STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078084	A. BUILDING: _____ B. WING _____	03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual survey and a complaint investigation on 03/21/18 through 03/23/18.	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: Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with resident's assessed needs, care plan, and current symptoms for 1 of 5 resident (#5) sampled including a resident with multiple falls resulting in 3 visits to the emergency room (ER) for bruising. The findings are: Review of Resident #5's current FL-2 dated 12/27/17 revealed: -The resident's diagnoses included a history of generalized epilepsy, osteoarthritis, heart failure, hypertension, hyperlipidemia, hypokalemia, edema, and dementia. -The resident was ambulatory. -The resident had convulsions/seizures. -The resident was continent of bladder and bowel. -The resident could verbally communicate needs. -The resident required range of motion exercises.	D 270		

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D 270	Continued From page 1 Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 12/29/2017. Review of Resident #5's current assessment and care plan completed 3/1/18 revealed: -The resident had dementia and due to her mental status change she wasn't able to complete her daily ADL's (activity of daily living). -The resident was able to perform self-care of her daily incontinence of bowel and bladder. -The resident was sometimes disoriented and forgetful. -The resident required extensive assistance from staff with bathing, grooming, dressing, and toileting. -The resident required extensive assistance from staff with ambulation. -The resident required limited assistance from staff with transferring. -The resident required limited supervision from staff with eating. Review of Resident #5's Licensed Health Professional Support (LHPS) quarterly review on 1/9/2018 revealed: -The resident required assistance with ambulation using assistive devices. -The resident required assistance with transferring. Review of a primary care provider (PCP) visit summary dated 1/12/2018 for Resident #5 revealed the resident was seen for a fall and the PCP had new orders for physical therapy consult-evaluate and treat, gait, strength and balance. Resident has had repeated falls. Review of Resident #5's physical therapy (PT)	D 270		

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progress notes from 01/22/18 - 03/02/18 revealed:
-The resident started physical therapy on 1/22/2018 two times per week for strength, gait, and transfers.
-The resident was discharged from physical therapy on 03/02/2018.
-PT attempted to provide treatment, with encouragement on 3/1/2018, resident refused, unwilling to participate.
-PT was unable to perform treatment with encouragement on 3/2/2018 increased paranoia, resident refused.

Review of accident / injury reports from January 2018 - March 2018 for Resident #5 revealed:
-Resident #5 had 15 falls from 1/3/2018 - 3/20/2018.
-Two of the 15 falls required visits to the emergency room (ER) including 1/30/2018 and 3/3/2018.
-Two of the ER visits 1/30/2018 and 3/3/2018 required, Fall Prevention in the Home, Easy to Read instructions, and follow up with Primary Care Physician.
-On 1/30/2018 (1:15 p.m.), the type of event, fall. Area of injury, back. Location of incident, resident's room. Nature of Injury, none. Interventions implemented to manage accident/incident section was blank.
-Emergency Medical Services (EMS) was called.

Review of an accident/injury report for Resident #5's dated 3/3/2018 revealed:
-On 3/3/2018 (8:00 p.m.), the type of event, found on floor. Area of injury, hip. Location of incident, resident's room. Nature of Injury, none. Interventions implemented to manage accident/incident section was blank.
-Emergency Medical Services (EMS) was called.

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D 270	Continued From page 3 Review of hospital emergency room visit form for Resident #5 dated 3/3/2018 revealed: -The resident was diagnosed with a fall and Paranoid ideation. -There were instructions for resident to schedule an appointment with Primary Care Physician as soon as possible for a visit. -History and Physical documented, "small UTI"; not given antibiotics; follow up for Altered Mental Status. Review of the facility's Weekly Falls Management Meeting worksheets from 3/6/2018 and 3/21/2018 revealed: -Documents dated 3/6/2018 Resident #5 last fall 3/3/2018. Interventions, increased rounding. Are Interventions Working, yes. New plan if applicable, section was blank. -Documents dated 3/21/2018 Resident #5 last fall 3/20/2018. Interventions, increased rounding. Are Interventions Working, no. New plan if applicable, section was blank. Observation of Resident #5 on 3/21/2018 11:39 a.m. and 3/22/2018 12:45 p.m. revealed: -The resident was sitting in her recliner chair in her room. -The resident was leaning forward in the recliner chair. -The resident would speak when asked questions. Interview with Resident #5 on 3/21/2018 11:41 a.m. -She was new admit to facility. -She slept in her recliner chair. -She used call bell for assistance. -She said the call bell response was too long at night.	D 270		

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D 270	Continued From page 4 Interview with a Personal Care Aide (PCA) on 3/23/2018 at 8:39 a.m. revealed: -Residents were checked on every two hours. -Residents had call bells to use, if assistance was needed. -She tried to keep a constant check on Resident #5 and watch her frequently because of her previous falls. -She witnessed one of Resident #5 falls. -If a resident fell vital signs were checked. -Staff were not to move a resident after a fall and were to get the Resident Care Coordinator (RCC). - If needed, staff was to send resident out to Emergency Room. Interview with second PCA on 3/23/2018 at 11:17 a.m. revealed: -Resident were checked on every two hours. -She witnessed Resident #5 fall on first shift, early to mid-February 2018. - They assisted her after and when she fell. - She reported the fall of Resident #5 to the medication aide (MA), and the MA came and evaluated Resident #5 and sent Resident #5 to the emergency room. Telephone interview with Resident #5's legal guardian on 3/23/2018 at 10:15 a.m. revealed: -The resident had several falls at home, prior to being admitted to current facility. -The resident lived alone with moderate assistance with home health agency services. -The resident's dementia and ADL's needs had progressed and that was why she was placed in the facility. -The facility staff communicated falls and emergency room visits with the legal guardian of Resident #5.	D 270		

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D 270	Continued From page 5 -The legal guardian did not know how often staff monitored the resident. Interview with the Resident Care Coordinator (RCC) on 3/23/2018 at 5:36 p.m. -She was aware of Resident #5's falls. -She was a member of the Facility's Weekly Falls Management Team and they discussed placing the resident in the Special Care Unit, or lowered bed. -She was aware resident received PT. -She was unaware of any other interventions implemented to manage accident/incident. Interview with the Administrator on 3/23/2018 at 6:49 p.m. revealed: -He was aware of Resident #5's falls. -He was a member of the Facility's Weekly Falls Management Team, discussed placing the Resident in the Special Care Unit, or lowered bed. -He was aware the resident received PT, but she refused last two sessions. -He was unaware of any other interventions implemented to manage or prevent Resident #5's falls. Interview with Resident #5's primary care provider (PCP) on 3/23/2018 at 4:47pm -She was aware of Resident #5's falls. -She was not aware that she had 15 falls. -She was open to discuss interventions with facility staff. -The resident had been to the emergency room on a few occasions due to falls. -The resident had a recent UTI around 03/03/2018, none since then. -She did not think the resident called for help when she needed it due to cognitive limitations. -She would order another PT evaluation.	D 270		

