STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: _____ B. WING _____	R-C 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on January 09, 2018 through January 12, 2018.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to maintain a clean living area free from unpleasant odors. The findings are: Observation of the entry of the facility on 01/9/18 at 9:30am revealed a strong urine odor was noted at the entry of the facility and on the men's and women's halls. Observations of the women's hall on 1/9/18 at 10:00am during the tour revealed: -There was a strong urine odor from the front of the women's hall to the end of the hall. -Both community bathrooms on the right and left side of the hall had a strong urine smell. -All resident rooms on the women's hall had a strong urine odor. Interview with a resident on 1/9/18 at 10:30 a.m.	D 075		

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D 075	Continued From page 1	D 075		

revealed:
-The smell in the facility had gotten worse in the last month.
-The personal care aides (PCAs) often left trash with wet incontinence briefs in the hall for long periods of time adding to the smell.

Interview with a second resident on 1/9/18 at 10:51 a.m. revealed:
-There was a urine smell in the building at times.
-If staff were too busy, they did not always change residents which made the smell in the building worse.

Interview with a housekeeper on 1/9/18 at 10:40am revealed:
-The resident rooms and bathrooms were cleaned every day and if the resident had a incontinent accident on the floor, the housekeepers cleaned it up.
-The hallways and rooms always had a bad odor because there were numerous residents in the facility who were incontinent.

Interview with a third resident on 1/9/18 at 10:59 a.m. revealed:
-There was always a urine smell in the hall.
-Some residents urinated in the hall and made the smell worse.

Interview with a fourth resident on 1/9/18 at 11:05am revealed:
-The housekeepers did not clean the floors and bathroom properly. They only emptied the trash and swept the floors if needed.
-There were multiple residents who could not control their bladder and bowels and urinated on the floors. The floors needed to be disinfected and cleaned good every day.
-The resident was in another resident's room

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visiting recently and there was feces on his bathroom floor. The resident asked the housekeeper to clean the floor, but when the resident left and came back later the same day, the feces remained on the floor.
-The resident kept the bedroom door closed in an attempt to keep from smelling of "poop and pee".

Observation of the hallways on 1/9/18 at 11:25am revealed a housekeeper spraying deodorizing spray down the women's hall.

Interview with another housekeeper on 1/9/18 at 11:30am revealed:
- She was spraying the hallway to attempt to decrease the odor.
-The aides were responsible for cleaning up urine and feces spills on the floors, but they did not always clean up after the residents, which caused an odor in the facility all of the time.

Interview with a 3rd housekeeper on 1/10/18 at 8:25 a.m. revealed:
-There was a strong smell of urine throughout the building.
-PCAs often changed residents and left the wet incontinent briefs in trash bags in the hallway.
-PCAs were supposed to take the trash out immediately but this rarely happened.
-PCAs were also supposed to empty residents' urinals but this happened infrequently due to staff being so busy.

Interview with a PCA on 1/10/18 at 8:00 a.m. revealed:
-Residents were not being bathed as they should because some of the staff did not follow shower schedules and that had added to the urine smell and odor in the building.
-Second shift PCAs often complained they were

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too busy and did not complete scheduled baths.
-The smell had worsened in the last month.

Interview with 4 staff on 1/10/18 revealed:
-They were aware of the odors on the women's and men's hall.
-The odor had been getting worse for a few months.
-The housekeepers were not cleaning the residents' rooms or the bathrooms daily.
-Some of the residents complained about the odor at times.

Interview with the housekeeper supervisor on 1/10/18 at 11:20am revealed:
-She had been working at the facility for 1 and ½ years.
-Housekeeping staff worked from 7:00am until 3:00pm and an extra housekeeper worked from 9:00am until 5:00pm.
-One housekeeper was scheduled for the men's hall, 1 housekeeper was scheduled for the women's hall and 1 housekeeper for the for the memory care unit.
-The housekeepers' daily responsibilities were dusting, emptying trash and sweeping/mopping in the common areas; cleaning the showers, sinks, toilets, mirrors, and floors in the common bathrooms; emptying trash, sweeping, disinfecting the bathrooms and replacing toilet paper in the residents' rooms.
-The housekeepers were responsible for deep cleaning a different resident room every day, which included moving furniture, sweeping, mopping, cleaning window, walls and blinds, cleaning and disinfecting the residents' bathrooms.
-The aides were responsible for changing bed linens.
-There was not a check list or sign off sheet for

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the housekeepers to document their tasks.
-Many of the residents' rooms had a continuous strong odor of urine, especially rooms at the end of the hallway on the assisted living unit.
-The facility may have to change cleaning products to get rid of the odors.
-She may have to check on housekeeping more often to assure they are performing their duties.
-Usually she did not check on the housekeepers as they performed their daily duties.

Interview with a family member on 1/11/18 at 10:50am revealed:
-When the family member visited the facility, there was always a strong smell of old urine in the hallways.
-The resident's room had a strong smell of old urine and needed a good cleaning. If someone was incontinent and bed linens and the floor was not kept clean daily, the room would smell.

Observations on 1/9/18 revealed:
-At 10:04am, there was a full urinal on a Resident's nightstand beside a nebulizer machine. There was a strong odor of urine in Resident's room.
-At 12:36pm, a full urinal remained on a Resident's nightstand beside a nebulizer machine. There continued to be a strong odor of urine in Resident room.
At 3:02pm, a full urinal remained on a Resident nightstand beside a nebulizer machine. There continued to be a strong odor of urine in Resident room.

Interview with a PCA on 1/10/18 at 9:33am revealed the odor in the halls has been worst since the pipes burst and water came in.

Observation of a residents room on 1/10/18 at

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D 075	Continued From page 5 3:45pm revealed: -There was urine on Resident floor in front of his bed and under his bed. -There was a strong odor of urine in Resident's room. Observation on 1/11/18 at 8:02am revealed: - There was a full urinal on Resident nightstand beside a nebulizer machine. -There was a strong odor of urine in a Resident's room. Interview with a PCA on special care unit on 1/11/18 at 10:23am revealed the smell is due to lack of care for the residents. Interview with the Executive Director on 1/12/18 at 10:00am revealed: -The housekeepers should be cleaning the resident bedrooms, the bathrooms every day which included sweeping, mopping, dusting, disinfecting the toilets, cleaning up urine and feces spills. -The PCAs should provide incontinent care to all residents who needed it, and should never delay care. -The PCAs should change the resident's bed linens if soiled and remove soiled linen and incontinent briefs from the rooms/hallways as soon as they are finished. -She was aware the odor in the hallway had gotten worse and was considering changing cleaning products. _____ The facility failed to assure the hallways on the assisted living unit were free of unpleasant odors, that spread through the entire assisted living unit, resulting in residents being subjected to	D 075		

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D 075	Continued From page 6 unpleasant odors within the facility and keeping their room door closed to avoid the offensive odors. This failure was detrimental to the welfare of the residents and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 2/2/18 revealed: -The Executive Director and/or housekeeping staff will walk the building daily to ensure there are no odors. -Housekeeping will continue to use products to make sure the facility is odor free. -The Executive Director or designee will monitor these processes. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2018	D 075		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings 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: TYPE B VIOLATION Based on observations and interviews, the facility failed to maintain a supply of washcloths, towels,	D 080		

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D 080	Continued From page 7 and bed linens for residents to use at all times. The findings are: Observation of the laundry closet on 1/11/18 at 10:46 a.m. revealed there were no washcloths or towels in the closet. Interview with the Laundry Attendant on 1/11/18 at 10:50 a.m. revealed: -There were about four towels in the laundry to wash. -There were no washcloths in the laundry to wash. -She had seen some washcloths being thrown away due to being soiled. -The Administrator ordered a large shipment of about 80-100 washcloths and towels about three weeks ago. -After about one week, the washcloths disappeared. -The Administrator placed a new order this week for washcloths and towels. -She was not sure if residents took the washcloths and towels. -Staff would search residents' rooms when they needed washcloths and towels for baths. -When staff located washcloths and towels in residents' rooms they would bring them to the Laundry Attendant to wash. Interview with Personal Care Aide (PCA) on special care unit on 1/11/18 at 11:09 revealed: -The PCA was unable to give baths because there were not enough towels and bath cloths. -She found only one bath cloth and zero towels on 1/11/18. Interview with another PCA on 1/11/18 at 11:51am revealed:	D 080		

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D 080	Continued From page 8 -The bath cloths and towels went missing. -"I don't know where the cloths and towels go, I have three baths to give today and found one towel." Interview with a third PCA on 1/12/18 at 3:50 p.m. revealed: -There were no washcloths or towels in the facility. -The Administrator ordered washcloths and towels but they always disappeared. -If she went through several residents' rooms she could likely find about two towels. -She was scheduled to do five showers that afternoon. Interview with a Medication Aide (MA) on 1/12/18 at 3:56 p.m. revealed: -There was an ongoing issue with having no washcloths and towels at the facility. -She was not sure what the PCAs did if there were no towels and washcloths available. Observation of a resident on 1/9/18 at 10:04am revealed the resident was lying on a green mattress without sheets. Observation of a resident on 1/10/18 at 8:10am revealed the resident was lying on a bed without sheets. Interview with a PCA on 1/10/18 at 9:33am revealed: -The PCAs were supposed to change the linen. - "He has gone through 3 shifts without sheets". -Linens were changed on the residents shower days and if soiled. Observation of the same resident 1/10/18 at 3:45pm revealed the resident was lying on a bed	D 080		

