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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Departmet of Social Services conducted an annual survey on 3/20/18 to 3/22/18.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents related to falls, one with injuries including a laceration on the forehead, fracture of the right clavicle, contusion of the left lower extremity and a non-displaced fracture of the left ankle, and a head injury (Resident #2), and a second resident on isolation protocol, with injuries which included a wrist fracture and a subdural hemotoma (Resident #1). The findings are: 1. Review of Resident #2's current FL-2 dated 2/23/18 revealed: - Diagnoses included a clavicle fracture, congestive heart failure (CHF), atrial fibrillation (AF), aortic stenosis, complete heart block, asthma, history of falls, tremors, glaucoma, hypertension, colitis, benign prostatic hyperplasia	D 270		

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(BPH) and depression.
-The level of care documented was assisted living facility.

Review of the fall incident reports revealed:
-Resident #2 had 4 falls from 01/04/18 to 3/14/18.
-3 of the 4 falls were documented as unwitnessed or "found on the floor".
-Documented injuries included; laceration on the forehead on 1/4/18, fracture of the right clavicle on 2/1/18, a contusion of the left lower extremity and non-displaced fracture of the left ankle on 2/14/18; and a head injury on 3/14/18.
-Further review of incident reports revealed 3 of the 4 falls happened on 2nd shift.

Review of Resident #2's Personal Service Care Plan dated 11/28/17 revealed:
-A rollator (a walker with wheels) was documented under "devices needed".
-Resident #2 required supervision for ambulation/locomotion.
-Resident #2 required assistance with toileting, dressing and transfers.
-There was no documentation regarding falls or increased supervision implemented to manage or reduce falls.

Interview with the medication aide (MA) on 3/22/18 at 8:00am revealed Resident #2 required hands on assistance with bathing, grooming, dressing and transfers.

Interview with the Area Health and Wellness Director (Area HWD) on 3/22/18 at 10:00am revealed:
-She did not know if Resident #2 was discussed at the stand up or collaborative meetings.
-She did not know of any interventions that have been implemented for Resident #2.

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D 270	Continued From page 2 Interview with Resident Care Coordinator (RCC) on 3/22/18 at 4:00pm revealed: -None of the assessment pages had been filled out on Resident #2's incident reports. -The previous Health and Wellness Director (HWD) had completed the assessment page. Interview with a medication aide (MA) on 3/22/18 at 2:30pm revealed: -She had not seen any interventions documented in the resident record or Personal Service Care Plan. -She did not implement any increased supervision for Resident #2. -She had not been instructed by her supervisors to increase supervision for Resident #2. Interview with a personal care assistant (PCA) on 3/22/18 at 2:50pm revealed she had not been instructed by her supervisor to increase supervision or implement any interventions for Resident #2 . Interview with a second MA on 3/22/18 at 3:15pm revealed: -The MAs had been instructed to complete an Incident Report if a resident had a fall. -If the resident had more than one fall or a tendency to fall, they were to call the primary care physician (PCP) and request a physical therapy (PT) consult. -She had not had a "stand up" meeting with the staff. -She had not been given any interventions to implement for residents who have had falls. -She had not been instructed by her supervisor to implement any interventions or increased supervision for Resident #2. -Since the HDW resigned 5 months ago, we had	D 270		

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not followed any format regarding residents who were fall risks.

Interview with a third MA on 3/22/18 at 3:25pm revealed:
-She completed the Incident Report form when a resident had fallen and filed it in the wall file folder in the Employee Lounge for the RCC to review.
-If the resident was injured, she contacted the RCC.
-She had not been informed by her managers of any specific interventions for residents who have fallen.
-"If we send them (the residents) to the Urgent Care or the Emergency Department (ED) we followed the orders they returned with."
-She was not instructed to increase supervision or provide specific interventions for Resident #2.

Interview with a second PCA on 3/22/18 at 3:45pm revealed:
- If she knew a resident had fallen, she checked on them more frequently and tried to keep them in the common areas for observation. This was not directed by her supervisor, but adopted through her experience.
-She was not instructed to increase supervision or provide specific interventions for Resident #2.
-She was not informed by her supervisors of any specific fall policy.
-There was no set time to check on the residents.

Interview with a fourth MA on 3/22/18 at 5:00pm revealed:
-She could not explain why 3 of the 4 falls happened on second shift.
-There was only 1 PCA and 1 MA on this floor and Resident #2 did not like to wait for staff to assist him.
-He had a desk chair with wheels in his room that

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he used frequently.
-His last fall was the result of slipping out of the chair as it was moving.
-When he returned to the facility from skilled nursing, she instructed resident not to use the desk chair and she placed the chair in the corner of his room. She initiated this measure on her own.
-She had not participated in any "stand up" meetings.
-She had not been instructed by her supervisors to implement any interventions or increase supervision for Resident #2.

Interview with the first MA on 3/22/18 at 5:10pm revealed:
-She had not participated in any "stand up" meetings or collaborative care meetings.
-MAs had to "determine the correct course of action in any situation ourselves".

Interview with the Licensed Professional Nurse (LPN) at Resident #2's PCP's office revealed:
-The PCP was notified by the facility Resident #2 had fallen on 2/2/18.
-This was the only communication the PCP had regarding Resident #2 since January 2018.
-The facility had not requested recommendations or interventions from the PCP regarding the fall.
-The PCP did not know the resident had fallen 3 additional times until his appointment at the office on 3/21/18.
-The PCP recommended physical therapy and occupational therapy to be initiated and to use a wheelchair for ambulation at the office visit on 3/21/18.

Interview with Resident #2 on 3/22/18 at 9:55am revealed:
-Before the last fall, he was using a rollator to

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ambulate in community. Now he had to use a wheelchair.
-The staff were "very slow to arrive at my room when I activated the call bell".
-Staff claimed to be short staffed as an explanation for the response time.
-Some staff persons are very attentive; "...others just do not care."
-He has complained to the ED and the HDW yet he has not seen any changes in response time or personal care.

Refer to interview with a medication aide (MA) on 3/22/18 at 2:30pm.

Refer to interview with a personal care assistant (PCA) on 3/22/18 at 2:50pm.

Refer to interview with Resident Care Coordinator (RCC) on 3/22/18 at 4:00pm.

Refer to interview with the HDW on 3/22/18 at 4:45pm.

Refer to interview with the Area Health and Wellness Director (Area HWD) on 3/22/18 at 10:00am.

Refer to the review of the Falls Management policy.

Refer to the review of the Post Fall Evaluation policy.

2. Review of Resident #1's FL 2 dated 12/11/17 revealed diagnoses included Alzheimer's dementia, ulcerative colitis, and iron deficiency anemia.

Review of Resident #1's hospital discharge

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summary dated 1/3/18 revealed:
-Resident #1 was admitted to a hospital on 12/28/17 with a history of ulcerative colitis and worsening diarrhea.
-On 1/3/18 a discharge diagnoses was documented as, "Clostridium Difficile (C-Diff), a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon, and E Coli UTI, type of bacteria commonly found in the gastrointestinal (GI) tract that has caused an infection in the urinary tract".
-On 1/3/18 Resident #1 was discharged back to the facility on vancomycin.
-There was no documentation Resident #1 was in isolation or to be put in isolation for the C-Diff once back at the facility.

Review of Resident #1's Incident Reports with Post Fall documentation included revealed:
-A fall with an injury of a fractured left ulna dated 1/21/18 did not have an incident report completed.
-An incident report with a head injury noted dated 3/11/18 did not have a post fall evaluation completed
-An incident report with an unspecific injury noted dated 3/19/18 did not have a post fall evaluation completed

Review of Resident #1's physician's visit notes revealed:
-A Primary Care visit dated 1/21/18 documented a follow up vist after a closed fracture of the distal end of the left ulna and cellulitis of the wrist.
-A follow up appointment dated 1/23/18 for an orthopedist documented Resident #1 with a diagnosis of a fracture of the left distal ulna and cellulitis.

Review of Resident #1's Progress Notes with

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various dates and times revealed:
-There were multiple documented entries pertaining to Resident feeling "overwhelmed", "restless", and "agitated" with being confined to her room.
-An entry dated 3/11/18 at 2:30pm documented as, "Resident was sent to the emergency room (ER) for a fall. Resident had a subdural hematoma on left side of head. The Residents' family took Resident #1 to the ER for evaluation. Resident returned from ER with orders to monitor and check vital signs every 2 hours".
-An entry dated 3/4/18 on 3rd shift documented as, "we cannot keep her safe, she can easily walk to the independent living (IL) or outside when we are in resident's rooms".
-An entry dated 2/22/18 on 3rd shift documented as, "Resident came from IL in the middle of the night yelling let me out, let me out. We cannot keep resident safe".
-An entry dated 1/20/18 at 1:30pm documented, "left wrist and hand had some edema, tender to touch, slightly red, able to move hand but some discomfort when using it to push up off the couch".
-An entry dated 1/21/18 with no time documented, "left wrist more swollen and tender to touch much warmer than the right hand".
-An entry dated 1/21/18 at 10:00pm documented, "resident has fracture of left distal ulna and cellulitis of the wrist".

Interview with a personal care aide PCA on 3/20/18 at 10:00am revealed:
-She was at the facility for 2 ½ years and worked 1st shift.
-Resident #1 was in isolation since returning from the hospital in January.
-The Health and Wellness Director (HWD) put Resident #1 in isolation for C-Diff because the

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stool culture was positive for C-Diff.
-The policy was the resident must have a negative stool culture to be cleared and come out of isolation.

Interview with the Area Health and Wellness Director (Area HWD) on 3/20/18 at 10:18am revealed:
-Resident #1 was in isolation for C-Diff.
-She did not know what the policy for infection control was for this facility, just the overall policy and a resident must have a negative stool culture to be released from isolation for C-Diff.
-She was not able to provide a copy of the infection control policy for C-Diff.

Interview with the HWD on 3/20/18 at 10:18am revealed:
-She was hired 4 weeks ago.
-Resident #1 was in isolation for C-Diff since returning from the hospital 1/3/18.
-All of the meals were served in Resident #1's room using all disposable items.
-Resident #1 could not come out of isolation until a negative stool culture was obtained.
-She was not able to provide a copy of the infection control policy for C-Diff.

Interview with Resident #1's Nurse Practitioner (NP) on 3/20/18 at 12:03pm revealed:
-Resident #1 was seen at the facility first on 2/5/18 while on 2nd round of vancomycin.
-On 2/5/18 she was informed by the facility about the need for a negative stool culture.
-She told the HWD, RCC and the Administrator that a negative stool culture would never happen.
-She expected the facility to revisit their infection control policy because Resident #1 should be out of isolation.
-She told the HWD to remove Resident #1 out of

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isolation and was told by the HWD that Resident #1 could not come out of isolation per the facility's policy until a negative stool culture was provided.
-She informed the HWD, RCC and the Administrator Resident #1 would never have a negative stool culture.
-She did not receive notification the isolation policy did not require a negative stool culture to be removed from isolation as of 3/20/18.
-It was the NP's expectation for the facility to notify her that the policy did not require a negative stool culture to come out of isolation.
-She attributed the diarrhea to Resident #1's ulcerative colitis because it is bloody not like C-Diff which is very watery.
-The extended amount of time Resident #1 was in isolation contributed to Resident #1's increase in dementia and depression, a 10 lb. weight reduction from 2/5/18 - 3/20/18, a total of a 14.5 % related to the lack of social interaction and a functional decline leading to falls.
-Resident #1 quality of life was seriously impacted because of the extended isolation.

Interview with a family member on 3/20/18 at 1:00pm revealed:
-She was a Nurse.
-Resident #1 did not need to be in isolation according to what she was told by the NP.
-Resident #1 would never have a negative stool culture and the facility would not take Resident #1 out of isolation because of that.
-Resident #1 was able to "do for herself" before the 12/28/18 hospitalization.
-Resident #1 took daily walks, enjoyed the sunshine and eating in the dining room with other residents prior to the isolation.
-Now Resident #1 was depressed, and very lonely because of being in isolation and not able to interact on a routine basis.

