of the end	D 367			
	to reorder it"I just have not had a	chance with everything				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	FE, ZIP CODE	
GOLDEN	CARE		UTH NC 41		
			CE, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 367	Continued From page	e 300	D 367		
	going on these last fe-She will re-order the Refer to interview with 10/17/17 at 11:45 a.m Interview with the Adr 11:45 a.m. revealed: -The MAs were responders onto the MARs -The MAs were support make sure it matched medications on handThe facility's Manage monitoring the MARs medical leave for two	the days." Haldol today (10/16/17). The the Administrator on the definition of the Administrator on 10/17/17 at the definition of the MARs and a the orders and the der was responsible for			
	omissions and "could problem was." -She was going to ha	n't imagine what the			
D 371	10A NCAC 13F .1004 Administration	I(n) Medication	D 371		
	(n) The facility shall a administered in accor measures that help to and transmission of d cross-contamination a	Medication Administration assure that medications are redance with infection control prevent the development lisease or infection, prevent and provide a safe and for staff and residents.			
	failed to assure infect prevent the developm disease or infection a	ns and interviews, the facility ion control measures to nent and transmission of			

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Division of Health Service Regulation					1	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLET	בט
					R-C	
		HAL031003	B. WING		10/17/	
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	ADDRESS, CITY, STAT	E ZIR CODE		
NAME OF FI	ROVIDER OR SUFFLIER			E, ZIF CODE		
GOLDEN	CARE		UTH NC 41			
	Г	WALLAG	CE, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 371	Continued From page	201	D 371			
D 37 1						
	during the morning m	nedication pass on 10/12/17.				
	The findings are:					
	Observation of the m					
	10/12/17 revealed:	orning medication pass on				
	-Staff A (medication a	aide) was preparing				
	· ·	dent #2 and she crushed the				
	medications in a pill crusher on the counter top at the nurses' station.					
	-She was wearing glo	oves.				
	-While she was crush	ning the medication, a roach				
		er top around the bottom				
		oowl of applesauce sitting on				
	the countertop.					
		ach on the floor with her				
	gloved hand and kille					
	-She continued to pre					
	crushed pills.	g some applesauce with the				
	•	gloves or wash her hands				
	after killing the roach					
		e from the open container				
		ne roach had been crawling				
	around.					
		e medications to the resident				
	at 7:55 a.m.					
	latanda 20 0	disation side (NAA)				
		dication aide (MA) on				
	10/12/17 at 7:56 a.m.	rayed about 2 weeks ago.				
		problems with roaches.				
	oy om maa some	production with rodonos.				
	Continued observation	on of the morning medication				
	pass on 10/12/17 rev					
	-Staff A removed her					
		nt #2's medications at 7:55				
	a.m.					
	-She did not wash or	sanitize her hands.				

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-She prepared and administered medications to

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-0	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
	OLUMBA DV OT		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 371	Continued From page	e 302	D 371			
	-She used gloves whe #16's blood sugar and 8:13 a.mShe did not wash or administering medica. Interview with the MA 8:15 a.m. revealed: -She usually washed between residentsShe must have forgotarts.	anitizer on the medication				
		nedication carts on 10/12/17 there was hand sanitizer on				
	5:40 p.m. revealed: -They had infection or medication aides afte -The MAs were suppo- hands or sanitize the	ontrol training for the er the survey in June 2017. osed to either wash their between each resident. available on the medication				
D 378	10a NCAC 13F .1006	6 (b) Medication Storage	D 378			
	10a NCAC 13F .1006	Medication Storage				
	requiring refrigeration safe manner under lo under the immediate	y the facility, including those n, shall be maintained in a ocked security except when				

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Division o	<u>of Health Service Regu</u>	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		HAI 024002	B. WING		R-(
		HAL031003			10/1/	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
001.5511		4002 SOL	TH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 378	Continued From page	e 303	D 378			
	oonanaoa mom page					
	This Rule is not met					
		ns and interviews, the facility				
		nedication carts and the				
	medication room were					
		not under the immediate or				
	direct physical superv	vision of the medication aide.				
	The findings are:					
	The findings are:					
	Observation on 10/13	2/17 from 8:23 a.m 8:25				
	a.m. revealed:	2/17 110111 6.23 a.111 6.23				
		/supervisor (MA/S) (Staff A)				
		es' station to turn off a door				
	alarm.	es station to turn on a door				
		wn the 100 Hall but left the				
	100 Hall medication of					
		ner sight and no other staff				
	was at the nurses' sta	_				
		urses' station at 8:25 a.m.				
	and went into the dini					
		ie nurses' station or the				
	medication cart from					
	-She returned to the r	nurses' station again at 8:34				
	a.m.					
	-She did not lock the	medication cart and she				
	walked back to the di	ning room within a few				
	seconds.					
	•	alked near the nurses'				
		nd back down the 100 Hall.				
		o the nurses' station at 8:38				
	a.m. and locked the n	nedication cart.				
		/S (Staff A) on 10/12/17 at				
	8:39 a.m. revealed:					
	-	he medications when she				
	was not at the nurses	s' station.				
	-She forgot to lock it.					

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STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003			R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	-	
			JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 378	Continued From page	e 304	D 378			
	a.m. revealed: -The MA/S (Staff A) which was parked be deskThe MA/S was preparadministering them to dining roomAt 11:50 a.m., the Mamedication cart into the medication cart after medication cart after medication -The medication cart unattendedAt 11:52 a.m., the Mamedication cart unattendedAt 11:54 a.m., the Mamedication cart and wen administer medication -She did not lock the -At 11:54 a.m., the Mamedication cart and lock the -At 11:54 a.m., the Mam	was left unlocked and A/S left the medication cart a at into the dining room to a to another resident. medication cart. A/S returned to the bocked the cart. B/17 from 10:34 a.m10:45				
	-The MA answered th	on her personal cell phone. te call, walked away from the				
	nurses' station and in -She then walked out front porch area.	side of the dining room to a				
		e nurses' station from the				
	were unlocked.	is (100 Hall and 200 Hall)				
	unlocked.	baskets of multiple bubble				

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cards of medications for multiple residents on the

counter of the nurses' station.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL031003	B. WING			
		TALUS 1003	1		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN	CARE		E, NC 28466			
	OLIMANA DY OT		,	DDOMDEDIO DI ANI OF CODDESCTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 070	0 " 15	005	D 070			
D 378	Continued From page	305	D 378			
	-There was 1 plastic I	basket with multiple bubble				
	cards sitting on top of	•				
		edicated ointment sitting on				
	top of the 100 Hall ca					
	•	A/S walked by the nurses'				
		door to get a resident a cup				
	of ice.	act. to got a rootdorn a dap				
		eside the nurses' station				
		into the kitchen while the				
		I unlocked and unattended.				
		o the nurses' station and				
	handed the resident a					
	nanded the resident a	a cup of ice.				
	Interview with the MA	VS (Staff A) on 10/13/17 at				
	10:46 a.m. revealed:	oc (otali A) oli 10/13/17 at				
		igh the over-supply of				
		at she needed to order.				
		der the medications because				
	they did not get mont					
	-	the medications when she				
	got the phone call.	ha madiaatiana				
	-She usually locked the	ne medications.				
	Intonioitl- # ^ !	ministrator 0= 40/40/47 =+				
		ministrator on 10/13/17 at				
	10:50 a.m. revealed:	ana aumanana ta ta 1				
		were supposed to keep the				
	medications locked w	men not under their				
	supervision.	h = NAA =				
		the MAs were not keeping				
		and the medication storage				
	area unlocked and ur	nattended.				
D 388	10A NCAC 13F .1007	7 (c) Medication Disposition	D 388			
	10A NCAC 13F .1007	7 Medication Disposition				
	(c) Medications, excl	uding controlled				
		destroyed at the facility or				
		cy within 90 days of the				

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STATE FORM 6899 DBPR11 If continuation sheet 306 of 419

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
			A. BOILBING.		
			B. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
OO! DEN	0405	4002 SOI	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 388	Continued From page	306	D 388		
2 000					
	expiration or disconting following the death of	nuation of medication or the resident.			
	T. D				
	This Rule is not met	as evidenced by: as and interviews, the facility			
		or return medications to the			
		ays of their expiration or			
	discontinuance by the	physician.			
	The findings are:				
	10/12/17 at 3:00 p.m.				
	labels with IV (intrave	•			
	Resident #4 in the ref	•			
		ibiotic was dispensed on on 09/05/17 and there were			
	2 left in the bag.	on 09/03/17 and there were			
	_	antibiotic was dispensed on			
	_	on 09/07/17 and there were			
		es of medicated topical			
	antiseptic cleanser wi	•			
	06/2015 and 10/2015				
	-There was a liquid at 04/2015.	ntacid with expiration date of			
	-There was a laxative 12/2016.	with expiration date of			
		f medicated shampoo with			
	expiration date of 12/2 -There was a bottle of				
	expiration date of 02/2	· ·			
	-There was a jar of bu	urn cream with expiration			
	date of 02/2017There was an Albute	rol inhaler for a deceased			
	resident.				
	-There was a steroid	eye drop dispensed on			

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Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
		131,200,1000			10/11/2011	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SO	UTH NC 41			
GOLDLIN	DAIL	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	
				,		
D 388	Continued From page	e 307	D 388			
	02/21/17 for a resider	nt who no longer lived at the				
	facility.					
	-There was a bottle o	•				
	-	17 for a resident who no				
	longer lived at the fac	cility.				
	Interview with the me	dication aido				
	(MA)/supervisor on 1					
	revealed:	0/12/17 at 0.10 p.m.				
	-The MAs were supposed to send medications					
	back to the pharmacy					
		n the refrigerator had been				
		health company for one of				
	the residents.	, , , , , , , , , , , , , , , , , , , ,				
	-The home health nur	rse would come to the facility				
	to administer the IV n	nedication.				
	-The resident was no	longer getting the IV				
	medication.					
		he home health agency to				
		ation since it was expired				
	and the resident was	no longer using it.				
		ministrator on 10/17/17 at				
	11:45 a.m. revealed:	e (MAs) had been trained to				
		s (MAs) had been trained to /as opened so they could				
	date insulin when it we determine the expirat					
		expired, they should be sent				
	back to the pharmacy					
	-She had told the MA					
	medications back to t					
		there were still expired				
	medications in the me	•				
	-The facility's Manage	er who had been on medical				
	, ,	ould have been responsible				
		ired medications were				
	returned.					
	-She was going to cle	ean out the medication room				
	herself.					

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STATE FORM 6899 DBPR11 If continuation sheet 308 of 419

Division of Health Service Regulation

DIVISION	i Health Service Regu	iation			ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	'
					R-C	
		HAL031003	B. WING		10/17/20)17
	20,425, 02, 01, 12, 12, 12, 12, 12, 12, 12, 12, 12, 1			T. 70.000		· -
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ILE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		OMPLETE DATE
IAG		,	170	DEFICIENCY)		
D 392	Continued From page	308	D 392			
D 392	10Δ NCΔC 13E 1008	(a) Controlled Substances	D 392			
D 002	10/11/0/10/10/10/10/10/10/10/10/10/10/10	(a) Controlled Substances	5 002			
	10A NCAC 13F 1008	Controlled Substances				
		ne shall assure a readily				
	` '	controlled substances by				
		eipt, administration and				
	-	ed substances. These				
	•	tained with the resident's				
	record and in such an	order that there can be				
	accurate reconciliation	n.				
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION					
		s, interviews, and record				
	reviews, the facility fa	-				
		nd failed to account for the				
		n of controlled substances				
		sidents (#3, #17) including a				
		I some Oxycodone tablets				
		ed with an anti-nausea				
		dent (#17) who had some				
		inophen tablets tampered				
		otassium supplement and a				
	stool softener.					
	The findings are:					
	The infantys are.					
	1. Review of Residen	t #3's current FL-2 dated				
		gnoses included diabetes				
		ascular disease, pneumonia,				
	and muscle weakness					
	Review of Resident #	3's physician's orders				
	revealed:					
	-There was an order of	dated 06/07/17 for				
	Oxycodone 10mg 1 ta	ablet 3 times a day.				
	-There was an order of	dated 08/23/17 for				
	Oxycodone 10mg 1 ta	ablet twice a day.				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 309 of 419

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			5 14/110		R-C	
		HAL031003	B. WING		10/17/2017	_
NAME OF DE	DOVINED OD SLIDDI IED	STDEET A	NNDECC CITY CTA	TE ZID CODE		
NAIVIE OF LI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN (CARE		UTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		-
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	
				,		\dashv
D 392	Continued From page	e 309	D 392			
ļ	-There was an order					
	Oxycodone 10mg 1 to	ablet twice a day.				
ļ	I					
	Interview with Staff E	(medication aide) on				
	10/12/17 at 6:48 p.m.	revealed:				
		5/17), she noticed a problem				
	with Resident #3's Ox					
ļ	-She noticed the Oxy	•				
	_	on the bubble card and the				
	·	not match the controlled				
	substance (CS) log.	of materiale controlled				
		in the bubble card were the				
		but had different imprint				
		out nad dilierent implint				
ļ	codes.	D				
		Practitioner (NP) who came				
	_	5/17 about it and the NP said				
	there were 2 different					
		Promethazine (for nausea)				
	and Oxycodone in the					
	,	/17), Staff E noticed there				
	was tape on the back					
	-She reported it to the					
	weekend" (referring to	o weekend of 10/07/17 -				
	10/08/17).					
	-The Administrator to	ld Staff E to make sure she				
	reported it to second	shift staff.				
		e worked as the MA on				
ļ	second shift, she wou	uld let Staff C who was also				
	· ·	A) help her administer				
	medications.	, - 1				
		00 Hall medication cart and				
		200 Hall medication cart.				
		he was working, Staff C				
		s to the medication cart				
		6 wanted a prn (as needed)				
	medication for tooth p					
		going to get 2 Tylenol to				
	give to the resident.					

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-While Staff E was standing in the hall talking with a family member, she saw Staff C put a pill in her

STATE FORM 6899 DBPR11 If continuation sheet 310 of 419

Division of	of Health Service Regu	ilation				
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL031003	B. WING		R- 10/1	C 7/2017
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	•	
GOLDEN	CARE		JTH NC 41 E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page pocket from a bubble		D 392			
	because she could se	sident #3's Oxycodone ee the pink tablets in the 8's Oxycodone tablets were				
	-When asked how she could see the small tablet from the hall, she stated she was standing near the nurses' stationShe did not confront Staff CShe reported it to the Administrator on Saturday,					
	10/07/17. -The Administrator sa Staff C.	aid she was going to talk to to the pharmacy or the local				
	law enforcement.	ninistrator would take care of				
	medication was not w	vorking. the pills from bubbles that				
		he visiting Nurse Practitioner p.m. and 10/13/17 at 12:40 sful.				
		dispensing records revealed tablets were dispensed on				
	on 10/12/17 revealed	Oxycodone 10mg tablets				
	-There were 60 tablet round tablets left in th	ts dispensed and 5 pink,				

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the only one with an unbroken seal.

-Bubbles #1, 2, 4, and 5 had transparent tape

STATE FORM 6899 DBPR11 If continuation sheet 311 of 419

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						0
			B. WING		R-	
		HAL031003	D. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
			1	DEFICIENCY)		
D 392	Continued From page	e 311	D 392			
	over the broken seals	s holding the tablets in place.				
		#3 was Oxycodone 10mg.				
	-The tablets in the oth	,				
	Promethazine 12.5mg					
		or #11-15 and #20-21 had				
		ent tape peeling from the				
	bubbles.	ent tape peemig from the				
		ycodone 10mg tablet in the				
	bubble card.	yeodone ronig tablet in the				
	babbic dara.					
	Review of the controll	led substance (CS) log for				
		done tablets dispensed on				
	09/18/17 revealed:					
		el on the CS log matched the				
		ard dispensed on 09/18/17				
		ke 1 tablet twice a day.				
		0 Oxycodone tablets were				
	received on 09/18/17.					
		CS log was 1 Oxycodone				
		inistered on 09/19/17 at				
	4:00 p.m.					
	•	CS log was 1 Oxycodone				
	_	ed on 10/11/17 at 8:00 p.m.				
	which left 6 tablets re	·				
	-The morning dose fo	_				
	documented on the C					
		umented as administered 3				
	•	/17 - 09/24/17, 10/02/17,				
	-	nd 10/09/17 instead of twice				
	a day.	Tid 10/09/17 illistead of twice				
	· ·	ites, first shift documented a				
		aff C documented she				
	_	noon and evening dose (to				
		moon and evening dose (to				
	equal 3 times a day).	p.m., Staff C noted the pill				
	count was 9 instead of					
	countersigned by Sta					
		C noted the pill was found unt was 10 and Staff B				
	in the cart and the col	uni was io and Stall D	1			1

Division of Health Service Regulation

countersigned it.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		HAL031003	B. WING		R-0 10/17	7/ 2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOL	JTH NC 41			
COLDEN		WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	BE	(X5) COMPLETE DATE
D 392	Continued From page	312	D 392			
	revealed she and Sta #3's Oxycodone in the taped it back in one o count. Review of Resident # medication administra -There was a comput Oxycodone 10mg tak 8:00 a.m., 4:00 p.m., -There was no Oxyco administered beside t documented the orde -There was a handwri 10mg take 1 tablet tw 8:00 p.mStaff documented Ox administered twice a -A total of 24 doses w administered from 09	ation record (MAR) revealed: er printed entry for e 1 tablet 3 times a day at and 8:00 p.m. done documented as the entry but staff r was "rewritten". itten entry for Oxycodone ice daily at 8:00 a.m. and exycodone 10mg was day from 09/01/17-09/30/17.				
	revealed: -There was a compute Oxycodone 10mg tak 8:00 a.m. and 8:00 pOxycodone was doct twice daily from 10/01	e 1 tablet twice a day at m. umented as administered I/17 - 10/12/17 (8:00 a.m.) s (but 26 tablets were				
	Resident #3 revealed -Staff documented 45	ews, and record reviews for : i tablets of Oxycodone were MARs but 54 tablets were				

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			5 4/140		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SOL	JTH NC 41			
GOLDEN (JAKE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	∋ 313	D 392			
5 002	administered on the CO9/19/17-10/12/17. -The CS log indicated on hand but there was tablet on hand and 4 were Promethazine 1 -The CS log did not mot accurately reflect on hand. Interview with the Administration of the substitution of the substitution hand been medication had been medication cart today been ordered. -She had not had a confort Resident #3. Interview with a third p.m. revealed: -"Pain pills" were county the staff who were	CS log from d there should be 6 tablets as only 1 Oxycodone 10mg other tablets in the card				
	Staff E, she noticed to medication cards.	ape on a resident's				
	-She was not sure, bu #3's pain medication.					
	-She could not recall with the tape on the c	what the medication was card.				
	-She asked Staff E at anything about it.	bout it and she didn't know				
	-There had not been a	any wrong counts lately.				
	2:40 p.m. revealed: -Resident #3's contro	with Staff C on 10/16/17 at olled substance was taped on e pills had fallen out of the				

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-She had noticed some pills in Resident #3's

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DIVISION	n rieaith Seivice Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	= IED
						С
		HAL031003	B. WING		1	7/2017
NAME OF D		OTDEET AD	DECC CITY OF	TE 7/D 00DE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
GOLDEN	CARE	4002 SOU				
			, NC 28466		1	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 392	Continued From page	314	D 392			
	bubble card did not lo	ook the same so she skipped				
		inched from the sealed				
	bubbles.					
		to anyone because the				
		Manager knew because				
	some MAs "report eve					
	-	ned about pain "a lot" even				
	after she got her pain	medication.				
	Interview with Reside	nt #3 on 10/17/17 at 10:25				
	a.m. revealed:					
	-She usually got her (Oxycodone twice a day, in				
	the morning and at ni					
		pain from her right leg				
	amputation.					
	 The pain medication sleepy. 	helped but it made her				
		W D : 1 4 //01 :				
		vith Resident #3's primary on 10/13/17 at 2:00 p.m.				
	revealed:	on 10/13/17 at 2.00 p.m.				
		any problems with Resident				
	#3's Oxycodone.	any problems man restaurn				
	-No one from the facil	lity had reported any				
	problems with the Ox	ycodone.				
		nat Oxycodone tablets had				
	been replaced with ot					
		ed to know about this.				
		lity had contacted him to get				
	a new prescription for	пе Охусоцопе.				
	Review of medication	s on hand for Resident #3				
		y of Oxycodone 10mg				
	tablets were dispense					
	Refer to telephone int	terview with the				
	Administrator on 10/1					
	, tarrillion ator on 10/1	2. 1. at 0. 10 p.m.				
	Pefer to interview with	h the medication aide (MA)				

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on 10/13/17 at 1:40 p.m.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C	,
		HAL031003	B. WING			7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From page	e 315	D 392			
	10/16/17 at 2:40 p.m.	terview with Staff C on				
	09/25/17 revealed: -Diagnoses included diabetic neuropathy,	diabetes mellitus with coronary artery disease,				
	atherosclerotic heart disease, hyperlipidemia, iron deficiency, chronic obstructive pulmonary disease, constipation, insomnia, pain, rash,					
	heartburn, urine retention, seasonal allergic rhinitis, wheezing, major depressive disorder, hypomagnesemia, gastroesophageal reflux disease, and pressure ulcer of right heel.					
	Review of a physician's order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled					
	substance used to tre pain.)	eat moderate to severe				
	Interview with Staff E 10/12/17 at 6:48 p.m.	,				
		ninophen tablets yesterday				
	Hydrocodone/Acetam the back of the card a	ninophen tablets had tape on and some of the pills in the				
	phone and there were	ills on the internet on her				
	Potassium Chloride 1 supplement), and Do softener) tablets in th	ninophen 5/325mg tablets, 0mEq tablets (potassium cusate Sodium 100mg (stool e bubble card. d it to any one at the facility.				