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D 080	Continued From page 9 without sheets. Interview with the Resident Care Coordinator (RCC) in training on 1/10/18 at 4:02pm revealed: -There resident did not like sheets on his bed. -He fussed at staff for putting sheets on the bed. -His bed was made, but he often rolled around and the sheets came off. Observation on 1/11/18 at 8:02am revealed the resident was lying on the bed without sheets. Second interview with the PCA on 1/11/18 at 8:59am revealed: -"We put sheets on the resident's bed." -"He has never fussed at me about putting sheets on the bed." -"I don't know why he doesn't have sheets on his bed." Interview with the resident on 1/11/18 at 9:15am revealed: -Every time staff put the sheets on the bed, the sheets slide off. -"I want sheets on my bed." Interview with the resident's family member on 1/12/18 at 12:50pm revealed: -Two weeks ago he did not have sheets on the bed during visit. -She did not speak to staff about sheets not being on the bed. Observation on 1/12/18 at 9:00am revealed the resident was lying on the bed with sheets on the bed. _____ The facility failed to assure a supply of clean towels, washcloths and sheets for resident use at	D 080		

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D 080	Continued From page 10 all times, resulting in residents not being bathed, placing them at risk for body odors and possibly skin breakdown and infection. This failure was detrimental to the welfare of the residents and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 2/5/18 revealed: -Towels and washcloths have been ordered on a monthly basis. -The Executive Director (ED) will continue to order towels ans washcloths monthly. -Care staff will be in-serviced by the ED and Resident Care Coordinator to notify management there are not sufficient towels and washcloths on hand. -The ED or designee will monitor the qualities of towels and washcloths weekly to ensure we have what we need. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2018	D 080		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by:	D 269		

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D 269	Continued From page 11 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide incontinent care, scheduled showers, and nail care for 3 of 10 sampled residents (#8, #9 and #10) including Residents #8 and #10 not recieving showers and incontinent care; Resident #10, and Resident #9 not recieving showers and nail care. The findings are: Interview with a resident on 1/9/18 at 10:20 a.m. revealed: -He had waited over an hour for staff to respond to his call bell. -This last happened about a month ago. -He was more likely to wait longer for assistance on second shift. -Last night he needed assistance to get to the bathroom but no personal care aide responded. -He requested assistance at 5:24 p.m. and it was 6:02 before the Medication Aide responded. -He was then taken to the bathroom. Interview with a second resident on 1/19/18 at 10:30 a.m. revealed: -Certain staff persons would ignore residents when they needed things. -This happened more on the second shift. -The third shift staff were least likely to assist residents. -If the resident pressed his call bell, staff might respond in five to ten minutes. -At other times, he would wait 30 to 45 minutes for staff to respond. Interview with a third resident on 1/9/18 at 10:59 a.m. revealed: -Staff get to residents "whenever they want to."	D 269		

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D 269	Continued From page 12 -The staff were usually pretty nice but had no sense of urgency. Interview with two residents on 1/9/18 at 11:07 a.m. revealed they did not call the staff because they were always busy. 1. Review of Resident #8's FL-2 dated 12/8/17 revealed diagnoses included abnormal gait and mobility, idiopathic gout of right wrist, muscle weakness, and atrial fibrillation. Review of the Resident Register revealed Resident #8 was admitted on 12/29/17. Review of Resident #8's care plan dated 1/9/17 revealed: -The resident required extensive assistance with showers and sponge baths and showers were scheduled 3 times a week on Monday, Wednesday and Friday. -The resident was incontinent of bladder and bowels and required assistance with toileting (transfer to toilet, remove and pull up pants, and hygiene after toileting). Interview with Resident #8 on 01/09/18 at 10:30am revealed: -The resident transferred herself from bed to her wheelchair without assistance, but needed assistance with incontinent care. The resident was incontinent of bladder and bowel at times. -Even though Resident #8 could transfer to the commode, she required assistance with changing incontinent briefs and cleaning perineal area of feces or urine. -When the resident pulled the call light or asked nursing staff to change her briefs, the staff always "make me wait". -At times, the resident had to wait in bed with a	D 269		

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dirty brief on for more than 2 hours.
-The resident pulled the soaked brief off, at times, when in bed to keep from lying in bed with a soaked/dirty brief on. Urine and feces would get on the sheets/blanket.
-The resident had been living at the facility since 12/29/17 and received her 1st bath on 01/8/18 after a family member had visited and asked the staff to give her a shower.
-The resident was supposed to receive a shower 3 times a week.
-The staff was not providing incontinent care in a timely manner or providing assistance with bathing, which caused the room to have a foul smell of urine and feces.
-The resident took a diuretic which made the resident urinate more frequently. "My brief is soaked now and I have been trying to get someone in here to change it."

Interview with Resident #8's family member on 01/11/18 at 10:50am revealed:
-The family member visited the resident on 01/08/18.
-The resident informed the family member she had not showered since admission to the facility.
-Since the resident was incontinent, her complaint was "legitimate" because the resident and her room had a foul odor.
-The family member informed the facility's "director" (did not know her name) and the resident was assisted with a shower the same day.
-Since Resident #8 was incontinent and could not clean herself, the staff should have made sure she was kept clean and dry.

Interview with another resident on 01/09/18 at 10:40am revealed:
-Residents received showers 3 times a week, but

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D 269	Continued From page 14 Resident #8 did not shower until 1/08/18. -The staff always waited a long time to answer the call light when she needed help changing her brief. -The staff would turn the call light off and tell her they would be back later. They would come back over an hour later. Interview with a 2nd resident on 01/09/18 at 11:05am revealed: -The resident had lived at the facility over 3 years and sometimes required assistance with personal care, such as dressing. -Sometimes, if the resident turned on the call light, the staff who came to the room and turned off the call light and did not follow-up. If the call light was turned on again, the staff just ignored it and did not answer the light. -The residents were supposed to receive showers 3 times a week, but when she or other residents asked the staff to assist them with showers, the staff would ignore the residents. -There have been repeated times the resident turned on the call light for assistance and it took so long for a staff to answer, the resident forgot what was needed. Interview with a personal care aide (PCA) on 01/11/18 at 11:10am revealed: -The PCA worked on the women's hall and provided assistance with Resident #8's personal care. -Resident #8 required assistance with showers, dressing, changing her incontinent briefs and cleaning her bottom after incontinent episode. -The PCA checked residents who were incontinent or required assistance to the bathroom every 2 hours. -Resident #8 was incontinent and "used the bathroom" in her bed.	D 269		

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D 269	Continued From page 15 -Sometimes the resident removed her incontinent briefs if the briefs were wet with urine and would wet the bed and call for staff to provide incontinent care. -The resident complained about staff taking a long time answering the call light and leaving her in urine and stool. -The PCA was not sure when the resident was scheduled for showers. Interview with a medication aide (MA) on 01/10/18 at 3:43pn revealed: -Resident #8 required assistance with showers and her showers were scheduled 3 times a week on evenings (2nd shift). -The resident was incontinent. The staff checked on her every 2 hours and provided incontinent care. - The staff checked her every 2 hours and -The resident called staff a lot and turned her call light on several times during 2nd shift. The PCAs were busy and had to provide care for other residents. Resident #8 would become upset when she had to wait. Interview with another PCA on 01/10/17 at 4:00pm revealed: -The PCA checked on Resident #8 every 2 hours and changed her incontinent brief if needed. -The resident was scheduled for showers 3 times a week. The resident was assisted with her shower and getting dressed. -The PCA did not know which days the resident was scheduled for showers or the last date the resident received a shower. -The resident called the PCAs almost constantly some evenings and had her call light on. -The staff could not always answer her call light immediately because they were busy with other residents.	D 269		

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D 269	Continued From page 16 Interview with the Resident Care Coordinator (RCC) on 01/12/18 at 10:00am revealed: -The PCAs should follow the bath schedule for all residents who received showers unless the resident refused and the resident should receive a sink bath or bed bath. -The RCC was not aware Resident #8 had not received a bath before 01/08/18. Interview with the Executive Director on 1/12/18 at 10:00am revealed: -Staff were expected to answer all call lights immediately and to provide incontinent care if needed. -If the staff was providing care for another resident, then another staff should follow-up with providing incontinent care. -A resident should never have to wait 30 minutes to an hour for staff to respond to a call light or provide assistance with incontinent care. Interview with Resident #8 on 01/12/18 at 2:15pm revealed the staff were checking on her more often and changing her brief. 2. Review of Resident #10's FL-2 dated 6/30/17 revealed diagnoses included muscle weakness, left-sided hemiplegia and hemiparesis following cerebral vascular accident, type 2 diabetes, hypertension. Review of Resident #10's Resident Register revealed the resident was admitted to the facility on 6/30/17. Review of Resident #10's Care plan dated 9/04/17 revealed: -The resident was incontinent of bladder and required assistance with transferring to the toilet.	D 269		