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D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to a build-up substance in the ice machine, food stored uncovered in the walk-in cooler, expired foods in the pantry and walk-in cooler, no sanitizer in the dishwasher during the cleaning cycles for 3 days and clean utensils stored upright in a dishwasher caddy. The findings are: 1. Observation of the ice machine in the kitchen on 03/21/18 at 4:09 p.m. revealed: -The ice machine's left door hinge cover was broken with a missing section and was covered with a build-up of a beige substance. -There was a build-up of a wet pink, brown and black colored substance on the lower portion of the white shield and a heavier concentration of a black and brown substance on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine. -There was a heavy concentration of the same black colored substance on the upper wall of the ice bin. -Water was dripping into the stored ice from the	D 283		

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D 283	Continued From page 7 white shield with the build-up. Interview with a cook on 03/21/18 at 4:10 p.m. revealed: -She had worked at the facility since it had re-opened in October of 2017. -She had not noticed the wet pink, black and brown substance on the white shield inside the ice machine. -There was not a cleaning schedule for the ice machine that she was aware of and she had never cleaned the ice machine. -She thought the Maintenance person cleaned the ice machine. Interview with a dietary aide on 03/22/18 at 8:45 a.m. revealed: -She had worked at the facility for 3 months. -She had never cleaned the ice machine, however, the Maintenance person cleaned it approximately 1-2 months ago and he took the front panels off. Interview with a second cook on 03/22/18 at 8:50 a.m. revealed: -She had worked at the facility "a couple of weeks". -She had not cleaned the ice machine and had not been trained to do so. Observation of a small ice machine in the dining room of the Special Care Unit (SCU) on 03/21/18 at 4:51 p.m. revealed a full bin of ice with no pink, black or brown build-up on the inside of the ice machine. Observation of a small ice machine in the Activity room on the Assisted Living (AL) side of the facility on 03/21/18 at 4:55 p.m. revealed a full bin of ice with no pink, black or brown build-up on the	D 283		

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D 283	Continued From page 8 inside of the ice machine. Interview with the Dietary Manager (DM) on 03/21/18 at 4:15 p.m. and 4:58 p.m. revealed: -She was not aware of any cleaning schedule for the ice machine. -She had not noticed the wet pink, black and brown build-up substance on the white shield inside the ice machine. -The Maintenance person cleaned the ice machine's filter every month. -She was not aware water was dripping down the white shield inside the ice machine and into the ice stored in the bin. Interview with the Administrator on 03/21/18 at 4:58 p.m. revealed dietary staff had been instructed to serve the residents' ice from the ice machine in the SCU and in the Activity room on the AL side or purchase ice today (03/21/18) until the ice machine had been thoroughly cleaned and inspected by him. Interview with the Maintenance person on 03/23/18 at 11:20 a.m. revealed: -He had worked at the facility for one month and "a few days". -He was responsible for cleaning out the back coils of the ice machine one time a month. -The ice machine had a flush cycle to clean the inside out. -He was trained by the "other guy" last month how to clean the back of the ice machine and flush the inside out. -He assisted the DM to clean and flush the inside of the ice machine on 03/21/18 using water and vinegar by pouring the vinegar into a dispenser spout. -"Black stuff" with no smell was removed from the ice machine after it was flushed and cleaned.	D 283		

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D 283	Continued From page 9 -He did not have a manufacturer's instruction manual for the ice machine. Interview with the Administrator on 03/21/18 at 4:58 p.m. revealed: -Dietary staff and the Maintenance person were responsible to assure the ice machine stayed clean. -He was not aware of a written schedule to clean the ice machine. -He was not aware water was dripping down the white shield inside the ice machine with the wet pink, black and brown build-up and into the ice stored in the bin. 2. Observation of the pantry on 03/21/18 at 5:10 p.m. revealed: -There was 1 unopened box of a no sugar added gingerbread mix with an expiration date of 06/01/17. -There were 5 unopened boxes of a no sugar added yellow cake mix with an expiration date of 05/05/17. -There was a 22 ounce jar of dried seasoning with an expiration date of 07/19/16. -There was a 5.5 ounce jar of dried basil with an expiration date of 06/21/16. -There was a 6 ounce jar of dried rosemary with an expiration date of 06/23/15. -There was a 40 ounce jar of garlic salt with an expiration date of 02/02/17. -There was an 18 ounce jar of chili powder with an expiration date of 04/04/16. Observation of the walk-in cooler in kitchen on 3/21/18 at 5:15 p.m. revealed: -There was a 5 lb. tub of pimento cheese, approximately half full with an expiration date of 01/01/18. -There was one uncovered sheet pan with	D 283		

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approximately 22 bowls of strawberries with whipped cream and pineapples with whipped cream stored on the top shelf of a storage rack, directly under the condensing unit and fan.
-There was a second uncovered sheet pan with approximately 24 bowls of strawberries with whipped cream stored on a lower storage shelf directly under an upper storage shelf used to store 2 large packages of shredded cheese and one large package of sliced cheese.

Interview with the cook on 03/21/18 at 5:20 p.m. revealed:
-She was trained to cover and label all foods with a date when foods were stored in the walk-in cooler.
-She had placed the two sheet pans with the strawberries and pineapple with whipped cream in the walk-in cooler and did not cover the fruit because she did not want to "mess up the whipped topping".
-She would cover the fruit and whipped cream immediately.
-She had not served the pimento cheese to any of the residents and did not know it was expired.

Interview with the second cook on 03/23/18 at 8:58 a.m. revealed:
-She had not served any pimento cheese to the residents.
-She always checked expiration dates on all foods before serving it to the residents.

Interview with DM on 3/21/18 at 5:25pm revealed:
-The strawberries and pineapple with whipped cream were prepared for dessert for the residents' dinner tonight (03/21/18).
-She was unaware the strawberries and pineapple were uncovered.
-Her expectation was for staff to cover all open

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containers in the walk-in cooler.
-She was unaware the pimento cheese had expired.
-She threw the pimento cheese away.

A second interview with the DM on 03/23/18 at 8:38 a.m. revealed:
-The DM and dietary staff were responsible for checking all foods weekly for expiration dates when food deliveries were made.
-The expired foods in the pantry came from a sister facility and must have been overlooked.

Interview with the Administrator on 03/21/18 at 5:34 p.m. revealed:
-Some of the foods in the pantry had recently been sent to the facility from a sister facility that recently closed.
-He had gone through the foods to check for the expiration dates when the foods were brought into the facility, however, some of the foods must have been brought in after he had checked them.

3. Review of the Sanitation Log in the kitchen on 03/23/18 at 10:13 a.m. revealed the log for the dish machine showed 7 of 20 days with a 0 parts per million (PPM) solution.