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					D 0	
			B. WING		R-C	
		HAL031003	D. WINO		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			TH NC 41	,		
GOLDEN	CARE					
		WALLACI	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
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TAG	REGOLATORT OR E	EGO IDENTII TING INI GRAMATION)	TAG	DEFICIENCY)	artic	
			+			
D 392	Continued From page	e 316	D 392			
	D ::					
	-Resident #17 usually					
		drocodone/Acetaminophen)				
	at night when he was	, ,				
	-She administered hir					
	Hydrocodone/Acetam	ninophen bubbles that were				
	sealed, not taped.					
	-Resident #17 had co	mplained that his pain				
	medication did not wo	ork at times.				
	-Resident #17 compla	ained of his stomach hurting				
	-	Imodium (for diarrhea) "the				
	other night" (could no					
	0 (o Imodium to the resident				
		ication he had from a recent				
	stay at a rehabilitation					
	-She did not documer	•				
	-one did not documen	it it on the MAIX.				
	Interview with a secon	nd medication aide (MA) on				
	10/12/17 at 7:30 p.m.					
		her for two Imodium tablets				
	on Monday, 10/09/17					
		er any Imodium to the				
	resident because he	did not have an order.				
		dispensing records revealed				
		taminophen 5/325mg tablets				
	were dispensed on 07	7/17/17.				
		ent #17's medication on				
	hand on 10/12/17 rev	realed:				
	-There were 2 cards of	of				
	Hydrocodone/Acetam	ninophen 5/325mg tablets on				
	hand.					
	-Both cards were disp	pensed on 07/17/17 for a				
	total of 75 tablets.					
		nsed with 60 tablets and the				
	other card with 15 tab					
		sed with 60 tablets had 8				
	tablets remaining in b					
	•	and 7 were sealed with				
	-Dunnies #4, 3, 4, 3, 6	and i were scaled willi	1		1	

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Hydrocodone/Acetaminophen 5/325mg tablets.

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		E SURVEY IPLETED
		HAL031003	B. WING	B. WING		R-C 0/17/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE ZIP CODE	,	_
TO THE OT THE	KOVIDEIK OK OO! I EIEK		UTH NC 41	12, 211 0002		
GOLDEN	CARE		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page	= 317	D 392			
	-The seal was broken and the pills taped in Sodium 100mg tablet -The second card disp 14 tablets remaining i -Bubbles #3-14 were Hydrocodone/Acetam -Bubble #1 was taped 10mEq tablet insideBubble #2 was taped Hydrocodone/Acetam insideBubble #15 was emp-There was a total of Hydrocodone/Acetam handThere was a card of and Potassium Chlori medication cart for Resame imprint codes a Potassium tablets obs Hydrocodone/Acetam Review of Resident # (CS) log for Hydrocodore/Acetam Review of Resident # (CS) log for Hydrocodorevealed: -There was no prescribe information was log with the resident's (dispensed on 07/17/and instructions to takmouthStaff C signed that 2 10/07/17The first dose admini 10/07/17 at 8:00 p.mThe last dose admining the second card of th	n on bubbles #1, 6, and 11 the bubbles were Docusate its. pensed with 15 tablets had in bubbles #1 - 14. sealed with ninophen 5/325mg tablets. d with a Potassium Chloride d with a ninophen 5/325mg tablet by but had tape stuck on it. 18 ninophen 5/325mg tablets on Docusate Sodium 100mg ide 10mEq on hand in the esident #17 that had the as the Docusate and served in the ninophen bubble cards. e17's controlled substance done/Acetaminophen ription label on the CS log. handwritten at the top of the s name, prescription number 17), name of the medication, ke 1 pill every 4 hours by e9 tablets were received on istered on the log was				
	-A total of 7 tablets we					

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administered on the CS log.

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DIVISION	of Health Service Regu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		
		HAL031003			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	UTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
0411.15	CLIMMADY CT			DDOVIDEDIS DI AN OF CODDECTIO	N O(E)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
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				DEFICIENCY)	
D 000	0 " 15	242	D 000		
D 392	Continued From page	318	D 392		
	Review of Resident #	17's July 2017-September			
		ninistration records (MARs)			
	revealed:	iniistration records (w// tres)			
	-There was a comput	or printed entry for			
		ninophen 1 tablet every 4			
	hours as needed on e				
		EACH MAR.			
	-No prn (as needed)	:			
	-	ninophen were documented			
		August 2017 - September			
	2017.				
		47.04.1.0047.144.5			
		17's October 2017 MAR			
	revealed:				
		dwritten and documentation			
	for all medications sta				
	-There was no entry f				
	_	ninophen written on the MAR			
	and therefore none w				
	administered in Octob	per 2017.			
	Interview with a medi	` ,			
	10/16/17 at 4:05 p.m.				
	-She gave Hydrocodo	one/Acetaminophen to			
	Resident #17.				
	-She had not noticed	the			
	Hydrocodone/Acetam	ninophen was not on the			
	MAR.				
	-She documented it o	on the CS log.			
	-She thought it may h	ave been left off of the MAR			
	since it was handwritt	ten.			
	-She did not know wh	ny Resident #17's October			
	2017 MAR was hand	written instead of printed by			
	the pharmacy.	•			
		any other October 2017			
	MAR or CS logs for R				
	Observations, intervie	ews, and record reviews for			
	Resident #17 reveale				

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-The CS log available for review for the

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1		_	_
			D 14//10		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE ZIP CODE		
TWANE OF T	TO VIDER OR OUT LIER		, ,	11 L, 211 OODL		
GOLDEN (CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
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				52.10.2.101)		
D 392	Continued From page	e 319	D 392			
	-	ninophen documented only 8				
	tablets of the 75 dispe					
	-Staff could not find a	ny other CS logs for this				
		t for the other 67 tablets				
	dispensed on 07/17/1	7.				
		rocodone/Acetaminophen				
	were documented as	administered on the July				
	2017-October 2017 M	MARs.				
	-The CS log on hand	indicated there should be 22				
	tablets on hand.					
	-There were 18 Hydro	ocodone/Acetaminophen				
	tablets because 4 tab	olets on hand were different				
	medications.					
	Interview with the Adr	ministrator on 10/13/17 at				
	10:50 a.m. revealed:					
	-The bubble cards for	Resident #4's controlled				
	medication had been	put in the bottom of the				
		nore had been ordered.				
		hance to review the CS logs				
	for Resident #17.	3				
	Telephone interview v	with Staff C on 10/16/17 at				
	2:40 p.m. revealed:					
	•	s complained about pain.				
	· · · · · · · · · · · · · · · · · · ·	olled substances were				
	"messed up".	ond dubotaneds were				
	-His bubble cards had	d tane on them				
	The babble darae had	a tape on them.				
	Interview with Reside	nt #17 on 10/12/17 at 8:04				
	p.m. revealed:					
	F	sometimes helped and				
	sometimes it did not.					
		name of his pain medication				
	or if he got more than	•				
		n medication every 4 to 6				
	hours if he needed it.					
		medication 3 or 4 times a				
		nedication 5 of 4 tillies a				
	day.	tome of stomach nain or				
	-⊓e denied any symp	toms of stomach pain or	I			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			25.25.110.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41 , NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 320	D 392		
	diarrheaHe had not asked or knowledge.	received any Imodium to his			
	[It was documented on Resident #17's October 2017 MAR that he was receiving Tylenol 325mg 2 by mouth 3 times a day at 8:00 a.m., 2:00 p.m. and 8:00 p.m.]				
	Interview with the Administrator on 10/16/17 at 9:00 a.m. revealed: -The CS logs should be filed in the resident's recordThe facility's Manager who was out on medical leave usually filed information in the recordsNo one took over filing information since the Manager had been out sick.				
	revealed a new suppl	ninophen 5/325mg tablets			
	Refer to telephone int Administrator on 10/1				
	Refer to interview with on 10/13/17 at 1:40 p	h the medication aide (MA) .m.			
	Refer to telephone int 10/16/17 at 2:40 p.m.	terview with Staff C on			
	10/12/17 at 8:19 p.mStaff reported to her some Hydrocodone to been replaced in the	with the Administrator on revealed: the "week before last" that ablets looked like they had cards with other medication. at the facility when it was			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMIT LETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
001 DEN	0485	4002 SOUT	TH NC 41		
GOLDEN	CARE	WALLACE	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 321	D 392		
		seen the bubble cards that vith. at the CS logs either. off C was taking the			
	were taped on the cou weeks agoShe had noticed the controlled substance	• •			
	2:40 p.m. revealed: -The MAs count controncoming MA at each -The MAs had noticed controlled substance -The MAs had noticed MARs so it did not material controlled substance.	d some of the pills in the drawer would fall out. d blanks on the CS logs or atch. to anyone because the Manager knew because			
	logs accurately reflect pain medications on hand Resident #17. Resident #17. Resident #17 hand been tampered with an anti-Resident #17's Hydrobeen tampered with a stools softener or a parthere was no CS log	codone/Acetaminophen had and 4 tablets replaced with a otassium supplement. to account for 67 hinophen tablets for Resident			

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OF DEFICIENCIES					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
FURRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	HAL031003	B. WING		R-C 10/17/20	17
		!		10/11/20	·
OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ARE					
- · · · · <u>-</u>	WALLAC	E, NC 28466			
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE CO	(X5) MPLETE DATE
Continued From page	322	D 392			
accountability of controlled substances was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.					
10/12/17 revealed: -24 hour report compl Aide placed on unpaid investigation from Hea -5 day report will be fil investigationPhysician will be noti identified during surve -Pharmacy and Sherif -Will do complete con -In-service for all Med drugs, counts and rep -Administrator will do weekly for one month.	eted and alleged Medication d leave pending results of alth Care Registry. led after facility fied of diversion of issue ey. ff notified today. trolled drug audit. lication Aides on control borts of discrepancies. random control drug checks , then randomly. FOR THE TYPE B				
10A NCAC 13F .1008 (h) The facility shall ediversions are reported enforcement agency and Registry as required by suspected drug diversions there sharmacy. There sharmacy	ensure that all known drug and the pharmacy, local law and Health Care Personnel by state law, and that all sions are reported to the all be documentation of the	D 399			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page accountability of contributed the residents and con Review of the facility's 10/12/17 revealed: -24 hour report compl Aide placed on unpair investigation from Hea- 5 day report will be fi investigationPhysician will be notified during survey -Pharmacy and Sherifi -Will do complete con- In-service for all Med drugs, counts and rep- Administrator will do weekly for one month CORRECTION DATE VIOLATION SHALL N 1, 2017. 10A NCAC 13F .1008 (h) The facility shall ed diversions are reported enforcement agency a Registry as required b suspected drug divers pharmacy. There shall	ARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 322 accountability of controlled substances was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 10/12/17 revealed: -24 hour report completed and alleged Medication Aide placed on unpaid leave pending results of investigation from Health Care Registry5 day report will be filed after facility investigationPhysician will be notified of diversion of issue identified during surveyPharmacy and Sheriff notified todayWill do complete controlled drug auditIn-service for all Medication Aides on control drugs, counts and reports of discrepanciesAdministrator will do random control drug checks weekly for one month, then randomly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	A BUILDING: B. WING B. WING AND AND AND AND AND AND AND A	OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28465 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 322 Continued From page 322 Continued From page 322 Continued From page 322 D 392 Continued From page 322 Continued From page 322 D 392 Continued From page 322 Continued From page 322 Continued From page 322 Continued From page 322 D 392 Continued From page 322 D 392 Continued From page 322 Continued From page 322 Continued From page 322 Continued From page 322 D 392 Continued From Page 322 Continued From Page 322 Continued From Page 322 Continued From Page 322 D 392 Continued From Page 322 D 392 Continued From Page 322 Continued From Page 322 Continued From Page 322 D 392 Continued From Page 322 D 392 Continued From Page 322 Continued From Page 322 D 392 Continued From Page 422 D 392 Continued From Page 422 Con	ABOLLINIS. B. WING. B. WING. R. C. 10/17/20 DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 SUMMARY STATEMENT OF DEPICIENCIES (EACH OPERICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REQULATORY OR LSC IDENTIFYING INFORMATION) D 392 Continued From page 322 accountability of controlled substances was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 10/12/17 revaled: -24 hour report completed and alleged Medication Aide placed on unpaid leave pending results of investigation from Health Care Registry. -5 day report will be filled after facility investigation. -Physician will be notified of diversion of issue identified during survey. -Pharmacy and Sheriff notified today. -Will do complete controlled drug audit. -In-service for all Medication Aides on control drugs, counts and reports of discrepancies. -Administrator will do random control drug checks weekly for one month, then randomly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017. 10A NCAC 13F .1008 (h) Controlled Substance (h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COL DEN	CARE	4002 SOUT	'H NC 41		
GOLDEN CARE WALLACE,		NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 323	D 399		
	This Rule is not met Based on observation reviews, the facility fa drug diversions of cor pharmacy, local law e	as evidenced by: as, interviews, and record iled to report suspected atrolled substances to the enforcement, and the Health stry for 2 of 2 sampled tho were prescribed			
	The findings are:				
	1. Review of Resident #3's current FL-2 dated 03/07/17 revealed diagnoses included diabetes mellitus, peripheral vascular disease, pneumonia, and muscle weakness.				
		3's physician's orders ed 09/18/17 for Oxycodone day.			
	Interview with Staff E (medication aide) on 10/12/17 at 6:48 p.m. revealed: -Last Thursday (10/05/17), she noticed a problem with Resident #3's OxycodoneShe noticed the Oxycodone tablets were punched out of order on the bubble card and the amount on hand did not match the controlled substance (CS) logShe noticed the pills in the bubble card were the same size and color but had different imprint codesThe next day (10/06/17), Staff E noticed there was tape on the back of the bubble cardShe reported it to the Administrator "last weekend" (referring to weekend of 10/07/17-10/08/17)On 10/06/17 while she was working, Staff C				
	asked her for the key	s to the medication cart 6 wanted a prn (as needed)			

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
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		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AN	ORESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OIL OUT FEILIN					
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
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				DEI IOIEITOT)		
D 399	Continued From page	e 324	D 399			
	medication for tooth p					
	-Staff C said she was	going to get 2 Tylenol to				
	give to the resident.					
	-While Staff E was sta	anding in the hall talking with				
	a family member, she	saw Staff C put a pill in her				
	pocket from a bubble					
	substance drawer.					
		sident #3's Oxycodone				
		ee the pink tablets in the				
		s's Oxycodone tablets were				
	pink.	of Oxycodonic tablets were				
	-She did not confront	Staff C				
	10/07/17.	e Administrator on Saturday,				
		id also was assissed to talle to				
		id she was going to talk to				
	Staff C.					
	•	to the pharmacy or the local				
	law enforcement.					
	-She thought the Adm	ninistrator would take care of				
	it.					
	Observation of Reside	ent #3's medication on hand				
	on 10/12/17 revealed	:				
	-There was a card of	Oxycodone 10mg tablets				
	dispensed on 09/18/1	7.				
	-There were 60 tablet	ts dispensed and 5 pink,				
	round tablets left in th					
		d tablets but bubble #3 was				
	the only one with an u					
	-	d 5 had transparent tape				
		s holding the tablets in place.				
		#3 was Oxycodone 10mg.				
	-The tablets in the oth	-				
	Promethazine 12.5mg					
		for #11-15 and #20-21 had				
	· · · · · · · · · · · · · · · · · · ·	ent tape peeling from the				
	bubbles.					
		sycodone 10mg tablet in the				
	bubble card.					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
			E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 325	D 399		
	Observations, intervier Resident #3 revealed -Staff documented 45 administered on the Madministered on hand and 4 were Promethazine 1 -The CS log did not madministration records reflect the quantity of Interview with Reside a.m. revealed: -She usually got her MadministrationThe pain medication sleepy. Refer to interview with not 10/13/17 at 1:40 p	ews, and record reviews for a tablets of Oxycodone were MARs but 54 tablets were CS log from a there should be 6 tablets as on 1 Oxycodone 1mg other tablets in the card 2.5mg tablets. The card tablets in the card 2.5mg tablets. The medication and it did not accurately Oxycodone on hand. The medication are the medication are the medication of the medication are the medication and the medication are the medication aide (MA) and the medication aide (MA) and the medication aide (MA) are the medication aide (MA) and the Administrator on the medication on the Administrator on the medication of the Administrator on the medication of the Administrator on the Market and the medication of the Administrator on the Market and the Administrator on the Administrator on the Market and the M			
	Refer to telephone int 10/16/17 at 2:40 p.m.	terview with Staff C on			
	Refer to interview with 10/13/17 at 5:37 p.m.	n the Administrator on			
	Refer to telephone int	terview with a pharmacist at			

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the facility's primary pharmacy on 10/17/17 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
COLDEN	CARE	4002 SOUT	TH NC 41		
GOLDEN	CARE	WALLACE	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 326	D 399		
	2:00 p.m.				
	Refer to interview wit office on 10/17/17 at	h a staff of the local Sheriff's 12:04 p.m.			
	09/25/17 revealed dia mellitus with diabetic disease, atherosclerc hyperlipidemia, iron d obstructive pulmonar insomnia, pain, rash, seasonal allergic rhin depressive disorder,	leficiency, chronic y disease, constipation, heartburn, urine retention, itis, wheezing, major			
	Review of a physician's order dated 07/17/17 for Resident #17 revealed an order for Hydrocodone/Acetaminophen 5/325mg take 1 tablet every 4 hours as needed. (Hydrocodone/Acetaminophen is a controlled substance used to treat moderate to severe pain.)				
	10/12/17 at 6:48 p.mShe noticed a proble Hydrocodone/Acetam (10/11/17) -She noticed the bubl Hydrocodone/Acetam the back of the card a card were not the sar -She looked up the pi phone and there were Hydrocodone/Acetam Potassium Chloride 1	em with Resident #17's ninophen tablets yesterday ble card for the ninophen tablets had tape on and some of the pills in the ne. fills on the internet on her e ninophen 5/325mg tablets, 0mEq tablets (potassium cusate Sodium 100mg (stool			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 327 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	:TED
						c
		HAL031003	B. WING	B. WING		7/2017
		HAL031003			10/1	772017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SOI	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
	OUR MAR DV OT		·			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			5.000			
D 399	Continued From page	e 327	D 399			
	-She had not reported	d it to any one at the facility.				
	-Resident #17 usually					
	_	drocodone/Acetaminophen)				
	at night when he was	• ,				
		codone/Acetaminophen				
	bubbles that were sea	•				
	bubbles that were see	alea, not tapea.				
	Telephone interview v	vith the Administrator on				
	10/12/17 at 8:19 p.m.					
		the "week before last" that				
	•	ablets looked like they had				
		cards with other medication.				
	•					
	_	blets were for Resident #17.				
		at the facility when it was				
	reported to her.					
		seen the bubble cards that				
	had been tampered w	vitn.				
	0 (5	1.114.71				
		ent #17's medication on				
	hand on 10/12/17 rev					
	-There were 2 cards of					
	_ ·	ninophen 5/325mg tablets on				
	hand.					
	total of 75 tablets.	pensed on 07/17/17 for a				
	-One card was disper other card with 15 tab	nsed with 60 tablets and the blets.				
		sed with 60 tablets had 8				
	· ·	oubbles #1 -7 and #11.				
	_	and 7 were sealed with				
		ninophen 5/325mg tablets.				
		on bubbles #1, 6, and 11				
		the bubbles were Docusate				
	Sodium 100mg tablet					
		pensed with 15 tablets had				
	14 tablets remaining i					
	-Bubbles #3-14 were					
	_	ninophen 5/325mg tablets.				
	I	d with a Potassium Chloride				
	10mEq tablet inside.					

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Division of Health Service Regulation

	of Health Service Regu				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
			 		
D 399	Continued From page	e 328	D 399		
	-Bubble #2 was taped	d with a			
	Hydrocodone/Acetam	ninophen 5/325mg tablet			
	inside.				
		oty but had tape stuck on it.			
	-There were a total of				
	-	ninophen 5/325mg tablets on			
	hand.	Decuacto Sadium 100ma			
		Docusate Sodium 100mg ide 10mEq on hand in the			
		esident #17 that appeared to			
	be the same tablets a	• •			
		ninophen bubble cards.			
	,				
		ews, and record reviews for			
	Resident #17 reveale				
	-The CS log available				
	tablets of the 75 dispe	ninophen documented only 8			
	-	iny other CS logs for this			
		it for the other 67 tablets			
	dispensed on 07/17/1				
		Irocodone/Acetaminophen			
		administered the July			
		nedication administration			
	records (MARs).				
	-The CS log on hand	indicated there should be 22			
	tablets on hand.				
		ocodone/Acetaminophen			
		olets on hand were different			
	medications.				
	Interview with Reside	ent #17 on 10/12/17 at 8:04			
	p.m. revealed:				
	•	sometimes helped and			
	sometimes it did not.				
		name of his pain medication			
	or if he got more than				
	_	n medication every 4 to 6			
	hours if he needed it.	-			

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-He usually got pain medication 3 or 4 times a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CADE	4002 SOUT	H NC 41		
GOLDLIN	CARE	WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 329	D 399		
	dayHe denied any symp diarrhea.	toms of stomach pain or received any Imodium to his			
	Refer to interview with on 10/13/17 at 1:40 p	h the medication aide (MA) .m.			
	Refer to telephone int Administrator on 10/1				
	Refer to interview with 10/13/17 at 10:50 a.m	h the Administrator on n.			
	Refer to telephone int 10/16/17 at 2:40 p.m.	terview with Staff C on			
	Refer to interview with 10/13/17 at 5:37 p.m.	h the Administrator on			
	·	terview with a pharmacist at harmacy on 10/17/17 at			
	Refer to interview with office on 10/17/17 at	h a staff of the local Sheriff's 12:04 p.m.			
	were taped on the conweeks agoShe told the Adminis ago)She had not observe the medication supply-She had noticed the	revealed: c of the medication cards introlled substances about 3 trator at that time (3 weeks and anyone taking pills from			

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STATE FORM 6899 DBPR11 If continuation sheet 330 of 419

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	IDENTIFICATION NUMBER:		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL031003	B. WING		
		HAL031003	1		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ΓΕ, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
	OLIMANA DV OT		·	DDOU/DEDIG DI ANI OF CODDECTION	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
5.000			D 000		
D 399	Continued From page	e 330	D 399		
	might document a pill	was dropped on the floor.			
		d the concerns about the			
	·	s to the pharmacy and she			
	did not know if anyon	•			
		nat the Administrator did			
		r it was reported to the			
	Administrator.				
		with the Administrator on			
	10/12/17 at 8:19 p.m.	revealed:			
	-Staff alleged that Sta	aff C was taking the			
	controlled substances	s the "week before last".			
	-She had not investig	ated the allegation.			
		ation for not investigating the			
	allegation.	anon for not invocagating the			
		ney had actually observed			
	Staff C or anyone else				
	_				
	-	d it to the pharmacy, local			
		he Health Care Personnel			
	Registry.				
		ministrator on 10/13/17 at			
	10:50 a.m. revealed:				
	-Staff C came into wo	ork her shift on third shift last			
	night (10/12/17).				
	-Staff C denied taking	any pills.			
		put Staff C back on the			
	schedule pending the				
	investigation.				
		out the 24 hour report form			
	for the HCPR.	cat are 2 i floar report form			
		s going to call the pharmacy			
	to report the problems				
	substances today (10				
	-She had not called the	ne local law enforcement yet.			
		with Staff C on 10/16/17 at			
	2:40 p.m. revealed:				
	-She had not observe	ed anyone take any pills from			