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D 269	Continued From page 17 -The resident required assistance with removing and pulling up garments and hygiene after toileting. Observation of Resident #10 on 1/11/18 at 9:00am revealed: -Resident #10 was sitting in her room in her electric wheelchair. -A foul smell of feces was in the hallway and in the resident room. -The resident was sitting near the edge of the wheelchair with her pants and briefs pulled down near her knees. -Stool was on the resident's buttocks and on the resident's chair seat. Interview with Resident #10 on 1/11/18 at 9:00am revealed: -The resident had been waiting for staff to assist her for 20 minutes. -The resident tried to take her pants off to use the bathroom, but could not get her pants off. -The resident had turned the call light on, but a staff (the resident did not know the staff's name) had come in the room and turned the light off without assisting her and did not return. -This happened all the time and the resident had to wait all the time for the staff to answer the call light, usually more than 30 minutes. -The resident turned the call light back on at 9:05am and at 9:20am, staff had not responded to the call light. -The resident had not reported her concerns to the Resident Care Coordinator (RCC) or Administrator but talked to other staff. Observation from Resident #10's room door at 9:20am on 1/11/18 revealed: -Two staff members were standing in the hallway near the medication cart.	D 269		

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D 269	Continued From page 18 -At 9:25am, staff was informed that Resident #10 had a bowel movement and needed assistance with incontinent care. -A PCA responded to the call light at that time. Interview with a PCA on 1/12/17 at 11:00am revealed: -Resident #10 required total care and usually used the call light to let the staff know if she needed to go to the bathroom. -The resident was paralyzed on the left side and could not walk or transfer without assistance. -The PCA usually checked on the resident every 2 hours and at times it took longer to answer the call light because the staff was busy with other residents. -Resident #10 complained that staff took a long time to answer the call light. -She did not know if the resident talked to the Administrator or RCC about her complaint. Interview with the RCC on 1/12/18 at 10:00am revealed: -She was not aware Resident #10 had to wait for long periods for staff to assist her to the bathroom. -Staff was expected to answer call lights immediately or as soon as they can and not just turn the light off. 3. Review of Resident #9's current FL-2 dated 10/25/17 revealed: -Diagnoses included cough, shortness of breath, asthma, chronic obstructive pulmonary disease, congestive heart failure, arthritis, gout, and pancreatitis. -Resident #9 was nonambulatory. -Resident #9 was continent of bowel and bladder. -Resident #9 required assistance with bathing	D 269		

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D 269	Continued From page 19 and dressing. Review of the Resident Register for Resident #9 revealed: -He was admitted to the facility on 10/17/16. -He required assistance with ambulation, bathing, grooming, and toileting. Review of Resident #9's care plan dated 10/10/17 revealed: -Resident #9 often resisted care and did not like to bathe. -He required numerous prompts to shower and could become agitated. -Resident #9 had a limited range of motion with his upper body. -He required extensive assistance with bathing and dressing. -He required supervision when toileting. Observation of Resident #9 on 1/9/18 at 10:37 a.m. revealed: -Resident #9 was asleep in bed. -His white pillows were brown in color on areas where the resident was laying. -There was a body odor coming from the resident. -Resident #9's foot was sticking out from under the cover exposing his socks with multiple holes and long toenails. Interview with a PCA on 1/9/18 at 10:39 a.m. revealed the resident slept a lot and probably had not been up for the day yet. Interview with a second PCA on 1/11/18 at 11:07 a.m. revealed: -She mostly assisted Resident #9 by emptying his urinal. -He was supposed to get a bath on second shift.	D 269		

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D 269	Continued From page 20 -Resident #9 often refused showers. Interview with a third PCA on 1/11/18 at 11:30 a.m. revealed: -Resident #9 was very independent. -He did not like anyone to assist him. -If he was offered a shower, the resident often refused. -Resident #9 often wore his clothing for a week or more at a time. -He mostly used his urinal. -She had not witnessed the resident attempting to get into the bathroom. -Staff had to get the resident out of the bed to change his sheets. -Resident #9 usually would go to the dining room for meals. Interview with a fourth PCA on 1/11/18 at 3:50 p.m. revealed: -Staff tried to assist Resident #9 but he refused to bathe. -She would try several more times if the resident refused. -PCAs were supposed to report the refusal of personal care to the Medication Aide to document. -She had not seen the resident's toenails. Interview with a Medication Aide on 1/11/18 at 3:56 p.m. revealed: -She had assisted Resident #9 with bathing and also with nail care. -Resident #9 would take showers. -She had never witnessed Resident #9 refuse a shower. -She saw Resident #9's toenails about a month ago and they "looked bad." Interview with Resident #9 on 1/11/18 at 2:05	D 269		

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p.m. revealed:
-He had not taken a bath since last week.
-He did not recall the day.
-He was supposed to bathe Monday, Wednesday, and Friday.
-He had not taken a bath on Monday and Wednesday but did not know why.
-He planned to take a shower tomorrow.
-He could not remember the last time his sheets were changed.
-He did not think they were changed last week despite having a bath last week.
-Staff changed his sheets when necessary.
-His toenails were "pretty long" and staff usually cut them.
- He believed it had been about two to three weeks since his toenails were last cut.

Observation of Resident #9 on 1/11/18 at 2:05 p.m. revealed:
-The resident was wearing the same clothing as he was wearing on 1/9/18 at 10:37 a.m.
-There was a body odor on Resident #9.
-The resident's pillows were brown in color.
-The resident was covered in a geen blanket noted on the bed on 1/9/18 at 10:37 a.m.

There was no documentation of Resident #9's personal care records related to bathing provided prior to the end of the survey.

Interview with the primary care physician (PCP) on 1/12/18 at 12:00 p.m. revealed:
-Resident #9 was independent.
-Resident #9 liked to be in control of his environment and liked things a certain way.
-The PCP had not received any notification of Resident #9 refusing personal care or showers.
-The PCP had not seen the resident's toenails.
-Resident #9 should have been seeing the

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D 269	Continued From page 22 podiatrist at the facility at least every three months. The facility's failure to provide incontinent care for Resident #8, who was not showered as scheduled and was left in urine soaked briefs and feces for extended periods, Resident # 10, who was left sitting in feces for extended periods, and Resident #9, who was not showered placed the residents at risk for skin breakdown and infection. This noncompliance was detrimental to the health and well-being of residents and constitutes a Type B Violation. Review of the facility's Plan of Protection dated 01/11/18 revealed: -All needed supplies and linens will be ordered today on 01/11/18. -Body assessments will be completed at every resident shower and followed up by the Resident Care Coordinator and Special Care Coordinator. -The Resident Care Coordinator and Special Care Coordinator will monitor showers daily beginning 01/12/18 to ensure completed as schedule. -Inservices for all staff will begin today about showers, body assessments, and prompt response to call lights and residents concerns. -The Executive Director, Resident Care Coordinator, and Special Care Unit coordinator will be responsible for conducting daily rounds and random body audits to ensure ongoing compliance with above process starting 01/12/18. -The Executive Director will ensure resident council meetings are held monthly and follow up with all identified concerns.	D 269		

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D 269	Continued From page 23 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2018	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the current care plan and impliment effective interventions for 1 of 2 sampled residents (Resident #1) who sustained 9 falls from July 2017 through December 2017 and had multiple injuries. The findings are: Review of the facility's Falls Policy revealed: -Each resident is to get a falls risk assessment tool completed after each fall. -Staff are to complete an incident report in its entirety for any fall. -Staff are required to do a 72 hour follow upon each resident that falls to investigate circumstances contributing to falls. -If a resident has 2 or more falls in a 4 week period then a Physical Therapy evaluation or other treatment intervention should be done.	D 270		

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Review of Resident #1's current FL-2 dated 01/02/18 revealed diagnoses included pneumonia, chronic pain syndrome, difficulty walking, depressive disorder, tobacco abuse, stomach function disorder, dementia, congenital hydrocephalus.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/01/06.

Review of Resident #1's current care plan dated 07/19/17 revealed:
-Resident #1 was only ambulatory with the use of an assistive device or aide.
-Resident #1 required supervision and assistance with ambulation.

Observation of Resident #1 on 01/09/18 at 10:30 AM revealed:
-The resident was sitting in a chair in the media room and had a blue cast on his right arm.
-The resident had a wheelchair sitting beside him.

Attempted interview with Resident #1 on 01/09/18 at 12:50 PM revealed the resident was not interviewable.

Review of an accident report dated 07/17/17 at 12:00 PM revealed:
-Resident #1 was found on the floor on his back in the dining room.
-Resident #1 did not have any injuries present at time he was found.
-Resident #1 was sent to the Emergency Room to be evaluated.

Review of the hospital discharge notes dated 07/17/17 revealed:
-Resident #1 was seen in the emergency room

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for a fall and sustained a closed head injury.
-Resident #1 was discharged back to the facility with instructions about fall prevention and to follow-up with primary care provider as needed.

Review of the facility care notes dated 07/17/17 revealed Resident #1 fell in the dining room and was sent to the emergency room for evaluation.

Review of an accident report dated 07/18/17 at 3:51 PM revealed:
-Resident #1 was found lying on his back in the hallway near the dining room.
-Resident #1 was complaining of left arm pain around the elbow area.
-Resident #1 was sent to the Emergency Room to be evaluated.

Review of the hospital discharge notes dated 07/21/18 revealed:
-Resident #1 was admitted to the hospital on 07/18/18 post sustaining a fall and left humeral fracture (left upper arm fracture) at the facility.
-Resident #1 had two back to back falls while at the facility.
-The first one he fell and was able to get up and fell a second time landing on his left side and complained of elbow pain and was brought to the emergency department for evaluation.

Review of the facility care note dated 10/13/17 revealed there was a note for 11:32 AM documented late entry from 09/20/17 and Resident #1 returned from rehab at this time.