Interview with the Dietary Manager (DM) on 3/23/18 at 10:13 am revealed:
-The Sanitizer Log was used to measure the strength of the sanitizer solution in the dish machine.
-The range was 50-800 PPM.
-Staff checked the range using sanitizer test strips.
-The zero readings on the Sanitizer Log was documented when there was no sanitizer in the dish machine.
-If there was no sanitizer in the dish machine the

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dishes were not getting sanitized.
-Staff were trained by either the manager or the second shift cook to look for a range of 50-800.
-If the reading was low, the expectation was for staff to recheck the solution strength or change the bucket to a new one full of sanitizer solution.
-There was no sanitizer solution in the building from 3/8/18- 3/14/18.
-She was aware there was no solution.
-Administration ordered the chemicals for the facility.
-She was unsure of the order schedule.

Observation in the kitchen on 03/21/18 at 4:12 p.m. and 03/23/18 at 8:58 a.m. revealed:
-Clean Forks were stored in a dish washer caddy with the tines of the forks in an upright position.
-Clean spoons were stored in a separate compartment of the same dishwasher caddy with the head of the spoons positioned in an upright position.

Interview with the second cook on 03/23/18 at 8:58 a.m. revealed she had not noticed the fork tines and the head of the spoons had been placed in the dishwasher caddy in an upright position.

Interview with the DM on 03/23/18 at 9:00 a.m. revealed:
-All utensils should be placed in the dishwasher caddy with the handle in an upright position in order not to contaminate the utensils.
-She had told the kitchen staff about this before.

Interview with the Administrator on 03/23/18 at 6:40 p.m. revealed:
-The dishwasher's sanitizer was delivered to the facility by a delivery truck.
-There were no days that the facility had ran out

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D 283	Continued From page 13 of sanitizer, however, the delivery truck had delivered a different colored container of the sanitizer solution and he had discussed this with the DM. -On the days "zero" was recorded on the Sanitizer Log, the kitchen staff ran everything through an extra hand cycle. -He expected for all foods to be covered and protected from contamination. -He expected for all eating utensils to be stored to protect from contamination. -In the past, he had left it up to the DM to make sure all areas were free of contamination, however, he did perform random spot checks to make sure foods were in date, hoods and ovens were clean. _____ The facility failed to protect foods from contamination that were being stored and served to residents as evidenced by a wet pink, black and brown build-up substance in the ice machine with water dripping over the built-up substance down into the ice stored in the ice machine's storage bin. The facility's failure to maintain a clean environment in the ice machine contaminated the ice which was detrimental to the health, safety and welfare of the residents and constitutes a TYPE B VIOLATION. _____ Review of a Plan of Protection submitted by the facility dated 03/22/18 revealed: -On 03/21/18, all ice disposed of and ice machine was immediately cleaned by dietary staff with maintenance assistance. -Monthly servicing of ice machine by Maintenance, immediately and ongoing. -Training would be provided to staff in the importance of keeping ice machine clean as to prevent contamination. -Monthly cleaning by dietary staff - immediately	D 283		

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D 283	Continued From page 14 and ongoing. -Cleaning would be monitored by Administrator on a monthly basis. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 07, 2018.	D 283		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 1 of 2 sampled residents (Resident #3) with a diagnosis of dementia and in a special care unit, who fell two times while recieving feeding assistance and sustaining injury in both instances. The findings are: Review of Resident #3's FL-2 dated 12/28/17 revealed diagnoses included dementia, Alzheimer's disease, failure to thrive, and anxiety disorder.	D 312		

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D 312	Continued From page 15 Review of Resident #3's care plan dated 2/15/18 revealed the resident required assistance with eating, transfers, and ambulation. Interview with a nursing assistant (NA) on the special care unit (SCU) on 3/22/18 at 8:30am revealed: -Resident #3 was doing much better than before she went to the hospital on 3/10/18 - 3/20/18. -The staff continued to provide total care including assisting with ambulation to the dining room for meals and feeding assistance in the dining room. -Staff always sat next to the residents when assisting with feeding. Interview with a personal care aide (PCA) on 3/22/18 at 11:00am revealed: -Resident #3 required assistance with her personal care which included feeding assistance, incontinent care, and assistance with ambulation. -The PCA was providing care for Resident #3 today (3/22/18). Observation of Resident #3 on 3/22/18 between 12:35pm and 1:00pm revealed: -Resident #3 was lying in a low bed awake and quiet, on her left side with a pillow behind her back. -At 1:00pm, the (PCA) carried a food tray in the resident's room and set the tray on the resident's bedside table, next to the resident's bed. -The food on the tray was pureed and was in several separate bowls sitting on a plate. Interview with the PCA (in Resident #3's room) at 1:00pm revealed: -The resident required feeding assistance and she was going to feed the resident in her bed propped up with pillows.	D 312		

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D 312	Continued From page 16 -The resident's family member had requested the resident be fed in bed after she was discharged from the hospital on 3/20/18. -The resident should have already been fed by another staff member while she was assisting with the lunch meal in the dining room. -When she realized the resident had not been fed, she picked up her tray from the kitchen. Observation of a PCA preparing to feed and feeding Resident #3 in her room on 3/22/18 at 1:05pm revealed: -The PCA attempted to place 1 of the 3 pillows on the resident's bed under her head. -The PCA left the room and came back in with the medication aide. -The PCA pulled the arm chair, in the resident's room, next to her bed (facing the bed). -The PCA and the MA transferred the resident from the bed to the arm chair. -The MA stood behind the chair about 1-2 minutes and then left the room. -The PCA began feeding the resident the pureed food which was in small single serving bowls. -The PCA picked up one bowl at a time and while standing over the resident, used a spoon and continuously fed the resident large spoonfuls of the pureed food. The PCA held each bowl under the resident's chin with one hand and the spoon in the other hand. -After the resident had eaten about half of her food, she became restless and started moving her arms and legs. -At 1:20pm, the resident screamed and made a sudden, jerky movement forward in the chair. The resident fell forward (to the left near the foot of the bed) out of the chair and hit her forehead/face directly on the floor. -The PCA was holding the bowl of food in one hand and the spoon in the other hand and was	D 312		

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standing in front of the resident, near her right side. The PCA did not attempt to stop the fall.
-The resident sustained a gash over her right eye and was actively bleeding.
-The PCA directed the surveyor to get help. Staff came to the resident's room and provided first aide to stop the bleeding. The resident's breathing was loud and gurgling for several minutes and the resident was unresponsive.
-The resident's primary care provider came to the resident's room, assessed her injuries and directed the staff to send the resident to the local emergency room (ER).
-Emergency medical technicians (EMT) arrived at 1:35pm to transport the resident to the local ER , the resident's breathing remained labored but her resident's eyes were opened and she was moving her extremities.

Review of an ER report dated 3/22/18 revealed:
-The resident was seen because of a fall.
-The resident was diagnosed with a laceration of the forehead (Steri-strips were applied over the laceration); a CAT scan of the head was done and the resident was diagnosed with a closed fracture of the nasal bone.