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the facility.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT	ΓΗ NC 41 , NC 28466		
040.15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	, 	PROVIDER'S PLAN OF CORRECTION	N ave
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 331	D 399		
	of taking pills from the -She denied taking ar -She last worked at thor Thursday.	hat she was being accused e facility. ny pills from the facility. ne facility on last Wednesday y scheduled to come back			
	Interview with the Administrator on 10/13/17 at 5:37 p.m. revealed: -The MA called the pharmacy today (10/13/17) to report the drug diversionShe called the local sheriff's office today (10/13/17) and left a voice message for the sheriff about the drug diversion.				
	Telephone interview with a pharmacist at the facility's primary pharmacy on 10/17/17 at 2:00 p.m. revealed: -A medication aide (MA) called the pharmacy and reported diversion of drug for Resident #3 and Resident #17 on 10/13/17 at 3:16 p.m. -He did the last drug reviews at the facility in August 2017 and he did not notice any problems with the controlled substances. -This was the first time this facility had reported any problems with drug diversion to the pharmacy.				
	10/17/17 at 12:04 p.m	port by the facility related to			
D 433	10A NCAC 13F .1201	(a) Resident Records	D 433		
	10A NCAC 13F .1201 (a) The following sha	Resident Records Il be maintained on each			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
COLDEN	CARE	4002 SOL	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 433	Continued From page	e 332	D 433		
	_	manner in the resident's re home and made available			
	Health Service Regul	ntatives of the Division of			
	departments of social				
		ns and the patient transfer			
		narge summary, when			
	applicable;	, y			
	(2) Resident Register	·· ,			
	(3) receipt for the follo	owing as required in Rule			
	.0704 of this Subchap	oter:			
	(A) contract for service	ces, accommodations and			
	rates;				
		ecified in Rule .0704(a)(2)			
	of this Subchapter;				
	(C) Declaration of Re	sidents' Rights (G.S.			
	131D-21); (D) the home's grieva	and procedures; and			
	(E) civil rights statem	•			
	(4) resident assessme				
	(5) contacts with the				
	physician service or o				
	• •	red in Rule .0902 of this			
	Subchapter;				
	(6) orders or written to	reatments or procedures			
	from a physician or of				
	professional and their				
		immunizations against			
	•	neumococcal disease			
	-	1D-9 or the reason the			
		ve the immunizations based			
	on this law; and	ma Natice of Discharge and			
		me Notice of Discharge and aring Request Form if the			
	resident is being or ha				
		es the facility for a medical			
		ecessary for that medical			
		ubparagraphs (1), (4), (5),			
		y be sent with the resident.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		LETED	
	HAL031003	B. WING		I	R-C / 17/2017	
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE			
GOLDEN CARE	4002 SOI	JTH NC 41				
OOLDEN GARE	WALLAC	E, NC 28466				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 433 Continued From page	333	D 433				
This Rule is not met a Based on observations interviews, the facility of records were maintain include failure to file movith residents' primary hospital discharge ordinampled (#1, #2, #17). The findings are: 1. Review of Resident 02/20/17 revealed: -Diagnoses included souncontrolled Type II diagnemia, and depression-There was an order to sugar (FSBS) before in Review of Resident #1 revealed: -There was an order down and the FSBS at 7:00 a.m., 11:8:00 p.mThere was an order down and the revealed of FSBS at 7:00 a.m., 11:8:00 p.mThere was an order down and the revealed of FSBS daily at 7:00 am, two hours after lunch, daily). Observation on 10/12/-There were multiple sounders, hospital dischall medication administration.	#1's current FL-2 dated enile dementia, abetes, hypertension, ocheck finger stick blood meals and at bedtime. I's physician orders ated 06/05/17 to check :30 a.m., 4:30 p.m., and ated 07/10/17 to fax esults to the primary care e every Wednesday. ated 08/23/17 to check before meals and bedtime, and at 2:00 a.m. (six times)					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251110.		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
	Г	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 433	Continued From page	e 334	D 433			
	Resident #1 dated 08 a pile of other papers -There were two bind medication aide/supe books with a physicia one binder for Reside include discontinuing providing a ½ peanut resident for bedtime series are was no documnospital visit in the redischarge summaryThere was no documnospital visit in the redischar	ers identified by a rvisor (MA/S) as the MAR n order dated 10/09/17 in ent #1 with multiple orders to insulin before meals and butter sandwich for the enack nightly. 1's record revealed: nentation of his 08/14/17 cord to include the hospital mentation of staff Resident #1's PCP with the leddesday on any date. If the physician order dated				
	9:10 a.m. revealed: -The orders for Resid places because the p blood sugar closelyThat may have been in the MAR book and -The items on the des-The Manager usually residents' chart, but s Telephone interview whealth Registered Nurevealed Resident #1 documentation was s	he was out sick. vith a Resident #1's Home urse on 10/17/17 at 9:30 a.m. 's orders and other cattered everywhere.				

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Division of	<u>of Health Service Regu</u>	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF B		OTDEET AD		TE 7/D 000E	•	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
			, NC 28466		T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 433	Continued From page	335	D 433			
2 100	Continued From page	2 000				
		s with the Administrator on				
		n., 10/16/17 at 2:56 p.m.,				
	and 10/17/17 at 12:40	o p.m.				
	2 Review of Residen	it #17's current FL-2 dated				
	09/25/17 revealed:	it in the durient to 2 duted				
		diabetes mellitus with				
	•	coronary artery disease,				
	atherosclerotic heart	disease, hyperlipidemia, iron				
	deficiency, chronic ob					
		, insomnia, pain, rash,				
		ntion, seasonal allergic				
		ajor depressive disorder,				
		astroesophageal reflux				
	disease, and pressure	e dicer of right neer.				
	Review of a physician	n' order dated 07/17/17 for				
	Resident #17 reveale					
	Hydrocodone/Acetam	ninophen 5/325mg take 1				
	tablet every 4 hours a	as needed.				
		minophen is a controlled				
		eat moderate to severe				
	pain.)					
	Interview with a medi	cation aide (MA) on				
	10/12/17 at 6:48 p.m.					
		em with Resident #17's				
		ninophen tablets yesterday				
	(10/11/17).					
	-She noticed the bubl					
	-	ninophen tablets had tape on				
		and some of the pills in the				
	card were not the sar	ne.				
	Davious of aboves	diananaina racerda raya alad				
		dispensing records revealed taminophen 5/325mg tablets				
	were dispensed on 0					
	word dispensed on the					

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Observations, interviews, and record reviews for

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZID CODE	
NAME OF T	TOVIDER OR OUT FILE		, ,	iie, zii oobe	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 433	Continued From page	336	D 433		
D 400	Continued From page	5 330	D 400		
	Resident #17 reveale	ed:			
	-The CS log available	e for review for the			
		ninophen documented only 8			
	tablets of the 75 dispe				
		ny other CS logs for this			
		t for the other 67 tablets			
	dispensed on 07/17/1				
		rocodone/Acetaminophen			
		administered the July 2017			
	-October 2017 MARs				
	•	indicated there should be 22			
	tablets on hand.				
		ocodone/Acetaminophen			
	tablets because 4 tab	lets on hand were different			
	medications.				
	Interview with a secon	nd MA on 10/16/17 at 4:05			
	p.m. revealed she cou	uld not locate any other CS			
	log for Resident #17's				
	Hydrocodone/Acetam				
	,	The state of the s			
	Interview with the Adr	ministrator on 10/16/17 at			
	9:00 a.m. revealed:				
		be filed in the resident's			
	record.	be med in the resident's			
		er who was out on medical			
	, ,				
		ormation in the records.			
		ng information since the			
	Manager had been or	ut sick.			
	Refer to the interview				
	•	rvisor (MA/S) on 10/12/17 at			
	2:40 p.m.				
	Refer to the interview	s with the Administrator on			
	10/12/17 at 10:05 a.m	n., 10/16/17 at 2:56 p.m.,			
	and 10/17/17 at 12:40	- '			
		-			
	3. Review of Residen	t #2's current FL-2 dated			

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4/6/17 revealed:

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	i rieaitii Service Regu		1		1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A PLUI DING:		CONSTRUCTION	(X3) DATE SU			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					R-C	,
		HAL031003	B. WING		1	/ //2017
		I IALOO 1000			1 10/1/	12011
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
001.55	CARE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J I	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 433	Continued From page	e 337	D 433			
	-The diagnoses include	ded Alzheimer's and				
	Hypertension.					
	-The resident was not	n-ambulatory.				
	-The resident required	d a geriatric chair (Geri				
	chair).	·				
	-The resident was inc	continent of bladder and				
	bowel.					
	Review of physician or revealed:	order for Resident #2				
		dated 9/6/17 for home				
	health to evaluate and					
		older with other residents'				
		ation administration records				
	(MARs) laying on the					
	(
	Review of Resident #	2's record revealed:				
	-The physician's orde	r dated 9/6/17 for home				
		d treat sacral ulcer was not				
	filed in the resident's	record.				
	-There was no docum	nentation by the facility staff				
	that a referral was ma	ade to home health such as				
	nursing or progress n					
		nentation made by facility				
	staff regarding a nota					
	• •	nentation made by home				
		ferral being received to				
	evaluate and treat a s	•				
		nentation made by home				
		uation and treatment of a				
	sacral ulcer.					
	Refer to the interview	with the first shift				
	medication aide/supe	rvisor (MA/S) on 10/12/17 at				
	2:40 p.m.					
		s with the Administrator on				
		n., 10/16/17 at 2:56 p.m.,				
	and 10/17/17 at 12:40) p.m.				

Division of Health Service Regulation

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
	OLIMANA DV. OT		, NC 28466	DROWDERIO DI AN OF CORRECTIO	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 433	Continued From page	e 338	D 433		
D 433	Interview with the first 2:40 p.m. revealed: -Hospital discharge of were "supposed to be -"The MAs got what the would be filed." -The Manager usually had been sick for seventhe MARs on the nutre physician and nur orders in them to be for the Manager was represented and filingSince the Manager had gotten be lined the filing had gotten be lined the first shift MA/S we maintaining the record. Interview with the Adri 2:56 p.m. revealed: -When there were physical assets the first shift makes the first	rders and physician orders e looked at." hey needed, and the orders or filed the orders, but she eral months. rse's desk and folders for see practitioner had multiple illed. ministrator on 10/12/17 at sponsible for resident and been out for two months, sehind. sence, the Administrator and ere responsible for	D 433		
		them in the resident's			
	-The Manager usually paper work. -Not everything was f	r filed all the orders and iled "right now." as going to try to get it			
	12:40 p.m. revealed: -The records were sc -She was going to pe and put the records ir	attered everywhere. rsonally do record reviews the medication room. esponsible for filing daily.			

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						0
		1141 004000	B. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SO	JTH NC 41			
GOLDEN	CARE		E, NC 28466			
			L, NC 20400	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
5 400			5 400			
D 433	Continued From page	339	D 433			
	-She had to get a sys	tem for orders and filing.				
	one had to get a eye	tog.				
D 420	40 A NOA C 42E 420E	Licelth Core Development	D 430			
D 438		Health Care Personnel	D 438			
	Registry					
	40 A NOA C 42E 420E	Licelth Core Development				
		Health Care Personnel				
	Registry	-l				
		oly with G.S. 131E-256 and				
		NCAC 130 .0101 and				
	.0102.					
	TI'S I I I I					
	This Rule is not met					
	FOLLOW-UP TO TYP	PE A2 VIOLATION				
	5					
		igs, the previous Type A2				
	Violation was not aba	ted.				
		s, interviews and record				
	•	iled to report allegations of				
		rug diversion to the North				
		Personnel Registry (HCPR)				
		ations for 4 of 4 staff (A, B,				
		vestigate and report injuries				
	•	2 of 2 residents (#1, #2) to				
	the HCPR.					
	The findings are:					
		personnel record revealed:				
		nentation of Staff C's hire				
	date.					
	-	personal care aide (PCA),				
	medication aide (MA)	, and supervisor.				

Division of Health Service Regulation

Telephone interview with Staff C on 10/16/17 at

STATE FORM 6899 DBPR11 If continuation sheet 340 of 419

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					R-0	C
		HAL031003	B. WING			7/2017
		070557.45		TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TI E, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
D 438	Continued From page	e 340	D 438			
	-She had left and can -She was last rehired	t the facility in August 2016. ne back as a rehire twice. on 09/01/17. ering medications again				
		ptember 2017 after she was				
		revealed: 5/17), she noticed a problem				
	with Resident #3's Ox -She noticed the Oxy punched out of order	•				
	substance (CS) log.	not match the controlled				
		in the bubble card were the out had different imprint				
	was tape on the back					
	-She reported it to the weekend" (referring to 10/08/17).	e Administrator "last o weekend of 10/07/17 -				
	-On 10/06/17, while s	he was working, Staff C s to the medication cart				
	medication for tooth p					
	give to the resident.	going to get 2 Tylenol to anding in the hall talking with				
		saw Staff C put a pill in her				
		sident #3's Oxycodone				
	card and Resident #3	ee the pink tablets in the 's Oxycodone tablets were				
	pinkShe did not confront	Staff C.				

Division of Health Service Regulation

-She reported it to the Administrator on Saturday,

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Division of	<u>of Health Service Regu</u>	lation			
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
		TIAL001000			10/11/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOL	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
D 438	Continued From page	e 341	D 438		
	10/07/17.				
		id she was going to talk to			
	Staff C.	ind sine was going to talk to			
		to the pharmacy or the local			
	law enforcement.	to the pharmacy of the local			
		ninistrator would take care of			
	it.				
	Observation of Residen	ent #3's medication on hand			
	on 10/12/17 revealed	:			
	-There was a card of	Oxycodone 10mg tablets			
	dispensed on 09/18/1				
		ts dispensed and 5 pink,			
	round tablets left in th				
		ad tablets but bubble #3 was			
	the only one with an u				
		d 5 had transparent tape			
		s holding the tablets in place.			
	-The tablets in the oth	#3 was Oxycodone 10mg.			
	Promethazine 12.5mg				
		or #11 - 15 and #20 - 21 had			
		ent tape peeling from the			
	bubbles.	and to be a mining in a mining			
	-There was only 1 Ox	cycodone 10mg tablet in the			
	bubble card.				
	Interview with Staff E				
	10/12/17 at 6:48 p.m.				
		m with Resident #17's			
		ninophen tablets yesterday			
	(10/11/17) -She noticed the bubb	ale eard for the			
		ole card for the ninophen tablets had tape on			
		and some of the pills in the			
	card were not the san	•			
		ills on the internet on her			
	phone and there were				
		ninophen 5/325mg tablets,			
		0mEq tablets (potassium			

Division of Health Service Regulation

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Division of Health Service Regulation

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
			A. BUILDING: _		
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
	CUMMADV CT		<u> </u>	DDOV/DED'S DI ANI OF CORDECTI	ON OFF
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	\ - /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE DATE
				DEFICIENCY)	
D 438	Continued From page	342	D 438		
		cusate Sodium 100mg (stool			
	softener) tablets in the				
	· ·	d it to any one at the facility.			
	-Resident #17 usually				
		drocodone/Acetaminophen)			
	at night when he was	, ,			
		codone/Acetaminophen			
	bubbles that were sea	aled, not taped.			
	Telephone interview v	vith the Administrator on			
	10/12/17 at 8:19 p.m.				
		the "week before last" that			
	· ·	ablets looked like they had			
		cards with other medication.			
	•	blets were for Resident #17.			
	_	at the facility when it was			
	reported to her.				
		seen the bubble cards that			
	had been tampered w				
		ent #17's medication on			
	hand on 10/12/17 rev	ealed:			
	-There were 2 cards of				
	Hydrocodone/Acetam hand.	ninophen 5/325mg tablets on			
	-Both cards were disp total of 75 tablets.	pensed on 07/17/17 for a			
		nsed with 60 tablets and the			
		sed with 60 tablets had 8			
		ubbles #1 -7 and #11.			
		and 7 were sealed with			
		ninophen 5/325mg tablets.			
		on bubbles #1, 6, and 11			
		the bubbles were Docusate			
	Sodium 100mg tablet				
	_	ensed with 15 tablets had			
	14 tablets remaining i				
	-Bubbles #3 - 14 were				
		ninophen 5/325mg tablets.			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 343 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
						_
			D WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF D		STDEET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		, ,	II E, ZIP CODE		
GOLDEN	CARE	4002 SO	JTH NC 41			
COLDEN	OAKE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 420	0 (15	0.10	D 420			
D 438	Continued From page	e 343	D 438			
	-Rubble #1 was taned	d with a Potassium Chloride				
	10mEq tablet inside.	a with a rotational official				
	-Bubble #2 was taped	d with a				
	-					
	_	ninophen 5/325mg tablet				
	inside.					
	-	oty but had tape stuck on it.				
	-There was a total of					
	Hydrocodone/Acetam	ninophen 5/325mg tablets on				
	hand.					
	-There was a card of	Docusate Sodium 100mg				
	and Potassium Chlori	ide 10mEq on hand in the				
		esident #17 that appeared to				
	be the same tablets a	• •				
		ninophen bubble cards.				
	Trydrocodone/Acctan	inoprien bubble cards.				
	Intonvious with the me	dication aida (MA) an				
		dication aide (MA) on				
	10/13/17 at 1:40 p.m.					
		k of the medication cards				
		ntrolled substances about 3				
	weeks ago.					
	-She told the Adminis	strator at that time (3 weeks				
	ago).					
	-She had not observe	ed anyone taking pills from				
	the medication supply	y.				
	-She had noticed the	documentation on the				
	controlled substance	logs were "off" like staff				
		was dropped on the floor.				
		nat the Administrator did				
		r it was reported to the				
	Administrator.	in was reported to the				
	Administrator.					
	Telephono intoniowy	with the Administrator on				
		with the Administrator on				
	10/12/17 at 8:19 p.m.					
	-Staff alleged that Sta					
		s the "week before last".				
	-She had not investig					
	-Staff did not report th	ney had actually observed				
	Staff C or anyone els	e take any pills.				
		d it to the Health Care				
	Personnel Registry (F					

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 344 of 419

Division of Health Service Regulation

Division o	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						_
			B. WING		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			TH NC 41	,		
GOLDEN	CARE					
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG	112002110111 0111		IAG	DEFICIENCY)		1
D 438	Continued From page	e 344	D 438			1
						1
	Interview with the Adr	ministrator on 10/13/17 at				1
		Tillistrator on 10/13/17 at				1
	10:50 a.m. revealed:	ulchan abiff on thind abiff last				1
		ork her shift on third shift last				1
	night (10/12/17).					1
	-Staff C denied taking					1
		put Staff C back on the				1
	schedule pending the	e outcome of her				1
	investigation.					1
		out the 24 hour report form				1
	for the HCPR.					I
	T	01. 6				I
		with Staff C on 10/16/17 at				1
	2:40 p.m. revealed:					1
		ed anyone take any pills from				1
	the facility.					I
	-There was "hearsay'					I
	accused of taking pills					1
		ny pills from the facility.				1
		ne facility on last Wednesday				1
	or Thursday.					1
		y scheduled to come back				1
	to work and she did n	ot know why.				I
						I
		ministrator on 10/16/17 at				1
	1:12 p.m. revealed:					1
	_	filling out the 24 hour report				1
		but she had not completed it				1
	yet.					1
		ne 24 hour report to the				1
	HCPR because it was					1
	-She would fax it toda	ay (10/16/17).				1
						1
	2. Review of Residen					
	_	Diabetes, Arthritis Severe,				
		lipidemia, Hypertension,				
	Chronic Obstructive F	Pulmonary Disease and				
	Mental Retardation.					
			1		l	i

Division of Health Service Regulation

Interview with Resident #18 on 08/22/17 at 4:40

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DIVISION (<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					D C
		1141 024002	B. WING		R-C
		HAL031003	B. W		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	TH NC 41		
GOLDEN	CARE		E, NC 28466		
			_, NC 20400		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 100			1 5 400		
D 438	Continued From page	e 345	D 438		
	p.m. revealed:				
	' ·	into her with the wheelchair.			
		the other resident on the			
	arm.				
		to hit the other resident.			
		e aide) grabbed her arm			
		ails dug into the resident's			
	arm and hand.	and dag mid the recidence			
	-The incident happen	ed on the morning of			
	08/22/17.	od on the menning of			
	00/22/17.				
	Interview with Staff D	on 10/17/17 at 8:55 a.m.			
	revealed:	on 10/1//1/ at 0.00 a.m.			
		ssing at another resident.			
		up a fork like she was going			
	to stab the other resid				
		ook off her belt off to hit the			
	other resident.				
	-Staff D grabbed Res	ident #18's arm, and			
		ust have gotten bruised by			
	her nails when she gr	- · · · · · · · · · · · · · · · · · · ·			
	J 3				
	Interview with Reside	nt #18's family member on			
	10/12/17 at 3:45 p.m.	-			
	· · · · · · · · · · · · · · · · · · ·	n Resident #18 and another			
	resident occurred, be	cause the resident ran into			
	Resident #18.				
		e end of July, beginning of			
	August 2017.	<i>y,</i> 3 3			
		dent #18, and dug her			
	fingernails into Reside				
		ail imprints in the resident's			
		ff broke the skin and it bled.			
	There were three are				
		aff came up to the family			
		am the one that dug my			
	fingers into [name of	• •			
		•			
	Interview with a medi	cation aide/supervisor			
	(MA/S) on 8/22/17 at				

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	DOVIDED OD CUDDUED	CTDEET AS	DRESS, CITY, STA	TE 710 CODE	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	IDRESS, CITT, STA	II E, ZIP CODE	
GOLDEN	^ADE	4002 SOL	JTH NC 41		
COLDLIN		WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-)
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 400	- · · · -		D 400		
D 438	Continued From page	e 346	D 438		
	-Resident #18's family	y member told her that Staff			
		ne resident's arm and hand.			
	•				
		the Manager after speaking			
	with the family member				
	-The Manager was av	ware of the incident.			
	Interview with the Ma	nager on 08/24/17 at 10:15			
	a.m. revealed:				
	-She was made awar	e of the incident on the			
	morning that it occurr				
	•	ionally hurt Resident #18.			
		Resident #18 was going to			
	-				
	hurt the other residen				
	-Staff D was protectin	-			
		ken her belt off to hit the			
	other resident.				
	-The resident bumped	d into Resident #18's walker			
	with her wheelchair a	nd it set Resident #18 off.			
	-Resident #18 could of	get agitated but had never			
	gotten aggressive.				
		Staff D about the incident,			
		she should have gone for			
	the belt instead of Re	<u> </u>			
	-She did not feel that				
	•	Care Personnel Registry			
	(HCPR) or that the inc				
		e Staff D was protecting			
	another resident.				
	-She did not report St	aff D to the HCPR.			
	Interview with the Adr	ministrator on 10/12/17 at			
	10:30 a.m. revealed:		1		
	-The Administrator ha	id not gotten any reports			
		o allegations of abuse.			
		report any allegations of			
	abuse to her when the	e manager was out.			
					