Review of an accident report dated 10/13/17 at 6:00 PM revealed:
-Resident #1 was found on the floor in the dining room.

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-No injuries were present at time of fall.
-Resident #1 was not sent to the Emergency Room to be evaluated.

Review of the facility care note dated 10/13/17 revealed:
-There was a note at 11:36 AM documented Resident #1 fell in the bathroom after his bath and primary care physician was made aware and wanted Resident #1 to be seen by Orthopedics doctor rather than going to the hospital.
-There was a note at 11:40 AM documented Resident #1 returned from Orthopedics physician with new orders to wear sling at all times due to repeated fracture.

Review of an Orthopedics physician note dated 10/17/17 revealed Resident #1 had a follow-up appointment with primary care physician for post fall and re-fracture of proximal left humorous.

Review of the falls management assessment tool dated 10/13/17 revealed:
-Staff were instructed to encourage and remind Resident #1 to wait for help.
-Resident #1 was recently discharged from Physical Therapy services due to primary physician's orders.

Review of an accident report dated 10/16/17 at 3:18 PM revealed:
-Resident #1 was found on the floor in his bedroom near the bathroom door.
-No injuries were present at time of fall.
-Resident #1 was not sent to the Emergency Room to be evaluated.

Review of an accident report dated 10/19/17 at 6:50 AM revealed:

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-Resident #1 was found on the floor in his bedroom near the bathroom door on his right side.
-No injuries were present at time of fall.
-Resident #1 was not sent to the Emergency Room to be evaluated.

Review of the falls management assessment tool dated 10/19/17 revealed staff were instructed to continue to remind Resident #1 to wait for help.

Review of an accident report dated 10/20/17 at 10:40 AM revealed:
-Resident #1 was found on the floor on his buttocks in front of his wheelchair.
-Resident #1 has some swelling and a scratch on the front of his head.
-The staff cleaned the scratch with normal saline and applied triple antibiotic ointment and a bandage.
-Emergency Medical Services were called and Resident #1's Power of Attorney refused transit to the Emergency Room.

Review of the facility care notes dated 10/20/17 at 12:08 PM revealed:
-Resident #1 was found on the floor and had some swelling above his right eye.
-The facility attempted to send Resident #1 to the emergency room for evaluation but the Power of Attorney refused the transport.

Review of the falls management assessment tool dated 10/20/17 revealed staff were instructed to continue to remind Resident #1 to wait for help.

Review of an accident report dated 11/05/17 at 9:15 PM revealed:
-Resident #1 was trying to get out of his wheelchair and fell and hit his head on the

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bathroom door.
-Resident #1 has some bruising noted but the report did not specify where the bruising was located.
-Resident #1 was not sent to the Emergency Room to be evaluated.

Review of the facility care notes dated 11/05/17 at 9:41 AM revealed:
-Resident #1 was found on the floor and a small bump on the back of his head.
-The facility called emergency medical transport and the Power of Attorney.
-The Power of Attorney refused to allow Resident #1 go out to the emergency room for evaluation.

Review of the falls management assessment tool dated 11/05/17 revealed:
-Staff were instructed to continue to remind Resident #1 to wait for help.
-Staff were instructed to increase monitoring of Resident #1.

Review of an accident report dated 12/13/17 at 7:30 AM revealed:
-Resident #1 was found on the floor of his bedroom.
-Resident #1 did not have any injuries present at time he was found.
-Resident #1 was not sent to the Emergency Room to be evaluated.

Review of a Physician's order dated 12/14/17 revealed:
-There was an order for Physical Therapy to evaluate and treat.
-Resident #1 could have weight bearing and range of motion as tolerated.

Review of an accident report dated 12/20/17 at

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D 270	Continued From page 29 8:15 PM revealed: -Resident #1 was found on the floor of another resident's bedroom. -Resident #1 had some bruising and swelling on his left hand. -Resident #1 was sent to the Emergency Room to be evaluated. -Resident #1 returned to the facility with a closed fracture to the fifth metacarpal on his left hand. Review of hospital discharge paperwork dated 12/20/17 revealed: -Resident #1 was seen in the emergency room for a fall and closed fracture of the phalanx digit of his left hand and a non displaced fracture of the fifth metacarpal bone of his left hand. -Resident #1 was discharged back to the facility with new pain medications and a follow up appointment with the Orthopedics Physician. Interview with Resident #1's Power of Attorney on 01/09/18 at 3:00 PM revealed: -Resident #1 fell in July of 2017 and received his first shoulder fracture. -Resident #1 was then put in rehab for about 2 months. -Resident #1 returned to the facility sometime in September 2017 but she was not sure of the exact date. -Shortly after his return, he sustained another fall and fractured the same shoulder again. -She was not sure when exactly after he returned that happened. -Resident #1 has had multiple falls since returning in September 2017, around 6-8 falls since his return to the facility after his rehab stay. -Resident #1 fell again about 2-3 weeks ago and fractured his left hand in two places. -Resident #1 fell again on 12/30/17 and re-injured the fingers that he had fractured a few weeks	D 270		

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ago.
-Resident #1 had been declining gradually and now was unable to walk and required assistance from staff to take care of himself or be transferred.
-She did not feel the staff were providing the care that he needed.
-She felt he needed more one on one care than he was receiving from the facility.
-She felt she had to be at the facility all the time to keep an eye on him since he was having so many falls.
-Resident #1 recently had a hospice referral put into place and she was waiting to see what their decision would be.
-The facility had spoken to her about placing Resident #1 in the memory care unit but she could not afford to have him placed in that unit.
-Resident #1's primary care physician had spoken with her about Resident #1 needing a higher level of care.
-She was working on trying to find placement somewhere else for him that she could afford but would take care of him properly as well.

Interview with a Medication Aide on 01/10/18 at 8:05 AM revealed:
-Resident #1 fell about 4 months ago and fractured his shoulder, she was not sure of the exact day.
-Resident #1 was sent to rehab for a short time and then returned to the facility but she was not sure when.
-The staff increased his supervision by checking on him more frequently to keep a closer eye on him when he returned to help prevent falls.
-The checks started every hour and have increased to every 15 minutes, and now there is usually a staff member with him all the time.
-Resident #1 always tried to get up on his own

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and do things but he was too weak to walk.
-The last fall she remembered was about 2-3 weeks ago he fell and fractured his hand.
-The staff had to assist him in and out of the wheelchair since he cannot walk.
-Resident #1's family member was at the facility almost everyday spending time with him.
-Resident #1 had several falls since returning from rehab but she was not sure how many.

Interview with a second Medication Aide on 01/11/18 at 2:10 PM revealed:
-Resident #1 used to walk but had now declined to a wheelchair and still requires assistance to transfer.
-Resident #1 fell a few months ago and fractured his shoulder but he was not sure what day.
-Resident #1 had 4 falls since the shoulder fracture but he was not sure.
-Resident #1 was always trying to stand and walk on his own and that is what causes him to fall.
-The facility did place a chair alarm on him at one time but Resident #1 kept throwing it into the floor and the batteries would come out.
-Resident #1 still had the chair alarm on his chair and it was still being used.
-The staff had increased supervision by doing more frequent checks with Resident #1 to help prevent falls.
-A couple of months ago they stated placing Resident #1 on the Special Care Unit during the day to increase supervision.
-Resident #1 could leave the Special Care Unit whenever he wants and a staff member will go with him or his family will come and spend time with him.
-Resident #1 did requires assistance to get in and out of the wheelchair and bed.
-If Resident #1 had a fall then they assess him and call the physician and family.

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-If he had hit his head then he automatically went out to the emergency room to be evaluated unless the family refuses.
-The staff increased supervision and did a 72 hour follow-up where the monitor and assess the fall to see how to prevent further falls.
-More frequent checks started off at evey 1 hour then increased to every 15 minutes.

Attempted interview with the primary care physician on 01/11/18 at 2:45 PM was unsuccessful.

Interview with the Resident Care Coordinator on 01/11/18 at 2:24 PM revealed:
-Resident #1 fell in July 2017 and had a shoulder fracture.
-Resident #1 went to Rehab for a short stay and returned sometime in September 2017.
-Resident #1 fell again in October of 2017 and re-fractured his shoulder.
-When Resident #1 returned from rehab they placed him in a closer room to the office and medication room so staff would be closer to him.
-The staff increased checks and monitoring, she thinks they were checking on him every 30 minutes.
-There was a bed alarm placed on his bed a few months; ago she was not sure exactly when it was placed.
-The physician ordered a fall mat at one time but it was not working so they got it discontinued.
-The fall mat would cause the resident to slide when he would stand up on it.
-The primary care physician and family have been made aware about all of the falls.
-Resident #1 has had some physical therapy ordered and he had been evaluated when he had a fall around Ocotober after he had returned from rehab.