Interview with the Special Care Coordinator/Resident Care Coordinator (SCC/RCC) on 3/22/18 at 3:30pm revealed:
-Resident #3 had required assistance with feeding since admission to the facility.
-The resident ate meals in the dining room but ate in her room since discharge from the hospital this week.
-The staff either fed her in her bed or sit her up in her chair to feed her.
-The resident's meal tray was set on her bedside table because the facility did not have a table to set the food tray on in the resident's room.

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-The staff should always sit in a chair to feed residents at eye level.
-The SCC/RCC did not know the PCA was standing while feeding the resident at lunch today.
-The resident should have been fed in her room after the other residents in the SCU had finished eating in the dining room.
-The resident should have been fed earlier than 1:00pm and the PCA should have been sitting in a chair, feeding the resident at eye level.
-The resident fell in the dining room on 2/22/18 during breakfast. She was sitting in a chair in the dining room and fell out of the chair, but the RCC did not remember the details of the fall.

Interview with Resident #3's family member on 3/22/16 at 3:55pm revealed:
-The facility informed her the resident was being fed in her room and "froze up", fell forward and hit her face on floor.
-The resident will be discharged back to the facility today. She had a fractured nose and a laceration on her forehead.
-The family member was concerned that the resident was allowed to fall while the staff was feeding her.
-The resident had fallen in February, 2018 while eating in the dining room. She fell forward and sustained a hematoma on her forehead. The resident was treated at the local ER and discharged back to the facility.
-The family was concerned the the previous fall may have occurred because the staff was not sitting near the resident while feeding her and could not prevent her from falling.

Interview with a 2nd shift PCA on 3/22/18 at 4:10pm revealed:
-Resident #3 always ate dinner in the dining

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room, never in her room.
-The PCA assisted the resident with ambulating to the dining room to eat.
The PCA always sat down in a chair beside the resident and fed her and ate without problems.
-The resident fell in the dining room during breakfast in February 2018, but the PCA did not know the details of the fall.

Review of an Incident/Accident report dated 2/22/18 at 7:30am revealed:
-Resident #3 fell in the SCU dining room and injured her head.
-The resident was sent to the local ER and discharged back to the facility.

Review of an ER report dated 2/22/18 revealed the resident was assessed for a minor head injury after a fall in the facility and discharged back to the facility.

Interview with a 2nd PCA on 3/22/18 at 4:20pm revealed:
-She had assisted the resident out of bed since she came back from the hospital this week.
-The resident was sitting up in in her arm chair earlier today (after breakfast), but she was sliding down in the chair and the PCA assisted her back to bed.
-The PCA has been feeding the resident meals in bed since she came back from the hospital.
-According to her PCA training at the facility, she should always sit down in a chair, with eye to eye contact, next to the resident when proving feeding assistance.
-She did not know why she was standing up when she fed Resident #3 at lunch today. She "had a feeling something was not right" with the resident.
-She did not attempt to stop the resident from falling because her hands were full with a spoon

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D 312	Continued From page 20 in one hand and a bowl in the other hand. "I should have dropped them". Interview with the Administrator on 3/22/18 at 4:11pm revealed: -It is not normal for Resident #3 to be fed in her room. -The resident was usually fed in the dining by staff and she ate her meals when other residents ate. -The resident always required feeding assistance for all meals. -The resident was discharged from the hospital earlier this week, which may have been the reason she was fed in her roo. -The staff should not stood over the resident when assisting her with her luch meal and could have used a table in the SCU TV room to set the lunch on on. -A training will be scheduled for the direct care staff to review feeding techniques. _____ The failure of the facility to assure residents (Resident #3) who required feeding assistance, received assistance with eating using safe feeding techniques resulting in the resident falling and sustaining facial and head injuries which constitutes a TYPE A1 violation. _____ Review of the facility's Plan of Protection dated 3/23/18 revealed: -Staff will assist residents in a manner in which their rights will not be violated and staff will not be neglectful of the resident and his/her well-being.	D 312		

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D 312	Continued From page 21 -Immediate training with staff regarding feeding techniques and proper way to assisted residents during mealtime. -Administrator and/or designee will monitor random meals 2-3 times a week times 7 weeks and randomly thereafter, to ensure that staff are assisting residents in accordance with their care plan and in a manner in which does not violate his/her resident rights. -Any staff found not following proper feeding techniques shall receive additional training and/or disciplinary action. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 22, 2018.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 10 residents (#6)	D 358		

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observed during the medication pass who received a fast acting insulin one hour before receiving a meal and for 1 of 5 sampled residents (#4) who received 11 doses of a blood pressure medication after the medication was discontinued and did not receive a second blood pressure medication as ordered.

The findings are:

1.Review of Resident #4 FL-2 dated 11/09/2017 revealed a diagnosis of Huntington disease.

a. Review of Resident #4's physician orders on 03/22/2018 revealed:
- An order dated 12/14/2017from the Primary Care Provide (PCP) for Inderal (a beta blocker used to treat high blood pressure) 20 mg two times per day.
-On 12/14/2018 the PCP wrote an addendum to her original note to disregard the order for Inderal as Resident is on Lopressor (a beta blocker) 25 mg two times per day: Will leave current medications as is patient not on Inderal is on Lopressor 25 mg po twice per day.
-Inderal was discontinued 03/01/2018.

Review of Resident #4's medication administration record (MAR) for January 2018 revealed:
-There was an entry for scheduled Inderal to be administered twice daily at 8:00 am and 8:00 pm.
-Inderal was administered twice daily for 29 days (01/01/2018- 01/03/2018 and 01/16/2018-01/31/2018).
-It was documented as being not given on 1/4/2018 or 1/5/2018 waiting for delivery.
-There was no documentation of why the Inderal was not administered on the other days.

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Review of the February 2018MAR for Resident #4 revealed:
-The Inderal was administered two times per day for 28 days (02/01/2018- 02/28/2018).

Review of MAR for March 2018 revealed:
-Inderal was not signed as being administered.
-The order for Inderal was handwritten as discontinued on 03/01/2018.

Review of blister pack of Inderal on 03/23/2018 revealed:
-11 out of 56 Inderal tablets were missing from the original package
-The dispense date for the Inderal was 03/14/2018.

Interview with Resident #4 on 03/21/2018 at 11:51am revealed:
-She felt she was "getting the wrong drugs".
-She did not feel well but was unable to describe her symptoms.

Interview with a medication aide (MA) on 03/23/2018 at 8:44 am revealed:
-She administered Inderal today (03/23/2018) to Resident #4.
-She did not see the resident's Inderal order was discontinued on 03/01/2018 on the MAR.
-She did not sign the MAR to show she had administered the Inderal.