	3. Review of Residen	t #6's FL-2 dated 09/05/16			

Division of Health Service Regulation

-Diagnoses included Congestive Heart Failure,

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Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					l BC
		HAL031003	B. WING		R-C 10/17/2017
					1 10/11/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
	Г		E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 347	D 438		
	Hypertension and Hy -Resident #6 was am -Resident #6 was occ bladder and bowel.				
	p.m. revealed most of	ident #6 on 10/13/17 at 5:33 f the time he stayed in his vroom until staff made him			
	recent as last weekThe PCA [named] (S	#6 sit up on 2nd shift, most staff B) had him sitting in told him to sit up in the chair			
	12:22 p.m. revealed:	ed with urine.			
	change the residents	revealed: doing their job; they don't			
	revealed: -Some staff would no especially Staff BStaff B stayed on the television; she worked worked some third sharkesidents asked for	e phone and watched d second shift now and			

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					R-0	C
		HAL031003	B. WING		1	7/2017
		TIALUSTUUS			1 10/1	112011
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOI	UTH NC 41			
GOLDEN (JARE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	KIATE	DATE
				,		
D 438	Continued From page	∍ 348	D 438			
	sign the door."					
	Sign the door.			ĺ		
	Interview with Staff B	on 10/12/17 at 3:12 p.m.				
	revealed:	011 10/12/17 at 0.12 p				
		be told all the time to go to				
	the restroom.	50 te.a a a. .e 12 G. 12				
	-The resident wore in	continent briefs.				
		e awake, but that did not				
	mean he knew to go t	•				
	-The resident knew w					
	-Staff B had to "stay o	on" Resident #6 about				
	stealing from other re	sidents and going to the				
	bathroom.					
		e him from the dining hall				
		l eating because he would				
	take the other resider					
		ad wet the bed, she would				
		Resident #6 if he wanted to				
	sit up for a little longe					
		it at the nurse's desk, in the				
	dining hall or in the da					
		en made to sit at nursing				
	he had gone in anoth	an eye on Resident #6 after				
	-	he nurse's desk yesterday.				
		sit at the desk that long				
	when he had sat at th	· ·				
		ic decir.				
	Second interview with	n Staff B on 10/12/17 at 7:50				
	p.m. revealed:					
	· · · ·) does is sit and get in bed				
	and eat."					
	-It was hard to get hin	n to even go outside.				
		mewhere else, not in a				
	home for old people."	1				
	-Staff assisted with to	oileting.				
	-She had to tell him to	o go to the restroom every				
		ould sit there and not go.				
	-Staff had to get him i	up and change him when he				

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wets himself.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL031003	B. WING		R-C 10/17	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	TH NC 41			
GOLDEN	CARE		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 349	D 438			
	-She had never told h because of toileting.	im he could not go to bed				
	Interview with Administry.m. revealed:	strator on 10/10/17 at 12:30				
	-She had been made Resident #6 sit at the	aware of staff making nurse's desk.				
		at Staff B (personal care				
	aide and medication a him sit up.	aide/supervisor) was making				
	•	Staff B and advised her				
		the right to lay down when				
	he wanted toShe had already talk	ed with Staff B so she did				
	not understand why s					
	reported the matter.					
		d knowledge of the 24 hour				
	Health Care Personne	rms for reporting to the el Registry (HCPR).				
	Second interview with 10/12/17 at 9:55 a.m.	revealed:				
	months.	een out on leave for two				
	-She had been manag Manager had been ou	ging the facility since the ut sick.				
	-She was told that a s	second shift PCA (Staff B)				
		sident #6 sit at the nurse's				
		se "he was a heavy wetter;" county before she could				
	-	nable to recall which staff				
	reported it to her).					
		ne incident; it was "the week				
	before last, just a one					
		the resident, but spoke spm-11pm staff; the alleged				
	staff, Staff B, was not	·				
		oncerns with the Staff B.				
		a formal investigation into				
	the allegations for ma	iking him sit up, but had				

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STATE FORM 6899 DBPR11 If continuation sheet 350 of 419

Division c	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					R-	·C
		HAL031003	B. WING		1	7/2017
NAME OF D		ethert an		TE 710 000E	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE		
GOLDEN (CARE		ITH NC 41			
			E, NC 28466			
(71.)13		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	·			DEFICIENCY)		
D 438	Continued From page	<u> </u>	D 438			
	. •					
	done the ground work					
		to detail with Staff B about				
	Resident #6 being ma					
	making Resident #6 s	stand the rationale behind				
	_	tten up and the write up				
	would be placed in the					
	-She would monitor the	-				
		hat she had to report to the				
		ady handled the incident.				
		ted the 24 hour reporting.				
		at she needed to report for				
	the safety of the resid					
		th Staff B in more detail				
	today and then would	I make the report to HCPR.				
	B. Interview with a Marevealed:	A/S on 08/07/17 at 9:30 a.m.				
	-On 8/4/17, Resident hall and asked for a p	#6 was sitting in the dining piece of gum.				
	-	the nurse's desk to get the				
	gum that was kept on	<u> </u>				
	-Resident #6's pants	were wet in the front.				
		er the nurse's desk as if he				
	wanted to reach behin					
		pray bottle and sprayed				
	Resident #6 in the fac	ce. quid in the bottle that the				
	·	quid in the bottle that the water and bleach mixture.				
		#6 to get his "nasty self" to				
	his room and change	,				
	-The MA/S went to as					
		he MA/S if she was going to				
	hit him.					
	-The MA/S did not rep	port the incident to the				
	-	e Manager was not going to				
	do anything about the	e incident.				
	•					

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A second interview with the MA/PCA, who was working when Staff A sprayed the bleach at

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PRINTED: 11/12/2017

Division o	of Health Service Regu	lation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S	ETED	
		HAL031003	B. WING		1	-C 17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE		
GOLDEN CARE 4002 SO		UTH NC 41				
GOLDLIA	CARL	WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 351	D 438			
	-On Friday, 8/4/17, Si asked for her pay che medication cartResident #6 was in tagainst the wallHe asked for gum arthere was some on the walked behind the picked up a bottle of thim; his pants in the foliated with staff A got loud with the ducked and put he "It's sad how Staff A revealed: -Staff A would never consumer that had told this staff A had family me "handicapped." -She would not want had to be placed in a residents should be	the dining room, sitting and the MA/PCA told him the medication cart. the nurse's desk. Staff A toleach water and sprayed front got wet. and said, "Look at you." Resident #6. his arm over his face. treats him." on 08/07/17 at 3:40 p.m. do that to a resident. w "who the vicious person lie." tembers there were them to be mistreated if they facility. treated like family. ant #6 on 08/07/17 at 5:20 ing okay.				

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could remember.

p.m. revealed:

#6 in the face.

her about the spray bottle.

-No one had sprayed him in his face as best he

Interview with the Manager on 08/15/17 at 2:30

-There was no way that Staff A sprayed Resident

-No staff or the resident had reported anything to

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
					1 10/11/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOI	JTH NC 41			
GOLDLIN	DAIL	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	RIATE DATE	
D 438	Continued From page	e 352	D 438			
	-"Resident #6 had to	have done something."				
	recordent no rida to	nave denie democrinig.				
	A second interview w	ith the Manager on 08/22/17				
	at 10:15 a.m. reveale	•				
		d Staff A to the Health Care				
	Personnel Registry (H	HCPR), because she did not				
	believe Staff A had do	one that.				
	-She was not at the fa	acility and did not see Staff A				
	do it.					
		reported the incident to her.				
		report to HCPR unless she				
	knew who Staff A's ac					
	-She did not know wh					
	-Staff A had done a lo	ot for the facility.				
		10/40/47				
	10:30 a.m. revealed:	ministrator on 10/12/17 at				
	-A staff was "let go" h	by the Manager for				
		(unable to recall date).				
		ad not gotten any reports				
		to allegations of abuse.				
	-	o report any allegations of				
	abuse to her when the					
		o managor mao out				
	C. Interview with a M.	A/S on 09/12/17 at 4:15 p.m.				
	revealed:	•				
	-They had donuts at t	the facility earlier in the				
	week.					
	-Resident #6 saw the	donuts and went behind the				
	desk and got one.					
		out of the kitchen, and saw				
	Resident #6 with the					
		dent #6 in the back and				
	pushed him down the					
		#6 that the donut had				
	•	Resident #6 would die.				
		aid to swallow the donut.				
		lesident #6 that it was okay				
	to eat the donut.					

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DIVISION	<u>it Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
HAL031003		B. WING		R-C	
		HAL031003			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	ITH NC 41		
GOLDEN (CARE		E, NC 28466		
		WALLAC	E, NC 20400		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	
170		,	IAG	DEFICIENCY)	
D 438	Continued From page	e 353	D 438		
	Interview with a DCA	on 00/40/47 of 4:20 n m			
		on 09/12/17 at 4:30 p.m.			
	revealed:	2/40/47) 11			
	`	9/10/17) there were donuts			
		sk, and Resident #6 had			
	gotten a donut.				
		he kitchen and started			
	shoving Resident #6				
		#6 there was poison in the			
	donut and that he was				
	-Resident #6 had star	•			
		ike he was scared to finish			
	eating the donut.				
		nd PCA on 10/12/17 at 3:30			
	p.m. revealed:				
		MA/PCA were at the desk			
	when Resident #6 wa	llked around and got a donut			
	hole to eat.				
	-Staff A jerked the do	nut out of Resident #6's			
	hand and said, "That"	s rat poison. I guess you will			
	die tonight."				
	-The PCA told Reside	ent #6 it was not rat poison.			
	Interview with Staff A	on 09/14/17 at 8:20 a.m.			
	revealed:				
	-If Resident #6 would	have wanted a donut, she			
	would have given him	n one.			
	-"Gosh, that never wa	as said."			
	-She knew where this	was coming from and she			
	was going to speak w				
	-"It was a bunch of lie				
	-If she would have do	ne it, she would had taken			
	the blame for it.				
	-Staff A did not know	why anyone would say that.			
		vorked with during the day,			
		uld have made up this story.			
		Saturday, and, then she			
	would quit.				
	Jaia yaiti		1		

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Interview with the Manager on 09/14/17 at 8:30

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: R-C 10/17/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X3) DATE SURVEY COMPLETED R-C 10/17/2017 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETED (X5)	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING: B. WING 4002 SOUTH NC 41 WALLACE, NC 284666 (X5) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING B. WING DATE 10/17/2017 10/17/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING B. WING DATE 10/17/2017 10/17/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
GOLDEN CARE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
WALLACE, NC 28466 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	
B 400	\neg
D 438 Continued From page 354 D 438	
a.m. revealed:	
-The Manager was "very angry."	
-She knew that there were donuts at the facility,	
because it was assisted living appreciation week.	
-She did not believe that Staff A would have said	
that.	
-If she found out who told this, she would fire	
them on the spot.	
-She would not report Staff A to HCPR because	
Staff A would quit.	
Interview with the Administrator on 10/12/17 at	
10:30 a.m. revealed:	
-The Administrator had not gotten any reports	
from anyone related to allegations of abuse.	
-She expected staff to report any allegations of	
abuse to her when the Manager was out.	
4. Review of Resident #1's current FL-2 dated	
02/20/17 revealed diagnoses included senile	
dementia, uncontrolled Type II diabetes,	
hypertension, anemia, and depression.	
Observation of Resident #1 on 10/11/17 at 11:03	
a.m. revealed:	
-He was in his room sitting in a recliner.	
-He had a yellowish/light green colored bruise on	
the right front and right side of his head that was	
about 2.5 by 2.5 inches in size.	
-He had a skin tear on his right arm near the	
elbow that was oval shaped and measured	
approximately 1 x 1.5 inches in size.	
-He had two dime sized circular scabs on his right	
arm; one above the elbow and the second one on	
the underside of the forearm.	
-He had a linear scabbed area on the underside	
of his right forearm that measured approximately	
2.5 inches long and was surrounded by redness.	
-He had a reddish colored bruised on his right	

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arm near his wrist and a reddish bruise on his

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		A. BOILDING.		R-C	
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
001 DEN	0455	4002 SOUT	TH NC 41		
GOLDEN	CARE	WALLACE	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 355	D 438		
	right hand.				
	ngni nana.				
	Interview with a person 10/11/17 at 11:05 a.m	onal care aide (PCA) on			
		ut she thought Resident #1			
		two weeks ago and got			
	"just skin tears" on his	s right arm. at his skin sometimes."			
		w Resident #1 got the bruise			
	on his head; she just	his head; she just noticed it "today."			
	Interview with a second PCA on 10/11/17 at 4:10				
	p.m. revealed: -She had been off for	a while and when she			
		econd shift on Monday			
	(10/09/17), she notice	ed the bruise on Resident			
		t know what happened or			
	how he got the bruise -She did not know ho	 w Resident #1 got the			
		he "always has some kind			
	of bruise."				
	Interview with a third p.m. revealed:	PCA on 10/12/17 at 1:45			
	•	bruise on Resident #1's			
		08/17); she did not know			
	how he got the bruise	always" had scratches and			
	bruises; the resident '	•			
		dication aide/supervisor			
	, ,	t 11:12 a.m. revealed: ver oriented and got bruised			
	"often."	on onenica ana got braisea			
	-Resident #1 had a hi	story of falls but had not			
	fallen within the last the				
		w Resident #1 got the			
		m or how long they had es were probably from him			
	hitting his arm agains				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
		11AE031003			10/1//2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
OO! DEN	0485	4002 SOI	JTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
D 438	Continued From page	e 356	D 438		
	-She did not know if the	he Primary Care Provider			
	(PCP) was aware of t				
		the yellow bruise on his			
		09/17); the bruise had not			
		ne she worked on Friday			
	(10/06/17).	ne one worked on I hady			
	•	w Resident #1 got the bruise			
	on his head.	W resident # 1 got the braide			
		as checked on his shower			
		day, Wednesday, and			
	Friday.	day, Wedneeday, and			
	i ilaay.				
	Interview with a secon	nd MA/S on 10/13/17 at 9:00			
	a.m. revealed:				
	-The process for unex	xplained injuries was to			
	notify the PCP and so	ometimes send pictures by			
	phone.				
		n hospice or home health			
	(HH), the unknown in	juries were reported to the			
	nurse.				
		urse was supposed to call			
		the Manager know; the			
	-	e a decision on what to do			
	next.				
	Paview of Posidost #	1's physician orders and			
	progress/nursing note				
		ocumentation related to the			
	injuries.	ocumentation related to the			
	•	cian orders, notifications, or			
		ijuries on the right arm			
	and/or bruise on his h	· -			
	Review of the staff co	mmunication notebook			
	revealed there was no	o documentation related to			
		m injuries or bruise on his			
	head.	-			
	Telephone interview v	vith the HH Registered			

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Nurse (RN) on 10/17/17 at 9:30 a.m. revealed:

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DIVISION	of Health Service Regu	iialion			T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL031003	B. WING			
		HAL031003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		4002 SO	UTH NC 41			
GOLDEN (CARE		E, NC 28466			
			JL, NO 20400	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(/	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		
				DEFICIENCY)		
D 438	Continued From page	e 357	D 438			
	-She last saw Reside	nt #1 on 10/11/17 and				
	observed the bruise of					
		nt #1 fell at the nurses'				
		sure of the date of his fall.				
		I the red rash on Resident				
	#1's face on 10/11/17					
	•	dent #1's right arm were				
	•	did not know how he got				
	them.					
		ns, records reviews, and				
	interviews, Resident	#1 was not interviewable.				
		with a Nurse Practitioner				
		PCP office on 10/16/17 at				
	3:31 p.m. revealed:					
		the PCP office about the				
	bruise on Resident #	1's head on 10/11/17.				
	-The NP was aware of	of the injuries to his arm; it				
	looked like he fell.					
	-Nobody could tell he	r how Resident #1 got the				
	arm injuries or bruise	on his head.				
	Interview with the Adr	ministrator on 10/13/17 at				
	10:30 a.m. revealed:					
	-The facility did not ha	ave a written policy for				
	injuries of unknown o	rigin and she was not aware				
	of any specific proces	ss the facility used or				
	followed for injuries o	•				
		were to be reported to the				
	-	s to send the resident to the				
	hospital.					
		staff were reporting to the				
		to the staff about what she				
		ney were supposed to do.				
		of the rule that unexplained				
		ed to be reported to health				
	-	ry; the facility had not been				
	-	ry, the facility flat flot beeff				
	reporting.					

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Division of Health Service Regulation

DIVISION	i Health Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	EIEU
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		HAL031003	B. WING		1	
		I IALUS 1003			1 10/1	7/2017
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
001 551	CARE	4002 SOI	JTH NC 41			
GOLDEN (CAKE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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				DEFICIENCY)		
D 438	Continued From page	e 358	D 438			
	5. Review of Residen	t #2's current FL-2 dated				
	4/6/17 revealed:					
	-The diagnoses include	ded Alzheimer's and				
	hypertension.					
	-The resident was no	n-ambulatory.				
	-The resident required	d a geriatric chair (Geri				
	chair).					
	-The resident was inc	continent of bladder and				
	bowel.					
		2's current Care Plan dated				
	4/6/17 revealed:					
	-The resident was alv					
		ally dependent on the staff				
	for eating, bathing, dr					
		ally dependent on the staff				
	for transfers to/from b	ed and chair.				
	Observation of Reside	ent #2 on 10/12/17 at 8:10				
	a.m. revealed:					
	-The resident was in t	the dining room sitting in a				
	Geri chair.	3				
		ing fed by a personal care				
	aide (PCA).	3 , 1				
	, ,	ressing on her right upper				
	arm and a dressing o					
		.0 by 0.25 inches in size				
	scab below her right l					
		.0 by 1.0 inches in size scab				
	below her left knee.					
	-The resident had mu	ltiple bruises on both arms				
	and both legs.					
		ns, record reviews, and				
	interviews, Resident	#2 was not interviewable.				
		10/10/17 1 0 17				
		on 10/12/17 at 8:15 a.m.				
	revealed:	D				
	-She did not know ho	w Resident #2 got the skin				

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tears or bruises.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(V2) MILITIDI E (CONSTRUCTION	(X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
			A. BOILDING			
		HAL031003	B. WING		R-C	
					10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
			DE, NC 28466			
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D 438	Continued From page	e 359	D 438			
	did not recall that Res prior being off work.	ork for a few days prior and sident #2 had the skin tears he physician had been				
	a.m. revealed: -The medication aide second PCA had rem resident's right upper -The resident's right unext to each otherThe first skin tear on 1.0 by 0.50 inches in blood tinged clear dra-The second skin tear tear on the right upper	ent #2 on 10/12/17 at 9:30 /supervisor (MA/S) and a soved the dressings on the arm and her left forearm. upper arm had two skin tears the top right upper arm was size, pink in color and had ainage. r was just under the first skin er arm, and was 0.50 by 0.50 a color and had blood tinged				
	a.m. revealed: -She did not know ho tears or bruisesShe did not rememb put on the resident's	he physician or family had				
	revealed: -She did not know wh Resident #2's armsThere were no physi orders) for dressing o -She did not know if t the skin tears.	on 10/12/17 at 9:40 a.m. nat caused the skin tears on cian orders (or standing changes. he physician was aware of the physician immediately.				