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D 270	Continued From page 33 -Resident #1 has had about 5-7 falls since October 2017 but she was not sure of the exact amount. Interview with the Administrator on 01/11/18 at 2:35 PM revealed: -Resident #1 fell sometime in July 2017 and had fracture of his shoulder. -She did not recall him having another fracture until he fell again in December 2017. -She felt he had about 8-10 falls since July 2017. -There was Physical Therapy ordered for the resident in October of 2017 due to falls. -There had been a bed alarm placed on his bed so staff would know when he was getting up out of bed. -Resident #1 had been moved to a different room in September 2017 so he was closer to the office and medication room so staff could monitor him better. -She had spoken with the Power of Attorney about placing him in the Special Care Unit but the Power of Attorney said she could not afford to place him there. -During the day they put Resident #1 in the Special Care Unit to help monitor him for falls. -Resident #1 had some falls since being placed on the Special Care Unit but the amount of falls had decreased. -Resident #1 can come out and leave the Special Care Unit anytime that he would like to and a staff member goes with him. -Resident #1 has had some falls since they have been putting him on the Special Care Unit but she was not sure how many. -She would be speaking with the Power of Attorney and the primary care physician about possible placement in a higher level of care for Resident #1.	D 270		

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D 270	Continued From page 34 The facility failed to assure the supervision of a resident (Resident #1) was being followed in accordance with the care plan and the needs of the resident implimenting effective interventions for the residents who has sustained 9 falls since July 2017 with multiple injuries. The facility's noncompliance placed the resident at risk for substantial harm or injury and constituted a Type A2 Violation. Review of the facility's Plan of Protection dated 01/10/18 revealed: -Fall risk assessments will be completed on all resident beginning 01/10/18. -All residents identified as high risk for falls will be added to the Falls Management Program and interventions implemented based on assessed needs. -All staff will be in-serviced/retrained about the Falls Management Program and the Executive Director will ensure this is done by 01/10/18. -The Executive Director will monitor interventions to ensure compliance and update as needed. -All falls will be discussed during morning stand-up meeting. -Falls Management meetings will be held monthly to discuss effectiveness and update interventions as needed, the Executive Director will ensure all of the above is implemented beginning 01/10/18. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 11, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 35 of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed, for 1 of 7 residents, to report an open leg wound to the health care provider and schedule diabetic nail care with a podiatrist for Resident #8. The findings are: Review of Resident #8's FL-2 dated 12/19/18 revealed diagnoses included pleural effusion, congestive heart failure, hypoxia, diabetes mellitus 2, morbid obesity, and hypertension. Review of the Resident Register revealed the resident was admitted to the facility on 2/07/17. a.Observation made on 1/10/18 at 3:30pm revealed: -There was an open wound on the front of the resident's left lower leg with a small amount of thick beige drainage. -The wound was the approximate size of a dime and had pink tissue around the edge. -There was not a dressing covering the wound. Interview with Resident #8 on 1/10/18 at 3:30pm revealed: - The wound has been on her leg for about 2 months. -The wound had been a problem for several years and would open up and it would heal when she was home. -No one at the facility provided treatment but staff was aware the wound was on her leg.	D 273		

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-The resident covered the wound with Vaseline to try to help it heal.
-The resident asked the medication aide (MA) for a band aid to cover the wound a few days ago, but the MA did not look at the wound.
-The resident's health care provider has not checked the wound.

Interview with a MA on 1/10/18 at 3:45pm revealed:
-She was aware of the wound on Resident #8's left leg.
-She observed the wound on the resident's left leg when a family member brought her back to the facility during Christmas (2017).
-The MA did not report the wound to the Resident Care Coordinator (RCC) or the resident's health care provider as expected, because the resident told the MA she wound take care of it herself.
-The MA did not know if anyone reported the wound to the health care provider.

Interview with the RCC in training on 1/10/18 at 4:00pm revealed:
-If staff observe any skin changes, including open wounds, staff should report to the MA, who reports changes to the resident's health care provider.
-The MA should document changes and report to the health care provider in the resident's record.

Observation on 1/10/18 at 4:00pm revealed:
-A personal care aide (PCA) placed a band aid over the wound on Resident #8's left leg.
-The RCC in training took the band aid off of the wound.
-The PCA stated the resident asked for a band aid and the MA give the PCA a band aid to place over the wound.

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Review of physician orders revealed no wound care orders for the wound on Resident #8's left leg.

Review of New Orders Notification/Clarifications revealed there was no documentation informing the resident's healthcare provider of the left leg wound.

Interview with the RCC on 1/12/17 at 9:40am revealed:
-She was not aware of the resident's left leg wound before 1/10/18.
-The wound should have been reported to the resident's health care provider by the MA.
-She talked to the resident's health care provider today and he will visit the resident and assess the wound next Tuesday (1/16/18).

Interview with Resident #8's health care provider on 1/12/18 at 11:45am revealed:
-The facility notified him of the wound on Resident #8's left leg on 1/11/18.
-He was not aware the resident had an open wound before 1/11/18.
-He visited residents at the facility every Tuesday, but last visit with Resident #8 was on 12/19/17 because she was complaining about neuropathy. The resident did not have any leg wounds.
-He planned to see the resident next Tuesday and will assess the wound and order wound care.

b. Observation of Resident #8 on 1/10/18 at 3:30pm revealed:
-Resident #8's toenails were long (over end of toes) on both feet.
-The resident was wearing bedroom shoes and only had her feet partially in the shoes.

Interview with Resident #8 on 1/10/18 at 3:30pm

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D 273	Continued From page 38 revealed: -She had seen a podiatrist only one time (about 10 months ago) since admission to the facility and had her toenails trimmed. -The resident could only wear bedroom shoes because if the inside of her regular shoes pushed against her long toenails, it would cause serve nerve pain which traveled up her legs. Interview with the RCC on 1/12/18 at 10:00am revealed: -The podiatrist has not visited the facility to do diabetic nail care since last February or March 2017. -The facility had a new podiatrist who will start making visits at the facility in January 2018. -Resident #8 will be seen by the new podiatrist. -She was not aware the residents toenails were long and painful. Interview with the Resident #8's primary health care provider on 1/12/18 at 11:45am revealed: -He was not aware Resident #8 had not been seen by a podiatrist in 10 months. -The facility was responsible for scheduling podiatry visits and he did not have anything to do with scheduling those visits. -Since the resident was diabetic, her nail care should be done every 2-3 months. _____ The facility failed to provide follow-up with Resident #8's health care providers for assessment and treatments of an open, draining leg wound and for diabetic nail care placed the resident at risk for infection and severe diabetic complications. This noncompliance was detrimental to the resident and constitutes a Type B violation. _____	D 273		

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D 273	Continued From page 39 Review of the facility's Plan of Protection dated 1/11/18 revealed: -There will be an audit for all resident records and will begin immediately on 01/12/18 to identify and issue requiring referal or follow-ups. -All identified issues will be followed up immediately and the Executive Director will be responsible for ensuring completion and ongoing compliance. -The Executive Director, Resident Care Coordinator, and Special Care Coordinator will conduct a minimum of 10% resident chart audits quarterly to ensure ongoing compliance beggining 01/12/18. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2018	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep 2 reach-in coolers, 2 freezers, kitchen floors, 2 food transport carts, the convection oven, the stove, and the ice machine clean and orderly. The findings are:	D 282		

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D 282	Continued From page 40 Observation of the hand washing sink on 1/9/18 at 2:00 p.m. revealed the basin of the sink was covered in a brown substance. Observation of the kitchen and pantry floor on 1/9/18 at 2:15 p.m. revealed the floor was sticky when walking on it. Interview with the Cook at 2:30 p.m. revealed the staff cleaned the floors two times daily. Observation of a food storage cart on 1/9/18 at 2:19 p.m. revealed: -There was dried white splatter on the second and third shelf. -There was stuck on dirt and brown grease stains on the side of the cart. Observation of the food transport carts on 1/9/18 at 2:20 p.m. revealed: -There were dried, brown liquid stains on the inside, back wall of the cart. -The sides of the cart were covered in white, dried splatter. Observation of reach-in freezer A on 1/9/18 at 2:23 p.m. revealed: -There was a 2x2 inch area at the bottom left of the freezer where the metal was sticking out. -There was a white, dried food substance on the door of the freezer to the right of the handle. -There was some rust on the bottom right of the freezer below the door. -There was a dried brown substance on the inside of the freezer bottom. -The gaskets of the freezer had dried brown and black stains. -There was a dried, brown substance on the sill of the door.	D 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 282	Continued From page 41 Observation of reach in freezer B on 1/9/18 at 2:25 p.m. revealed: -There was a loose handle on the door. -There was a dried, white splatter to the left of the door. -There was a dried, brown substance on the inside of the freezer bottom. Observation of the convection oven on 1/9/18 at 2:28 p.m. revealed: -There was stuck on brown grease on the front of the oven. -The glass of the doors was brown with grease stains. Observation of the stove on 1/9/18 at 2:29 p.m. revealed: -The stovetop had brown grease stains. -There was grease on the oven door. -The hood above the stove was covered in brown dust and yellow grease stains. -There were dried grease stains on the side of the range. Observation of the ice machine on 1/9/18 at 2:30 p.m. revealed: -There was a white, dried substance on the top and bottom of the machine. -There was a dried, brown substance on the right side of the machine. Observation of reach-in cooler A on 1/9/18 at 2:45 p.m. revealed: -The bottom grates of the cooler had dried, white stains. -There was a dent on the door of the cooler above the handles. -There were white food particles in the handles of the door. -There were dried, brown stains on the gaskets of	D 282		

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the door.
-There was a dried, white substance on the left side of the cooler door.

Observation of reach-in cooler B on 1/9/18 at 2:50 p.m. revealed:
-There were white smudges and a dried, brown splatter on the bottoms of both doors.
-The gaskets of the cooler had black and brown stains.
-There was a dried, brown substance in the bottom of the freezer on the inside.
-There were dried, black and white stains on the bottom of the cooler.
-There was a broken gasket on the left door of the cooler.