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D 270	Continued From page 10 -It was her understanding after she talked with the NP that after being on isolation for an extended amount of time led Resident #1 to a 14.5 % reduction in her weight since released from the hospital 1/3/18 and an increase in Resident #1's depression because of the seclusion and lack of regular interaction with people. -Resident #1 would socialize in the dining room every day with every meal prior to isolation. -Now Resident #1 was secluded to her room and could not interact with the other residents on a daily basis. -Resident #1 only interacted with the staff when the MAs or PCAs brought in Resident #1's medications or food. -Resident #1's food was dropped off and left there for Resident #1 to set up for herself and now with the dementia getting worse Resident #1 did not even know to open her food tray and give her cues. There was no one there to give her cues to eat or to prompt her to eat more if Resident #1 was only picking at her food. -She contributed the decline in Resident #1's health to the isolation and the decreased social interaction. -She expected the facility to provide Resident #1 more frequent checks and to help set up the meals in Resident #1's room and prompt Resident #1 to eat. -She was told by the Administrator, Resident #1 would not be taken out of isolation without a negative stool culture. Interview with the Executive Director (ED) on 3/21/18 at 9:55am revealed: -Resident #1 was in isolation since her return from the hospital 1/3/18 due to C-Diff. -She did not know if Resident #1 was in isolation at the hospital but because of the C-Diff and a	D 270		

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"positive" stool culture, she put Resident #1 in isolation.
-Her facility policy required a negative stool culture to remove from isolation.
-The facility's policy was to keep on isolation until a negative stool culture was obtained in order to protect other residents and staff.
-She did not provide a facility copy of the policy that required a negative stool culture before a resident would be released out of isolation.

Interview with a MA on 3/21/18 at 5:10pm revealed:
-She spoke with the NP about removing Resident #1 from isolation but told the NP that per the AHWD and the ED Resident # 1 could not come out of isolation until a negative stool culture was received.
-Resident # 1 was in the room by herself all the time except when she gave her medications or took her food.
-Resident #1 broke her arm in 1/2018.
-Resident #1 could not remember what happened just that it hurt and 3 days later a family member took her to the urgent care and came back with a cast.
-Resident #1 had a second unwitnessed fall this month and sustained a subdural hematoma and she had no idea of how it happened.
-Resident #1 had a third unwitnessed fall this month as well and she had no idea of how it happened.
-Resident #1 could not recall or remember things.
-There was no increase in supervision after each fall because of the isolation.
-Resident #1 was in isolation and the amount of staff on the floor made it difficult to check on Resident #1 more often.

A second interview with Resident #1's family

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member on 3/22/18 at 10:00am revealed:
-She took Resident #1 to the urgent care on 1/21/18 with a swollen left wrist, that was also red and painful to the touch.
-Resident #1 could not give an explanation to what happened to cause the injury.
-She took Resident #1 to the urgent care on 3/11/18.
-Resident #1 was complaining that she fell.
-It was an unwitnessed fall and Resident #1 could not remember what happened.
-Resident #1 had a swollen place on her head.
-She brought Resident #1 back with instructions to monitor blood pressure every 2 hours for 24 hours and monitor for signs and symptoms of lethargy, slurred speech and bleeding of the head.
-The facility was to call 911 if any of the above happened.

A second telephone interview with the NP on 3/22/18 at 2:49pm revealed:
-The isolation was a contributing factor in the decline of Resident #1.
-Resident #1 was put in isolation and did not need to be after 2/5/18.
-Since 2/5/18 Resident #1 was confined to her room, isolated from everyone except for minimal interactions with the staff, causing the dementia and depression to progress.
-Resident #1 became more withdrawn, and her appetite to decrease drastically causing a 10 lb. weight decrease in one month, which caused a functional decline resulting in some falls.
-On 2/19/18, 3/11/18 and 3/13/18 she spoke with MA's and HWD about the need for more frequent checks on Resident #1 because of the isolation, falls and the weight loss.
-She expected the facility to increase the supervision with Resident #1 because of the

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isolation, lack of social interaction and decline in Resident #1's functional ability.
-"How do you know what is going on" with a resident unless you check on them.
-Resident #1 should have been checked on more than every 2 hours while in isolation, especially after falls.

A second interview with the same MA on 3/22/18 at 3:57pm revealed:
-All falls were to be documented in the nurse's notes along with filling out an incident report.
-All incident reports were to be sent to HWD.
-The HWD was responsible for filling out the post fall assessment which included interventions.
-The post fall interventions were the instruction/interventions for the staff to follow, for example with a head injury there was an increase in supervision.
-There were no instructions given on the post fall interventions sheet provided after every fall since last year around when the last HWD left.
-Resident #1 did not have any post fall assessments completed.

Interview with a second PCA on 3/22/18 at 4:17pm revealed:
-She let the ED know about the issues with a delay in resident care back in 8/2017 but nothing was done.
-Other residents would not get the supervision they needed because of the time spent in the rooms with the residents that required more time and care.
-We need more help on the floor during first and second shift, like a floater during the high care times (e.g. mornings when getting 5 high care residents up and shower times) because the only 2 on the hall are in with those residents and when call lights go off then no one can answer them.

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D 270	Continued From page 14 -She let the ED know again in 1/2018 but the request was denied by the ED. -Resident #1 was put in isolation for C-Diff in 1/2018. -She delivered meals to Resident #1 and answered the call bell when Resident #1 called out. -She knew about some falls with Resident #1 but there was no increase in supervision after each fall. -She did not know what the fall policy was. Interview with a third PCA on 3/22/18 at 4:17pm revealed: -She was not aware of a fall policy. -"We just check on people when we can". -There were 4 residents on this floor that were in wheelchairs and oxygen which were considered "more care" residents so she tag teams with the PCA from the other floor to complete the personal care duties. -She could not answer the call bells when she was in the room with those 4 residents or when she was giving showers. -Resident #1 was in isolation and the only time she went in there was to deliver her meal and if she rang the call bell. -Resident #1 fell 3 times that she knew of and there was no increase on supervision with Resident #1. Interview with a second MA on 3/22/18 at 4:22pm revealed: -She was a MA on second shift. -If a fall occurred and caused injury, an incident report was filled out and the physician and family were notified. -The incident report was given to the HWD. -The HWD was responsible for filling out the post fall evaluation.	D 270		

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D 270	Continued From page 15 -She was not instructed to check on Resident #1 more frequent than delivering meals and when Resident #1 used the call bell. Interview with a third MA on 3/22/18 at 4:22pm revealed: -If a fall resulted in an injury then 911 was called, the physician and family were to be notified. -An incident report was filled out and given to the RCC. -She did not know what a post fall evaluation was. -Resident #1 was in isolation for C-Diff. -Resident #1 had to have a negative stool culture to come out of isolation. -She did not do more frequent checks on anyone even after a fall and she was not instructed to do so. A third telephone interview with a family member on 3/23/18 at 11:00am revealed: -Resident #1 was complaining of her left arm hurting during a visit on 1/18/18. -It was reported to the MA on duty and the MA told her they would keep an eye on it since they did not know what happened to cause it to hurt. -On 1/19/18 during a visit Resident #1 complained of pain, redness and swelling in her wrist, and again it was reported to the MA and again the MA told her they would keep an eye on it. -On 1/21/18 the same MA called the family notifying them Resident #1 was complaining of severe pain and upon examination the left arm was very swollen, red and painful to the touch. -She went to the facility and took Resident #1 to the urgent care where an x-ray was obtained and Resident #1 received a diagnosis of a left distal ulnar fracture and a temporary cast. -Resident #1 was to see an Orthopedist on 1/23/18.	D 270		

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-On 3/11/19 Resident #1 had an unwitnessed fall and she took Resident #1 to the urgent care again and Resident #1 received a diagnosis of a subdural hematoma.
-The written discharge instructions by the physician were given to a MA and the MAs were to monitor vital signs for Resident #1 every 2 hours for 24 hours and check to make sure Resident #1 could be awakened easily. Also check for equal hand strength or signs and symptoms of a stroke.
-She was not aware of the fall on 3/19/18.
-She expected the facility to check on Resident #1 especially after falls more frequent than every 2 hours while in isolation.
-The staff informed her that Resident #1 would be checked on more than every 2 hours due to the "unwitnessed falls".
-Resident #1 used to be very independent and since February 2018 had declined greatly and she attributed the decline to the extended isolation and lack of social interactions.
-If Resident #1 was around people, for example, in the dining room for her meals, then she would receive cues to eat, and would receive some encouragement to eat.

Refer to interview with a medication aide (MA) on 3/22/18 at 2:30pm.

Refer to interview with a personal care assistant (PCA) on 3/22/18 at 2:50pm.

Refer to interview with Resident Care Coordinator (RCC) on 3/22/18 at 4:00pm.

Refer to interview with the HDW on 3/22/18 at 4:45pm.

Refer to interview with the Area Health and

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D 270	Continued From page 17 Wellness Director (Area HWD) on 3/22/18 at 10:00am. _____ Interview with a medication aide (MA) on 3/22/18 at 2:30pm revealed: -She had not been instructed by her supervisors to implement any specific interventions for residents who were a fall risk. -Third shift may have been instructed to check on residents who have hit their head hourly, but she had not seen any documentation of that. -The MAs had not been instructed to look at the environment in the room for possible hazards. Interview with a personal care assistant (PCA) on 3/22/18 at 2:50pm revealed: -She had not been instructed on any specific interventions for residents who were a fall risk by her supervisors. -She walked beside residents with walkers or canes if they have had falls. -She attempted to direct residents to common areas where they could have more supervision and encouraged them to use their call bell when they needed assistance. -She had "adopted these strategies from her own experience." -She had not seen any documentation for interventions or environmental precautions. -She had not participated in any "stand up" meetings with the staff. Interview with the HDW on 3/22/18 at 4:45pm revealed: -She had not completed the Fall Management program as part of her orientation training. -She did not know the falls policy for the facility. -There were no clear directives from management to staff regarding falls.	D 270		

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-She had not found a policy relating to how often staff checked on residents.
-The incident reports were filed in the employee lounge on a wall file folder.
-The ED entered the information from the Incident Report to the electronic Personal Service Plan for that resident after completion.
-There was currently no system for determining if a resident required more supervision.

Interview with Resident Care Coordinator (RCC) on 3/22/18 at 4:00pm revealed:
-An Incident Report was to be completed every time a resident fell.
-The MA completed the first page of the Incident Report which detailed date and time of incident; description of incident and any other pertinent information relevant to the fall.
-He completed the last page which specified who was contacted; the family member, the PCP, the Power of Attorney (POA), and the date and time of the incident.
-The second page was an assessment page. This page included compliance and safety interventions, changes in medical or cognitive status, change in medications, change in ability to ambulate, and change in the environment.
-The previous Health and Wellness Director (HWD) had completed the assessment page.

Interview with the Area Health and Wellness Director (Area HWD) on 3/22/18 at 10:00am revealed:
-According to the falls policy, the staff notified the Power of Attorney (POA) or designated family member and the primary care physician (PCP) when a fall or incident occurred.
-The staff discussed falls in the community at the stand up and collaborative meetings.
-The staff requested a physical therapy consult if

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necessary.

Review of the Falls Management Policy revealed:
-Residents who sustain a fall should have a post fall investigation completed with interventions identified to reduce the potential for future falls and injuries.
-The ED and the HWD were responsible for verifying that staff completed the Falls Management Training Course during orientation and yearly.
-Identification of the resident risk factors relating to falls was embedded into the evaluation system.
-Resident falls were noted in the resident record and on the incident reports.
-A post fall investigation was to be completed after a resident fall and individualized interventions (i.e. medication changes, removing rugs, night lights, hip protectors, act.) were included in his/her service plans.
-If a fall occurred; assist the resident, call 911 if needed, notify the HWD and the ED, notify the physician for evaluation, care and treatment if indicated, notify the family, document the fall/injuries, resident response, and interventions taken in the resident record, review the fall in the morning stand up meeting to verify that the post fall was underway, discuss resident falls at the next collaborative care review meeting, additional interventions should be noted on the resident service plan if recurrent falls occur and all fall were tracked as a clinical indicator for quality improvement opportunities.