Interview with the same MA on 03/23/2018 at 8:58 am revealed:
-Inderal was discontinued on the MAR.
-She referred to the MAR when giving medication instead of using the package instructions from the pharmacy.
-Someone had been giving Resident #4 Inderal in March because some of the tablets were missing

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from the package.
-Physician orders got pulled from the record and faxed to pharmacy by the Resident Care Coordinator (RCC).
-The RCC was responsible for documenting resident's order changes in the residents' record.
-She did not know why she did not sign the MAR or why she gave the Inderal on 03/23/2018.
-She had been taught to refer to the MAR when giving medications.

Interview with the same MA on 03/23/2018 at 3:27 pm revealed:
-She gave Resident #4 an Inderal on 03/12/2018 but did not sign for it on the MAR.
-She forgot to sign the MAR.
-The RCC wrote the instructions on the MAR and blood pressure logs.
-She used the logs written by the RCC instead of referring the MAR.
-She was unsure why she used the logs from the RCC instead of the MAR.
-She had been taught to refer to the MAR when giving medications.

Interview with the Resident Care Coordinator (RCC) on 03/23/2018 at 9:07 am revealed:
-She did not know why the Inderal was being given but thought "it might be for blood pressure."
-The order for Inderal was started before she started work for the facility.
-She did not read the physician notes.
-Medication orders should be written in the physician orders section of the chart.
-Inderal should not have been on the medication cart since it was discontinued on 03/01/2018.
-Medications were put on the cart by 3rd shift and should have been checked against the MAR.
-The third shift was responsible for putting medication on the cart for new orders and

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removing the medication for discontinued orders.
-The MA and the RCC should have pulled the Inderal off the cart on the day it was discontinued if the third shift did not remove it.
-She had been checking behind the MA but did not know the Inderal was still on the cart.
-MA's were trained to follow the MAR.
-She always follows the MAR.

Interview with the RCC on 03/23/2018 at 3:36 pm revealed:
-Medication might have been given and not signed for on the MAR.
-It would be her mistake if there were incorrect entries that were transcribed on the MAR or a log.
-The MA should be reviewing the MAR prior to administering medication.
-She did not know why the instructions were not clarified.

Interview with the PCP on 03/23/2018 at 4:38 pm revealed:
-She added the Inderal as needed due to tachycardia (rapid heartbeat) and anxiety.
-She did not remember the order for Inderal being listed on the MAR without parameters when to use.
-Inderal was discontinued at the request of resident's family member.
-Possible side effects to taking this medication if it is not needed would be bradycardia (slow heart beat), trouble breathing and 'typical cardiac responses'.

Interview with Pharmacist from facility's contracted pharmacy on 03/23/18 at 11:17 am revealed:
-Possible side effects of taking Inderal when not needed would be reduced heart rate and lower blood pressure.

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D 358	Continued From page 26 -The PCP wrote a prescription for Inderal on 12/15/18. -He was unaware the Inderal was discontinued on 03/01/2018. -There were 56 tablets of Inderal sent to the facility on 03/07/2018. Interview with the Administrator on 03/23/2018 at 9:25 am revealed: -He expected the MA and the RCC to verify all medications received from the pharmacy according to the MAR. -If there was a medication on the medication cart that was not on the MAR, then staff should check the PCP's orders. -If the medication was discontinued, the medication should have been pulled from the medication cart and if it was not clear to start, continue or discontinue a medication then the MA was responsible to contact the PCP for clarification. b. Review of physican orders for Resident #4 revealed: -An order for Lopressor 25 mg PRN for HR over 100, hold for BP less than 90/60 was ordered on 11/30/2017. -An order for Lopressor 25 mg two times per day, hold if blood pressure is less than 100/60, heart rate is less than 60 was ordered on 12/08/2017. Review of December 2017 MAR for Resident #4 revealed: -The Lopressor was administered on 12/11/2017 and 12/13/2017. -The resident's blood pressure was 98/68 on 12/11/17. -The resident's blood pressure was 92/62 on 12/13/17.	D 358		

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D 358	Continued From page 27 Review of January 2018 MAR and blood pressure documentation for Resident #4 revealed: -No BP or HR was recorded on 01/01/2018 8:00 am. No Lopressor was administed. -The resident's blood pressure was 110/78 with a HR of 84 on 01/01/2018 at 8:00 pm. No Lopressor was administered. -The resident's blood pressure was 114/76 with a HR of 116 on 01/02/2018 at 8:00 am. No Lopressor was administered. -The resident's blood pressure was 120/74 with a HR of 110 on 01/02/2018 at 8:00 pm. No Lopressor was administered. -The resident's blood pressure was 123/88 with a HR of 117 on 01/03/2018 at 8:00 pm. No Lopressor was administered. Review of physician orders dated 01/05/2017 for Resident #4 revealed: -The Lopressor 25 mg twice daily was discontinued. -The Lopressor 25 mg twice daily PRN was continued. Review of February 2018 MAR for Resident #4 revealed: -The resident's blood pressure was 91/65 with a HR of 101 on 02/01/2018 at 8:00 am. No Lopressor was administered. -The resident's blood pressure was 104/67 with a HR of 103 on 02/02/2018 at 8:00 pm. No Lopressor was administered. -The resident's blood pressure was 105/68 with a HR of 106 on 02/04/2018 at 8:00 am. No Lopressor was administered. -The resident's blood pressure was 121/80 with a HR of 115 on 02/12/2018 at 8:00 am. No Lopressor was administered. -The resident's blood pressure was 112/86 with a	D 358		

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HR of 112 on 02/15/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 106/78 with a HR of 101 on 02/16/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 103/73 with a HR of 102 on 02/17/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 102/61 with a HR of 103 on 02/18/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 102/60 with a HR of 101 on 02/19/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 101/62 with a HR of 100 on 02/20/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 106/61 with a HR of 110 on 02/21/2018 at 8:00 am. No Lopressor was administered.
-The resident's blood pressure was 122/75 with a HR of 107 on 02/21/2018 at 8:00 pm. No Lopressor was administered.

Review of physician orders dated 03/01/2018 revealed Lopressor 25 mg PRN was discontinued.

Interview with RCC on 03/23/2018 at 3:36 pm revealed:
-It was her expectation if a resident had very low blood pressures that the MA would contact the physician's office for instructions.

Interview with PCP on 03/23/2018 at 4:38 pm revealed:
-She added the Lopressor due to tachycardia (rapid heartbeat) and anxiety.
-Lopressor was discontinued.
-Possible side effects to taking this medication if it

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is not needed would be bradycardia (slow heart beat), trouble breathing and 'typical cardiac responses'.

Interview with Pharmacist from facility's contracted pharmacy on 03/23/18 at 11:17 am revealed:
-Lopressor and Inderal should not be given at the same time because they are both beta blockers and have the same function.
-Possible side effects of taking Lopressor when not needed would be reduced heart rate and lower blood pressure.

Interview with the Administrator on 03/23/2018 at 9:25 am revealed:
-If there was a medication on the medication cart that was not on the MAR, then staff should check the PCP's orders.
-If the medication was discontinued, the medication should have been pulled from the medication cart and if it was not clear to start, continue or discontinue a medication then the MA was responsible to contact the PCP for clarification.