Observation of the undated weekly kitchen cleaning schedule on 1/9/18 at 2:15 p.m. revealed:
-Staff should clean under the dishwashing table.
-Staff should clean the coffee preparation area.
-Staff should clean the refrigerator and move it out from the wall and clean behind it.
-Staff should clean the ice machine monthly.

Interview with the Cook on 1/9/18 at 3:30 p.m. revealed:
-The freezers and coolers were cleaned when dirty and "once in a blue moon."
-She could not recall the last time the freezers and coolers were cleaned.

Interview with the dietary aide on 1/9/18 at 3:40 p.m. revealed:
-Staff washed dishes daily, took out the trash, stocked food, and mopped floors.
-Cooks wiped down the tables.
-Dietary aides cleared off the dishes.
-The Cook mopped the kitchen and dining room

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floor at night.
-Housekeeping mopped the kitchen and dining room floors in the morning.
-The stove should be cleaned weekly.
-Food transport carts should be cleaned at night and wiped down on the inside and outside.
-Food transport carts used to be taken outside and sprayed down with hot water, but this had not been done since the weather change.
-Freezers and coolers were cleaned at different times mostly when it appeared dirty.

Interview with the dietary aide and cook on 1/10/18 at 12:04 p.m. revealed:
-They did not have the proper supplies to scrub the oven and the other appliances in the kitchen.
-The Administrator had ordered more supplies.

Review of the new weekly cleaning schedule for 1/7/18 through 1/13/18 revealed:
-The inside and outside of the ovens should be cleaned.
-The freezers and the doors should be cleaned weekly.
-The refrigerator should be cleaned and pulled away from the wall and mopped.
-The grill and steam well area should be cleaned.

Interview with the Administrator on 1/11/18 at 9:25 a.m. revealed:
-She monitored the kitchen daily.
-The kitchen manager last worked at the facility last week but had since resigned.
-The Administrator posted the new cleaning schedule on 1/11/18.
-She posted it on the bulletin board in the kitchen.
-This schedule repeated weekly for the remainder of the month.
-She expected the vents above the stove to be wiped down daily.

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D 282	Continued From page 44 -The stove should be wiped down daily. -She was unsure if staff took the stove apart to clean it. -She expected the oven to be cleaned once weekly. -Floors should be mopped and swept twice daily at 2:00 p.m. and after dinner.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to provide three snacks daily by failing to provide an evening snack. The findings are: Interview with a resident on 1/9/18 at 10:10 a.m. revealed: -He got snacks two times daily at the facility. -He did not know exactly what times they were served. Interview with a second resident on 1/9/18 at 10:20 a.m. revealed: -Snacks were served two times daily. -He could not remember the specific times. Interview with a third resident on 1/9/18 at 10:30	D 298		

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a.m. revealed:
-Snacks were served twice daily.
-There was a morning and afternoon snack.

Interview with a fifth resident on 1/9/18 at 10:40 a.m. revealed he got snacks two times daily.

Interview with a sixth resident on 1/9/18 at 10:51 a.m. revealed snacks were served twice daily at 10:30 a.m. and 2:30 p.m.

Interview with a seventh resident on 1/9/18 at 10:56 a.m. revealed snacks were served at 10:00 a.m. and also in the afternoon.

Interview with two residents on 1/9/18 at 11:07 a.m. revealed snacks were served twice daily at 10:00 a.m. and 3:00 p.m.

Interview with the Cook on 1/9/18 at 2:55 p.m. revealed:
-Snacks were served at 10:00 a.m. and 2:30 p.m.
-There was no evening snack anymore.
-Staff stopped giving an evening snack about a month or more ago.
-They believed an evening snack would keep the residents up longer at night.

Interview with a dietary aide on 1/9/18 at 2:58 p.m. revealed:
-Snacks were served at 10:00 a.m. and 2:30 p.m.
-There had not been a night snack in over three months.
-Kitchen staff used to prepare sandwiches for diabetic residents' evening snack.
-This stopped about three months ago due to the sandwiches not being used and having to be thrown away in the morning.
Observation of snack time on 1/9/18 at 3:00 p.m. revealed residents were served brownies and

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D 298	Continued From page 46 coffee. Review of the facility snack menu for afternoon on 1/9/18 revealed residents should have been served ½ cup of fruit. Interview with a Medication Aide on 1/9/18 at 3:12 p.m. revealed: -She usually worked second shift. -Snacks were served once daily at 3:00 p.m. -Residents were usually served crackers or chips. Observation of snack time on 1/10/18 at 10:30 a.m. revealed residents were served bags of chips and coffee. Review of the facility snack menu for the morning snack on 1/10/18 revealed residents were to be served ½ cup of fruit. Interview with a Personal Care Aide on 1/11/18 at 3:50 p.m. revealed: -Snacks were served at 10:00 a.m. and 3:00 p.m. -There was no longer an 8:00 p.m. snack. -The evening snack stopped over a year ago. -She believed the evening snack should be restarted because residents complained that they were hungry. -She would go to the kitchen and find residents a snack if they requested one. Interview with a Medication Aide on 1/11/18 at 3:56 p.m. revealed: -Snacks were served at 10:00 a.m. and 2:00 p.m. -An evening snack was served in the special care unit at 8:00 p.m. -She was not sure why residents in assisted living no longer got an evening snack. Interview with the Administrator on 1/12/18 at	D 298		

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D 298	Continued From page 47 10:15 a.m. revealed: -Snacks were served twice daily at 10:00 a.m. and 3:00 p.m. -They had stopped doing an evening snack some time ago. -They did not see the need for an evening snack due to residents having dinner and dessert. -She was not aware that an evening snack was mandatory. -She planned to restart the evening snack that day 1/12/18.	D 298		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered for 3 of 3 residents sampled (#11, #12, #13) with physician's orders for nectar thickened liquids. The findings are: 1. Review of Resident #11's current FL-2 dated 3/9/17 revealed: -Diagnoses included myocardial infarction, atrial fibrillation, chronic renal disease, gastroesophageal reflux disease, and	D 310		

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hypertension.
-The resident was on a regular diet with nutritional supplements three times daily.

Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 08/27/15.

Review of Resident #11's diet order dated and signed by the physician on 8/8/17 revealed a regular diet order with thickened liquids of nectar consistency.

Observation of the kitchen area on 1/9/18 at 2:18 p.m. revealed:
-There was a typed list of seven residents who were to receive thickened liquids.
-Resident #11 was not listed on this list.

Observation of the kitchen area on 1/10/18 at 12:49 p.m. revealed:
-There was a clear plastic container of thickener with a scoop inside the container.
-There were instructions to the left of the container with measurements needed to thicken liquids.
-There were instructions on how to thicken clear and full liquids.
-Eight ounces of clear liquids required two tablespoons of thickener to be nectar consistency.
-Eight ounces of full liquids required two teaspoons of thickener to be nectar consistency.

Observation of the dietary aide preparing Resident #11's beverages on 1/10/18 at 12:04 p.m. revealed:
-The dietary aide poured about six ounces of premade nectar water into a cup without measuring.

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D 310	Continued From page 49 -She then added about two ounces of tea directly from the tea dispenser into the same cup. -She then added a scoop of thickener to the cup and stirred the nectar water, tea and thickener together. Interview with the dietary aide on 1/10/18 at 12:06 p.m. revealed: -She was trained upon hire to make thickened liquids by the kitchen manager and also by watching a video. -She did not use measuring cups or spoons and made all drinks from memory. Observation of Resident #11 at lunch on 1/10/18 at 12:25 p.m. revealed: -The resident was served 8 ounces of nectar thick water and 8 ounces of tea with thickener. -The resident also had a cup of coffee without thickener. -The resident was also given 8 ounces of milk without thickener. Observation of Resident #11 on 1/10/18 at 12:32 p.m. revealed the resident coughed twice. Observation of Resident #11 on 1/10/18 between 12:37 p.m. to 12:43 p.m. revealed the resident took four sips of coffee. Observation of Resident #11 on 1/10/18 at 1:05 p.m. revealed the resident coughed once. Interview with the acting Resident Care Coordinator (RCC) on 1/10/18 at 12:44 p.m. revealed: -She believed the resident made the cup of coffee himself at the coffee station in the dining room. -She would remove the cup of coffee and replace it with a thickened cup.	D 310		

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D 310	Continued From page 50 Interview with Resident #11 on 1/10/18 at 12:46 p.m. revealed another resident seated at the table had prepared the cup of coffee for him and brought it to the table. Observation of Resident #11 on 1/10/18 at 12:48 p.m. revealed he was given a thickened cup of coffee by the acting RCC. Interview with the Transportation Director on 1/10/18 at 12:52 p.m. revealed: -She was helping out in the kitchen and occasionally helped with snacks. -Resident #11 never got his coffee thickened. -Resident #11 did not need his coffee thickened. Interview with a Medication Aide on 1/10/18 at 12:54 p.m. revealed: -Resident #11 requested a glass of milk with his lunch. -The dietary aide poured a glass of milk for the resident. -She was not sure if the milk had been thickened. Interview with a second Medication Aide on 1/10/18 at 12:58 p.m. revealed: -Resident #11 drank sodas in his room. -He also would have staff fill up a water bottle every morning after breakfast to take to his room. -This was regular water and was not thickened. -He had never seen Resident #11 choking. Observation of Resident #11 on 1/10/18 at 1:01 p.m. revealed: -Resident #11 was served an 8 ounce cup of thickened milk. -The other 8 ounce cup of milk without thickener was removed from the table.	D 310		

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Interview with a second dietary aide on 1/11/18 at 12:00 p.m. revealed:
-She had already prepared drinks for Resident #11.
-She had been instructed by the kitchen manager to give the resident the thickest premade water.
-The water she gave him came in a yellow box.