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DIVISION	of fleatin Service Regu	ialion				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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			D 14/11/0		R-	
		HAL031003	B. WING		10/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	ATE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN			KIE, ZII GODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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				BEITOLENOT		
D 438	Continued From page	e 360	D 438			
	Review of Resident #					
	-There was no docum	nentation by the facility staff				
	related to the injuries	such as nursing or progress				
	notes.					
	-There was no docum	nentation made by staff that				
	her current arm skin t	ears, scabs on both knees				
	or bruises on arms ar	nd legs were reported to the				
		er (PCP), family or hospice.				
	ĺ	, , ,				
	Second interview with	n MA/S on 10/12/17 at 9:55				
	a.m. revealed:					
		ed the physician's medical				
	assistant of Resident					
		ical assistant informed her				
	<u> </u>	aning/dressing the skin				
	tears.	and Norman (DNI) would not				
		red Nurse (RN) would call				
	the physician to obtai					
	cleaning/dressing the					
	· ·	the MA/S to leave the				
	dressings off the skin					
	•	ıld arrive later that day to				
	clean/dress the skin t	ears.				
	Interview with the hos	spice RN on 10/12/17 at				
	12:07 p.m. revealed:					
	-This was the first tim	e she had seen Resident #2				
	since her discharge fi	rom hospice in June 2017.				
	-She was waiting on a	a physician order to				
	clean/dress the skin t					
	- The hospice RN ofte	en performed dressing				
		s on Resident #2 prior to her				
	discharge from hospi					
	alsonarge from flospi	55 III 54II 6 1017.				
	Interview with MA/S a	on 10/13/17 at 9:10 a.m.				
	revealed:	711 10/10/17 at 3.10 a.III.				
		ios of unknown crisis was to				
		ries of unknown origin was to				
		and send pictures by phone				
	if requested.					
	-The process for skin	tears was the MA would				

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE S	
			7. 55.15.110.		R-	С
HAL031003		B. WING		1	7/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
		WALLACE	, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 361	D 438			
	on it and document itThe MA would write when it was changed -The MA should chan -The MA should give change about any res -Resident #2 had ban no writing on them no appliedThere was no verbal MA/S for the current s	ge the dressing the date ge the dressing each day. a verbal report at shift sident with skin tears. dages on each arm that had dring when they had been report ever given to the skin tears on Resident #2. y of Resident #2's current				
	a.m. revealed: -"I am not sure what to unknown origin." -"I was not aware that the HCPR" (Health Columbia) -"We do not have a wounknown origin." -The current process decision of whether of old the Administrator"I am not sure if the strained on emergenciilam not aware of au Interview with the PC revealed:	t they are to be reported to are Personnel Registry). ritten policy on injuries of was the Supervisor made a r not to call EMS. I a question they could call staff have been formally				
	-His expectation was write down any issues residents and fax it to with a phone call to the	that the facility staff would s/requests pertaining to their office, and follow-up ne office alerting them. on 10/12/17 and spoke with				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 362 of 419

Division of Health Service Regulation

STATEMENT OF CERCICINOUS AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER COMENTED AND STATEMENT OF CERCION NUMBER HALDS1803 STREET ADDRESS, CITY, STATE, ZP CODE 4002 SOUTH NC 41 WALLACE, NC 28468 PROVIDERS RAM OF CORRECTIVE ACTION NUMBER (CACH CORRECTIVE ACTION NUMBER PRECEDED BY FULL PRINTING CONTINUED FROM STATEMENT OF CERCIONCIPE (CACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED ON THE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE CONTINUED FROM SHOULD BE CROSS REFERENCED TO THE APPROPRIATE D 438 Continued From page 362 The MAN'S and asked if there were any issues he needed to be aware of. - The MAN'S reported to the physician on 10/12/17 that there were no issues. -1 am very upset about the communication issues with the facility. Interview with a family member on 10/17/17 at 8:50 am. revealed: -1+e would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8:50 am. revealed: -1+e did not know how she got the current skin tears on each am. -The skin tears have been on and off with her for the last one year." -1-the skin tears have been on and off with her for the last one year." -1-the skin tears have been on and off with her for the last one year." -1-the skin tears have been on and off with her for the last one year." -1-the skin tears have been on and off with her for the last one year." -1-the skin tears during this survey process. -1-the normal process they would follow for skin tears was the MA/S would contact the physician and the home health hospice nurse for plan of care.	Division of	of Health Service Regu	ilation				
NAME OF PROVIDER OR SUPPLIER ### AUGUS SOUTH NO 41 **WALLACE, NO 28466** ### AUGUS SOUTH NO 41 ### AUGUS SOURH	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER SITREFT ADDRESS, CITY, STATE, JIP CODE 4002 SOUTH NC 41 WALLACE, NC 28468 PREAD (PACH DEPOISING WIST STATEMENT OF DEFICIENCIES (PACH DEPOISING* WIST SE PRECEDED BY PULL TAG D 438 Continued From page 362 the MA/S and asked if there were any issues he needed to be aware of. -The MA/S reported to the physician on 10/12/17 that there were no issues. "I am very upset about the communication issues with the facility." - He would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8:50 am revealed: He was aware of the skin tears that are now scabs on Resident #2's lower legs. He thought those older skin lears on her legs may have come from the Gert chair because she moved her legs constantly. He did not know how she got the current skin tears on each arm. "The skin tears have been on and off with her for the last one year." - The skin tears have been on and off with her for the last one year." - The skin tears have been on and off with her for the last one year." - The skin tears that ears to anyone after the staff had informed him. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: - She was list made aware of (Resident #2's) current skin tears was the MA's would contact the physician and the home health' hospica nurse for plan of care. The facility failed to investigate allegations of abuse by Staff A and Staff D, allegations of neglet by Staff B, and allegations of foring	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STAYE, ZIP CODE 4002 SOUTH NO. 41 WALLACE, NO. 28466 DUILID PRETTIX 1AG SUMMANY STAYEMENT OF DESCENACIES PRETTIX 1AG CANDIFICIAL PROCEPTION MUST RE PRECEDED BY PILL 1AG COMPACT 1AG CONSTRUCTION SIGNATURE AND PROVIDERS DESPICIAL CONSTRUCTION SIGNATION SIGNATION 1AG CONTINUED FROM PAGE 362 the MA/S and asked if there were any issues he needed to be aware ofThe MA/S reported to the physician on 10/12/17 that there were no issues"I am very upset about the communication issues with the facility." - He would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8:50 a.m. revealed: -He was aware of the skin tears that are now scabs on Resident #2's lower legsHe thought those older skin tears on her legs may have come from the Geri chair because she moved her legs constantly, -He did not know how she got the current skin tears on each armThe skin tears have been on and off with her for the last one year." -The skin tears have been on and off with her for the last one year." -The skin tears have been on and off with her for the last one year." -The skin tears that ears to anyone after the staff had informed him. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: -She was first made aware of (Resident #2's) current skin tears was the MA/S would contact the physician and the home health/ hospice nurse for plan of care. The facility failed to investigate allegations of engled by Staff 8, and allegations of funge							
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WALLACE, NC 24866 PROVIDERS PLAN OF CORRECTION PREPIX TAG PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CRAN OF CRAN OF PROVIDERS PLAN OF CRAN OF CRA	COLDEN	CADE	4002 SOU	TH NC 41			
PREFIX TAG D 438 Continued From page 362 the MA/S and asked if there were any issues he needed to be aware of. -The MA/S reported to the physician on 10/12/17 that there were no issues. -T am very upset about the communication issues with the facility." - He would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8.50 a.m. revealed: -He was aware of the skin tears that are now scabs on Resident #2's lower legs. -He thought those older skin tears on her legs may have come from the Geri chair because she moved her legs constantly. -He did not know how she got the current skin tears on each arm. -The skin tears have been on and off with her for the last one year." -The staff previously called him and told him about skin tears and often applogized for "calling too much". -The had not reported the skin tears to anyone after the staff had informed him. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: -She was first made aware of (Resident #2's) current skin tears on sess they would follow for skin tears was the MA/S would contact the physician and the home health/ hospice nurse for plan of care. The facility failed to investigate allegations of neglect by Staff B, and allegations of one gleet by Staff B, and allegations of the staff and the properties of the staff and the properties of the staff and the properties of the staf	GOLDLIN	CARL	WALLACI	E, NC 28466			
PREFIX TAG D 438 Continued From page 362 the MA/S and asked if there were any issues he needed to be aware of. -The MA/S reported to the physician on 10/12/17 that there were no issues. -T am very upset about the communication issues with the facility." - He would be contacting the Administrator to follow up on his concerns. Interview with a family member on 10/17/17 at 8.50 a.m. revealed: -He was aware of the skin tears that are now scabs on Resident #2's lower legs. -He thought those older skin tears on her legs may have come from the Geri chair because she moved her legs constantly. -He did not know how she got the current skin tears on each arm. -The skin tears have been on and off with her for the last one year." -The staff previously called him and told him about skin tears and often applogized for "calling too much". -The had not reported the skin tears to anyone after the staff had informed him. Interview with Administrator on 10/17/17 at 11:10 a.m. revealed: -She was first made aware of (Resident #2's) current skin tears on sess they would follow for skin tears was the MA/S would contact the physician and the home health/ hospice nurse for plan of care. The facility failed to investigate allegations of neglect by Staff B, and allegations of one gleet by Staff B, and allegations of the staff and the properties of the staff and the properties of the staff and the properties of the staf	(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(Y5)
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Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN (CARE		ITH NC 41			
			E, NC 28466		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	E
D 438	Continued From page	e 363	D 438			
	resulted in these staff facility, which expose abuse, neglect and di failure resulted in sub physical, mental and neglect to the resider Unabated Type A2 Vi					
	Review of the facility's Plan of Protection dated 10/12/17 revealed: -Reports will be completed immediately (24 hours) to Health Care Personnel Registry and investigation will begin and 5 day Report will follow for Staff A, B, C, and DAny injury of unknown origin will be reported, including Resident #1 and #2Continued monitoring and ensuring reports are being filed with the registry on all incidences reported or observedIn the future, all allegations of abuse, neglect, exploitation and drug diversion will be reported immediately as required per AdministratorFacility staff will be in-serviced to report any allegations to the Administrator.					
D 448	10A NCAC 13F .1211 Procedures 10A NCAC 13F .1211 Procedures		D 448			
	10A NCAC 13F .1211Written Policies And Procedures (a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following: (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's					

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DIVISION	n nealth Service Regu	iation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
			D. WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	DOVIDED OD CUDDUED	CTDEET AD	DRESS, CITY, STA	TE 710 CODE	
NAME OF PI	ROVIDER OR SUPPLIER		, ,	II E, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
COLDEN	OAIL	WALLACE	E, NC 28466		
(Y4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 448	Continued From page	e 364	D 448		
	reaction to medication	as as developed in			
	reaction to medication	•			
		ensed health professional			
	who is authorized to o	dispense or administer			
	medications;				
	(2) use of alternative	es to physical restraints and			
	the care of residents	who are physically			
		ped in consultation with a			
	registered nurse;	oca iii concanation with a			
		aty and amarganay			
	(3) accident, fire safe	ety and emergency			
	procedures;				
	(4) infection control;				
	(5) refunds;				
	(6) missing resident;				
	(7) identification and	supervision of wandering			
	residents;				
	•	physical aggression or			
	assault by a resident;				
	-				
	(9) handling of reside				
	(10) visitation in the fa				
	(11) smoking and alco	ohol use.			
	This Rule is not met	as evidenced by:			
		•			
		the facility failed to develop			
	-	and procedures related			
		es to include changes in			
	resident condition.				
	The findings are:				
	J				
	Interview with a nerso	onal care aide (PCA) on			
	10/12/17 at 7:50pm re				
		ow what to do when a			
		njury or emergency; she was			
	never trained.				
	-She would report it to	a MA/S.			
		when needed, but she did			

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not know the actual process.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOUT	H NC 41			
GOLDEN	CARE	WALLACE,	NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 448	Continued From page	e 365	D 448			
	(MA/S) on 10/13/17 a in resident's status or	cation aide/supervisor at 9:00am revealed changes residents' complaints were where except the staff report notebook.				
	Interview with a second MA/S on 10/13/17 at 5:30pm revealed: -The process for a change in residents' status "depends on what's going on but the Primary					
	MA.	was "usually" called by the not always documented in				
	the resident's record	but it was supposed to be nift communication notebook.				
	revealed:	MA/S on 10/12/17 at 3:30pm				
	staff were supposed t					
	who was supposed to	ved the change was the one or call the PCP.				
	10:30am, 10:54am ar at 9:45am revealed:	dministrator on 10/13/17 at nd 6:36pm, and on 10/16/17				
	related emergencies condition.	ritten policies on healthcare or change in resident				
		e MA/S had been ng a resident to the hospital. aff were expected to call 911.				
		nad a policy or system in				
	documentation relate					
		n and emergencies. a change in resident's status sident frequently, notify the				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU COMPLE	
			R WING		R-0	
		HAL031003	B. WING		10/17	7/2017
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		TH NC 41 E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 448	Continued From page	e 366	D 448			
	and notification. -The Medication Aide physician. -She did not know if sexpectations; she wowhat she expected arto do. -The facility currently place for changes in sexphysician was notified. -She would implement possible and assure a sexpected arto do.	d. It a policy as soon as all staff were trained. policy book.				
D 449	10A NCAC 13F .1211 Procedures 10A NCAC 13F .1211 Procedures	(b) Written Policies And Written Policies And	D 449			
	(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.					
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide training to 5 of 5 sampled staff (A, B, C, D, E) on the facility's policies and procedures including administration, ordering, disposition and storage of medications, use of physical restraints, accident and emergency procedures, supervision of wandering residents, and management of physical aggression or					

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(X3) DATE SURVEY COMPLETED	
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/17/2017	
(VE)	
(X5) COMPLETE	
DATE	
+	

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DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		TED
						_
			D 14#110			C
	HAL031003 B. WING		10/1	7/2017		
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	TE, ZII GODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
D 449	Continued From page	e 368	D 449			
		h the Administrator on				
	10/16/17 at 8:40 a.m.					
		s personnel record revealed:				
	-There was no docum	nentation of Staff D's hire				
	date.					
	-Her job description re	evealed that she was hired				
	as a Nurse Aide.					
	-There was no docum	nentation of training on				
	facility policies or prod					
	personnel record.					
	por common recordi					
	Refer to interview with	h the Administrator on				
	10/16/17 at 8:40 a.m.					
	10/10/17 at 0.40 a.m.					
	5 Paview of Staff E's	s personnel record revealed:				
		4/4/17 as a Medication Aide				
	(MA) and Supervisor.					
		nentation of training on				
	facility policies or pro	cedures in Staff E's				
	personnel record.					
		on 10/17/17 at 3:13 p.m.				
	revealed:					
	-She was hired in Ma	rch or April 2017.				
	-She was a MA/S.					
	-She had not had any	training on facility policies				
	and procedures.					
	Refer to interview witl	h the Administrator on				
	10/16/17 at 8:40 a.m.	revealed:				
	Interview with the Adr	ministrator on 10/16/17 at				
	8:40 a.m. revealed:					
		e facility's Manager about				
	the personnel files.					
	-The Manager could r	not find any more				
	information for the pe					
		sponsible for the personnel				
	ilies and making sure	all staff met qualifications				

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	n rieditii Service Regu				1		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED	
					R-C		
		HAL 024002	B. WING		1		
		HAL031003			10/1	7/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		4002 50	UTH NC 41				
GOLDEN	CARE		CE, NC 28466				
		VVALLA	JE, NC 20400				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE	
IAG	REGOEATORT OIL	is a second contract of the second contract o	TAG	DEFICIENCY)	W (1 L		
D 449	Continued From page	e 369	D 449				
	and requirements						
	and requirements.						
	-	een out on medical leave for					
	about 2 months and v	was unavailable for					
	interview.						
		sponsibility of the personnel					
		er went on medical leave.					
	-There was no system						
	Manager or to monito						
	-The facility did not ha	ave written policies and					
	procedures to her known	owledge.					
	-There were no polici	-There were no policies and procedures for					
		ncies, infection control,					
	physical restraints, or						
		lop written policies and					
		ould be oriented and trained					
	on them.						
	on thom.						
D 405	404 1104 0 405 4504		D 405				
D 485	10A NCAC 13F .1501	• •	D 485				
	Restraints And Altern	atives					
	10A NCAC 13F .1501	_					
	Restraints And Altern	atives					
	(d) The following app	olies to the restraint order as					
	required in Subparag	raph (a)(2) of this Rule:					
	(1) The order shall inc	dicate:					
	(A) the medical need						
	(B) the type of restrai						
		the restraint is to be used;					
	and	,					
	(D) the time intervals	the restraint is to be					
	• •	d, but no longer than every					
	30 minutes for checks	-					
	releases.	S and two nodis for					
		nined from a physician other					
		hysician, the facility shall					
		hysician of the order within					
	seven days.						
		r shall be updated by the					
	resident's physician a	it least every three months					

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
		070557.40	20500 0171/ 074	TE 7/0 000E	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ILE, ZIP CODE	
GOLDEN	CARE	4002 SOU			
		WALLACE	, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
		,		DEFICIENCY)	
D 405	0 (15	070	D 485		
D 485	Continued From page	e 370	D 465		
	following the initial or	der.			
	(4) If the resident's ph	nysician changes, the			
	physician who is to at	ttend the resident shall			
	update and sign the e	existing order.			
	(5) In emergency situ	ations, the administrator or			
	administrator-in-charg	ge shall make the			
		to the need for a restraint			
		tion of use until a physician			
		t with a physician shall be			
		and documented in the			
	resident's record.				
	(6) The restraint orde	r shall be kept in the			
	resident's record.				
	This Rule is not met	as evidenced by:			
	FOLLOW-UP TO TYP	-			
	TOLLOW-OF TO TH	L B VIOLATION			
	The Type B Violation	was abated.			
	Non-compliance cont				
	Based on observation	ns, record reviews, and			
		failed to ensure an order for			
	a restraint was currer	nt and complete as required			
	for 1 of 1 sampled res	sidents with a gait belt used			
	as a restraint in a who	eelchair (Resident #13).			
	The findings are:				
		451 0 1 4			
		13's current FL-2 dated			
	3/20/17 revealed:	ded about noise strict			
	-The diagnoses including the INP (
	,	International Normalized or excessive bleeding or			
	clotting), and peripher				
	Gotting), and penpile	iai vasculai uiscasc.			
	Review of the Primary	y Care Provider's (PCP)			
	order dated 2/12/2010				
	-The order stated "wh				
		lude the medical need for			

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the restraint.

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DIVISION	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					l _	_
			D WING		R-C	
		HAL031003	B. WING		<u> 10/1</u>	7/2017
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TO VIDER OIL OUT LIER		, ,	iie, zii oobe		
GOLDEN	CARE		ITH NC 41			
00252.11	57 ti t =	WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 485	Continued From page	e 371	D 485			
	The order did not inc	dude the type of restraint to				
	be used.	clude the type of restraint to				
		clude the period of time the				
	restraint was to be us					
		clude the time intervals the				
		ecked and released, but no				
	longer than every 30	minutes for checks and two				
	hours for releases.					
	-The restraint order w	as over two years old; it was				
	to be updated by the resident's physician at least					
	every three months for	ollowing the initial order.				
	•	5				
	Review of Resident #	13's record revealed:				
	-There was no assess	sment or care plan that				
	addressed the use of					
		nentation for checks on the				
		ne restraint, or timing of the				
	restraint use.	ic restraint, or tilling of the				
	restraint use.					
	Observation of Decid	ent #13 on 10/11/17 at 11:50				
		in the dining room in his				
		d with a gait belt; the gait				
		esident's waist and secured				
	to the back of the who	eelchair.				
		ent #13 on 10/11/17 at 1:35				
	p.m. revealed:					
	-The resident was sitt	ting in a wheelchair in the				
	dayroom on 100 Hall.					
		t around the resident's				
	_	oked together on the back				
	side of the wheelchair	-				
	Observation of Reside	ent #13 on 10/11/17 at 4:02				
	p.m. revealed he was					
	•	ait belt around his stomach				
	and hooked together	on the back of the				
	wheelchair.					
			1	1		

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Observation of Resident #13 on 10/12/17 at