Review of the Post Fall Evaluation revealed:
-The initial evaluation was to be completed by who was on the scene first (i.e. what did the resident say happened and other factors involved?).
-A secondary evaluation was to be completed by

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D 270	Continued From page 20 the HWD or the ED, (i.e. what risk factors contributed to the fall, interventions added to the service plan to decrease future falls/injuries, compliance with safety interventions, change in medical/cognitive status, changes in medications, change in ability to ambulate, gait disturbances or decreased mobility, an any other interventions noted?). The facility failed to provide supervision for residents in accordance with the residents' current symptoms as evidenced by 2 of 2 sampled residents related to extended isolation resulting in falls, seclusion and a 10 lb. weight loss in 1 month (Resident #1), and 4 falls documented with injuries which included, laceration on the forehead, fracture of the right clavicle, contusion of the left lower extremity and a non-displaced fracture of the left ankle, and a head injury (Resident #2). The failure of the facility to provide supervision for the residents resulted in the serious injuries and neglect of residents and constitutes a Type A1 violation. _____ The facility failed to provide supervision for residents in accordance with the residents' current symptoms as evidenced by 2 of 5 sampled residents related to extended isolation resulting in falls, seclusion and a 10 lb. weight loss in 1 month (Resident #1), and 4 falls documented with injuries which included, laceration on the forehead, fracture of the right clavicle, contusion of the left lower extremity and a non-displaced fracture of the left ankle, and a head injury (Resident #2). The failure of the facility to provide supervision for the residents resulted in the serious injuries and neglect of residents and constitutes a Type A1 violation. _____ Plan of Protection was provided by the facilityon	D 270		

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D 270	Continued From page 21 3/22/18: -The HWD will review all falls/incidents and develop plan to address care needs. -In absence of the HWD, the ED or designee will be responsible. -Review will include falls within the last 90 days and ongoing. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 21, 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 of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for 3 out of 5 sampled residents (#1, #3, #4) resulting in Resident #3 not being served thickened liquids as ordered and being hospitalized with aspiration pneumonia, Resident #1 being isolated in her room causing an increase in her dementia and depression and a significant loss of weight, and Resident #4 refusing to wear thrombo-embolic deterrent (TED) hose because she needed a larger size. The findings are:	D 273		

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1. Review of Resident #3's current FL2 dated 2/19/18 revealed:
-Diagnoses included history of cerebrovascular accident (CVA) with residual hemiparesis and history of aspiration pneumonia.
-There was a physician's order for a dysphagia diet with nectar thickened liquids.

a. Review of Resident #3's hospital discharge summary dated 9/15/17 revealed:
-Resident #3 was hospitalized from 9/10/17 to 9/15/17.
-Resident #3's discharge diagnoses included pneumonitis due to inhalation of food and vomit along with acute respiratory failure with hypoxia.
-During his hospitalization, Resident #3 had a video swallow evaluation and was found to have dysphagia so a texture modified diet with nectar thickened liquids was ordered.

Review of Resident #3's hospital discharge summary dated 2/19/18 revealed:
-Resident #3 was hospitalized from 2/6/18 to 2/19/18.
-Resident #3's discharge diagnoses included aspiration pneumonia in the setting of dysphagia secondary to having a CVA in 2016.
-A physician's order for "honey thickened liquids only, not thin liquids given aspiration risk."
-Documentation that Resident #3 "had coughing and aspiration with a regular consistency diet, and both FEES (fiber-optic endoscopic evaluation of swallowing) and barium swallow confirmed that the patient consistently aspirated with thin liquids. He had been successful with a mechanical soft diet with honey thickened liquids and should remain on this diet indefinitely to prevent future aspiration events."

Review of Resident #3's emergency department

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discharge summary dated 3/4/18 revealed he was diagnosed with pneumonia.

Observation of the lunch meal service on 3/20/18 at 12:35pm revealed:
-Resident #3 was served a peanut butter and jelly sandwich, potato chips, and vanilla ice cream.
-Resident #3 was served water and tea not thickened.

Interview with the dietary cook on 3/20/18 at 12:40pm revealed:
-Resident #3 was served a regular diet with thin liquids because "he had signed a waiver."
-She confirmed with the Dietary Services Coordinator that Resident #3 still had a waiver (negotiated risk agreement) in place.

Review of Resident #3's negotiated risk agreement revealed:
-Resident #3, the Dietary Services Coordinator and the Executive Director (ED) had signed the facility's negotiated risk agreement on 9/18/17.
-There was documentation the final agreement specified Resident #3 could choose to have regular texture foods and thin liquids.
-The line for "signature of nurse" was left blank.
-There was documentation the negotiated risk agreement should be reviewed and modified if necessary as part of the service plan review or additionally for incidents related to the negotiated risk agreement.

Interview with the Area Health and Wellness Director (HWD) on 3/20/18 at 4:56pm revealed:
-She had completed the Licensed Health Professional Support (LHPS) evaluation for Resident #3 on 2/20/18, the day after his hospital discharge.
-She interviewed staff and according to them,

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Resident #3 "was scared due to his recent hospitalization for aspiration pneumonia and planned to adhere to his texture modified, thickened liquid diet" so she didn't think obtaining another negotiated risk agreement was necessary.
-Typically, when a negotiated risk agreement was completed, the Primary Care Physician (PCP) would be notified and this would be documented in the "resident log" section of the medical record.

Interview with the ED on 3/20/18 at 5:22pm revealed:
-She and the Dietary Services Coordinator had discussed the negotiated risk agreement with Resident #3 and they had all signed the agreement on 9/18/17.
-"It would cover us if we served a different diet than what was ordered for a resident."
-"Residents had the right to opt out of their recommended diet."
-The PCP had not been notified of the risk agreement signed on 9/18/17 because "the agreement was between the resident and the facility."
-Resident #3's insurance had changed in February 2018 and he did not currently have a PCP.

Interview with the Dietary Services Coordinator on 3/21/18 at 8:25am revealed:
-Resident #3 had been admitted to the facility on 4/20/17 on a texture modified diet with honey thickened liquids.
-Resident #3 often requested thin liquids and foods not on his diet.
-He and the ED discussed with Resident #3, the risks of not following his diet, including aspiration pneumonia and the resident elected to sign the negotiated risk agreement on 9/18/17.

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D 273	Continued From page 25 -He was informed by the Area HWD after Resident #3's 2/19/18 hospital discharge, Resident #3 was to follow a texture modified diet with nectar thickened liquids. -He did not know Resident #3 was still being served a regular diet with thin liquids. -However, if a risk agreement was on file, staff were allowed to serve a regular diet with thin liquids if the resident requested it. Interview with Resident #3's former Nurse Practitioner (NP) on 3/21/18 at 3:40pm revealed: -She had not been notified by the facility Resident #3 had signed a negotiated risk agreement specifying he could choose to have regular texture foods and thin liquids. -Resident #3 had been her patient up until February 2018 when his insurance had changed. -She last saw him on 12/7/17. -Resident #3 was on a texture modified diet and thickened liquids due to a previous stroke with hemiparesis and difficulty swallowing. -She was aware Resident #3 would request food and liquids not on his ordered diet. -She had discussed with Resident #3, the risk of not complying with his diet including choking and aspiration pneumonia after his hospitalization in September 2017. -Staff had expressed concerns to her that Resident #3 might not fully understand the risks involved due to his dementia. -She would expect staff to serve Resident #3 a texture modified diet with thickened liquids as ordered to protect him from aspirating. -If Resident #3 requested foods and liquids not on his diet, she would expect the staff to educate him each time regarding the risk involved. -If Resident #3 continued to request foods and liquids not on his diet, she would expect the facility to meet with the resident and his family to	D 273		

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discuss the risks with both parties.
-She would have expected the facility to notify her of his continued non-compliance.
-She was aware Resident #3 had been hospitalized in September 2017 with aspiration pneumonia, but did not know about the hospitalizations in February and March 2018.
-Being served a regular diet and thin liquids was likely the cause of him being hospitalized multiple times with aspiration pneumonia.

Interview with Resident #3 on 3/22/18 at 11:15am revealed:
-He had been on a "soft" diet and honey thickened liquids prior to his admission to this facility and up until his hospitalization in February 2018 when he was changed to a "soft" diet with nectar thickened liquids.
-The "management staff" had educated him about the risks of not following his diet and "that's when I had to sign the risk agreement, absolving them from liability if I aspirated."
-Staff did not revisit the negotiated risk agreement with him after him initially signing it in Sept. 2017.
-He requested the staff give him regular liquids because he did not like the taste of the thickened liquids when they added powdered thickener to them, and he felt thickened liquids contributed to his constipation.
-Each staff person mixed the powdered thickener differently so it could taste "better or worse."
-"I have a terrible problem with constipation. You don't know how bad I have to strain, and I'm afraid of what straining will do to my two hernias. I've already had hernia surgery once."

b. Interview with a medication aide (MA) on 3/22/18 at 12:49pm revealed:
-She had been a MA at this facility for 16 years.
-She always worked first shift and often worked a

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"double" to cover second shift so she was very familiar with Resident #3.
-She always worked on the floor where Resident #3 resided.
-Resident #3 complained "fairly often" of constipation.
-Resident #3 received two scheduled medications for constipation, Miralax and senna.
-Resident #3 also had a PRN order for another medication used to treat constipation, Colace.
-When Resident #3 complained of constipation, she would encourage him to drink more liquids or drink warm prune juice.
-He would typically have "a very large bowel movement every 4 days" that required the staff to physically "break it up so that it would go down the toilet."
-She had not administered PRN Colace to Resident #3 in the past 3 months.
-Resident #3 should be offered his PRN Colace each time he complained of constipation.
-When asked why she had not offered PRN Colace to Resident #3 she replied "I don't know."
-She could not recall ever having notified Resident #3's PCP of his problem with constipation.

A second interview with Resident #3 on 3/22/18 at 3:15pm revealed:
-He often reported his constipation to the MAs.
-When he reported his constipation to the MAs, they would encourage him to drink more liquids.
-If staff would mix his thickened liquids correctly and if his constipation could be treated, he would "absolutely" adhere to his thickened liquid diet to prevent aspiration pneumonia.
-"I'm not fond of the idea of dying."

Attempted telephone interview with Resident #3's family member on 3/22/18 at 1:13pm was

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D 273	Continued From page 28 unsuccessful. 2. Review of Resident #1's FL 2 dated 12/11/17 revealed diagnoses included Alzheimer's dementia, ulcerative colitis, and iron deficiency anemia. a. Review of Resident #1's hospital discharge summary dated 1/3/18 revealed: -Resident #1 was admitted 12/28/17 with a history of ulcerative colitis and worsening diarrhea. -Resident #1 was seen by a Gastroenterologist on 12/28/18 and the assessment was documented as, "diarrhea Clostridium Difficile (C-Diff), a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon positive, ulcerative colitis and urinary tract infection (UTI)". -The plan for Resident #1 was documented as, "continue vanomycin". -On 12/31/18 a second Gastroenterologist consulted and the following assessment was documented, "C-Diff positive, ulcerative colitis, UTI, anemia and dementia". -On 12/31/18 the plan was documented as, "will continue to monitor, continue vacomycin by mouth for 2 weeks, and add a probiotic". -No isolation was ordered or recommended. -On 1/3/18 a discharge diagnoses was documented as, "Clostridium Difficile diarrhea, and E Coli UTI". -On 1/3/18 Resident #1 was discharged back to the facility on vancomycin. -There was no documentation Resident #1 was in isolation or to be put in isolation for the C-Diff once back at the facility. Observation during initial tour on 3/20/18 at 9:40am revealed Resident #1's room had an isolation cart outside and no signage on the door.	D 273		

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D 273	Continued From page 29 Interview with a personal care aide (PCA) on 3/20/18 at 9:40am revealed: -Resident #1 was in isolation for C-Diff. -Resident #1 was in isolation since her return from the hospital on 1/3/18. -She was told by the Health and Wellness Director (HWD) Resident #1 was in isolation. Interview with the Area Health and Wellness Director (AHWD) on 3/20/18 at 10:18am revealed: -Resident #1 was in isolation for C-Diff. -In order to be released out of C-Diff isolation a "negative" stool culture must be obtained per their policy. -She was told by the Gastroenterologist (GI) Resident #1 "would never have a negative" stool culture. -She was aware the primary care physician wanted Resident #1 out of isolation back in February but would not remove Resident #1 out of isolation per their infection control policy for C-Diff. -She could not provide a copy of the facility's isolation protocol policy for C-Diff. Interview with the Health and Wellness Director (HWD) on 3/20/18 at 10:18am revealed: -Resident #1 was put in isolation after returning from hospital with a positive C-Diff stool culture. -Resident #1 had to have a "negative stool culture to be removed out of isolation according to the facility's policy. -She did not call the primary care physician to get orders involving isolation after Resident #1 returned from the hospital. -Resident #1 was not in isolation at the hospital but the policy documented a negative stool culture was needed to be removed out of isolation.	D 273		

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D 273	Continued From page 30 -She was not able to provide a facility copy of the isolation policy on C-Diff. Interview with Resident Care Coordinator (RCC) on 3/20/18 at 11:00am revealed: -Resident was put in isolation after returning from hospital with a diagnoses of C-Diff. -The Executive Director (ED) told the staff that the isolation will continue until a "negative" stool culture is received. -He could not provide a facility copy of the isolation policy on C-Diff. Interview with Resident #1's Nurse Practitioner (NP) on 3/20/18 at 12:03pm revealed: -Resident #1 was seen at the facility first on 2/5/18 while on 2nd round of vancomycin. -On 2/5/18 she was informed by the facility about the need for a negative stool culture. -She told the HWD, RCC and the ED that a negative stool culture would never happen. -She expected the facility to revisit their infection control policy because Resident #1 should be out of isolation. -She told the HWD to remove Resident #1 out of isolation and was told by the HWD that Resident #1 could not come out of isolation per the facility's policy until a negative stool culture was provided. -She did not receive notification the isolation policy did not require a negative stool culture to be removed from isolation as of 3/20/18. -It was the NP's expectation for the facility to notify her that the policy did not require a negative stool culture to come out of isolation. -She attributed the diarrhea to Resident #1's ulcerative colitis because it is bloody not like C-Diff which is very watery. -The extended amount of time Resident #1 was in isolation contributed to Resident #1's increase in dementia and depression, a 10 lb. weight	D 273		

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reduction from 2/5/18 - 3/20/18, a total of a 14.5 % related to the lack of social interaction and a functional decline leading to falls seriously impacted Resident #1's quality of life.