Observation of the reach in cooler on 1/11/18 at 12:02 p.m. revealed the yellow box of premade water was honey consistency.

Interview with the second Medication Aide (MA) on 1/11/18 at 12:04 p.m. revealed:
-He had given Resident #11 medications that morning with his nutritional shake.
-The shake came in a 6 ounce container.
-The MA had added 1.5 tablespoons of thickener to the nutritional shake.
-He used a regular silver spoon to measure the thickener.
-Resident #11 had no issue drinking the nutritional shake.
-He had not witnessed Resident #11 coughing at any point.

Review of the thickener instructions revealed six ounces of full liquids would require two teaspoons of thickener to achieve nectar consistency.

Observation of Resident #11 at lunch time on 1/11/18 at 12:17 p.m. revealed another resident poured a cup of coffee and gave it to Resident #11.

Observation of Resident #11 on 1/11/18 at 12:28 p.m. revealed Resident #11 drank two sips of the coffee.

Interview with the RCC on 1/11/18 at 12:45 p.m.

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D 310	Continued From page 52 revealed the diet order had been changed for Resident #11. Observation of the new diet order for Resident #11 on 1/11/18 at 1:00 p.m. revealed a telephone order for Resident #11 to have thin liquids as tolerated signed by the physician on 1/10/18. Observation of kitchen staff on 1/11/18 at 12:19 p.m. revealed the measuring spoons were in the dishwasher. Observation of a second dietary aide preparing a thickened drink for Resident #11 on 1/11/18 at 12:21 p.m. revealed she picked up the container of thickener and poured an amount into the cup using a butter knife. Interview with a second dietary aide on 1/11/18 at 12:23 p.m. revealed: -She was unsure where the instructions were to make thickened drinks. -The facility had purchased measuring spoons earlier that day. -She had used a regular spoon prior to having measuring spoons but they were all on the table during lunch. -She usually stirred the drink to determine how thick it was before serving it. Interview with Resident #11 on 1/12/18 at 11:15 a.m. revealed: -He liked the premade thickened water because it lubricated his food when eating and kept him from choking. -The premade drinks were better than the ones the staff made for him. -The drinks staff prepared for him were not the right consistency and were often too thin or too thick.	D 310		

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-He had sent drinks back to the kitchen in the past.
-He did not like his milk or coffee thickened.
-He preferred his tea with ice and a straw.
-He did not have an issue drinking water and sodas in his room.
-Staff filled his water bottle with regular water every morning after breakfast.
-He took his medications with a nutritional shake.
-The shakes were usually not thickened as they were already thick enough.

Interview with the primary care physician for Resident #11 on 1/12/18 at 12:00 p.m. revealed:
-Resident #11 should be on a regular diet with regular liquids.
-Resident #11 had a history of choking and there was some concern with him aspirating on liquids.
-Resident #11 previously had speech therapy and they evaluated him and found him to be okay.
-He believed the order for thickened liquids had not been changed due to being overlooked.
-If Resident #11 was given honey thickened liquids, it would not pose a risk.
-If Resident #11 was given a thinner consistency of liquid he could aspirate.
-He believed the staff were likely giving Resident #11 thinner liquids at Resident #11's request.
-He was notified earlier this week by the staff that Resident #11 was drinking thin liquids in his room without difficulty.
-He believed it was okay for Resident #11 to be switched to thin liquids if he was not choking.

Refer to interview with the Administrator on 1/12/18 at 10:10 a.m.

2. Review of Resident #12's current FL-2 dated 12/5/17 revealed:
-Diagnoses included dementia with behavioral

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disturbance, Huntington's disease, ataxia, and brain atrophy.
-There was a diet order for a mechanical soft diet with thickened liquids.

Review of Resident #12's Resident Register revealed the resident was admitted to the facility on 8/23/16.

Observation of the kitchen area on 1/9/18 at 2:18 p.m. revealed:
-There was a typed list of seven residents who were to receive thickened liquids.
-Resident #12's name was on this list.

Interview with a third dietary aide on 1/12/18 at 11:06 a.m. revealed:
-She knew what residents received thickened liquids.
-The residents did not like the drinks too thick.
-Residents would send drinks back to the kitchen if they were too thick.
-She had been told by the kitchen manager to use honey thick water if out of the nectar water.
-She did not use a measuring cup but they had them in the kitchen.
-She was trained to make thickened liquids by watching a video when she was hired.
-She did not use the instructions for thickened liquids.
-She made thickened liquids from memory.
-She believed those instructions came with the thickener.

Observation of the dietary aide preparing nectar thickened tea on 1/12/18 at 11:08 a.m. revealed:
-She used a blue cup for the tea preparation.
-She estimated the cup was about eight ounces and she verified that the cup was about eight ounces with the Cook.

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-She filled the cup with tea to the top line, pointed to the teaspoon measuring spoon and stated that she used two of those full of thickener for tea, and then added two teaspoons of thickener before stirring the drink.

Observation of Resident #12 in the dining room on 1/12/18 from 12:13 p.m. to 12:15 p.m. revealed:
-Resident #12 drank 8 ounces of tea with ice without thickener.
-Resident #12 drank four ounces of water with ice without thickener.
-The resident coughed twice.
-Staff gave the resident 8 ounces of thickened tea and 8 ounces of thickened water.

Observation of Resident #12 on 1/12/18 at 12:26 revealed the resident drank all 8 ounces of thickened tea and 8 ounces of thickened water.

Interview with a Personal Care Aide (PCA) on 1/12/18 at 2:40 p.m. revealed:
-Resident #12 usually got thickened liquids.
-Residents did not always sit in the same seats but the tables already had drinks on them.
-Occasionally staff made mistakes and would give Resident #12 regular drinks.

Interview with a second PCA on 1/12/18 at 2:46 p.m. revealed:
-Resident #12 usually got milk, water, juice, and tea to drink.
-Sometimes the drinks were not thickened.
-There was confusion among staff at times as to what Resident #12 should get.
-Sometimes the kitchen staff would forget to send thickened drinks.
-There used to be a diet list inside the food transportation cart that specified which residents

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D 310	Continued From page 56 got thickened liquids. Interview with the Medication Aide on 1/12/18 at 3:00 p.m. revealed Resident #12 took his medicines in pudding. Interview with the Special Care Unit Coordinator on 1/12/18 at 2:52 p.m. revealed: -Resident #12 should have received thickened liquids. -She was not aware Resident 12 had not received thickened liquids. -There was a listing on the cart that detailed which residents were on thickened liquids. -Thickened liquids came from the kitchen covered in plastic wrap so that staff would know the difference. Based on observations, interviews, and record reviews, Resident #12 was not interviewable. Refer to interview with the Administrator on 1/12/18 at 10:10 a.m. 3. Review of Resident #13's current FL-2 dated 12/5/17 revealed: -Diagnoses included Lewy body dementia, dysphasia, acute respiratory failure, fracture of head and neck femur, and symbolic dysfunction. -There was a diet order for puree diet with nectar thickened liquids. Review of Resident #13's Resident Register revealed the resident was admitted to the facility on 12/30/15. Observation of the kitchen area on 1/9/18 at 2:18 p.m. revealed: -There was a typed list of seven residents who were to receive thickened liquids.	D 310		

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D 310	Continued From page 57 -Resident #13's name was on this list. Observation of Resident #13 at lunch time on 1/12/18 from 12:19 p.m. to 12:20 p.m. revealed: -The resident sat down at the table with 10 ounces of tea with ice without thickener and 8 ounces of water with ice without thickener. -The resident was served a plate of pureed food. -The personal care aide removed the drinks from the table. Observation of Resident #13 on 1/12/18 from 12:23 p.m. to 12:30 p.m. revealed: -The resident coughed four times. -The kitchen staff had not sent thickened drinks for Resident #13. -The resident had eaten 100% of the meal but had not received a drink. -The resident coughed three times. -The resident was served 12 ounces of a thickened nutritional shake, 12 ounces of thickened water, and 12 ounces of thickened tea. -The resident drank two ounces of thickened water. -The resident drank two ounces of nutritional shake. -The resident drank none of the tea. Interview with a Personal Care Aide (PCA) on 1/12/18 at 2:40 p.m. revealed: -Resident #13 usually got thickened drinks but some PCA's had made mistakes in the past and given Resident #13 regular drinks. -This last happened last week when Resident #13 began choking on Tuesday. -Resident #13 often walked around the unit and would grab other residents' drinks sitting on the table. -She did not think it was a good idea that staff preset the tables with drinks.	D 310		

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D 310	Continued From page 58 -Staff tried to watch Resident #13 closely to prevent her from picking up extra drinks if they had enough staff to do so. Interview with a second PCA on 1/12/18 at 2:46 p.m. revealed: -Resident #13 always got thickened liquids with meals and snacks. -She did not think the drinks were always thickened to the right consistency. -She believed the drinks usually did not have enough thickener in them. -Resident #13 choked while drinking this morning at breakfast. -Resident #13 had choked numerous times. -Resident #13 had issues with remembering to swallow at times. Interview with the Special Care Unit Coordinator (SCUC) on 1/12/18 at 2:52 p.m. revealed: -Resident #13 usually got thickened drinks. -Some drinks were thicker than others and they were often made differently. -Resident #13 had ongoing issues with choking. -Resident #13 had choked last month while eating a French fry she took from another resident. -Resident #13 often wandered around the unit and would take other residents' food. -Staff had to do the Heimlich maneuver last month when the resident choked. -Staff tried to supervise the resident closely in the dining room. Based on observations, interviews, and record reviews Resident #13 was not interviewable. Refer to interview with the Administrator on 1/12/18 at 10:10 a.m.	D 310		