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
			A. BOILDING.		
			P WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SO	UTH NC 41		
GOLDEN	CARE	WALLAC	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
D 485	Continued From page	e 372	D 485		
	12:22 p.m. revealed:	and with his family.			
	-He was on the front	porch with his family			
	member.	his whoolohair with a gait			
		his wheelchair with a gait ach that was hooked on the			
	back side of the whee				
	back side of the whee	eichail.			
	Rased on observation	ns, record reviews, and			
		#13 was not interviewable.			
	interviews, resident	TO Was not interviewable.			
	Interview with Reside	nt #13's family member on			
	10/12/17 at 12:22 p.n				
	-	he gait belt all of the time			
	when he was in his w	_			
	-She requested the g	ait belt for Resident #13 to			
	prevent him from falling				
	-The PCP was aware	Resident #13 used the gait			
	belt as a restraint.				
	-She consented to the	e gait belt and had			
	-	or the gait belt from the			
	PCP.				
		ne gait belt should be on file.			
		ent #13 up and down applied			
	and removed the gait				
	· ·	nts about how staff applied			
	or removed the gait b	ert.			
	Intorvious with a norce	onal care aide at 11:55 a.m.			
	on 10/17/17 revealed				
	-Resident #13 wore the				
		ne got up in the morning,			
		t when he went to bed.			
		Resident #13 from falling.			
		3			
	Interview with a medi	cation aide/supervisor			
	(MA/S) on 10/17/17 a	ıt 12:00 p.m.:			
		he gait belt whenever he			
	was in his wheelchair				
		at got Resident #13 up or			
	toileted him applied a	nd removed his gait belt.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU ⁻ WALLACE	ГН NC 41 , NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 485	another facilityFacility staff had not the proper use of rest Attempted telephone #13's PCP on 10/17/1 p.m. was unsuccessfulnterview with the Adr 5:55 p.m. revealed: -She was unaware the physician order, asseuse of a restraint on Facility. The normal process would insure the order plan are up-to-dateThere was no policy A gait belt is a device transfer residents with position to another, froor while assisting resignoblems with balance.	while ago" on restraint use at thad any recent training on raints. interview with Resident 7 at 11:45 a.m. and 12:30 ul. ministrator on 10/16/17 at there was no updated ssment or care plan for the Resident #13. was that the Supervisor r, assessment and care	D 485		
D911	G.S. 131D-21 Declar Every resident shall h		D911		
	This Rule is not met	as evidenced by:			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R-C		
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU WALLACE	TH NC 41 E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D911	Continued From page	374	D911			
	interviews, the facility resident was treated versional care.	ns, record reviews, and failed to assure each with dignity as related to				
	The findings are:					
	Based on observations, record reviews, and interviews, the facility failed to provide personal care in accordance with the assessed needs for 3 of 5 residents sampled (#3, #6, #15). [Refer to Tag D269, 10A NCAC 13F. 0901(a) Personal Care and Supervision (Type B Violation)].					
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912			
	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 as related to health care, nutrition and food service, training on care of diabetic residents, adult care home medication aides training and competency, housekeeping and furnishings, other requirements, other staff qualifications, and examination and screening for controlled substances.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMITECTED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOUT				
			, NC 28466			_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ē
D912	Continued From page	e 375	D912			
	The findings are:					
	reviews, the facility far from the primary care residents sampled (# for weights and 2 of 2 with orders for blood Tag D276, 10A NCAC Care (Type B Violation 2. Based on observative reviews, the facility far diets were served to 3 (#1, #2, #4) who had (#2) and nutritional suto Tag D310, 10A NC and Food Service (Tymon 3. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 3. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative reviews, the facility far medication aides (C, by a licensed health produced to Tag D310, 10A NC and Food Service (Tymon 5. Based on observative (Tymon 5	ions, interviews, and record illed to assure therapeutic 3 of 3 residents sampled orders for thickened liquids applements (#1, #4). [Refer AC 13F. 0904(e)(4) Nutrition type B Violation)]. ions, interviews, and record illed to assure 2 of 5 E) sampled received training professional on the care of or to administering insulin to ag D164, 10A NCAC 13F. re of Diabetic Residents				
		ions, interviews, and record illed to assure 3 of 4 staff				
	sampled (B, C, E) wh	o administered medications				
	•	hour and 10 hour or 15 hour cation administration training				
	courses as required;	1 of 4 sampled medication				
		the written medication aide				
		dication aides sampled (B, schecklist completed prior to				
	administering medica	tions. [Refer to Tag D935, dult Care Home Medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPL	
	HAL031003 B. WING			R-	C 7/2017	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 10/1	112011
GOLDEN	CARE	4002 SOUT WALLACE,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D912	(Type B Violation)]. 5. Based on observat reviews, the facility fa sanitation classification with a North Carolina Health Sanitation scotimes. [Refer to Tag I 0306(a)(4) Housekee (Unabated Type B Violation)]. 6. Based on observat facility failed to assure were maintained at a Fahrenheit (F) to a m for 7 of 13 water fixture bathrooms and the content of 100 and 200 Halls fixtures with steam of D113, 10A NCAC 13F Requirements (Unabated Type B Violation)]. 7. Based on interview facility failed to assure (C, D, E) had a criminal accordance with G.S. [Refer to Tag D139, 1 Other Staff Qualification Violation)]. 8. Based on interview facility failed to assure for the presence of completed upon hire sampled who were himper to the sampled who were himper to the presence of completed upon hire sampled who were himper to the presence of completed upon hire sampled who were himper to the presence of completed upon hire sampled who were himper to the presence of the pre	competency Requirements cions, interviews and record iled to maintain an approved on at all times in the facility Division of Environmental re of 85 or above at all D077, 10A NCAC 13F. ping and Furnishings blation)]. cions and interviews, the re the hot water temperatures minimum of 100 degrees aximum of 116 degrees F res sampled in the residents' common hall bathrooms on res of the facility, including 3 reserved. [Refer to Tag F. 0311(d) Other reted Type B Violation)]. The sand record reviews, the res 5 of 5 staff sampled (A, B, real background check in results of the facility of the sample of	D912	DELIGITION ()		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BOILDING		
HAL031003		B. WING		R-C 10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOU	TH NC 41		
GOLDLIN	DARL	WALLACI	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D914	Continued From page	: 377	D914		
D914	G.S. 131D-21(4) Decl	aration of Residents' Rights	D914		
	Every resident shall h 4. To be free of menta neglect, and exploitat This Rule is not met a Based on observation interviews, the facility were free of abuse an				
	rights, medication adr and supervision, heal adult care home infec	ministration, personal care th care personnel registry,			
	The findings are:				
	reviews, the Administroverall management, procedures of the faci implemented to maint be free of serious har evidenced by the Mar (Administrator-in-Cha to contact 911 for a refeeling well and was convestigate allegations staff to the Health Carresident abuse allega 2017; and the failure from the facility of the failure	rge) refusing to allow staff esident (#11), who was not confused; refusing to so of abuse and report two re Personnel Registry for tions received in August to maintain substantial cules and statutes governing related to health care, ation, resident rights, pervision, health care			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE	
TVAIVIL OF T	NOVIDER OR OUT FEEL	4002 SOUT		12, 211 0002	
GOLDEN	CARE	WALLACE,			
0(0)15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	d over
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D914	Continued From page	e 378	D914		
D914	nutrition and food ser physical restraints, of training and qualificat training on diabetic recontrolled substances screening, all of which Administrator/Administrator/Administrator/Administrag D176, 10A NCAC of Facilities (Unabate 2. Based on observat interviews, the facility and routine health caresidents sampled (#related to failing to not physician (PCP) of el 400 as ordered for a of 15 occasions; of ur tears and bruising for inappropriate sexual (#6); of a resident's (#prosthetic leg being ut to wear it; of a resident well, burning upon uriand increased confus for diagnosis of sepsi with a change in statudizziness, exhibited s status and refused to emergent medical ever found deceased in his referral for home hea for treatment of a sacto assure a resident (for evaluation of a she	keeping and furnishings, vice, controlled substances, ther staff qualifications, tions for medication aides, esidents, screening for and criminal background the are the responsibility of the strator-in-Charge. [Refer to C 13F. 0601(a) Management d Type A1 Violation)]. Lions, record reviews, and a failed to assure the acute are needs were met for 6 of 8 1, #2, #3, #6, #10, #11) as of the primary care evated blood sugars over diabetic resident (#3) on 14 nexplained injuries of skin at two residents (#1, #2); of behaviors from a resident (#3) complaints of a suncomfortable and refusing ant complaints of not feeling ination, decreased appetite sion prior to a hospitalization is (#11); of a resident (#10)	D914		
	, , ,	Health Care (Unabated Type			

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Division of	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
and Plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	∃IED
					R-0	c l
		HAL031003	B. WING		1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AN	DRESS, CITY, STA	TE, ZIP CODE		
	COURT CIT ON OUT FILET	4002 SOU		, 3352		
GOLDEN	CARE		, NC 28466			
24.0.15	CLIMMADY CT		1	PROVIDER'S PLAN OF CORRECTION	vi	2/5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D914	Continued From page	e 379	D914			
	3 Raced on observat	tions, record reviews, and				
		failed to assure three				
		#15) were protected from				
	• • • •	sault from Resident #6 who				
		nts' rooms, stole a resident's				
		et into bed with a resident				
	(#15), and touched a	resident in a sexual manner				
	without consent (#14)					
		ere free from physical abuse				
	- ·	nd Staff D); failed to assure				
		d #8) were free of neglect by				
	-	's (#6) personal care needs				
		rced to sit at the nurse's				
		B), and personal care was t (#8), who was left lying on				
		and received burns and				
	blisters to her back; a					
		cked up from a local store				
	` , .	nount of time. [Refer to Tag				
		F. 0909 Resident Rights				
	(Unabated Type A1 V	/iolation)].				
		tions, interviews, and record				
	reviews, the facility fa					
		ed for 3 of 4 residents (#13,				
		luring the medication pass				
		nsulin and medications for e, diabetes, prevention of				
	•	retic (#16); a medication for				
		; and prevention of heart				
	• • • • • •	nd for 5 of 6 residents (#1,				
		ed including errors with				
		otic pain medications (#3,				
		nfection (#1, #2, #4); and a				
	•	y (#2). [Refer to Tag D358,				
	10A NCAC 13F. 100 ²					
	Administration (Type	A2 Violation)].				
		,				
	5 Resed on observat	tions interviews and a	1	1		

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record reviews, the facility failed to provide

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING			R-C)/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
GOLDEN	CARE		UTH NC 41 E, NC 28466			
0/4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF (COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D914	(#6), who was known rooms, took food from attempted to climb in (#15) and allegedly s female resident (#14) to Tag D270, 10A NC Care and Supervision 6. Based on observative reviews, the facility far abuse, neglect and d Carolina Health Care and conduct investigation C, D), and failed to in of unknown origin for the HCPR. [Refer to	n to 1 of 5 sampled residents n to wander into residents'	D914			
	reviews, the facility fainfection control policic Centers for Disease (guidelines to assure procedures for the us diabetic residents sai #18, #19, #20, #21) y monitoring resulting i glucometers. [Refer t 131D-4.4A(b)(1) Adu Prevention Requirem Violation)]. 8. Based on observative reviews, the facility fair retrievable records at use and administration for 2 of 2 sampled residues.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. 501251140.		R-C	
HAL031003		B. WING		10/17/2017		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
			, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D914	Continued From page	e 381	D914			
	medication and a resi Hydrocodone/Acetam and replaced with a p stool softener. [Refer	ed with an anti-nausea ident (#17) who had some ninophen tablets tampered otassium supplement and a r to Tag D392, 10A NCAC ed Substances (Type B				
	facility failed to assure E) had no substantiat North Carolina Health upon hire according to Tag D137, 10A NCAC	vs and record reviews, the e 3 of 5 staff sampled (B, C, ed findings listed on the a Care Personnel Registry o G.S. 131E-256. [Refer to C 13F. 0407(a)(5) Other Staff ated Type B Violation)].				
D932	G.S. 131D-4.4A (b) A Requirements	CH Infection Prevention	D932			
	G.S. 131D-4.4A Adult Prevention Requirem	t Care Home Infection ents				
	 (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. 					

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	ot Health Service Regu FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		COMPLETED	
HAL031003		B. WING		R-C 10/17/2017		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CADE	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D932	Continued From page	e 382	D932			
	home staff is exposed fluids of another persignificant risk of tran hepatitis C, or other burst f. Procedures to prohibit exudative lesions engaging in direct respotential for contact burst equipment, or devices dermatitis until the county (2) Require and monificallity's infection conus (3) Update the infection ecessary to prevent	ollowed when adult care d to blood or other body on in a manner that poses a smission of HIV, hepatitis B, bloodborne pathogens. ibit adult care home staff s or weeping dermatitis from sident care that involves the between the resident, s and the lesion or indition resolves. tor compliance with the trol policy.				
	This Rule is not met FOLLOW-UP TO TYPE					
	Based on these findir Violation was not aba	ngs, the previous Type B ted.				
	reviews, the facility fa infection control polic Centers for Disease (guidelines to assure p procedures for the us diabetic residents sar	ns, interviews, and record illed to implement a written y consistent with the federal Control and Prevention proper infection control e of glucometers for 9 of 9 mpled (#1, #3, #7, #16, #17, with orders for blood sugar				

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monitoring resulting in the shared use of

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	or periornoiro		(VO) MULTIPLE	CONSTRUCTION	OVO) DATE OUR!
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
, , , , , , , , , , , , , , , , , , , ,	5. 66.4.26.16.1	152.111116/1116111161115211	A. BUILDING: _		00 22.25
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	CTDEET AI	DDRESS, CITY, STA	TE ZID CODE	
NAME OF T	NOVIDER OR 3011 LIER		, ,	TE, ZII GODE	
GOLDEN	CARE		JTH NC 41		
	Г	WALLAC	E, NC 28466		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
IAO		,	l lAG	DEFICIENCY)	
D000			B000		
D932	Continued From page	383	D932		
	glucometers.				
	The findings are:				
	,	Center for Disease Control			
	, , ,	elines for infection control			
		commends blood glucose			
	,,,	lucometers) should not be			
		lents. If the glucometer is to			
		n one person, it should be			
	cleaned and disinfect	ed per the manufacturer's			
	instructions. If the ma	nufacturer does not list			
	disinfection information	on, the glucometer should			
	not be shared betwee	en residents.			
	Review of the owner's	s manual for Brand A			
	glucometer revealed:				
		or one person use ONLY.			
		neter or lancing device with			
	anyone".				
	-"Do not use on multip				
		se monitoring system could			
		hogens after use, even after			
	cleaning and disinfect	-			
	_	cting the meter destroys			
	most, but not necessa	arily all, blood-borne			
	pathogens.				
		proughly with soap and			
		nd after handling the meter,			
	_	s, or test strips as contact			
	with blood presents a				
		mmediately after getting any			
	blood on the meter or				
		he meter at least once a			
	week.				
		operated by a second			
	person who provides	testing assistance, the			
	meter and lancet devi	ice should be disinfected			
	prior to use by the se				
		he meter with "ONLY PDI			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
		11AE001000		<u></u>	10/11/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SOI	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	
				,		
D932	Continued From page	e 384	D932			
	Super Sani Cloth Wip	nes"				
	Super Sam Cloth Wip					
	Review of the owner's	s manual for Brand B				
	glucometer revealed:	5aaa. 15. 2.aa 2				
	-The glucometer is in	dicated for home or				
	-	e management of patients				
	with diabetes.					
	-Healthcare profession	nals performing blood tests				
		nultiple users must always				
	•	uld follow the infection				
		rocedures approved by their				
	facility.					
		stored in its carrying case.				
		the meter using a damp				
	cloth and mild soap.					
		solutions include: 70%				
		nixture of 1 part ammonia, 9 ure of 1 part household				
	bleach, 9 parts water.	•				
		er instructions on how to				
	disinfect the meter.	indiadiono di novito				
	Review of the owner's	s manual for Brand C				
	glucometer revealed:					
	-The blood glucose m	nonitoring system "is for one				
	your lancing device w	vith anyone".				
	-"DO NOT use on mo	re than one person."				
	•					
	~					
		u water, or OSHA approved				
		aroughly before using to test				
	-The blood glucose monitoring system "is for one person use ONLY. DO NOT share your meter or your lancing device with anyone". -"DO NOT use on more than one person." -All parts of the blood glucose monitoring system could carry blood-borne diseases after use, even after cleaning and disinfection. -Cleaning removes blood and soil, disinfecting removes infectious agents. -Clean the meter when visibly dirty. -Wipe the meter with a clean, lint-free cloth dampened with mild detergent/soap, 10% household bleach and water, or OSHA approved disinfectant. - Let Meter air dry thoroughly before using to test. -Do not use alcohol to clean the meter as it will					

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Division (of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPL	ETED	
			7 50.25			
						·C
		HAL031003	B. WING	B. WING		7/2017
NAME 05 B	20,4250 02 01 02 150	077777.17	DDE00 01TV 0T4	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	II E, ZIP CODE		
GOLDEN	CARE	4002 SOU	TH NC 41			
COLDLIN	OAIL	WALLACE	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	<u> </u>	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D932	Continued From none	205	D932			
D932	Continued From page	300	D932			
	cause damage to the	meter.				
		ns on how to disinfect the				
	glucometer was provi					
	glacomotor was provi	404.				
	Review of a letter dat	ed 07/20/17 from the local				
	county health service					
	-	icable disease coordinator				
	•					
		cility regarding an infection				
		to sharing of glucometers				
	with multiple resident					
		informed the glucometer				
	had already been rep					
	problem was identifie	d.				
	-Record review revea	led the nine diabetic				
	residents did not have	e Hepatitis B or C infection.				
	-Each resident had a	designated monitor and				
	testing supplies label	ed with their names.				
	-The facility Manager	had discussed the breach				
		served using the glucometer				
	on multiple residents.					
		mmended staff be educated				
		onitoring practices as soon				
	as possible.	rittering practices as seen				
	•	nging to single-use lancets.				
	_	could not verbalize the				
	cleaning process for					
		Wipes were available but				
		immediately as glucometers				
	should be cleaned aff	er each use.				
	5	100/07/47 6 44 4				
		ed 08/07/17 from the local				
	county health service					
		icable disease coordinator				
		ling a complaint of improper				
	glucose monitoring at					
	-It involved the use of	f a single glucometer for				
	multiple residents.					
		mplaint was also received in				
	July 2017.					
		or's visit to the facility, staff				
		•	1	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	COMPLETED	
	R-C	
HAL031003 B. WING	10/17/2017	
	1	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN CARE 4002 SOUTH NC 41		
WALLACE, NC 28466		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES	` -/	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROP		
DEFICIENCY)		
D932 Continued From page 386 D932		
D932 Continued From page 386 D932		
were unable to provide proper cleaning protocol		
for glucometers and no Sani cloth wipes were		
available.		
-Directives given to the facility included:		
immediate in-service for all staff regarding safe		
glucose monitoring practices; dispose of all		
glucometers suspected to have been used by		
multiple residents and purchase new ones; purchase Super Sani Cloth Wipes as		
recommended by the manufacturer and provide		
in-service on cleaning of glucometers; replace		
pen lancet devices with single use lancet devices;		
update policies and procedures for glucose		
monitoring and provide copy to county health		
services.		
Interview with the Administrator on 10/13/17		
revealed:		
-The facility did not have a written infection		
control policy and procedure.		
-The facility's policy was the medication aides were supposed to clean/disinfect the glucometers		
with Sani-wipe cloths after each use of the		
glucometers.		
guestination		
Observations, interviews, and record reviews		
during the survey from 10/11/17 - 10/13/17 and		
10/16/17 - 10/17/17 revealed:		
-There were 8 diabetic residents currently		
residing in the facility who required blood sugar		
monitoring and each resident had their own		
glucometer labeled with their name.		
-There was 1 glucometer in the medication cart		
for a resident who had been discharged from the facility in June 2017 but had current readings in		
the memory of the glucometer.		
-Nine of 9 sampled diabetics had readings in their		
glucometers that did not match their documented		
blood sugars.		

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
					R-	C
		HAL031003	B. WING		1	7/2017
		TIALUS 1003			10/1	772017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SOU	TH NC 41			
GOLDEN	CARE	WALLACI	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR I	ESCIDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	MAIL	57.1.2
D932	Continued From page	e 387	D932			
	1 Review of Resider	nt #16's current FL-2 dated				
	06/10/17 revealed:	it in to o darroint i E E dated				
		type II diabetes mellitus with				
		se - stage 3, hypertension,				
		nonia, sepsis, and moderate				
	protein malnutrition.	, , ,				
	•	for the fingerstick blood				
	sugar (FSBS) to be c	hecked.				
	Observation of Reside	ent #16's Brand B				
	glucometer on 10/13/	17 revealed:				
	-The glucometer was	stored in the top drawer of				
	the 200 hall medication	on cart.				
	-The glucometer was	stored in a separate				
	compartment and lab	eled with the resident's				
	name.					
	_	s stored in a separate				
	•	iders in the top drawer.				
		of single-use disposable				
	lancets in the drawer.					
	D : (1)					
		ry data for Resident #16's				
	Brand B glucometer of					
		n the glucometer reflected				
	the current date and t					
		ngs in the memory of the				
		ates ranged from 09/28/17				
	(7:02 a.m.) - 10/12/17 -The readings ranged					
		3S readings were a.m.				
	readings.	33 readings were a.m.				
		12 FSBS readings in the				
	p.m. (10/12/17 at 8:27					
		Freadings in the memory for				
		r 10/06/17 - 10/08/17.				
		readings for 10/12/17 at				
	6:59 a.m., 7:44 a.m.,					
		or 10/12/17 at 6:59 a.m. was				
	•	cumented on the log was				

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Division of Health Service Regulation

	of Health Service Regu				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF S	DOVIDED OD GUDDUED	0.75557	DDDEGG OITY OT	TE ZID CODE	-
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE	
GOLDEN	CARE		UTH NC 41		
	I		E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D932	Continued From page	e 388	D932		
		or 09/29/17 at 6:59 a.m. was cumented on the log was			
	October 2017 FSBS I -The resident's FSBS 8:00 a.m. and 8:00 p. 10/12/17. -The FSBS readings -There were 18 of 30 log that were not in the from 09/28/17 - 10/12	was checked twice daily at m. from 09/28/17 - ranged from 103 - 215. documented FSBS on the memory of the glucometer 2/17.			
		readings in the glucometer BS documented on the			
	p.m. revealed: -Staff usually checked eveningsHis blood sugar "run having any problems -Staff used a glucome cart.	ant #16 on 10/17/17 at 2:20 If his blood sugar in the Is good" and he was not with it. In eter from the medication In had his own glucometer in			
	Refer to interview with aide (MA) on 10/12/1	h a second shift medication 7 at 7:50 p.m.			
	Refer to interview with at 1:13 p.m.	h a first shift MA on 10/13/17			
	Refer to interview with 10/13/17 at 5:40 p.m.	h the Administrator on			
	Refer to interview with 10/17/17 at 11:45 a.m	h the Administrator on n.			

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPL	COMPLETED	
					l R-	C
		UAL 024002	B. WING		1	_
		HAL031003			10/1	17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE		
		4002 SOU	TH NC 41			
GOLDEN	CARE		, NC 28466			
	OUR MAR DV OT		1			1
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D033	O		D932			
D932	Continued From page	2 389	D932			
	2. Review of Resider	nt #1's current FL-2 dated				
	02/20/17 revealed dia	ignoses included type II				
		controlled, senile dementia,				
	hypertension, hyperlip					
	depression.	one of the contract of the con				
	шор. сос.с					
	Review of a physician	n's order dated 08/23/17 for				
	Resident #1 revealed					
		ars (FSBS) before meals, 2				
		d at 2:00 a.m. (6 times a				
	day).	a at 2.00 a.m. (0 times a				
	uay).					
	Observation of Reside	ent #1's Brand C glucometer				
	on 10/16/17 revealed					
		stored in the top drawer of				
	the 100 hall medication					
	-The glucometer was					
	=	eled with the resident's				
	name.					
	_	s stored in a separate				
	-	iders in the top drawer.				
		of single-use disposable				
	lancets in the drawer.					
	D					
		y data for Resident #1's				
	Brand C glucometer of					
		ometer reflected the current				
	date of 10/16/17.					
		ometer was 23 minutes				
		e current time of 2:14 p.m.				
		ngs in the memory of the				
	•	01/17 (2:25 a.m.) - 10/16/17				
	(11:37 a.m.)					
		from 20 - "HI" (greater than				
	600 according to the					
	-There were no FSBS	readings in the memory for				
	10/06/17 - 10/10/17.					
	-Twelve of the FSBS	readings in the memory did				
		1's readings on the FSBS				

log.

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DIVISION	n nealth Service Regu	iation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		1141 024 002	B. WING		R-C
		HAL031003	D. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		4002 SOL	TH NC 41		
GOLDEN (CARE		E, NC 28466		
		WALLAC	=, NC 20400		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(/
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAO		,	IAG	DEFICIENCY)	
D932	Continued From page	e 390	D932		
	Poviou of Posidont #	1's October 2017 FSBS log			
		1's October 2017 F3B3 log			
	revealed:	was shooked 02 times from			
		was checked 93 times from			
		out only 63 FSBS readings			
	-	of Resident #1's glucometer			
	for that time period.				
		ranged from 20 - "HI".			
		in the memory were not			
	documented on the F				
	-For example, the res				
		on 1012/17 at 11:30 a.m. but			
	this reading was not i	n the memory of the			
	glucometer.				
	-For example, the res				
		on 10/14/17 at 12:00 noon			
	but this reading was r	_			
		mented FSBS reading on			
	•	0/06/17 - 10/10/17 that were			
	not in the memory of	Resident #1's glucometer.			
	Refer to interview with	h a second shift medication			
	aide (MA) on 10/12/1	7 at 7:50 p.m.			
	Refer to interview with	h a first shift MA on 10/13/17			
	at 1:13 p.m.				
	Refer to interview with	h the Administrator on			
	10/13/17 at 5:40 p.m.				
	Refer to interview with	h the Administrator on			
	10/17/17 at 11:45 a.m	1.			
	3. Review of Resider	nt #3's current FL-2 dated			
	03/07/17 revealed:				
	-Diagnoses included	diabetes mellitus, peripheral			
	vascular disease, pne				
	weakness.	-,			
		for fingerstick blood sugars			

Division of Health Service Regulation

(FSBS) 4 times daily.