Interview with a family member on 3/20/18 at 1:00pm revealed:
-She was a Nurse.
-Resident #1 did not need to be in isolation according to what she was told by the NP.
-Resident #1 would never have a negative stool culture and the facility would not take Resident #1 out of isolation because of that.
-Resident #1 was able to "do for herself" before the 12/28/18 hospitalization.
-Resident #1 took daily walks, enjoyed the sunshine and eating in the dining room with other residents prior to the isolation.
-Now Resident #1 was depressed, and very lonely because of being in isolation and not able to interact on a routine basis.
-It was her understanding after she talked with the NP that after being on isolation for an extended amount of time led Resident #1 to a 14.5 % reduction in her weight since released from the hospital 1/3/18 and an increase in Resident #1's depression because of the seclusion and lack of regular interaction with people.
-Resident #1 would socialize in the dining room every day with every meal prior to isolation.
-Now Resident #1 was secluded to her room and could not interact with the other residents on a daily basis.
-Resident #1 only interacted with the staff when the MAs or PCAs brought in Resident #1's medications or food.
-Resident #1's food was dropped off and left there for Resident #1 to set up for herself and "now with the dementia getting worse Resident

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#1 did not even know to open her food tray and give her cues. There was no one there to give her cues to eat or to prompt her to eat more if Resident #1 was only picking at her food".
-She contributed the decline in Resident #1's health to the isolation and the decreased social interaction.
-She expected the facility to provide Resident #1 more frequent checks and to help set up the meals in Resident #1's room and prompt Resident #1 to eat.
-She was told by the Administrator, Resident #1 would not be taken out of isolation without a negative stool culture.

Interview with the ED on 3/21/18 at 9:55am revealed:
-Resident #1 was in isolation since return form hospital 1/3/18 due to C-Diff.
-She did not know if Resident #1 was in isolation at the hospital but because of the C-Diff and a "positive" stool culture, Resident #1 was put in isolation by her.
-Her facility policy required a negative stool culture to remove from isolation.
-She did not provide a copy of the facility infection control policy.
-The facility's policy was to keep in isolation until a negative stool culture was obtained in order to protect other residents and staff.
-She did not notify the NP for guidance related to the C-Diff other than to ask for a stool culture to be done and if it was negative then Resident #1 would be released out of isolation.

Interview with the Area Health and Wellness Director (Area HWD) on 3/22/18 at 4:31pm revealed:
-She provided a copy of the facility's C-Diff infection control policy.

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D 273	Continued From page 33 -According to thier policy, Resident #1 did not need to be in isolation. -She removed Resident #1 out of isolation and a MA took Resident #1 to the dining room to have supper with the rest of the residents. b. Interview with Resident #1's Nurse Practitioner (NP) on 3/20/18 at 12:03pm revealed: -Resident #1 was seen at the facility first on 2/5/18 while on 2nd round of vancomycin. -She documented a 10 lb. weight reduction from 2/5/18 - 3/20/18, a total of a 14.5 % related to the lack of social interaction and a functional decline leading to falls seriously impacted Resident #1's quality of life. Interview with a family member on 3/20/18 at 1:00pm revealed: -It was her understanding after she talked with the NP that after being on isolation for an extended amount of time lead Resident #1 to a 14.5 % reduction in her weight since released from the hospital 1/3/18. -Resident #1 only interacts with the staff when the MAs or PCAs bring in Resident #1's medications or food. -Resident #1's food was dropped off and left there for Resident #1 to set up for herself and now with the dementia getting worse Resident #1 does not even know to open her food tray and start eating. There is no one there to give her cues to eat or to prompt her to eat more if Resident #1 was only picking at her food. -She expected the facility to provide Resident #1 more frequent checks and to help set up the meals in Resident #1's room and prompt Resident #1 to eat. Interview with a second PCA on 3/22/18 at 4:17pm revealed:	D 273		

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D 273	Continued From page 34 -She delivered meals to Resident #1 and answered the call bell when Resident #1 called out. -She did not set up Resident #1's food and picked up the tray later. -Resident #1 did not eat her meals sometimes and reported it to the medication aide (MA). Interview with third PCA on 3/22/18 at 4:17pm revealed: -Resident #1 was in isolation and the only time she went in there was to deliver her meal and if she rang the call bell. -She did not set up the meal just would deliver it and pick up the tray and put the tray in Resident #1's trash in the room. -She did not keep track of the amount consumed by Resident #1. 3. Review of Resident #4's current FL2 dated 5/18/17 revealed diagnoses included atrial fibrillation, hypothyroidism, hypertension, hyperlipidemia, right total hip revision. Review of Resident #4's physician's orders revealed an order dated 12/27/17 that TED hose should be applied in the morning and removed at bedtime. Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated 1/29/18 listed thrombo-embolic deterrent (TED) hose as an assigned task. Review of Resident #4's electronic Medication Administration Record (eMAR) for January 2018 revealed: -Application of TED hose had been documented as refused on 8 days, including: 1/9/18, 1/10/18, 1/11/18, 1/16/18, 1/19/18, 1/20/18, 1/21/18, and 1/24/18.	D 273		

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-TED hose were documented as being applied on all other days during January at 8:00am.

Review of Resident #4's eMAR for February 2018 revealed:
-Application of TED hose had been documented as refused on 7 days, including: 2/2/18, 2/16/18, 2/18/18, 2/21/18, 2/26/18, 2/27/18, and 2/28/18.
-TED hose were documented as being applied on all other days during February at 8:00am.

Review of Resident #4's eMAR for March 2018 (3/1/18 - 3/20/18) revealed:
-Application of TED hose had been documented as refused on 9 days, including: 3/2/18, 3/3/18, 3/4/18, 3/7/18, 3/8/18, 3/12/18, 3/14/18, 3/17/18, 3/18/18.
-TED hose were documented as having been applied on all other days between 3/1/18 and 3/20/18, including 3/20/18 at 8:00am.

Observation of Resident #4 on 3/20/18 at 9:56am revealed she was not wearing TED hose.

Observation of Resident #4 on 3/22/18 at 3:45pm revealed:
-She was not wearing TED hose.
-Her feet and legs were slightly swollen.

Interview with Resident #4 on 3/22/18 at 3:45pm revealed:
-The doctor had told her "a while back" that she should wear TED hose, and the facility had ordered them for her.
-She had tried a few times to wear them but they were "too small" and someone had said they were going to try to get her a different size (was unable to recall who had told her this).
-"I never wear them."
-She had not been sick in a long time, so she had

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not seen the doctor in several months.
-She was not sure if the doctor was aware that she was not wearing her TED hose.
-The facility staff had not been asking her on a daily basis about wearing the TED hose.
-If she had a pair of TED hose that fit her properly, she would be agreeable to wearing them.

Interview with a nurse at Resident #4's Nurse Practitioner's (NP) office on 3/22/18 at 10:37am revealed:
-The doctor had ordered the TED hose on 12/27/17.
-There were no subsequent orders to discontinue to the order for TED hose.
-They had no documentation of communication from the facility that the resident had been refusing to wear the TED hose or that a different size might be needed to meet her needs.

Review of Resident #4's Care Notes revealed documention on 12/23/17 the resident had a negative x-ray and ultrasound, and to "encourage to wear TED hose."

Confidential interview with a medication aide (MA) revealed:
-When asked about residents who wore TED hose, she did not mention Resident #4.
-Resident #4 had an order for TED hose, but that she refused when they tried to put them on.
-She was not aware how often Resident #4 refused to wear TED hose.
-She generally would take medications to Resident #4 at night, and by that time, she never had any TED hose on because Resident #4 had already removed them.

Confidential interview with another MA revealed:

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D 273	Continued From page 37 -Resident #4 had an order for TED hose, and application/removal of the TED hose appeared on the eMAR. -Resident #4 frequently refused to wear TED hose. -When the physician came to the facility, the facility staff communicated with her that Resident #4 continued to refuse to wear the TED hose, but they did not routinely document doing so anywhere. -The facility did not communicate with the physician regarding TED hose refusals unless the physician happened to be in the facility. Confidential interview with a personal care aide (PCA) revealed: -Resident #4 did have TED hose, but she refused to wear them because they were "too tight." -She would "sometimes" attempt to put them on her, but Resident #4 always refused. Attempted telephone interviews with Resident #4's NP on 3/22/18 at 10:37am and 3:25pm were unsuccessful. Interview with the Health and Wellness Director on 3/22/18 at 4:20pm revealed: -She recently became aware of Resident #4's refusals to wear TED hose, and had informed staff that refusals needed to be documented in the resident's record, and if a pattern of refusal had been identified, the doctor would need to be notified so that they could consider getting an order to discontinue the TED hose. -She was not aware that Resident #4 thought that her TED hose were the wrong size, and that she thought someone was supposed to be getting a different size for her. The facility failed to assure referral and follow up	D 273		

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D 273	Continued From page 38 to meet the health care needs for 3 of 5 sampled residents (#1, #3, #4). The facility failed to notify the physician in regards to Resident #3 signing a negotiated risk agreement and staff routinely serving him a regular diet with thin liquids resulting in Resident #3 being hospitalized with aspiration pneumonia on two occasions. The facility failed to communicate with Resident #1's physicians in regards to her being on facility imposed isolation precautions for C-diff diarrhea resulting in Resident #1 having an increase in her dementia and depression, having a 10 lb. loss of weight, and a functional decline leading to falls. The failure of the facility to meet health care needs resulted in the serious injury of residents and constitutes a Type A1 violation. Review of the Plan of Protection submitted by the facility dated 3/21/18 revealed: -The facility will serve Resident #3 honey thickened liquids until the diet order can be clarified at his physician's appointment on 3/26/18. -The HWD will review all charts by 3/25/18 to insure the required follow up with general practitioners has occurred. -All discharge paperwork including the FL2 will be reviewed by the HWD or designee to insure orders are consistent and clear as they occur. -The HWD will be responsible to evaluate acute changes in condition and follow up as needed with physicians. -Orders from doctor's and hospitals will be sent to the general practitioner for coordination of care and agreement of continuing treatment. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 21, 2018.	D 273		

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D 276	Continued From page 39	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 3 of 5 sampled residents related to recording the number of stools per day (Resident #1), physical therapy (PT) and occupational therapy (OT) (Resident #2) and compression sleeves (Resident #5). The findings are: Review of Resident #1's FL 2 dated 12/11/17 revealed diagnoses included Alzheimer's dementia, ulcerative colitis, and iron deficiency anemia. Review of Resident #1's hospital discharge summary dated 1/3/18 revealed: -Resident #1 was admitted 12/28/17 with a history of ulcerative colitis and worsening diarrhea. -On 1/3/18 a discharge diagnoses was documented as, "Clostridium Difficile (C-Diff) diarrhea, a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon and E Coli UTI, a type	D 276		

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of bacteria commonly found in the gastrointestinal (GI) tract that has caused an infection in the urinary tract".".
-On 1/3/18 Resident #1 was discharged back to the facility.