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D 310	Continued From page 59 Interview with the Administrator on 1/12/18 at 10:10 a.m. revealed: -The kitchen manager contacted her that morning and resigned. -She would be monitoring dietary until that position was filled. -She planned to order all premade thickened liquids. The facility's failure to thicken liquids as ordered, for 3 residents with swallowing problems placed the residents at risk for aspiration. This failure was detrimental to the health and wellbeing or the residents and constitutes a Type B violation. Review of the facility's Plan of Protection dated 01/12/18 revealed: -Pre-thickened liquids were ordered on 01/11/18 and the community will only use pre-thickened liquids going forward beginning 01/12/18. -Until the order arrives the facility has borrowed some pre-thickened liquids from another community. -The Executive Director and Resident Care Coordinator will monitor meal services daily for 1 week and then weekly after to ensure ongoing compliance with serving meals beginning 01/12/18. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 26, 2018.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 60 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications in accordance with physician orders for 2 of 7 sampled residents (Resident #4 and Resident #7) including a resident almost receiving the wrong dose of insulin and a resident who was receiving medications when they should have been held. The findings are: 1. The medication error rate was 2% as evidence by observation of error out of 34 opportunities during the 8:00 AM medication pass on 01/10/18. A. Review of Resident #7's current FL-2 dated 10/10/17 revealed: -Diagnoses included hypertension, diabetes type 2, muscle weakness, trans-ischemia attack, and other muscle-spams. -There was a physician's order for Novolog (fast acting insulin) administer 12 units three times per day after meals. Hold if finger stick blood sugar is less than 150. Observation of the medication pass on 01/10/18 at 7:15 AM revealed Resident #7's finger stick blood sugar was 168.	D 358		

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D 358	Continued From page 61 Observation of the medication pass on 01/10/18 at 7:22 AM revealed: -The Medication Aide drew up insulin with the top of the plunger between the lines marking 14 and 15 units. -She tilted the syringe towards her and did not hold it straight up when she was looking at the measurement. -The Medication Aide went into the resident's room to administer the insulin. -When asked how much insulin was in the syringe she stated 12 units. -She then looked at the syringe at eye level and said it might be a little more than 12. -She then adjusted the dose to 12 units of Novolog Insulin. -The Medication Aide then walked back into the room and administered the insulin to the resident at 7:25 AM. Observation on 01/10/18 at 7:40 AM revealed Resident #7 received his meal tray and started to eat which was 15 minutes after he received his Novolog Insulin. Interview with the Medication Aide on 01/10/18 at 7:45 AM revealed: -She did not know she had drawn up too much insulin. -She thought she had only drawn up 12 units. -She gave the insulin before the meal because that is how the resident likes to take his insulin. -She did not give the medication until right before he went down to eat. -The doctor had not been made aware that Resident #7 was getting his insulin before meals. -She would make sure to follow physician orders until the order could be changed. -She would make sure to check her insulin a	D 358		

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second time from now before administering the insulin.

Attempted interview with the primary care physician on 01/11/18 at 2:45 PM was unsuccessful.

Interview with the Resident Care Coordinator on 01/12/18 at 2:50 PM revealed:
-She was not aware of any prior medication administration issues.
-All the staff are trained on the cart and signed off by the Licensed Health Professional Support nurse.
-All staff had recently received more medication administration training in 2017.
-She would make sure that the Medication Aide was retrained in administering insulin.

Interview with the Administrator on 01/12/18 at 2:39 PM revealed:
-All Medication Aides were trained on the cart for 4 days.
-All staff receive training on administering insulin in their diabetes and medication administration training.
-She was not aware of any prior medication administration errors.
-All Medication Aides will get an in-service about administering medications.

2. Review of Resident #5's FL-2 dated 12/19/17 revealed:
- Diagnoses included pleural effusion, congestive heart failure, hypoxia, diabetes mellitus 2, morbid obesity, and hypertension.
-An order for Humalog insulin (fast acting insulin used to lower blood sugars) 6 units, subcutaneous injection, 3 times a day after

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meals. Hold for blood sugar readings less than 150.

Review of the Resident Register revealed the Resident #5 was admitted to the facility on 2/07/17.

Interview with Resident #5 on 1/9/18 at 10:10am revealed:
-The resident was diabetic, received insulin 3-4 times a day and the staff checked her blood sugars 4 times a day.
-The resident only ate 2 meals every day and never ate breakfast since admission to the facility.
-The resident usually slept until about 10 or 11:00am and ate a snack such as crackers or a honey bun, when she woke up.
-The resident was administered insulin every morning around 8:00am while she was in bed.

Review of the resident's January 2018 medication administration record (MAR) revealed:
-From 1/1/18 to 1/10/18, Resident #5 was administered Humalog insulin 6 units at 8:30am.
-From 1/1/18 to 1/10/18, the resident's blood sugars were between 177 and 224 at 7:00am and between 138 and 322 at 11:00am.

Review of the resident's December 2017 MAR revealed:
-From 12/1/17 to 12/31/17, the resident was administered Humalog insulin, 6 units, at 8:30am.
- From 12/1/17 to 12/31/17, the resident's blood sugars were between 153 and 225 at 7:00am and between 138 and 410 at 11:00am.

Interview with a medication aide (MA) on 1/9/18 at 10:30am revealed:
-She administered 6 units of Humalog insulin to Resident #5 this morning at 8:30.

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D 358	Continued From page 64 -The resident did not eat breakfast. She always slept late and did not eat breakfast. Interview with Resident #5 on 1/11/18 at 9:45am revealed she did not eat breakfast on 1/10/18 or this morning. Interview with another MA on 1/11/18 at `12:40pm revealed: -She administered 6 units of Humalog insulin to Resident #5 on 1/10/18 at 8:30. -The resident did not eat breakfast. Interview with a 3rd MA on 1/11/18 at 2:50m revealed: - She administered 6 units of Humalog insulin to Resident #5 this morning at 8:30. -She was not sure if the resident ate breakfast this morning. Interview with resident #5 on 1/11/18 at 2:10pm revealed the resident did not eat breakfast this morning. Interview with the RCC on 1/11/18 at 2:30pm revealed: -According to the orders, Resident #5's insulin scheduled for 8:30am should be administered after breakfast. -The MAs should not administer the insulin in the morning if the resident did not eat breakfast and they should have reported this to her medical provider. -The RCC was to follow-up with the MAs to assure they are following the orders completely. Interview with a 4th MA on 1/12/18 at 9:30am revealed: -Resident #5 did not eat breakfast this morning. -The resident's blood sugar was 274 at 7:00am	D 358		

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D 358	Continued From page 65 today. -She administered Humalog insulin at 8:30am today. She has never held the resident's insulin if she did not eat breakfast. -She has never reported that the resident did not eat breakfast to her health care provider Interview with Resident #5's primary medical provider on 1/12/18 at 11:45am revealed: -The order was correct and the resident should be administered the Humalog insulin after meals. -Since the resident's blood sugars have not been low, he was not worried about the resident receiving her 8:30am dose of Humalog insulin if she did not eat breakfast. -The facility contacted him yesterday (1/11/18) for clarification of Humalog insulin order. Review of clarification order dated 1/11/18 revealed an order for Humalog, 6units, subcutaneous, 3 times a day after meals based on blood sugars, not intake.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant	D912		

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federal and state laws and rules and regulations as related to personal care and supervision, nutrition and food service, and health care.

The findings are:

1. Based Based on observations and interviews, the facility failed to maintain a clean living area free from unpleasant odors. [Refer to Tag 0075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishing (Type B Violation)].

2. Based on observations and interviews, the facility failed to maintain a supply of washcloths, towels, and bed linens for residents to use at all times. [Refer to Tag 0080, 10A NCAC 13F .0306(a)(6) Housekeeping and Furnishing (Type B Violation)].

3. Based on observations, record reviews, and interviews, the facility failed to provide incontinent care, scheduled showers, and nail care for 3 of 10 sampled residents (#8, #9 and #10) including Residents #8 and #10 not recieving showers and incontinent care; Resident #10, and Resident #9 not recieving showers and nail care. [Refer to Tag 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the current care plan and impliment effective interventions for 1 of 2 sampled residents (Resident #1) who sustained 9 falls from July 2017 through December 2017 and had multiple injuries. [Refer to Tag D0270, 10A NCAC 13F .0902 (b) Personal Care and Supervision. (Type A2 Violation)].

5. Based on observations, interviews and record

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D912	Continued From page 67 reviews, the facility failed, for 1 of 7 residents, to report an open leg wound to the health care provider and schedule diabetic nail care with a podiatrist for Resident #8. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care. (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered for 3 of 3 residents sampled (#11, #12, #13) with physician's orders for nectar thickened liquids. [Refer to Tag D0310, 10A NCAC 13F .0904 (e)(4) Therapeutic Diets. (Type B Violation)].	D912		