Refer to review of the facility's undated Medication Administration Policy and Procedure.
2. Review of Resident #6's current FL-2 dated 10/05/2017 revealed:
-Diagnoses included diabetes mellitus, congestive heart failure, fibromyalgia, altered mental status and unspecified neurocognitive disorder.
-Medication orders included Humalog insulin 10 units three times daily, hold for blood sugar less than 150.

Review of a physician's orders sheet dated 02/15/2018 for Humalog insulin 15 units three

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D 358	Continued From page 30 times daily with meals, hold if patient does not eat a meal. Review of Resident #3's March 2018 medication administration record (MAR) revealed there was a preprinted entry for Humalog 15 units three times daily with meals, hold if patient does not eat a meal. Observations during the noon medication pass on 03/21/2018 from 11:29am until 11:38am revealed: -The Supervisor checked Resident #6's finger stick blood sugar (FSBS) level and it was 106 at 11:29am. -The Supervisor prepared and administered Humalog insulin 15 units subcutaneously to Resident #6 at 11:31am. -Resident #6 was lying in her bed at the time of Humalog administration. -There was no food or drink offered to Resident #6. -The Residential Care Coordinator (RCC)/Special Care Coordinator (SCC) interrupted the medication pass and asked the Supervisor to come with her. Interview with a housekeeper on 03/21/2018 at 11:57am revealed the lunch meal was at 12:00pm and residents were gathering in the dining room for the lunch meal. Observation on 03/21/2018 from 11:57am until 12:13pm revealed: -Resident #6 was lying in her bed with her eyes closed from 11:57am until 12:13pm. -At 12:11pm, residents were seated in the dining room with drinks on the table. -There were no plates of food on any of the tables.	D 358		

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D 358	Continued From page 31 Interview with the Supervisor on 03/21/2018 at 12:13pm revealed she had "stay on" Resident #6 to make sure the resident went to the dining room and ate lunch. Observations on 03/21/2018 from 12:13pm until 12:32pm revealed: -At 12:13pm, the Supervisor aroused Resident #6 and told the resident, "You need to eat because I gave you your insulin," the resident was groggy and responded, "I don't want to eat, I'm not hungry." -The Supervisor said to Resident #6, "You need to eat so your blood sugar don't drop," and the resident replied, "I'm not going nowhere right now until I get ready." The Supervisor told Resident #6 she would stand outside the room and wait for her to get ready. -At 12:19pm, Resident #6 went into her bathroom. -At 12:24pm, Resident #6 came out of the bathroom and asked the Supervisor, "Why are you still here?" -The Supervisor required prompting at 12:24pm, to offer food/drink and notify the RCC/SCC and PCP. -The Supervisor offered to bring Resident #6 a tray of food from the kitchen and Resident #6 said, "I don't want anything, my blood sugar is fine." -At 12:26pm, the RCC/SCC entered Resident #6's room with the Supervisor. -Resident #6 told the RCC/SCC she did not want to eat. -The RCC/SCC instructed the Supervisor to contact Resident #6's PCP. -At 12:32pm, the Supervisor returned to Resident #6's room with a tray of food and said she had left a voice message for Resident #6's PCP.	D 358		

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Interview with the Supervisor on 03/21/2018 at 12:19pm revealed:
-Resident #6 was usually resistant and did not cooperate with staff with getting her FSBS checked, taking her insulin and eating meals.
-She would wait to give Resident #6 her meal time insulin until the resident went down to the dining room sometimes, but she usually believed Resident #6 when the resident said she was going right down to the dining room.
-She thought Resident #6 was awake when she gave the resident her Humalog insulin and that the resident said she was going to the dining room for lunch.

Interview with the Administrator on 03/21/2018 at 12:54pm revealed:
-Resident #6 frequently refused to eat and had the right to refuse.
-Most of the time staff could "coax" the resident into eating.
-In instances where Humalog insulin had been administered and the resident then refused to eat, he expected staff to notify the resident's PCP.
-The medication aide (MA) or Supervisor, whoever gave the insulin, was responsible for contacting the PCP.

Interview with Resident #6 on 03/23/2018 at 5:26pm revealed:
-She did not remember getting her FSBS checked or receiving insulin injections at all.
-She would never refuse getting her FSBS checked, getting her insulin or eating meals.
-She had just finished her dinner meal.
-She did not know if her FSBS were ever high or low.
-It would not be good for her FSBS to be low because that made her feel "Yuck."
-Sometimes she felt "yuck" even if the staff had

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D 358	Continued From page 33 not given her insulin so she did not know the difference. Interview with the Supervisor on 03/22/2018 at 11:50am revealed: -There were six residents with FSBS checks four times daily and she normally started checking FSBSs at 11:00am daily for lunch time. -She normally administered insulin if it was scheduled for administration at the same time the FSBS was checked. -When an order for insulin was to hold if the resident did not eat, she did not give the insulin until after the resident ate (instead of with the FSBS check) because she was not supposed to give the insulin if the resident did not eat. -She had given Resident #6 her Humalog insulin on 03/21/2018 before lunch because she believed the resident was going to eat lunch. -When there was an order to hold insulin if the resident did not eat and she had administered insulin and the resident did not eat then she would bring the resident a plate of food like she did on 03/21/2018. -Normally, if a resident's FSBS was high or low or the resident did not eat, she would contact the resident's PCP and document the PCP contact on the back of the MAR and in the resident's record. -She had received diabetic training when the facility reopened in November 2017. -The nurse went over each insulin, how they worked and drawing up insulin. -The nurse also reviewed signs and symptoms of high and low blood sugar. Interview with a MA on 03/23/2018 at 5:40pm revealed: -She gave Resident #6 her Humalog insulin when she knew the resident had eaten, "so after her meal."	D 358		

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D 358	Continued From page 34 -Resident #6 had short term memory loss and would say she was going to go to the dining and then forget about going. Telephone interview with the facility's pharmacist on 03/23/2018 at 5:15pm revealed Resident #6's Humalog should not be given until the resident was eating because if the resident did not eat, the Humalog should not be given. Telephone interview with Resident #6's PCP on 03/23/2018 at 4:26pm revealed: -Resident #6 was known to frequently refuse FSBS checks, insulin and meals. -Staff had notified her about Resident #6 receiving insulin prior to the lunch meal on 03/21/2018 and subsequently refusing to eat. -Staff informed her Resident #6 said she was going to eat and then did not, she believed staff checked her FSBS and the resident was fine. -Resident #6 should probably be given her Humalog insulin while she was sitting down at a meal or immediately after eating a meal. -She was not sure of specific notifications of Resident #6 refusing meals after receiving insulin prior to 03/21/2018. -She did not think facility staff had contacted her about clarifying when to give Resident #6 her Humalog insulin ordered with meals. -Humalog insulin was meant to prevent a hyperglycemia (high blood sugar) episode and could create a drop in blood sugar if the Humalog was given so far in advance of a meal. Review of Physician Contact sheet, Physician's orders and Care Notes for Resident #6 dated 11/04/2017 through 02/24/2018 revealed there was no documentation that facility staff contacted Resident #6's PCP for the resident having refused a meal and/or refused a meal after	D 358		