Review of a physician visit noted dated 2/12/18 revealed, a weight loss due to diarrhea and a decreased appetite.

Review of Resident #1 physician's order dated 2/19/18 revealed; to please document the number of stools per day.

Review of the progress notes dated 2/19/18 at 7:19pm revealed the physician "also wants documentation on Resident #1 stools".

Further review of progress notes from 2/19/18 to present revealed no documentation of the number of stools per day.

Further review of Resident #1's record revealed no documentation of the number of stools per day for Resident #1.

Review of Resident #1's February 2018 electronic medication administration record (eMAR) and treatment administration record (TAR) revealed there was no order transcribed to record the number of stools per day.

Review of Resident #1's March 2018 eMAR and TAR revealed no order transcribed to record the number of stools per day.

Interview with the Area Health and Wellness Director (AHWD) on 3/20/18 at 10:18am revealed:
-Resident #1 was in isolation for C-Diff.

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D 276	Continued From page 41 -She did not record the number of stools per day on Resident #1. -She was not aware of an order to document or record the number of stools per day on Resident #1. Interview with Resident Care Coordinator (RCC) on 3/20/18 at 11:00am revealed: -He did not know of an order to record the number of stools per day for Resident #1. -He did not record the number of stools per day for Resident #1. -If stools were to be documented then they would be documented in the nurse's notes or on the TARs or the eMARs. Interview with Resident #1's Nurse Practitioner (NP) on 3/20/18 at 12:03pm revealed: -Resident #1 was seen at the facility first on 2/5/18. -She saw Resident #1 on 2/19/18 and wrote an order to document the number of stools per day related to the diarrhea and weight loss. -It was her expectation for the facility to document the number of stools per day in order to identify when the symptoms of the C-Diff were gone to remove Resident #1 out of isolation. Interview with a family member on 3/20/18 at 1:00pm revealed: -She was a nurse. -Resident #1 had diarrhea a lot and the staff was not keeping track of the number of stools per day. -She was not aware the facility did not document the number of stools per day. -She considered it very important to document the number of stools per day because it would show Resident #1 was not having symptoms of C-diff and expected the facility to follow the NP's orders.	D 276		

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D 276	Continued From page 42 Interview with the Executive Director (ED) on 3/20/18 at 6:00pm revealed: -She did not know about an order to record the number of stools per day for Resident #1. -The MAs received the orders from the providers and should enter them into the eMAR. -The MAs should fax all orders over to the pharmacy. -There were no checks before 3/20/18 to ensure the orders from the providers matched the eMARs. 2. Review of Resident # 2's current FL2 dated 2/23/18 revealed: -Diagnoses included a clavicle fracture, generalized weakness; congestive heart failure (CHF), atrial fibrillation (AF), asthma, a history of falls, tremors, glaucoma, benign prostatic hyperplasia (BPH) and depression. -An order was written on the FL2 for physical therapy (PT) and occupational therapy (OT) 3-5 times a week. Review of the fall incident reports revealed: -Resident #2 had 4 falls from 01/04/18 to 3/14/18. -3 of the 4 falls were documented as unwitnessed or "found on floor". -Documented injuries included; laceration on the forehead on 1/4/18, fracture of the right clavicle on 2/1/18, a contusion of the left lower extremity and non displaced fracture of the left ankle on 2/14/18; and a head injury on 3/14/18. -Further review of incident reports revealed 3 of the 4 falls happened on 2nd shift. Interview with Resident #2 on 3/20/18 at 9:50am revealed: -He had been to the hospital several times in the past few months for injuries related to falls.	D 276		

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D 276	Continued From page 43 -He was discharged from the skilled rehabilitation facility on 2/28/18 with orders to continue PT and OT. -He had an unwitnessed fall in his room on 3/14/18 and incurred a head injury. -He had not received PT or OT since returning to the assisted living facility. "The staff doesn't know anything when I ask them" (about my therapy). -Resident #2 ambulated independently in a wheelchair. "I was using my rollator to walk around until my last fall." -He was anxious to begin therapy to get back to his baseline and was frustrated he could not get any assistance. Interview with the Resident Care Coordinator (RCC) on 3/21/18 at 4:00pm revealed: -Resident #2 had been hospitalized for pneumonia and a gastrointestinal (GI) bleed on 12/26/18 and 12/28/18. -Resident #2 was in a skilled facility from 2/9/18-2/28/18 related to injuries from falls. -Resident has had several falls in the past few months. -Resident #2 had an unwitnessed fall in his room (3/14/18) since he returned from rehabilitation. -He did not know the resident had orders for PT/OT on the FL2 dated 2/23/18. -The medication aides (MAs) were responsible for initiating the referral orders. Interview with the Executive Director (ED) on 3/22/18 at 11:00am revealed: -When a resident returned with PT/OT orders, we referred them to the facility's physical therapy department. -If the resident was independent, the resident would follow up with those orders. -We try to "work it out" and help them with the referral, but if they were independent "we let them	D 276		

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do it."
-Resident #2 was independent with his doctor appointments and referrals.
-She did not know he had an order from 2/28/18 for PT/OT.
-She expected the RCC to assist Resident #2 if necessary.

Interview with the MA on 3/22/18 at 11:15am revealed:
-When a resident returned with orders for PT/OT, they were referred to the facility's physical therapy team.
-A file box was located on the wall in the employee lounge where the orders for PT/OT were placed.
-The physical therapists checked the file box 2-3 times a week.
-If an order for therapy services were on an FL2, " ... I guess we would call the therapists and let them know. We don't leave FL2's in the PT/OT order box."
-If the resident's insurance did not reimburse therapy services at the facility's therapy team, she did not know what happened.
-"I guess we would have to let someone know. I have never had to deal with that scenario."

Interview with the facility's physical therapist on 3/21/18 at 11:35am revealed the therapist did not have Resident #2 on his schedule as a client.

Telephone interview with the facility's PT coordinator on 3/21/18 at 2:35pm revealed:
-Resident #2's insurance company did not cover PT/OT services through the facility's in house therapy team.
-She tried to direct residents to other companies if her assistance was requested.
-The resident did not contact her directly for

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assistance.
-She thought Resident #2's previous home health agency would be initiating care since they were on his discharge orders from the skilled facility.
-She had not reached out to any other home health services for Resident #2.

Telephone interview with Resident #2's primary care physician's (PCP) nurse on 3/22/18 at 10:15 am revealed:
- The PCP was not aware of the PT/OT orders for Resident #2.
-The discharge FL2 from the skilled facility was not sent to the PCP for verification.
-The only correspondence from the facility since January was an incident report regarding a fall on 2/2/18.
-The PCP would expect the facility to follow the PT and OT orders on the discharge FL2 from the skilled rehabilitation facility due to Resident #2's repeated falls.

Interview with Area Health and Wellness Director (Area HWD) on 3/22/18 at 9:40am revealed:
-She did not know Resident #2 had a PT/OT order on his re-admission FL2 dated 2/28/18.
-The RCC should oversee the PT/OT resident orders.
-The referral should go to our physical therapy department first.
-If the resident's insurance does not cover the facility's therapy plan, the coordinator should have contacted other home health agencies to get the treatment the resident needed.
-She did not know the coordinator was not actively searching for a home health company for this order.

Interview with Health and Wellness Director (HWD) on 3/22/18 at 3:55pm revealed:

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D 276	Continued From page 46 -She had been employed by the facility for 2 weeks. -She did not know Resident #2 had an order for PT/OT from 2/28/18. -She was not sure of the process for referrals for PT/OT services in this facility.	D 276		
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, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician orders for a texture modified diet with nectar thickened liquids. The findings are: Review of the therapeutic diet list posted in the kitchen on 3/20/18 revealed Resident #3 was to be served a texture modified diet with nectar thickened liquids. Review of the therapeutic diet menu for lunch on 3/20/18 revealed residents on a texture modified diet were to be served: -Chicken tortellini soup with chunks of meat and vegetables less than ½ inch in size.	D 310		

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D 310	Continued From page 47 -Choice of a Dijon chicken sandwich (ground chicken served with gravy on a soft bun with shredded lettuce) or bratwurst with sauerkraut (ground bratwurst served with gravy and soft, well-cooked sauerkraut) or baked sole served with veloute sauce or a hot pork sandwich (ground pork served with gravy on soft white bread with shredded lettuce) or a chef salad (green peppers and tomatoes omitted with ground turkey and ground ham served over shredded lettuce). -Choice of potato pancakes served tender with applesauce or peas with carrots served tender and well-cooked or sautéed zucchini with apples served tender and well-cooked. -A soft dinner roll with butter. -Choice of a vanilla cookie served soft, or a sugar free sugar cookie served soft, or chilled pears. Review of a typed sign posted in the serving kitchen on 3/20/18 revealed the following guidance for staff in regards to thickened liquids: -Nectar thickened liquids pour smoothly, like syrup. -If drinks were not pre-thickened, read instructions prior to mixing consistency. Different thickening products/brands may have slightly different directions and/or mixture combinations. -No ice in drinks. -No ice cream (It does not hold its texture when eating. When the mouth heats it, it melts to thin/regular liquid.) Observation on 3/20/18 from 12:00pm to 1:35pm of the lunch meal service revealed: -Resident #3 was served a peanut butter and jelly sandwich, potato chips and vanilla ice cream. -Resident #3 was served iced water and iced tea not thickened. -Resident #3 coughed periodically throughout the	D 310		

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meal.
-Resident #3 consumed 100% of his food and drinks.

Interview with the dietary cook on 3/20/18 at 12:40pm revealed:
-She was aware Resident #3's diet was listed as being texture modified with nectar thickened liquids on the therapeutic diet list.
-Resident #3 was always served a regular diet with thin liquids because "he had signed a waiver."
-She confirmed with the Dietary Services Coordinator that Resident #3 still had a waiver (negotiated risk agreement) in place.

Review of Resident #3's current FL2 dated 2/19/18 revealed:
-Diagnoses included cerebrovascular accident (CVA) with residual hemiparesis and history of aspiration pneumonia.
-A physician's order for a dysphagia diet with nectar thickened liquids.

Review of the texture modified diet menu for dinner on 3/20/18 revealed residents on a texture modified diet were to be served a ground crab cake and tender soft French fries.

Observation of the dinner meal service on 3/20/18 at 6:00pm revealed:
-Resident #3 was served a ground crab cake, French fries, honey thickened water and nectar thickened tea.
-Resident #3 did not have any coughing episodes.

Observation of the serving kitchen on 3/20/18 at 6:05pm revealed:
-1 opened container of pre-thickened honey

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consistency water.
-There were no containers of pre-thickened nectar consistency water.
-There were no containers of pre-thickened tea.

Interview with a dietary server on 3/20/18 at 6:07pm revealed:
-She prepared and served drinks to Resident #3.
-She had been told by the Resident Care Coordinator (RCC) at the beginning of dinner service Resident #3 was to be served a texture modified diet with thickened liquids.
-The kitchen was out of pre-thickened tea so she had used powdered thickener and mixed Resident #3's tea to a nectar consistency.
-She had served pre-thickened honey consistency water to Resident #3.
-She had served Resident #3 liquids with different consistencies because she had forgotten what his diet order was since it had been "awhile since they had served him thickened liquids."
-She was aware of the therapeutic diet list posted in the kitchen indicating Resident #3 was to be served nectar consistency liquids but she had not referred to it prior to serving his drinks.

Review of Resident #3's hospital discharge summary dated 9/15/17 revealed:
-Resident #3 was hospitalized from 9/10/17 to 9/15/17.
-Resident #3's discharge diagnoses included pneumonitis due to inhalation of food and vomit along with acute respiratory failure with hypoxia.
-During his hospitalization, Resident #3 had a video swallow evaluation and was found to have dysphagia so a texture modified diet with nectar thickened liquids was ordered.