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STATEMENT OF DEPICIENCIES AND PLAND OF CORRECTION AND PLAND OF CORRECTION	DIVISION	n Health Service Regu	iation				
HAL031003 HAL031003 B, VINIG	, ,		(X2) MULTIPLE	CONSTRUCTION	1 ' '		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NO 41 WALLACE, NC 28466 PROPRIATE AND COMMENT OF PROPRINGES (EACH CERTICAL VEY AUGUST OF PROPRIATE OF PR	AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLE	TED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NO 41 WALLACE, NC 28466 PROPRIATE AND COMMENT OF PROPRINGES (EACH CERTICAL VEY AUGUST OF PROPRIATE OF PR							_
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 WALLACE, NC 28466 DAY JID PREFER RECOULDERY ON STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL PLAY RECOULDERY ON STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL PLAY RECOULDERY ON STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL PLAY RECOULDERY ON STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FILL PLAY D932 Continued From page 391 D932 Continued From page 391 D932 Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer on 10/13/17 revealed: -There was a supply of single-use disposable lancets in the drawer. -There was a supply of single-use disposable lancets in the drawer. -There was 63 readings in the memory of the glucometer on 10/13/17 revealed: -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented 55BS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was dockeded and not 10/13/17 at 4.45 p.m. but			1141 024002	B WING		1	
COLDEN CARE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-RETERRINED TO PREFIX TAG CROSS-RETERRINED TO PREFIX TAG CROSS-RETERRINED TO PAPPORPAIT COME CACH CORRECTIVE ACTION SHOULD BE COME!* D932 Continued From page 381 D932			HAL031003	D: 111110		10/1	//201/
GOLDEN CARE WALLACE, NC 28466 (KA) D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CASH DEVICE) COMPLETE CASH DEPRICED ON MUST BE PRECEDED BY TULL PREFIX TAG (RACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE OF COMPLETE D	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN CARE WALLACE, NC 28466 (KA) D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (CASH DEVICE) COMPLETE CASH DEPRICED ON MUST BE PRECEDED BY TULL PREFIX TAG (RACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE OF COMPLETE D			4002 SOL	TH NC 41			
SUBMENT STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CONDECTION (SCAND AFFORMATION) PREFIX PROVIDERS PLAN OF CONDECTION (SCANDARD PROPRIATE DATE)	GOLDEN (CARE					
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) D932 Continued From page 391 Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment with dividers in the top drawer. -Tan energy of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:28 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ware not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented a SA4 on 10/09/17 at 4.445 p.m. but			WALLACI	E, NC 20400			
D932 Continued From page 391 Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cartThe glucometer was stored in a separate compartment and labeled with the resident's nameEach glucometer was stored in a separate compartment with dividers in the top drawerThere was a supply of single-use disposable lancets in the drawerThere was a supply of single-use disposable lancets in the drawerThere was a fored in a separate compartment with dividers in the top drawerThere was a supply of single-use disposable lancets in the drawerThere was a supply of single-use disposable lancets in the drawerThere was a fored timeThere were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:28 a.m.) - 10/13/17 (10:28 a.m.) -The readings ranged from 50 - 347Fifteen of the FSBS readings in the memory did not match Resident #3's september 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time periodThe FSBS results on the log ranged from 50 - 420Eight documented FSBS on the log were not in the memory of Resident #3's glucometerFor example, the resident's FSBS was documented as 34 on 10/09/17 at 4.45 p.m. but							
Desirution of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:28 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the memory did not match Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 34 do n 10/09/17 at 4.445 p.m. but		,			· ·		
Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the memory did not match Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 344 on 10/09/17 at 4,45 p.m. but	IAG		,	IAG			
Observation of Resident #3's Brand A glucometer on 10/13/17 revealed: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the memory did not match Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 344 on 10/09/17 at 4,45 p.m. but				+			
on 10/13/17 revaled: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings on the FSBS log. Review of Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but	D932	Continued From page	e 391	D932			
on 10/13/17 revaled: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings on the FSBS log. Review of Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but							
on 10/13/17 revaled: -The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:26 a.m.) -The readings ranged from 50 - 347. -Friteen of the FSBS readings on the FSBS log. Review of Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but		Observation of Desid	ant #21a Drand A alveanator				
-The glucometer was stored in the top drawer of the 200 hall medication cart. -The glucometer was stored in a separate compartment and labeled with the resident's name. -Each glucometer was stored in a separate compartment with dividers in the top drawer. -There was a supply of single-use disposable lancets in the drawer. Review of the memory data for Resident #3's Brand A glucometer on 10/13/17 revealed: -The date and time on the glucometer reflected the current date and time. -There were 63 readings in the memory of the glucometer dated 09/25/17 (10:38 a.m.) - 10/13/17 (10:28 a.m.) -The readings ranged from 50 - 347. -Fifteen of the FSBS readings in the memory did not match Resident #3's readings on the FSBS log. Review of Resident #3's September 2017 and October 2017 FSBS logs revealed: -The resident's FSBS was checked 71 times from 09/25/17 - 10/13/17 but there were only 67 readings in the memory of Resident #3's glucometer for that time period. -The FSBS results on the log ranged from 50 - 420. -Eight documented FSBS on the log were not in the memory of Resident #3's glucometer. -For example, the resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but			_				
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-For example, the resident's FSBS was documented as 344 on 10/09/17 at 4:45 p.m. but		•	•				
documented as 344 on 10/09/17 at 4:45 p.m. but							
this reading was not in the memory of the							
glucometer.		_					

Division of Health Service Regulation

-The resident's FSBS was documented 4 times a

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Division of Health Service Regulation

	of Health Service Regu		1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AIND PLAIN (PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _			MI LETED	
						R-C	
		HAL031003	B. WING			0/17/2017	
NAME OF D	ROVIDER OR SUPPLIER	etheet /	ADDRESS, CITY, STA	TE ZID CODE			
NAIVIE OF F	ROVIDER OR SUFFLIER			TE, ZIF CODE			
GOLDEN	CARE		OUTH NC 41				
			CE, NC 28466				
(X4) ID		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETE	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE		DATE	
				DEFICIENCY)			
D932	Continued From page	a 302	D932				
5002			5002				
		04/17, 10/07/17, 10/11/17,					
		re were 5 readings each of					
	those days in the me	mory of the glucometer.					
	Intoniou with Booida	ent #3 on 10/17/17 at 10:25					
	a.m. revealed:	ent #3 on 10/17/17 at 10.25					
		and FSBS checks about 3					
	or 4 times a day.	and i obo checks about o					
		gh sometimes she would					
	have to get 60 units of						
	•	vous" when her FSBS was					
	high.						
		es ran low and she would get					
	"nervous and shaky".						
	-	ed different glucometers for					
		was not sure because the					
	glucometers looked t	ne same.					
	Defer to intension wit	h a second shift medication					
	aide (MA) on 10/12/1						
	aide (ivi/t) on 10/12/1	7 dt 7.00 p.m.					
	Refer to interview wit	h a first shift MA on 10/13/17					
	at 1:13 p.m.						
	·						
	Refer to interview wit	h the Administrator on					
	10/13/17 at 5:40 p.m.						
		h the Administrator on					
	10/17/17 at 11:45 a.n	n.					
	4 Review of Residor	nt #7's current FL-2 dated					
	10/04/17 revealed:	III #1 5 CUITEIII FL-2 Udleu					
		type II diabetes mellitus with					
		se, Alzheimer's dementia,					
		yroidism, hematuria, urinary					
		kidney injury, and acute					
	encephalopathy.						
		for fingerstick blood sugars					
	(FSBS).	-					

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Division of	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017
		HALUSTUUS			10/17/2017
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41 E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D932	Continued From page	e 393	D932		
		7' previous FL-2 dated order to check FSBS 4			
	on 10/16/17 revealed				
	the 100 hall medication. The glucometer was				
		eled with the resident's			
	compartment with div	s stored in a separate iders in the top drawer.			
	-There was a supply of lancets in the drawer.	of single-use disposable			
	Brand A glucometer of	y data for Resident #7's on 10/16/17 revealed: ometer reflected the current			
	-The time on the gluc minutes prior to (2:10	ometer was 1 hour 4 p.m.) the current time of			
		ngs in the memory of the 01/17 (6:18 a.m.) - 10/16/17			
	(5:48 a.m.) -The readings ranged				
	-There were no reading 10/02/17 - 10/03/17.				
	-Eleven of the FSBS readings in the memory did not match Resident #7's readings on the FSBS log.				
	Review of Resident #	7's October 2017 FSBS log			
	-The resident's FSBS	was checked 47 times from ut there were 48 readings in			
		ent #7's glucometer for that			
		ranged from 111 - 568.			

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Division of Health Service Regulation

	or rieditir Service Regu				1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		EIED
					l _{R-}	C
		1141 024002	B. WING		1	_
		HAL031003	J		10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOU	TH NC 44			
GOLDEN	CARE					
		WALLACE	, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/(IL
				,		
D932	Continued From page	e 394	D932			
		in the memory did not match				
	documentation on the	•				
	-There were 3 FSBS	readings on the FSBS log				
	that were not in the m	nemory of the resident's				
	glucometer					
	-For example, the res	ident's FSBS was				
	documented as 111 o	n 10/05/17 at 2:00 a.m. but				
	this reading was not in	n the memory of the				
	glucometer.	•				
	9.2.2					
	Refer to interview with	h a second shift medication				
	aide (MA) on 10/12/1					
	alac (1417 t) off 107 127 1	7 dt 7.00 p.m.				
	Pefer to interview with	h a first shift MA on 10/13/17				
		TA III SE SIIIIE WA OH 10/13/17				
	at 1:13 p.m.					
	Defer to interview with	h the Administrator on				
		h the Administrator on				
	10/13/17 at 5:40 p.m.					
	D (() ()					
		h the Administrator on				
	10/17/17 at 11:45 a.m	1.				
		nt #17's current FL-2 dated				
	09/25/17 revealed:					
	-Diagnoses included					
		coronary artery disease,				
	atherosclerotic heart	disease, hyperlipidemia, iron				
	deficiency, chronic ob	structive pulmonary				
		, insomnia, pain, rash,				
		ntion, seasonal allergic				
		ajor depressive disorder,				
		istroesophageal reflux				
	disease, and pressure	. •				
		for fingerstick blood sugars				
		•				
	(FSBS) to be checked	J.				
	Davidson (C. 1. 1.1	-ld d-t- ! 07/00/17 (
		n's order dated 07/20/17 for				
		d an order to check FSBS 3				
	times a day before me	eals.				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 395 of 419

Division of Health Service Regulation

Division C	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	≣TED
						<u> </u>
		HAL031003	B. WING	B. WING		C 7/2017
		HAE031003			10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CARE	4002 SOU	TH NC 41			
GOLDEN CARE WALLACE,		E, NC 28466				
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D932	Continued From page	e 395	D932			
						ı
	Observation of Resid					ı .
	glucometer on 10/13/					ı .
	•	stored in the top drawer of				ı ,
	the 200 hall medication					ı .
	-The glucometer was	· ·				ı !
	=	eled with the resident's				ı .
	name.					ı .
		is stored in a separate				ı .
		viders in the top drawer.				ı .
		of single-use disposable				ı .
	lancets in the drawer.					
	Review of the memor	ry data for Resident #17's				
	Brand A glucometer of					ı
		n the glucometer reflected				ı
	the current date and t					ı
		S readings in the memory of				ı
		I 10/05/17 (7:38 a.m.) -				1
	10/13/17 (7:19 a.m.)	(1
		in the memory ranged from				1
	46 - 321.	, 5				1
	-Nine of the 30 FSBS	readings in the memory did				1
	not match the resider	-				1
	documented on the F	SBS log.				1
	1					I
	Review of Resident #	f17's October 2017 FSBS log				1
	revealed:					1
	-The resident's FSBS	S was checked 28 times from				1
		out there were 30 readings in				1
	the memory of the res	sident's glucometer for that				1
	time period.					1
		on the log ranged from 66 -				1
	321.					1
	-The resident's FSBS					1
	-	y from 10/06/17 - 10/11/17				1
		emory had 2 readings for				1
		/17, 5 for 10/09/17, and 3 for				1
	10/11/17.					1

Division of Health Service Regulation

Refer to interview with a second shift medication

STATE FORM 6899 DBPR11 If continuation sheet 396 of 419

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		HAL031003	B. WING		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OTHER	NOVIDEN ON OUT FEET		UTH NC 41	12, 211 0002	
GOLDEN	CARE		E, NC 28466		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE DATE
				,	
D932	Continued From page	e 396	D932		
	aide (MA) on 10/12/1	7 at 7:50 p.m.			
	D-ft itii+	L - first - biff NAA 40/40/47			
	at 1:13 p.m.	h a first shift MA on 10/13/17			
	Pofor to intonvious wit	h the Administrator on			
	10/13/17 at 5:40 p.m.				
	10/10/11 dt 0:10 p.m.	•			
	Refer to interview wit	h the Administrator on			
	10/17/17 at 11:45 a.m	1.			
	6. Review of Resider	nt #18's current FL-2 dated			
	05/04/17 revealed:	m no o canoni i E E datod			
		diabetes, hypertension, and			
	mental retardation.				
		to check fingerstick blood			
	sugars (FSBS).				
	Review of a physiciar	n's order dated 07/19/17 for			
		ed an order to check FSBS			
	twice daily.				
	0, ,, ,,	1 //401 B 1 A			
	Observation of Resid glucometer on 10/16/				
		stored in the top drawer of			
	the 200 hall medication				
	-The glucometer was				
	compartment and lab	eled with the resident's			
	name.				
		s stored in a separate			
		riders in the top drawer. of single-use disposable			
	lancets in the drawer.				
	is lock in the drawer.	•			
	Review of the memor	ry data for Resident #18's			
		on 10/16/17 revealed:			
		n the glucometer reflected			
	the current date and	time.			

Division of Health Service Regulation

-There were 25 FSBS readings in the memory of the glucometer dated 08/15/17 (7:00 a.m.) - $\,$

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		HAL031003	B. WING	B. WING		C 7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOU				
	I		E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	e 397	D932			
D932	10/15/17 (8:54 a.m.) -The FSBS readings is 51 - 298There were no FSBS 08/25/17 - 10/14/17Twenty-three of the 2 memory did not match readings documented. Review of Resident # 2017 FSBS log revea -The resident's FSBS from 08/15/17 - 10/15 readings in the memory glucometer for that tir -The FSBS on the log. Refer to interview with aide (MA) on 10/12/17. Refer to interview with 10/13/17 at 5:40 p.m. Refer to interview with 10/17/17 at 11:45 a.m. 7. Review of Resider 09/14/16 revealed: -Diagnoses included on hypothyroidism, anxietinsomnia, and osteoal	in the memory ranged from S readings in the memory for 25 FSBS readings in the the the resident's FSBS I on the FSBS log. 18's August 2017 - October led: was checked 116 times i/17 but there were only 22 bry of the resident's me period. I ranged from 135 - 513. In a second shift medication 7 at 7:50 p.m. In a first shift MA on 10/13/17 In the Administrator on the Administrat	D932			
	Brand A glucometer of	y data for Resident #1's on 10/16/17 revealed: ometer reflected the current				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 398 of 419

Division of Health Service Regulation

Division o	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
					_	0
		1141 004000	B. WING		R-	
		HAL031003	B: Willo		10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			ITH NC 41			
GOLDEN	CARE					
		WALLACI	E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG		200 .22	IAG	DEFICIENCY)	=	
D932	Continued From page	e 398	D932			
	data of 40/40/47					
	date of 10/16/17.					
	-The time on the gluc					
	• •	p.m.) the current time of				
	3:21 p.m					
		6 readings in the memory of				
	•	09/26/17 (5:51 a.m.) -				
	10/16/17 (6:11 a.m.)					
	•	in the memory ranged from				
	182 - 314.					
		readings in the memory for				
		p.m. and 257 at 6:09 a.m.				
		eadings in the memory did				
	not match Resident #	19's readings on the FSBS				
	log.					
		19's September 2017 and				
	October 2017 FSBS I	•				
		was checked 20 times from				
		it there were 22 reading in				
	the memory of Reside	ent #19's glucometer for that				
	time period.					
		g ranged from 182 - 314.				
	-There was no FSBS	documented on the log for				
	10/08/17 but there wa	as a FSBS reading of 214 on				
	10/08/17 in the memo	ory of the glucometer.				
	Interview with Reside	ent #19 on 10/11/17 at 10:55				
	a.m. revealed:					
	-She was borderline of	diabetic and staff checked				
	her blood sugar once	a day.				
	-Her blood sugar was	s usually in the 200s.				
	-She had her own glu	cometer when she lived at				
	home.					
	-She thought staff use	ed one glucometer for				
	everybody at the facil					
	, , ,	•				
	Refer to interview with	h a second shift medication			ĺ	
	aide (MA) on 10/12/1					
	· ,	P	1	1		i l

Division of Health Service Regulation

Refer to interview with a first shift MA on 10/13/17

STATE FORM 6899 DBPR11 If continuation sheet 399 of 419

Division (<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	·
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/201	17
					10/11/201	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SO	UTH NC 41			
COLDEN	OAIL	WALLAC	CE, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		MPLETE DATE
IAG		,	IAG	DEFICIENCY)		
5000			5000			
D932	Continued From page	e 399	D932			
	at 1:13 p.m.					
	Defer to interview wit	h the Administrator on				
	10/13/17 at 5:40 p.m.					
	10/10/17 at 0.40 p.m.					
	Refer to interview wit	h the Administrator on				
	10/17/17 at 11:45 a.n	١.				
	8. Review of Resider	nt #20's current FL-2 dated				
	07/25/17 revealed:					
	-Diagnoses included	• •				
		peripheral vascular disease.				
		to check fingerstick blood				
	sugars (FSBS).					
	Observation of Resid	ent #20's Brand A				
	glucometer on 10/13/					
	_	stored in the top drawer of				
	the 200 hall medication	on cart.				
	-The glucometer was	stored in a separate				
	compartment and lab	eled with the resident's				
	name.					
	_	s stored in a separate				
	1	riders in the top drawer. of single-use disposable				
	lancets in the drawer.					
	lancets in the drawer.	•				
	Review of the memor	y data for Resident #20's				
	Brand A glucometer of					
	-The date and time or	n the glucometer reflected				
	the current date and					
		readings in the memory of				
		09/26/17 (6:07 a.m.) -				
	10/11/17 (7:13 a.m.)	: 4b				
	_	in the memory ranged from				
	65 - 375.	3 readings in the memory for				
	10/07/17, 10/12/17, o	- ·				

Division of Health Service Regulation

-Two of the 16 FSBS readings in the memory did

not match the resident's FSBS readings

STATE FORM 6899 DBPR11 If continuation sheet 400 of 419

Division of	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL031003	B. WING		R-C 10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	CE, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	ΓΕ
D932	Continued From page	400	D932			
	documented on the F	SBS log.				
	October 2017 FSBS Id- The resident's FSBS 09/26/17 - 10/12/17 by readings in the memoral glucometer for that tine. The FSBS on the logenther was no reading of the glucometer. The FSBS was 153 cm.	was checked 17 times from ut there were only 16 ry of the resident's				
	-"It runs okay."	ood sugar in the mornings. cometer they used to check ney used the same				
	aide (MA) on 10/12/17	n a second shift medication 7 at 7:50 p.m. n a first shift MA on 10/13/17				
	at 1:13 p.m.					
	Refer to interview with 10/13/17 at 5:40 p.m.					
	Refer to interview with	n the Administrator on				

Division of Health Service Regulation

10/17/17 at 11:45 a.m.

in the closed record revealed:

9. Review of Resident #21's FL-2 dated 04/06/17

-Diagnoses included diabetes, congestive heart

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Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL031003	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	FE, ZIP CODE	
GOLDEN	CAPE	4002 SOL	JTH NC 41		
OOLDEN	OAIL	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D932	Continued From page	. 401	D932		
	fibrillation, gastroesop degenerative joint dis depression, anxiety, a -There was no order t sugars (FSBS). Review of Resident # the resident went to the did not return to the fa Observation of Reside glucometer on 10/13/-The glucometer was the 200 hall medication -The glucometer was compartment and laborameEach glucometer was compartment with div	ent #21's Brand A 17 revealed: stored in the top drawer of on cart. stored in a separate eled with the resident's s stored in a separate iders in the top drawer. of single-use disposable			
	1:13 p.m. revealed: -She did not know wh glucometer was in the medication cartThe resident no long her glucometer should medication cartThe resident went to rehabilitation facility a was not coming back Review of the memor Brand A glucometer of the date and time or the current date and to	e top drawer of the 200 hall er lived at the facility and d not be stored in the the hospital and then to a bout 2 to 3 months ago and to this facility. y data for Resident #21's n 10/13/17 revealed: n the glucometer reflected			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 402 of 419

Division of	<u>of Health Service Regu</u>	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R-0	C
		HAL031003	B. WING		1	7/2017
		OTDEET W		TE 7/0 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		JTH NC 41			
		WALLAC	E, NC 28466			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D932	Continued From page	e 402	D932			
		1 06/28/17 (1:00 a.m.) -				
	10/11/17 (6:06 p.m.)					
	-The FSBS readings 75 - 498.	in the memory ranged from				
		s in the memory were				
		sident no longer lived at the				
	facility.	Tuent ne lenger mod at all				
	-There was 1 FSBS re	eading in 06/2017.				
		S readings in 07/2017.				
	-There were 6 FSBS					
	-There were 4 FSBS	•				
	-There were 22 FSBS	S readings in 10/2017.				
	Review of Resident #	21's June 2017 FSBS log				
		's last documented FSBS				
	was 226 on 06/19/17	at 8:00 a.m.				
	Bofor to interview with	h a second shift medication				
	aide (MA) on 10/12/1					
	uide (1717 t) on 107 127 1	7 dt 7.55 p.m.				
	Refer to interview with	h a first shift MA on 10/13/17				
	at 1:13 p.m.					
		h the Administrator on				
	10/13/17 at 5:40 p.m.					
	Refer to interview with	h the Administrator on				
	10/17/17 at 11:45 a.m					
		nd shift medication aide				
	(MA) on 10/12/17 at 7	•				
	_	they ran out of test strips for				
	the Brand A glucomet	ters. e test strips for at least 2				
	weeks.	test strips for at least 2				
		told the MAs to use the				
	, ,	y admitted resident who had				
	-	r and had a supply of test				
	strips.	,				