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D 358	Continued From page 35 receiving a scheduled dose of Humalog insulin. Review of Resident #6's March 2018 MAR revealed: -On 03/21/2018 at 11:20am, on the bottom back of one page of the MAR, the Supervisor documented Resident #6's FSBS was checked, insulin (given), then resident refused to go to lunch, contacted (PCP). -On 03/21/2018 (no time, "continued"), on the top back of a second page of the MAR, the Supervisor documented Resident #6's PCP stated to encourage the resident to eat, the Supervisor took a plate of food to the resident's room, but the resident refused and had a "bad attitude the whole time I was trying to get her to eat." Resident #6 "finally went to the dining room and ate lunch." -On 03/21/2018 at 5:00pm, the Supervisor documented Resident #6 refused her FSBS check. -There was no documentation that facility staff contacted Resident #6's PCP for the resident having refused a meal and/or refused a meal after receiving a scheduled dose of Humalog insulin prior to 03/21/2018. Review of Resident #6's January and February 2018 MARs revealed there was no documentation that facility staff contacted Resident #6's PCP for the resident having refused a meal and/or refused a meal after receiving a scheduled dose of Humalog insulin. Review of a physician's order sheet dated 03/21/2018 for Resident #6 revealed the RCC/SCC documented the PCP was notified the resident was given SSI (sliding scale insulin) before lunch and the PCP stated to encourage the resident to eat.	D 358		

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D 358	Continued From page 36 Interview with the RCC/SCC on 03/23/2018 at 5:31pm and 7:14pm revealed: -She had spoken with the Supervisor about Resident #6 and the Supervisor said she had not rechecked Resident #6's FSBS on 3/21/18 around lunch time because the PCP did not tell her to. -The Supervisor also said she tried to check Resident #6's FSBS at 5:00pm, but the resident refused. -She was responsible for contacting the PCP for clarification of most orders if the order was not clear or incomplete. -If the MAs did not understand a PCP's order, the MA would call and get clarification. Interview with the Administrator on 03/23/2018 at 9:25am revealed if the order was written to hold if the resident did not eat, he expected the MA to contact the PCP for clarification. Review of the facility's undated Diabetic Testing and Insulin Administration Policy and Procedure revealed there was no information regarding when to administer fast/long acting insulins and when to contact the PCP regarding insulins and blood sugar levels. Refer to review of the facility's undated Medication Administration Policy and Procedure. _____ Review of the facility's undated Medication Administration Policy and Procedure revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -The MAR will be updated and changed when medication or treatment orders from the	D 358		

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D 358	Continued From page 37 prescribing practitioner were changed. -In the event of medication errors and adverse reactions to medications, facility staff will notify a physician or appropriate health professional and their immediate supervisor and document any orders received by the physician or health professional and actions taken by the facility to comply with the order. _____ The faility failed to administer blood pressure medications for 1 of 5 sampled residents and insulin for 1 of 10 residents observed during the medication pass.The facility's failure to discontinue administering Inderal (a blood pressure medication) as ordered by the primary care provider to Resident #4 for 11 doses placed Resident #4 at risk for low blood pressure and low heart rate; and to hold Humalog (a fast acting insulin) if Resident #6 did not eat a meal as ordered by the PCP, when Resident #6 was given the scheduled 12:00pm dose of Humalog 15 units prior to the lunch and meal and subsequently refused to eat the meal which placed the resident at risk for low blood sugar. The facility's failure to administer medications as ordered placed Resident #4 at risk for low blood bressure and a low heart rate and Resident #6 at risk for low blood sugar which was detrimental to the health, safety and welfare of Residents #4 and #6, and constitutes a Type B Violation. _____ The facility provided the following Plan of Protection on 03/23/2018 as follows: -Resident #4's vital signs were obtained to ensure the resident was stable and the physician was notified of the medication error. -The medication (Inderal) was immediately removed from the medication cart to be returned to the pharmacy. -The RCC/designee will conduct a medication	D 358		

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D 358	Continued From page 38 cart audit to ensure no other discontinued medications are on the medication carts. -An insulin guide was added to the MAR book and MA staff received additional diabetic training on 03/21/2018. -Batch medications will be verified by the Administrator/RCC upon delivery, prior to the batch change over for 90 days then randomly thereafter, but no less than quarterly. -The Administrator/RCC will conduct medication pass observations 2-3 times per week to ensure residents are receiving medications as ordered. -Medication cart audits will be conducted 3 times per week by the RCC/designee to ensure all medications on the cart are as ordered by the physician for 90 days and then weekly thereafter. -Staff will receive additional training on medication and insulin administration by 03/31/2018. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 8, 2018.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Type B Violation	D 438		

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Based on observations, interviews, and record reviews, the facility failed to report 1 sampled resident (Resident #1) who had an injury of unknown origin, a chest contusion, to the Health Care Personnel Registry.

The findings are:

Review of Resident #1's current FL-2 dated 10/24/17 revealed:
-Diagnoses included dementia, cerebrovascular disease, and schizophrenia, history of thrombosis and embolism, anemia, contracture of joint, hypertensive disorder and gastroesophageal reflux disease.
-The resident was constantly disoriented.
-The resident required total care assistance from staff.
-The resident's recommended level of care was for a Special Care Unit (SCU)

Review of Resident #1's Resident Register revealed an admission date on 11/14/17.

Review of Resident #1's assessment and care plan dated 11/17/17 revealed the resident required physical assistance from staff with eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of the facility's Care Notes for Resident #1 revealed:
-On 03/08/18, there was a handwritten entry (no time was documented) with documentation the resident had a mass on her upper right chest. The resident's primary care provider (PCP) was contacted and an x-ray (an imaging test to view the inside of the body such as bones and organs) was ordered.
-On 03/08/18, there was a second handwritten

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LUMBERTON ASSISTED LIVING	550 BAILEY ROAD LUMBERTON, NC 28359

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entry (no time documented) with documentation the resident was complaining of pain and was hurting every time she moved her right arm. She had a "mass on the upper chest (right side)". The resident was sent to a local hospital and the family was contacted.
-On 03/09/18, there was a third handwritten entry (no time was documented) with documentation the resident was back at the facility, the resident's responsible person was aware and "1 new medication (naproxen)".

Review of a telephone order signed by the PCP for Resident #1 revealed on 03/08/18 an x-ray of the chest was ordered due to swelling.