Review of Resident #3's hospital discharge summary dated 2/19/18 revealed:

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-Resident #3 was hospitalized from 2/6/18 to 2/19/18.
-Resident #3's discharge diagnoses included aspiration pneumonia in the setting of dysphagia secondary to having a CVA in 2016.
-A physician's order for "honey thickened liquids only, not thin liquids given aspiration risk."
-Documentation that Resident #3 "had coughing and aspiration with a regular consistency diet, and both FEES (fiber-optic endoscopic evaluation of swallowing) and barium swallow confirmed that the patient consistently aspirated with thin liquids. He had been successful with a mechanical soft diet with honey thickened liquids and should remain on this diet indefinitely to prevent future aspiration events."

Review of Resident #3's emergency department discharge summary dated 3/4/18 revealed he was diagnosed with pneumonia.

Review of Resident #3's negotiated risk agreement revealed:
-Resident #3, the Dietary Services Coordinator and the Executive Director (ED) had signed the facility's negotiated risk agreement on 9/18/17.
-There was documentation the final agreement was Resident #3 could choose to have regular texture foods and thin liquids.
-The line for "signature of nurse" was left blank.
-There was documentation the negotiated risk agreement should be reviewed and modified if necessary as part of the service plan review or additionally for incidents related to the negotiated risk agreement.

Interview with the Area Health and Wellness Director (HWD) on 3/20/18 at 4:56pm revealed:
-She had completed the Licensed Health Professional Support (LHPS) evaluation for

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Resident #3 on 2/20/18, the day after his hospital discharge.
-She interviewed staff and according to them, Resident #3 "was scared due to his recent hospitalization for aspiration pneumonia and planned to adhere to his texture modified, thickened liquid diet" so she didn't think obtaining another negotiated risk agreement was necessary.
-Typically, when a negotiated risk agreement was completed, the Primary Care Physician (PCP) would be notified and new diet orders obtained.

Interview with the Executive Director (ED) on 3/20/18 at 5:22pm revealed:
-She and the Dietary Services Coordinator had discussed the negotiated risk agreement with Resident #3 and they had all signed the agreement on 9/18/17.
-She was under the impression "it would cover us if we served a different diet than what was ordered for a resident."
-"Residents had the right to opt out of their recommended diet."
-The PCP had not been notified of the risk agreement signed on 9/18/17 because "the agreement was between the resident and the facility."

Interview with the Dietary Services Coordinator on 3/21/18 at 8:25am revealed:
-He was responsible for the training and oversight of all dietary staff.
-Resident #3 had been admitted to the facility on 4/20/17 on a texture modified diet with honey thickened liquids.
-Resident #3 often requested thin liquids and foods not on his diet.
-He and the ED discussed with Resident #3 the risks of not following his diet, including aspiration

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pneumonia and the resident elected to sign the negotiated risk agreement.
-He was informed by the Area HWD after Resident #3's 2/19/18 hospital discharge, Resident #3 was to follow a texture modified diet with nectar thickened liquids.
-The dietary server was responsible for plating residents' food and serving their drinks.
-He did not know Resident #3 was still being served a regular diet with thin liquids.
-However, if a risk agreement was on file, staff were allowed to serve a regular diet with thin liquids if the resident requested it.

Interview with Resident #3's former Nurse Practitioner (NP) on 3/21/18 at 3:40pm revealed:
-Resident #3 had been her patient up until February 2018 when his insurance had changed.
-She last saw him on 12/7/17.
-Resident #3 was on a texture modified diet and thickened liquids due to a previous stroke with hemiparesis and difficulty swallowing.
-She was aware Resident #3 would request food and liquids not on his ordered diet.
-She had discussed with Resident #3 the risk of not complying with his diet including choking and aspiration pneumonia.
-Staff had expressed concerns to her that Resident #3 might not fully understand the risks involved due to his dementia.
-She had not been notified by the facility Resident #3 had signed a negotiated risk agreement specifying he could choose to have regular texture foods and thin liquids.
-She would expect staff to serve Resident #3 a texture modified diet with thickened liquids as ordered to protect him from aspirating.
-If Resident #3 requested foods and liquids not on his diet, she would expect the staff to educate him each time regarding the risk involved.

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-If Resident #3 continued to request foods and liquids not on his diet, she would expect the facility to meet with the resident and his family to discuss the risks with both parties.
-She was aware Resident #3 had been hospitalized in Sept. 2017 with aspiration pneumonia, but did not know about the hospitalizations in Feb. and March 2018.
-Being served a regular diet and thin liquids was likely the cause of him being hospitalized multiple times with aspiration pneumonia.

Observation of a dietary server mixing thickened water for Resident #3 on 3/22/18 at 12:30pm revealed:
-The instructions on the can of thickener indicated to mix 2 tablespoons (T) plus 1 ½ teaspoons (tsp) of powder into 6 ounces (oz.) of liquid to create a honey consistency.
-The dietary server mixed the incorrect amounts of powder into water.
-The dietary server mixed 1 T. plus 1 tsp. of powder into 6 oz. of water and indicated it was ready to be served to Resident #3.

Interview with the dietary server preparing Resident #3's thickened water on 3/22/18 at 12:30pm revealed:
-She had been a dietary server at this facility for 11 years.
-Resident #3 was to be served honey thickened liquids until clarification could be obtained from his PCP on whether he should be on nectar thick or honey thick liquids.
-She did not realize she mixed the powder incorrectly.
-No one had trained her on how to mix the thickened liquids to the proper consistency.
-She was supposed to read the directions on the thickener container but she did not have her

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glasses on so she was unable to read it.
-When Resident #3 requested regular liquids, she would provide them to him because he had signed a waiver.
-She had never attempted to educate Resident #3 on the risks of not following his ordered diet.

Interviews with Resident #3 on 3/20/18 at 12:45pm and 3/22/18 at 11:15am revealed:
-He had been on a "soft" diet and honey thickened liquids prior to his admission to this facility and up until his hospitalization in Feb. 2018 when he was changed to a "soft" diet with nectar thickened liquids.
-The "management staff" had educated him about the risks of not following his diet and "that's when I had to sign the risk agreement, absolving them from liability if I aspirated."
-He was served a peanut butter and jelly sandwich, potato chips and vanilla ice cream at the lunch meal service on 3/20/18 because that was what he requested.
-The dietary servers typically served him whatever he requested.
-He was served iced tea and iced water at the lunch meal service on 3/20/18 because the servers knew he did not like thickened liquids.
-He requested the staff give him regular liquids because he did not like the taste of the thickened liquids when they added powdered thickener to them, and he felt thickened liquids contributed to his constipation.
-Each staff person mixed the powdered thickener differently so it could taste "better or worse."

Interview with the Area Health and Wellness Director on 3/22/18 at 4:33pm revealed:
-Dietary servers were expected to refer to the posted therapeutic diet list prior to serving residents to ensure they are served their

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physician ordered diet.
-The Dietary Services Coordinator was responsible for the training and oversight of all dietary staff.
-The facility had a policy that only pre-thickened liquids should be used and no powdered thickeners that required staff to mix them.
-She would address the policy with the Dietary Services Coordinator to ensure only pre-thickened liquids were used in the future.

The facility failed to serve Resident #3, who had a history of aspiration pneumonia, a texture modified, nectar thickened diet as ordered by his physician. Serving Resident #3 a regular diet with thin liquids put him at risk for aspiration pneumonia occurring again. This was detrimental to the health, safety and welfare of the resident which constitutes a Type B violation.

Review of the Plan of Protection submitted by the facility dated 3/20/18 revealed:
-The facility will assure Resident #3 is served the diet as ordered by the physician until clarified.
-The HWD and Resident Care Coordinator (RCC) will meet with the dining staff and care staff to review the correct diet for Resident #3 and will monitor meal services.
-The HWD and RCC will review the diet recommendations with Resident #3. If the resident wishes to refuse the recommended diet, then proceed with the negotiated risk agreement and contact the physician for the appropriate order.
-The HWD and RCC will review all resident records to assure diet orders match the diets being served.
-The HWD and RCC will review the diet order process with dining and clinical staff (including

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D 310	Continued From page 56 review of orders post-hospitalization). CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 6, 2018.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure contact with the prescribing physician for verification of orders for 1 of 5 sampled residents and clarification of orders for 2 of 5 sampled residents related to an FL2 not dated and signed by a prescribing physician within 24 hours of the resident being readmitted to the facility (Resident #2); two different diet orders dated on the same day (Resident #3), and instructions from a wound care physician for a compression sleeve (Resident #5).	D 344		

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D 344	Continued From page 57 The findings are: 1. Review of Resident # 2's current FL2 dated 2/23/18 revealed: - Multiple diagnoses included a clavicle fracture, congestive heart failure (CHF), atrial fibrillation (AF), aortic stenosis, complete heart block, asthma, history of falls, tremors, glaucoma, hypertension, colitis, benign prostatic hyperplasia (BPH) and depression. -The medications listed included amlodipine besylate tablet 10milligrams (mg) once a day, a finasteride tablet 5 mg once a day, a flomax capsule 0.4mg once a day, vitamin D3 tablet 1000 units once a day, buspirone HCL tablet 15mg 2 times a day, metoprolol tartrate tablet 25 mg twice a day and a Tylenol tablet 325mg take 2 tablets every 4 hours as needed (PRN). Review of Resident #2's record revealed he was admitted to the hospital on 2/1/18 - 2/9/18 for a fall resulting in a clavicle fracture and generalized weakness. Review of Resident #2's record revealed he was admitted to a skilled rehabilitation facility on 2/9/18 and readmitted to the facility on 2/28/18. Review of Resident #2's record revealed: -There were 25 medications Resident #2 was receiving prior to his hospitalization. -He returned to the facility with physician orders for 9 medications. -16 medications were not reordered upon his readmission which included; an entry for balsalazide disodium 750 mg, scheduled to be administered 3 times a day at 9am, 2pm and 7pm, for gastrointestinal health; celexa 20mg, scheduled to be administered once a day at 9am for depression; colazal 2,250 mg, scheduled to be	D 344		

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administered at 8am, 2pm and 8 pm, for inflammation due to colitis; flonase, 2 sprays in both nostrils up to 4 times a day, prn for congestion; lasix 20 mg, scheduled to be administered once a day at 8am, for retention of fluid related to CHF; lactinex 1 tab, scheduled to be administered twice a day before meals, for intestine and colon health; latanoprost 0.005% 1 drop in each eye, scheduled to be administered at bedtime, for glaucoma to decrease eye pressure; lisinopril 40 mg, scheduled to be administered once a day at 9am, for high blood pressure; Preparation H suppository, scheduled to be administered every 12 hours, as needed for hemorrhoidal discomfort; pyridium 200mg, scheduled to be administered prn every 8 hours, for urinary burning; Senna plus 8.6-50mg, scheduled to be administered every 12 hours, as needed for constipation; sodium chloride 0.65% nasal spray, 1 spray by nasal route, scheduled to be administered as needed for congestion; topamax 100mg, scheduled to be administered twice a day at 9am and 7pm, as an anticovulsant; duoneb 0.5-2.5 nebulizer treatments 1 vial, scheduled to be administered prn every 6 hours, for shortness of breath and urispas 100 mg scheduled to be administered prn up to 3 times a day for painful urination.

Interview with the medication aid (MA) on 3/21/18 at 10:15am regarding the procedures for processing new orders on an FL2 revealed:
-The MAs faxed the FL2 to the pharmacy with the medications listed.
-The MAs transcribed the orders onto the eMAR.
-The MAs filed the FL2 in the chart.
-Prescribing medical practitioners were not sent a copy of the FL2 for verification.
-The primary care physician and cardiologist for Resident #2 were not sent a copy of the FL2 for

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D 344	Continued From page 59 verification. Interview with MA #2 on 3/21/18 at 11:25am revealed: -She received orders from a prescribing practitioner or a new FL2 and recorded the orders in the New Order Tracking form. -She transcribed the orders onto the eMAR system. -She documented in the resident's chart when a new order had been received. -She faxed the orders to the pharmacy. -She filed the FL2 in the resident's record. -She did not send an FL2 she received to the prescribing practitioners for verification. -She had not received any directive from her Supervisor to send an FL2 to the physicians for clarification. Interview with the pharmacist on 3/21/18 at 11:10am revealed: -The facility faxed FL2's with medications listed to the pharmacy. -The pharmacy received an FL2 for Resident #2 on 3/1/18. Interview with the Resident Care Coordinator (RCC) on 3/21/18 at 8:55am revealed: -He had not instructed the MA's to send the FL2 to the PCP or prescribing practitioner to review upon re-admission to the facility. -A new FL2 is faxed to the pharmacy by the MA and filed in the resident's chart. -He did not know he was to contact the prescribing physician for verification or clarification of orders for medications and treatments if the FL2 was more than 24 hours old when the resident was readmitted to the facility. Interview with the Health and Wellness Director	D 344		

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(HWD) on 3/21/18 at 1:15pm revealed:
-She assumed the position of HWD 2 weeks ago and had not finished her orientation training.
-She did not know that re-admission FL2 orders were not being verified with the PCP and other prescribing physicians.