Division of Health Service Regulation

-The Manager told the MAs to use that

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			
					R-	·C
		HAL031003	B. WING		10/1	17/2017
			•			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
001 0511	0455	4002 SOU	ΓH NC 41			
GOLDEN	CARE	WALLACE	, NC 28466			
040.15	CLIMMADV CT.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D932	Continued From page	e 403	D932			
	alugameter for all of t	he regidents until they could				
	•	he residents until they could				
	get more strips for Bra	-				
	-They shared that glu					
	residents who had the	e Brand A glucometers				
	during that time.					
	-They had an infection	n control class sometime				
	after the survey in 06	/2017 but prior to running				
	out of strips in 08/201					
	•	any glucometers between				
		ident of not having strips in				
	08/2017.	addit of flot flavilig outpoint				
		of any alugameter charing				
		of any glucometer sharing				
	between residents cu	•				
	•	ny policies and procedures				
	for infection control.					
	-She did not recall be	ing instructed on cleaning				
	the glucometers.					
	Interview with a first s	hift MA on 10/13/17 at 1:13				
	p.m. revealed:					
	•	nt had their own glucometer				
	labeled in the medica	-				
		w glucometers for some of				
		_				
		could not recall the date				
	when they received the					
	-They were not support					
	glucometers between					
	 She denied sharing t 	he glucometers between the				
	residents.					
	-She was not aware of	of any MAs sharing the				
	glucometers between	the residents.				
	_	y the FSBS readings in the				
		neters did not match some				
		e residents' FSBS logs.				
	or the readings on the	, recidente i obo loga.				
	Interview with the Adr	ministrator on 10/13/17 at				
		iiiiiotiatoi oii 10/13/17 at				
	5:40 p.m. revealed:	and and describe a few ()				
	-They had infection co					
	medication aides afte	r the survey in June 2017				

Division of Health Service Regulation

and there were problems with staff sharing

STATE FORM 6899 DBPR11 If continuation sheet 404 of 419

Division of Health Service Regulation

DIVIDIOTI C	it Health Service Regu	lation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		ETED
			_			_
					R-	C
		HAL031003	B. WING		10/1	7/2017
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
GOLDEN (ADE	4002 SOI	JTH NC 41			
GOLDLIN	ZAIL	WALLAC	E, NC 28466			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V I	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D000	0 " 15	10.1	Door			
D932	Continued From page	e 404	D932			
	glucometers between	the residents				
	•	lucometers for residents				
	after the last survey (
	, ,	•				
	-The facility had not d					
		res for infection control.				
	•	facility had been out on				
	medical leave for abo	out 2 months.				
	-The Manager did not	t develop any written policies				
	and procedures for in	fection control since the				
	previous survey to he	er knowledge.				
	-	he Manager had told the				
	medication aides to s					
		residents in 08/2017 when				
	they ran out of strips.					
		staff were currently sharing				
		stall were currently sharing				
	glucometers.					
	-They were not support	osed to share the				
	glucometers.					
		charged residents should not				
	be stored in the medi					
		ne pharmacy today about				
	getting new glucomet					
	-She would have an i	n-service with the				
	medication aides abo	ut the glucometers.				
	Interview with the Adr	ministrator on 10/17/17 at				
	11:45 a.m. revealed:					
	-She had contacted a	local pharmacy to get more				
	glucometers for the re					
	-The pharmacist was					
		glucometer company about				
	getting more glucome					
		no timeline on when the				
	glucometers would be	e optained.				
	-					
		ucometers between 9 of 9				
	diabetic residents in t	he facility receiving				
	fingerstick blood suga	ar (FSBS) checks. Eight of 8				
		multiple FSBS readings				
		ory of their glucometers that				

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 405 of 419

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
			7 50.25.110.			_
		1141 024002	B. WING	R WING		C 7/2047
		HAL031003			10/1	7/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
COLDEN	CADE	4002 SO	UTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D932	Continued From page	e 405	D932			
	did not match ESBS r	readings documented on				
		e of the residents left the				
	_	out her glucometer was still				
		edication cart and had 49				
	•	ded in the memory of the				
		resident no longer lived at				
	~	ost recent FSBS reading				
	dated 10/11/17. The	failure of the facility to				
	implement infection of	ontrol procedures consistent				
		er for Disease Control (CDC)				
	•	nental to the health and				
		its due to possible exposure				
	of blood borne pathog					
	sharing of glucometer					
	Unabated Type B Vio	lation.				
	-	s Plan of Protection dated				
	10/13/17 revealed:					
	after each use.	ucometer use and cleaning				
	 Notify physician and breach of infection co 	health department on ontrol.				
	 Replace glucometers resident. 	s used for more than one				
		ne beginning today with staff				
	(Medication Aides) ar been in-serviced.	nd continue until all have				
		be disinfected immediately.				
	•	onitor glucometers to ensure				
		only daily for one week, then				
	weekly.					
	-Will compare with blo					
		cy will be developed and				
	implemented.					
D935	G S & 131D-4 5B(b) 4	ACH Medication Aides;	D935			
2000	Training and Compete					
	G.S. § 131D-4.5B (b)	Adult Care Home				

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STATE FORM 6899 DBPR11 If continuation sheet 406 of 419

Division of Health Service Regul	ation			
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				D.C
	HAL031003	B. WING		R-C
	HALUSTUUS			10/17/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
001 PEN 04 PE	4002 SOU	JTH NC 41		
GOLDEN CARE	WALLACI	E, NC 28466		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(>1.).2	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
			DEI IGIENCI)	
D935 Continued From page	÷ 406	D935		
Medication Aides; Tra	ining and Competency			
Evaluation Requireme				
·				
(b) Beginning October	r 1, 2013, an adult care			
home is prohibited fro	m allowing staff to perform			
any unsupervised me	dication aide duties unless			
that individual has pre				
	g the previous 24 months in			
	r successfully completed all			
of the following:				
	g program developed by the			
	des training and instruction			
in all of the following:				
a. The key principles	of medication			
administration.				
	s for Disease Control and			
_	on infection control and, if			
applicable, safe inject	•			
	oring or testing in which			
_	e potential for bleeding			
exists.	1			
` '	aluation consistent with 10A			
	10A NCAC 13G .0503.			
	m the date of hire, the			
	completed the following:			
a. An additional 10-ho	- · · -			
developed by the Dep				
_	n in all of the following:			
1. The key principles of administration.	Ji medication			
	s of Disease Control and			
	on infection control and, if			
applicable, safe inject				
'''	oring or testing in which			
	e potential for bleeding			
exists.	, potential for biceding			
	veloped and administered			
	alth Service Regulation in			
	ection (c) of this section.			

Division of Health Service Regulation

STATE FORM 6899 DBPR11 If continuation sheet 407 of 419

Division of Health Service Regulation

	of Health Service Regu	lation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					D 0
		1141 004000	B. WING		R-C
		HAL031003	5:		10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		4002 SOI	JTH NC 41		
GOLDEN	CARE		E, NC 28466		
			<u>, </u>		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(/
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
	0 " 15	407	DOSE		
D935	Continued From page	e 407	D935		
	This Rule is not met	as evidenced by:			
	TYPE B VIOLATION	· · · · · · · · · · · · · · · · ·			
	Based on observation	ns, interviews, and record			
		iled to assure 3 of 4 staff			
		o administered medications			
		hour and 10 hour or 15 hour			
		ation administration training			
		1 of 4 sampled medication			
	· ·	the written medication aide			
	. , .	dication aides sampled (B,			
	-	checklist completed prior to			
	administering medica				
	The findings are:				
	1. Review of Staff C's	personnel record revealed:			
		nentation of Staff C's hire			
	date.				
	-She was hired as a F	Personal Care Aide (PCA),			
	Medication Aide (MA)	* **			
	I	tation that Staff C had a			
	medication clinical sk	ills checklist completed			
	06/27/17.	·			
	-There was no docum	nentation Staff C had passed			
	the written medication				
		nentation Staff C completed			
		nedication aide training			
	course.	Č			
	Review of the resider	its' September 2017 and			
		ition administration records			
	and blood sugar logs	revealed:			
	-Staff C documented				
	medications including				
	10/03/17, and 10/07/				
	-Staff C documented				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			R WING		R-C
		HAL031003	B. WING		10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE		JTH NC 41		
		WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D935	Continued From page	e 408	D935		
	medications including 09/06/17, 09/07/17, 0 09/15/17, 09/16/17, 0 09/24/17, and 09/29/	9/10/17 - 09/12/17, 9/19/17, 09/21/17 -			
	2:40 p.m. revealed: -She was hired in Aug supervisor She left and came b -She was last rehired -She started administ around the end of Se rehiredShe administered me -She thought she tool exam over a year ago was the state medica -She did not recall tak 15 hour state approve -The Manager was su confirmation that she -She could look for he	on 09/01/17. ering medications again ptember 2017 after she was edications including insulin. k some type of medication b but she did not know if it tion aide written exam. king the 5 hour, 10 hour, or ed medication aide courses. upposed to go online and get			
		h the Administrator on			
	Refer to interview with 10/17/17 at 2:00 p.m.	h the Administrator on			
	-Staff B was hired on -There was no job title	personnel record revealed: 10/25/16. e in the personnel record. ation aide clinical skills			

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-There was no documentation of Staff B passing

the written medication aide exam. -There was no documentation of Staff B

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D.C.
		HAL031003	B. WING		R-C 10/17/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOUT			
		WALLACE,	NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D935	Continued From page	e 409	D935		
	completing the 5 hour approved medication	r, 10 hour, or 15 hour state aide training courses. ation aide verification form			
	administration records	nts' October 2017 medication s (MARs) revealed Staff B tration of medications on 7.			
	revealedStaff B was hired bef personal care aideShe was now a medibegan administering in				
	by the Administrator, Nurse. -There was a certifica	6/17 revealed:			
	Refer to interview with 10/16/17 at 8:40 a.m.	h the Administrator on			
	Refer to interview with 10/17/17 at 2:00 p.m.	h the Administrator on			
	-Staff E was hired on aide (MA) and superv -There was documen	personnel record revealed: 04/04/17 as a medication visor. tation Staff E had completed skills checklist on 04/04/17.			

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STATE FORM 6899 DBPR11 If continuation sheet 410 of 419

Division of Health Service Regulation

DIVISION	of Health Service Regu	liation			_	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL031003	B. WING			
		HALU31003			10/17/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	FE, ZIP CODE		
		4002 SQ	UTH NC 41			
GOLDEN (CARE		E, NC 28466			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	I	
				DEFICIENCY)		
D005	0 " 15	440	Door			
D935	Continued From page	e 410	D935			
	-There was documen	tation Staff E passed the				
		de exam on 01/23/08.				
		nentation Staff E completed				
		nedication aide training				
	course.	nedication and training				
		ation aide verification form				
	for Staff E.	ation aide verification form				
	ioi otali L.					
	Review of residents'	Sentember 2017 and				
		ation administration records				
	and blood sugar logs -Staff E documented					
	medications including					
	10/02/17, and 10/04/					
	-Staff E documented					
	medications including					
	09/10/17, 09/12/17, 0					
	09/21/17, 09/23/17, 0	9/27/17, and 09/28/17.				
	Interview with Ctoff F	on 10/16/17 of 2:12 n m				
		on 10/16/17 at 3:13 p.m.				
	revealed:	Manakan Annii 0047 MA				
		March or April 2017 as a MA				
	and supervisor.	h. t-l the 5/40 have so the				
	·	ly taken the 5/10 hour or the				
	· ·	previous facility, but never				
		er certificates; she thought				
	she had the training i					
	-The Manager had never requested copies of any training hours.					
		n any MA training since				
	being employed at the	e тасшty.				
	Defeat 1.1 1 11 11	la tha a Autorioi () (
		h the Administrator on				
	10/16/17 at 8:40 a.m.	•				
		h the Administrator on				
	10/17/17 at 2:00 p.m.					
	Interview with the Adı	ministrator on 10/16/17 at				

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8:40 a.m. revealed:

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Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D MINO		R-C
		HAL031003	B. WING		10/17/2017
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STA	TE ZID CODE	
NAME OF T	NOVIDEN ON 3011 LIEN		, ,	TE, ZII GODE	
GOLDEN	CARE		UTH NC 41		
COLDEN	o,	WALLAC	E, NC 28466		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	· - /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D935	Continued From page		D935		
D933	Continued From page	÷ 411	D933		
	-She checked with the	e facility's Manager about			
	the personnel files.	,			
	-The Manager could r	not find any more			
	information for the pe				
	-	sponsible for the personnel			
		all staff met qualifications			
	•	all stall filet qualifications			
	and requirements.	an an madical lague for			
		een on medical leave for			
	about 2 months and v	vas unavallable for			
	interview.				
		sponsibility of the personnel			
	_	er had not been available.			
	-There was no system				
	Manager or to monito	r the personnel files.			
	Interview with the Adr	ministrator on 10/17/17 at			
	2:00 p.m. revealed:				
	-She had been in con	tact with the pharmacy			
	about training, but co	uld not remember the date			
	she was given for trai	ning.			
	-She was told by the	pharmacy that the training			
	was offered on-line.	. ,			
		e on-line training, print off			
	the training for the sta	• .			
		follow-up with the check off.			
priarriacy stair would to		Tollow up with the offect on.			
	The facility failed to a	ssure 3 of 4 medication			
	aides, who were administering medications, including insulin, to all residents in the facility,				
	-	training and qualifications			
		stration. The facility's			
	failure to have qualifie				
		tions was detrimental to the			
		Ifare of the residents, which			
	constitutes a Type B	Violation.			
	Review of the facility's	s plan of protection dated			
	10/16/17 revealed:				
	-Administrator will be	responsible for medication			

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aide qualifications.

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DIVISION	n nealth Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			D 14/11/0	R-		
		HAL031003	B. WING		10/17/2	2017
NAME OF DE	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STA	TE ZID CODE		
NAIVIE OF FI	NOVIDER OR SUFFLIER			TIE, ZIF GODE		
GOLDEN (CARE	4002 SO	UTH NC 41			
00252.1	57 ti t =	WALLAC	E, NC 28466			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	HATE	DATE
				DEFICIENCY)		
D935	Continued From page	e 412	D935			
	Madiantian sides was	at base was sinced training				
		st have required training				
	•	ck offs before administering				
	medications.					
		schedule training class and				
	•	f to follow with 15 hour				
	training.					
	-	oleted online and hands on				
	, ,	nd each medication aide will				
		ete training by 10/27/17.				
		s to be scheduled following				
	completion of 15 hour	r class and annual training				
	required thereafter.					
	-Administrator will rev	riew files monthly for				
	required training.					
	-Medication aide qual	lifications will be completed				
	immediately for Staff	B, C, and E, as soon as RN				
	can schedule class.					
	-Documentation of me	edication aides passing				
	written exam will be n					
	CORRECTION DATE	FOR THE TYPE B				
	VIOLATION SHALL N	IOT EXCEED DECEMBER				
	1, 2017.					
	, -					
Doos	C C S 121D 45 (a) Ex	ramination and agreening	D992			
D332	G.S.9 131D-43 (a) Ex	camination and screening	D992			
	C C C 121D 45 Ever	mination and corooning for				
		mination and screening for				
		olled substances required				
	for applicants for emp	ployment in adult care				
	homes.					
	(-) A # -	and the same and the same of t				
		ment by an adult care home				
		ticle to an applicant is				
		oplicant's consent to an				
	examination and scre					
		mination and screening shall				
		rdance with Article 20 of				
		neral Statutes. A screening				
	procedure that utilizes	s a single-use test device				

Division of Health Service Regulation

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Division of	of Health Service Regu	lation			_	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMILE	LILD
			B. WING		R-C	
		HAL031003	B. WING		10/1	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE		UTH NC 41			
		WALLAC	DE, NC 28466		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D992	Continued From page	e 413	D992			
	may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.					
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	facility failed to assure for the presence of co	and record reviews, the e examination and screening ontrolled substances was for 4 of 5 staff (B, C, D, E) red after 10/01/13.				
	The findings are:					
		s personnel record revealed: 10/25/16 as a personal care tation of a controlled				

Division of Health Service Regulation

substance screening in Staff B's personnel file

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		HAL031003	B. WING		10/17/2017	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
GOLDEN	CARE	4002 SOI	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D992	Continued From page	e 414	D992			
	that was done on 05/09/16 by another place of employment. -There was no documentation of a controlled substance screening prior to hire. Interview with Staff B on 10/17/17 at 5:20 p.m. revealed: -She was hired before August 2016. -She started performing medication aide duties on 10/09/17. -She had not taken a drug screening and had never been asked to take one by the facility.					
	Refer to interviews wi 10/16/17 at 8:40 a.m.	th the Administrator on and 9:31 a.m.				
	Review of Staff C's personnel record revealed: There was no documentation of Staff C's hire date.					
	-Staff C was rehired.					
	-She was hired as a personal care aide (PCA)There was no documentation of a controlled substance screening prior to hire.					
	Telephone interview with Staff C on 10/16/17 at 2:40 p.m. revealed:					
	-She was first hired at the facility in August 2016She had left and came back as a rehire twiceShe was last rehired on 09/01/17.					
		ering medications again ptember 2017 after she was				
	-She used drug scree place of employment remember the date of -She had not been as	ening results from another to get rehired, but did not f the drug screening. eked to submit to a drug				
	screening. Based on interviews a	and record reviews, there				

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were allegations of drug diversion against Staff C.

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	of Health Service Regu				1	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	JI GORNEG HON	IDENTIFICATION NUMBER:	A. BUILDING: _		COWIFLETED	
					R-C	
		HAL031003	B. WING		I	7/2017
		TIALUUTUUU			10/1	772017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		4002 SOL	JTH NC 41			
GOLDEN	CARE	WALLAC	E, NC 28466			
(V4) ID	QUMMARV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(V5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D992	Continued From page	. 415	D992			
D332	Continued From page	5 4 15	D332			
	[Refer to findings und	ler Tag D438 10A NCAC 13F				
	.1205 Health Care Pe					
		0 , 1				
	Refer to interview wit	h the Administrator on				
	10/16/17 at 8:40 a.m.	and 9:31 a.m.				
	3. Review of Staff D's	s personnel record revealed:				
		nentation of Staff D's hire				
	date.					
		a personal care aide (PCA).				
		of a drug screening dated				
		tained while she was taking				
	classes at the local co					
		nentation of a controlled				
	substance screening					
		prior to rimor				
	Interview with Staff D	on 10/17/17 at 8:55 a.m.				
	revealed:	o				
		at the facility in May 2017.				
	-She was hired as a F					
		rug screening since being				
	employed at the facili					
		eening that she had taken				
		de course through the local				
	community college to	<u> </u>				
		goromprojean				
	Interview with the Administrator on 10/16/17 at					
		taff D was hired on 05/01/17				
	as a personal care ai					
	Refer to interview wit	h the Administrator on				
	10/16/17 at 8:40 a.m.					
	4. Review of Staff F's	s personnel record revealed:				
	-Staff E was hired on					
		Medication Aide (MA) and				
	Supervisor.	nosioadori ido (mirt) aria				
	•	tation that a controlled				
		had been completed on				
		nrough her primary care				
	J(a E U 11/11/15 (f	irough her philially care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
GOLDEN	CARE	4002 SOI	JTH NC 41		
OOLDLIN	OAIL	WALLAC	E, NC 28466		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D992	Continued From page	416	D992		
5002	provider (PCP)Staff E was positive for the explaining the positive for the explaining for the exp	for opiates. nentation from the PCP results from 11/11/15. nentation of a controlled prior to hire on 04/04/17. ministrator on 10/16/17 at Staff E had a positive			
	revealed: -She had been emplo 2017She was a MA and S-She was aware of the She "had the flu, if I dook medication with e-She had not been as hire to the facility but Refer to interview with 10/16/17 at 8:40 a.m. Interview with the Administration of the shear of the facility but the shear of the shear	e positive drug screening. can remember correctly and codeine". ked to take a drug test upon she was willing to do so.			
	the personnel filesThe Manager could r information for the pe -The Manager was re				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	A. BUILDING:		00 22.125		
		HAL031003	B. WING		R-C 10/17/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	·
		4002 SOU	TH NC 41		
GOLDEN	CARE	WALLACI	E, NC 28466		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D992	Continued From page	e 417	D992		
	and requirements.				
		een on medical leave for			
	about 2 months and v				
	interview.				
	-No one took over res	sponsibility of the personnel			
	files since the Manag	er was unavailable.			
	-There was no syster	m to check behind the			
	Manager or to monito	•			
		hat drug screenings had not			
	been done upon hire.				
		ing kit that she could start			
	using immediately for	drug screenings.			
	The facility failed to perform urine screenings for controlled substances upon hire for 4 staff who provided direct care to residents; 3 of the 4 staff were medication aides and administered medications including controlled substances to residents. One of the medication aides had a positive drug screen with no documentation provided by a physician explaining the reasoning for the positive screening. There were allegations of drug diversion against a second medication aide who did not have a controlled substance screening prior to hire. This failure was detrimental to the safety and welfare of the residents, which constitutes a Type B Violation.				
	10/16/17 revealed: -Administrator will be for controlled substar -Screening for contro completed on all emp-Any employee who controlled screening documentation by 10/20/17.	lled substances will be bloyees prior to hiring.			
		why they are receiving before beginning work			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4)ID PREFIX TAG COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 418 scheduleStaff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2017.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 418 scheduleStaff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER						₹- C	
GOLDEN CARE 4002 SOUTH NC 41 WALLACE, NC 28466 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 418 scheduleStaff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER			HAL031003	B. WING		10	/17/2017
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE	NAME OF P	ROVIDER OR SUPPLIER			, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	GOLDEN	CARE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D992 Continued From page 418 schedule. -Staff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	(VA) ID	SLIMMARY ST			PROVIDER'S PLAN O	E CORRECTION	(VE)
scheduleStaff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE
-Staff C will have urine test screening immediatelyStaff E's physician will be contacted immediately to get reason for positive drug screeningScreening for controlled substances will be completed before hire and randomly as indicatedAdministrator will audit all personnel files for drug screening to ensure screens are negativeAdministrator will monitor files monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D992	Continued From page	e 418	D992			
	D992	scheduleStaff C will have urin immediatelyStaff E's physician w to get reason for posi -Screening for contro completed before hire -Administrator will au screening to ensure s -Administrator will mode CORRECTION DATE VIOLATION SHALL N	e test screening fill be contacted immediately tive drug screening. Illed substances will be and randomly as indicated. dit all personnel files for drug screens are negative. Initial personnel files monthly.	D992			

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