Interview with Area HWD on 3/21/18 at 4:05pm revealed:
-She visited the facility 2-3 days a week.
-She did not know that the prescribing physicians were not being notified for verification of new orders on FL2's for residents being readmitted to the facility.
-She had no knowledge of areas that needed her attention if staff did not alert her when she arrived.
-She assumed the RCC was overseeing the notification of the physicians regarding readmission orders.

Interview with the Executive Director (ED) on 3/21/18 at 5:05pm
-She did not know that the prescribing physicians were not being notified regarding re-admission orders.
-She did not know that orders had to be signed and dated by a physician within 24 hours of readmission to the facility.
-She thought that was the HDW's responsibility.
-In the absence of an HDW, the Area HDW was assisting the facility with processes and procedures.
-She thought the Area HDW would oversee the medication process and procedures.

Interview with Psychiatric Nurse Practitioner on 3/21/18 at 10:30am revealed:
-She was not informed by the facility staff the Celexa 20mg take 1 tablet once a day she

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prescribed was not on the new FL2.
-She would have to re-evaluate the resident to determine if the Celexa should be continued at the present time.

Telephone interview attempted with cardiologist on 3/22/18 at 9:00am with a message left on the triage answering line.

Telephone Interview with the licensed practical nurse (LPN) at the primary care physician (PCP)'s office on 3/23/18 at 11:23am revealed:
-The PCP was not sent the discharge FL2 from the skilled facility for verification of orders.
-The PCP did not know 14 medications the resident was being administered prior to hospitalization and skilled rehabilitation admission were not reordered on his readmission to the facility.
-The PCP stated those medications were necessary to treat his CHF, heart failure, glaucoma, colitis, asthma, hypertension and seizures.

Interview with Resident #2 on 3/22/18 at 9:55am revealed:
-He does not know the name of all of his medications but he knows how many pills he should take.
-He mentioned to the MA he was not receiving the correct number of pills.
-The MA stated he received what the physician ordered.
-He had not seen a physician since his return to the facility (2/28/18) until 3/21/18.
- On 3/21/18, at his appointment with the PCP, the physician renewed the prescriptions for the medications (14) he was receiving prior to his hospitalization.
2. Review of Resident #3's current FL2 dated

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D 344	Continued From page 62 2/19/18 revealed: -Diagnoses included history of cerebrovascular accident (CVA) with residual hemiparesis and history of aspiration pneumonia. -A physician's order for a dysphagia diet with nectar thickened liquids. -There was no order for weekly blood pressure or pulse checks. Review of Resident #3's hospital discharge summary dated 2/19/18 revealed: -A physician's order for "honey thickened liquids only, not thin liquids given aspiration risk." -Documentation that Resident #3 "had coughing and aspiration with a regular consistency diet, and both FEES (fiber-optic endoscopic evaluation of swallowing) and barium swallow confirmed that the patient consistently aspirated with thin liquids. He had been successful with a mechanical soft diet with honey thickened liquids and should remain on this diet indefinitely to prevent future aspiration events." Review of the therapeutic diet list posted in the kitchen on 3/20/18 revealed Resident #3 was to be served a texture modified diet with nectar thickened liquids. Interview with the Health and Wellness Director (HWD) on 3/20/18 at 4:52pm revealed: -She had been employed at this facility for 4 weeks. -She had been responsible for reviewing new physician orders, beginning 2 weeks ago. -She had not obtained clarification of which diet order Resident #3 should be on because she was not employed at the facility on 2/19/18. Interview with the Resident Care Coordinator (RCC) on 3/20/18 at 5:45pm and 3/21/18 at	D 344		

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D 344	Continued From page 63 11:35am revealed: -He had been the RCC for 5 months and prior to that he was a medication aide (MA). -He and the HWD were responsible for reviewing physician orders received Mon.-Fri. during the day. -If he nor the HWD were there, MAs were responsible for reviewing new physician orders. -Resident #3 had returned from the hospital on 2/19/18 at 8:00pm so an MA had been responsible for reviewing his new orders. -The MA was responsible for reviewing the FL2 and hospital discharge summary and then completing "a new order tracking form" in the notebook kept at the nurses' station. -He, MAs or the HWD were responsible for performing a double check of the "new order tracking form" to ensure all orders had been processed and clarified if necessary. -"No one was really doing the double checks though. The MAs need more training on it." -Resident #3 changed health insurances in Feb. 2018. -Resident #3's former Primary Care Provider (PCP) did not accept his new insurance so he currently did not have a PCP. -Resident #3 had an appointment scheduled with a new PCP on 3/26/18. Review of the "new order tracking form notebook" revealed Resident #3 did not have a form dated for 2/19/18. Interview with a MA on 3/21/18 at 11:02am revealed: -She had been employed with this facility for 1 year. -She was the MA on duty when Resident #3 returned from the hospital on 2/19/18. -If a resident returned to the facility from the	D 344		

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hospital after business hours, it was the MA's responsibility to review their hospital discharge summary and new FL2 if applicable, comparing both to the resident's orders on their current electronic Medication Administration Record (eMAR).
-MAs were responsible for entering new orders onto the eMAR and notifying the facility's contracted pharmacy of any medication changes.
-If medication changes were made, a "new order tracking form" was to be completed.
-Diet order changes were not documented on the "new order tracking form."
-If the resident's diet order changed or if clarification of the diet order was needed, the MAs were to fax a "physician's diet order sheet" to the PCP.
-She did not fax a "physician's diet order sheet" to the PCP because she did not realize the diet order on the hospital discharge summary was different from the order on the FL2.
-She had since found out Resident #3 did not have a PCP after his health insurance changed in Feb. 2018.

Interview with the Executive Director (ED) on 3/20/18 at 5:22pm revealed:
-The RCC and MAs were responsible for reviewing new FL2s and hospital discharge summaries for new orders and evaluating the follow up needs and medication changes.
-The HWD was responsible for double checking the RCC and MAs.
-The facility did not have a HWD on staff when Resident #3 returned from the hospital on 2/19/18.
-The Area HWD was responsible for covering in the absence of the HWD.
-The HWD and RCC were responsible for notifying the Dining Services Coordinator of any

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diet order changes.
-The Dietary Services Coordinator was responsible for creating the therapeutic diet list for the dietary staff to follow.

Interview with the Area HWD on 3/20/18 at 5:40pm revealed:
-She visited the facility 1 to 2 times per week.
-She was there to support the facility's staff and to complete the Licensed Health Professional Support (LHPS) evaluations on residents.
-She was not responsible for double checking behind the RCC and MAs during the absence of a facility HWD.

Attempted telephone interview with Resident #3's former NP on 3/22/18 at 3:25pm was unsuccessful.
3. Review of Resident #5's current FL2 dated 10/9/17 revealed diagnoses included restless leg syndrome, hypertension, hyperlipidemia, insomnia, constipation, macular degeneration, gastroesophageal reflux disease, and anxiety.

Review of Resident #5's Physician Visit Notes revealed:
-Documentation on 12/13/17 she was diagnosed with cellulitis of the right lower extremity and that she was being referred to wound care for treatment.
-Documentation from a wound care physician dated 1/9/18 included an "instructions" page with "compression/edema control: apply Medi-grip compression sleeve, Size D (moderate compression) in single layer to right lower leg/foot when out of bed to control swelling."

Review of Resident #5's electronic Medication Administration Record (eMAR) and Treatment Administration Records (TAR) for January 2018 -

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D 344	Continued From page 66 March 2018 revealed there was no entry for the application or removal of a compression sleeve. Interview with the Resident Care Coordinator (RCC) on 3/21/18 at 3pm revealed: -Resident #5 did not have any compression stockings. -He was not aware of the recommendation on the paperwork from the physician's visit from 1/9/18 for Resident #5 to have a compression sleeve, size D for her right lower leg/foot. -It was not technically a signed order, but if he had been aware of the recommendation, he would have followed up with the physician's office to clarify this recommendation with the physician. -When a resident had a new order for compression stockings, a task should be added to the TAR so staff would be aware that the resident required assistance applying/removing them. -Either the personal care assistant (PCA) or the medication aide (MA) would provide assistance to residents with application and removal of compression stockings. -MAs would document in the eMAR system when compression stockings were applied or removed. Observation of Resident #5 on 3/21/18 at 3:55pm revealed: -Resident #5 was observed to be wearing a very thin, stretchy gauzy material sleeve on both of her legs. -No sores or skin breakdown were observed. -Her skin was very thin, and she had varicose veins. Interview with Resident #5 on 3/21/18 at 3:55pm revealed: -The home health nurse that was treating her leg wound several months ago had given her the	D 344		

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gauzy sleeves to wear at that time.
-The nurse would cut the sleeves off a big roll of material.
-She had not received home health services in a while because the sore on her leg was now healed.
-She was not sure how long the sleeves were supposed to last and stated that she "may have already been wearing them longer than she was supposed to."
-The ends of the sleeves would often fray and she would trim that part off, and that they were looser now than they used to be.
-She wore the thin gauzy sleeves to "protect her skin" because her skin was so thin and would open up at the "least little bump" on anything.
-She had seen other residents wearing a different kind of compression stocking, but she didn't know if that was what she should be using.
-Staff only assisted her with getting set up for bathing and dressing.
-She was able to complete the tasks of dressing and bathing independently.
-No staff had ever mentioned to her anything about wearing a compression stocking.
-She did not recall any physician discussing with her the need for a compression stocking while her wound was being treated.

Confidential interview with a MA revealed:
-Resident #5 wore some type of stocking or sleeve, but it was not a compression stocking.
-She was not aware that a physician had recommended that Resident #5 should have compression stockings.

Confidential interview with a PCA revealed:
- Resident #5 was independent with regard to dressing.
- Resident #5 did not wear compression

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D 344	Continued From page 68 stockings. Interview with the HWD on 3/22/18 at 4:20pm revealed: -She began working at the facility about 3 weeks ago. -She was not aware of the recommendation for Resident #5 to have compression stockings. Attempted phone interviews with Resident #5's primary care physician's office on 3/21/18 at 1:20pm and on 3/22/18 at 10:22am were unsuccessful. Attempted phone interview with Resident #5's wound care physician on 3/21/18 at 1:45pm was unsuccessful.	D 344		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. The findings are: A. Based on observations, interviews, and record	D912		

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reviews, the facility failed to provide supervision for 2 of 5 sampled residents related to falls, one with injuries including a laceration on the forehead, fracture of the right clavicle, contusion of the left lower extremity and a non-displaced fracture of the left ankle, and a head injury (Resident #2), and a second resident on isolation protocol, with injuries which included a wrist fracture and a subdural hemotoma (Resident #1). [Refer toTag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

B. Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for 3 out of 5 sampled residents (#1, #3, #4) resulting in Resident #3 not being served thickened liquids as ordered and being hospitalized with aspiration pneumonia, Resident #1 being isolated in her room causing an increase in her dementia and depression and a significant loss of weight, and Resident #4 refusing to wear thrombo-embolic deterrent (TED) hose because she needed a larger size. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

C. Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 3 of 5 sampled residents related to recording the number of stools per day (Resident #1), physical therapy (PT) and occupational therapy (OT) (Resident #2) and compression sleeves (Resident #5). [Refer to Tag 276 10A NCAC 13F 0902 (c) (3-4)].

D. Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician orders for a

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D912	Continued From page 70 texture modified diet with nectar thickened liquids. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. E. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, resident assessments, supervision, personal care, staffing, nutrition and food service, housekeeping and furnishings, and residents' rights. [Refer to Tag 980 GS 131 D-25 Implementation (Type A1 Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including	D932		

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D932	Continued From page 71 cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to monitor compliance of the facility's infection control policy 1 of 1 residents in isolation for Clostridium Difficile (C-Diff), (Resident #1). The findings are:	D932		

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D932	Continued From page 72 Review of the facility policy for C-Diff revealed: -Staff should wash hands with soap and water. -Staff should follow universal precautions and wear gloves while taking care of the resident. -If soiling of clothes is likely, a gown should also be worn. -With asymptomatic colonization the resident had no symptoms and is colonized with C-Diff; therefore the stool samples from these residents may test positive for the organism. -Residents who are asymptomatic do not need to be sequestered. -A resident with C-Diff colonization or disease does not need to have the absence of diarrhea or negative stool culture(s) before transfer to or return to the community occurs. -Laundry should be handled as little as possible with gloved hands. Laundry should be transported in an enclosed sanitary manner (e.g. in a plastic bag) and promptly machine washed with detergent in hot water at the maximum cycle length and dried in a hot dryer. -The treatment for C-Diff was generally treated with antibiotic therapy for 10 days as prescribed by the healthcare provider. Review of Resident #1 FL 2 dated 12/11/17 revealed diagnoses included Alzheimer's dementia, ulcerative colitis, and iron deficiency anemia. Review of Resident #1's hospital discharge summary dated 1/3/18 revealed: -Resident #1 was admitted 12/28/17 with a history of ulcerative colitis and worsening diarrhea. -On 1/3/18 a discharge diagnoses was documented as, "Clostridium Difficile diarrhea, and E Coli UTI". -On 1/3/18 Resident #1 was discharged back to	D932		

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D932	Continued From page 73 the facility on vancomycin. Further review of Resident #1's record revealed numerous documentation in the progress notes related to Resident #1 leaving her room, walking in the hallways and walking to the independent living side while in isolation. Review of the Center for Disease Control (CDC) recommendations for C-Diff revealed: -Poor handwashing plays a key role in the spread of infection. -Staff were to wash their hands after patient contact. -Washing hands after patient contact with soap and water was the preferred policy. Observation during initial tour on 3/20/18 at 9:40am revealed: -Room #1210 had an isolation cart outside of the door complete with the following personal protective equipment (PPE); gown, gloves, mask and shoe covers. -The door was not labeled as of what kind of isolation. -Inside room #1210 there was a small waste basket with a clear bag in it in the closet not near the exit of the room. -The closet had a laundry basket with a clear bag in it. -The bathroom located in the room had a small waste basket with a clear bag in it. -The personal care aide (PCA) exited a resident's room with gloves on carrying soiled linens into another resident's room to give assistance with that residents bed sheets, laying the soiled linens on the floor then exiting the room with all of the linen and delivered the dirty linens to the dirty utility room down the hall. -The same PCA changed her gloves and	D932		

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D932	Continued From page 74 proceeded to walk in and out of 3 other resident's rooms to assist with other tasks. Interview with a PCA on 3/20/18 at 10:00am revealed: -Resident #1 was in isolation since returning from the hospital in January. -The Health and Wellness Director (HWD) put Resident #1 in isolation for C-Diff because the stool culture was positive for C-Diff. -The policy was the resident must have a negative stool culture to be cleared and come off of isolation. -She wore a gown, gloves, shoe covers and a mask to enter Resident #1's room every time regardless of the care provided. -She received the once a year infection control training that was mandated by the state about the middle of last year. -Resident #1 received her showers in her room. -The facility could not handle the isolation laundry so Resident #1's family took the laundry home with them. -She did not receive any "specialized training" for the care of a resident with C-Diff. -After providing care for Resident #1, she washed her hands down the hall in the kitchenette of the activities room (approximately 30 ft. from Resident #1's room). Observation of PCA on 3/20/18 at 10:05am revealed: -After completing patient care for Resident #1, all of the isolation PPE was removed and placed in the small waste basket in the closet and then the waste basket was moved near the entry door. -After exiting Resident #1's room, the PCA used hand sanitizer that was on the wall across from Resident #1's room. -She did not walk down the hallway to the closest	D932		

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D932	Continued From page 75 sink to wash her hands (approximately 30 ft. from Resident #1's room). Interview with the HWD on 3/20/18 at 10:18am revealed: -Resident #1 was in isolation for C-Diff since returning from the hospital 1/3/18. -All staff must wear a gown, gloves, mask and shoe covers while in Resident #1's room. -The family did the laundry for Resident #1 because of the isolation. -There was no specific training for applying and removing PPE (i.e., proper order). -Resident #1 could not come out of isolation until a negative stool culture is given. -Infection control was taught yearly. -She was not sure if she was responsible for the isolation education. Interview with the Area Health and Wellness Director (AHWD) on 3/20/18 at 10:18am revealed: -Resident #1 was on isolation for C-Diff. -The HWD was responsible for the education on infection control. -A resident must have a negative stool culture to be released out of isolation. Interview with Resident #1's Nurse Practitioner (NP) on 3/20/18 at 12:03pm and 3/22/18 at 2:49pm revealed: -Resident #1 was seen at the facility first on 2/5/18 while on 2nd round of vancomycin. -She told the HWD to remove Resident #1 from isolation and was told by the HWD that Resident #1 could not come out of isolation per the facility's policy until a negative stool culture was provided. -She told the HWD, RCC and the Executive Director (ED) that a negative stool culture would never happen.	D932		

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D932	Continued From page 76 -She expected the facility to revisit their infection control policy because Resident #1 should be out of isolation. -She informed the HWD, RCC and the ED Resident #1 would never have a negative stool culture. -She told the HWD, RCC and the ED that Resident #1 completed a second round of vancomycin in 2/2018 and was asymptomatic for C-Diff and would come out of isolation in 2/2018. -The facility staff would also follow the guideline for handwashing using soap and water after resident care. -Resident #1 quality of life was seriously impacted because of the extended isolation related to the facility not following their own infection control policy. Interview with a family member on 3/20/18 at 1:00pm revealed: -She did all of the laundry for Resident #1 because of the isolation. -She was told by the HWD and the ED Resident #1 would have to stay on isolation because Resident #1 did not have a negative stool culture. -Resident #1 did not need to be in isolation according to what she was told by the NP. -Resident #1 would never have a negative stool culture and the facility would not take Resident #1 out of isolation because of that. -Resident #1's NP wanted Resident #1 off of isolation but the facility will not remove Resident #1 without a negative stool culture. Interview with the ED on 3/21/18 at 9:55am revealed: -Resident #1 was on isolation since return form hospital 1/3/18 due to C-Diff. -She did not know if Resident #1 was in isolation at the hospital but because of the C-Diff and a	D932		

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	HAL060060	A. BUILDING: _____ B. WING _____	03/22/2018

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D932	Continued From page 77 "positive" stool culture, Resident #1 was put in isolation by her. -Her facility policy required a negative stool culture to remove out of isolation and did not provide a copy of the C-Diff isolation policy. -The facility's policy was to keep in isolation until a negative stool culture was obtained in order to protect other residents and staff. -The HWD was responsible for the staff education of residents on isolation. -Resident #1 came out of her room several times a day and was redirected back into her room. -Resident #1 was found on the independent living side many times and was brought back to her room. -She expected the staff to wear a gown, gloves, mask and shoe covers. -The PPE was to be removed outside of the room and put into a red bio-hazard bag and taken to the soiled utility room. -The staff were to wash their hands at the nearest sink which was in the activity room kitchenette. -She did not know food was sometimes prepared in the activity room kitchenette. -It was not acceptable to use hand sanitizer. -All residents with C-Diff must be confined to their room. -The laundry for isolation residents used bleach and regular detergent. -She did not know the family was washing Resident #1's clothes. -She expected the staff to follow the infection control policy. Interview with a second family member on 3/21/18 at 3:00pm revealed he has tried to get Resident #1 out of isolation since 2/2018. Interview with a second MA on 3/21/18 at 5:10pm revealed:	D932		

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D932	Continued From page 78 -She put on a gown, gloves, mask and shoe covers to enter Resident #1's room to take Resident #1 medications. -She used hand sanitizer after exiting Resident #1's room. -Sometimes she washes her hands down the hall in the activity room kitchenette after leaving Resident #1's room. -She could not provide the facility's policy for infection control. Interview with a third MA on 3/22/18 at 4:22pm revealed: -Resident #1 was in isolation for C-Diff. -Resident #1 had to have a negative stool culture to come out of isolation. -She used hand sanitizer after patient care and sometime would go to the kitchenette area to wash her hands. -She did not know the policy for C-Diff isolation, just what the HWD told her. Interview with the Area Health and Wellness Director (AHWD) on 3/22/18 at 4:31pm revealed: -She provided a copy of the facility's C-Diff infection control policy. -According to thier policy, Resident #1 did not need to be in isolation. -She removed Resident #1 out of isolation and a MA took Resident #1 to the dining room to have supper with the rest of the residents.	D932		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate	D980		

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D980	Continued From page 79 training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration, resident assessments, supervision, personal care, staffing, nutrition and food service, housekeeping and furnishings, and residents' rights. The findings are: Interview with the facility Administrator on 3/21/18 at 9:55am revealed: -She was in the facility 40+ hours a week. -She makes the decisions about the facility's operation. Confidential interview with a medication aide (MA) revealed: -The Administrator's office was way over on the Independent Living (IL) side and rarely came out of the office to see what went on in the facility. -She asked for extra help in January and was told no by the Administrator. -The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were new and the staff did not get instructions regarding the overall operations except for shift times and assignments.	D980		

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D980	Continued From page 80 Confidential interview with a staff member revealed the RCC and the HWD cannot do their jobs because the job descriptions/duties were not defined by the Administrator. A. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents related to falls, one with injuries including a laceration on the forehead, fracture of the right clavicle, contusion of the left lower extremity and a non-displaced fracture of the left ankle, and a head injury (Resident #2), and a second resident on isolation protocol, with injuries which included a wrist fracture and a subdural hemotoma (Resident #1). [Refer toTag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. B. Based on observations, interviews and record reviews, the facility failed to assure contact with a medical professional for 3 out of 5 sampled residents (#1, #3, #4) resulting in Resident #3 not being served thickened liquids as ordered and being hospitalized with aspiration pneumonia, Resident #1 being isolated in her room causing an increase in her dementia and depression and a significant loss of weight, and Resident #4 refusing to wear thrombo-embolic deterrent (TED) hose because she needed a larger size. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. C. Based on observations, interviews, and record reviews, the facility failed to implement physicians' orders for 2 of 5 sampled residents related to recording the number of stools per day (Resident #1) and applying a compression sleeve to the leg/foot (Resident #5). [Refer to Tag 276	D980		

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D980	Continued From page 81 10A NCAC 13F .0902(c)(3-4) Health Care]. D. Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident (Resident #3) with physician orders for a texture modified diet with nectar thickened liquids. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. E. Based on record reviews and interviews, the facility failed to ensure contact with the prescribing physician for verification of orders for 1 of 5 sampled residents and clarification of orders for 2 of 5 sampled residents related to an FL2 not dated and signed by a prescribing physician within 24 hours of the resident being readmitted to the facility (Resident #2); two different diet orders dated on the same day (Resident #3), and instructions from a wound care physician for a compression sleeve (Resident #5). [Refer to Tag 344 10A NCAC 13F .1002(a) Medication Orders]. F. Based on observations, interviews, and record reviews, the facility failed to monitor compliance of the facility's infection control policy 1 of 1 residents on isolation for Clostridium Difficile (C Diff), (Resident #1). [Refer to Tag 932 ACH Infection Prevention Requirements 131D 4.4(A)(b)(2)]. The Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to medication administration,	D980		

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D980	Continued From page 82 supervision, serious injuries from falls, Therapeutic diet errors, infection control and residents' rights. These failures exposed residents to a variety of problems including serious medication errors, neglect related to personal care and supervision and inadequate management of the facility. Therefore these failures exposed residents to substantial risk that death or serious physical harm, abuse, or neglect will occur and constitute a Type A1 Violation. _____ Review of the Plan of Protection submitted by the facility dated 3/22/18 revealed: -The HWD is to oversee clinical areas of care. In absence of the HWD, the ED or designee will be responsible for assuring regulatory compliance/resident care needs are addressed. -Will develop a plan to include job responsibilities by job title-to include a contingency when primary clinical leadership role is vacant. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 21, 2018.	D980		