Review of Resident #1's x-ray report dated 03/08/18 revealed:
-The examination included the chest and indicated swelling.
-The impression included that there was central pulmonary venous congestion (increased pulmonary blood volumes) without overt pulmonary edema and there was no focal pneumonia evident by the front view.

Review of a local hospital emergency room (ER) report dated 03/09/18 for Resident #1 revealed:
-The resident arrived to the ER at 3:18 p.m. from the facility for a "bruise" and swelling to the right anterior chest wall x 2 days.
-The resident had chief complaints of chest wall pain and there was "obvious bruising noted of chest wall".
-There was documentation the facility did not witness the injury.
-The resident had normal range of motion.
-There was erythema (redness of the skin) and ecchymosis (a discoloration of the skin resulting from bleeding underneath) to the right chest wall,

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no gross hemorrhage and no open wounds.
-There was no visualized displaced rib fracture from x-ray.
-The final diagnoses included contusion (another name for a bruise that is caused when blood vessels are damaged or broken as the result of a blow to the skin) of right chest wall.
-The resident was given a prescription for Naproxen (used to reduce inflammation and pain) 500mg to take one twice daily with food for 10 days.
-The physician discussed the case with the family member and the resident and they "feel safe at the nursing home at this time" and the family member would continue to observe the resident.
-The resident was discharged.

Review of the facility's incident / accident reports revealed there was not an incident or accident report for Resident #1 on 03/08/18.

Review of Resident #3's record revealed there was no documentation of a 24 hour report being completed or sent to the Health Care Personnel Registry (HCPR) for Resident #1's chest wall contusion of unknown origin.

Based on observations, interviews and record reviews it was determined Resident #1 was not was not interviewable.

Observation of Resident #1 on 03/22/18 at 12:41 p.m. revealed:
-The resident was sitting in a wheelchair with an attached table in front of the resident in her room.
-Two personal care aides (PCAs) transferred the resident from the wheelchair to the bed using a Hoyer lift (used for transfers by using a pad that connects to a frame with a mechanical pump to lift a person for transfers).

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D 438	Continued From page 42 -The resident's upper chest had a light yellowish green bruised area on her upper chest with a purplish yellow bruising under both breasts. Interview with the same two PCAs that transferred Resident #1 from the wheelchair to the bed using the Hoyer lift on 03/22/18 at 12:50 p.m. revealed: -A raised and bruised area on the resident's chest happened on 3rd shift approximately 2-3 weeks ago and the bruise was there when they came in for 1st shift. -They thought third shift staff had reported the area on the resident's chest. -They (3rd shift) said the resident had fallen. Interview with a third PCA on 03/22/18 at 4:50 p.m. revealed: -She had worked at the facility for 2 years. -When she came to work on second shift about 2 weeks ago she noticed a lump on the right side of Resident #1's chest while she was undressing the resident for her bath. -The "lump" on her chest was not there the prior day when she worked second shift. -First shift did not report any issues to her concerning Resident #1 when she reported to work for her shift that day. -She immediately redressed Resident #1 and before proceeding with the resident's bath, reported the area to the Resident Care Coordinator/Special Care Coordinator (RCC/SCC). Interview with the Supervisor in Charge on 03/23/18 at 5:31 p.m. revealed: -She was not working when the area on Resident #1's chest was found and nothing had been reported to her about it. -When she came to work she was told Resident	D 438		

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#1 had went to the hospital and when she asked why she was told for an area on her chest.
-No one had reported to her what they thought might have happened to Resident #1.
-The Administrator had asked her if she knew anything about the swelling and bruising on Resident #1's chest.
-When Resident #1 returned to the facility from the hospital she remembered that she looked at the area on her chest and there was a "light, not dark" bruise on her chest.

Interview with the RCC/SCC on 03/23/18 at 10:25 a.m. revealed:
-On 03/08/18, a PCA reported to her that Resident #1 had a "mass" sticking out on one side of her chest.
-The RCC/SCC took a picture of the area on Resident #1's chest and sent it to the PCP who then ordered an x-ray.
-The x-ray "did not show anything" and was told by the PCP to monitor Resident #1.
-Staff called her the next day and reported Resident #1 was acting like she was in pain when she moved so she instructed staff to send the resident to the hospital.
-The Administrator had spoken with all staff in the SCU trying to figure out what had happened to Resident #1.
-The "mass" on Resident #1's chest happened before the resident received the Hoyer lift.
-She did not do an incident or accident report and was not sure what a 24 hour HCPR report was for.

Interview with the Administrator on 03/23/18 at 12:47 p.m. revealed:
-He thought that he remembered Resident #1 was diagnosed from the local emergency room with a contusion.

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D 438	Continued From page 44 -He looked at the area on Resident #1's chest after she returned from the ER and the area was not very discolored in his opinion but was raised. -The resident's arms were extremely contracted and she would hit and become agitated when trying to look at the area on the right side of her chest. -The area on Resident #1's chest looked more "clinical versus anything else" and he thought maybe a bone or something had been pulled or something "internally" had caused the raised area. -Resident #1 was a 2 person transfer and she was never alone because she was in the Dayroom and never alone with anyone and it had never crossed his mind that someone could have caused the raised area on her chest. -He had spoken with several staff on each shift and there was no way to pinpoint how long Resident #1 had the raised area and nothing that had been reported. -There were no residents with any known aggressive behaviors identified in the SCU. -He did not complete a 24 hour HCPR report. A second interview with the Administrator on 03/23/18 at 5:56 p.m. revealed: -He was in the process of completing a 24 hour HCPR report regarding the area on Resident #1's chest and would send the report to the HCPR section. -The reason he had not sent a report to HCPR for Resident #1 because he did not think it was related to an injury of unknown origin. _____ The failure of the facility to accurately report an injury of unknown source to the N. C. Health Care Personnel Registry was detrimental to the health, safety and welfare of Resident #1 and all other residents at the facility which constitutes a Type B	D 438		

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D 438	Continued From page 45 Violation. _____ Review of a Plan of Protection submitted by the facility dated 03/23/18 revealed: -The Administrator would immediately report injuries of unknown source and allegations of resident abuse, neglect or exploitation to the Health care personnel registry according to the above rule area 03/23/18 and on-going. -The Administrator would begin an immediate internal investigation on the injury of unknown source and would report findings to HCPR according to rule area 03/23/18 and on-going. -The Administrator/designee would conduct random resident and staff interviews to ensure that resident rights were not being violated, monthly x 4 months then randomly thereafter 03/23/18 and on-going THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 07, 2018.	D 438		
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,	D912		

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appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration, nutrition and food service and reporting injures of unknown origin to Health Care Personnel Registry.

The findings are:

1.Based on observations, interviews, and record reviews, the facility failed to report 1 sampled resident (Resident #1) who had an injury of unknown origin, a chest contusion, to the Health Care Personnel Registry. [Refer to Tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

2. Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to a build-up substance in the ice machine, food stored uncovered in the walk-in cooler, expired foods in the pantry and walk-in cooler, no sanitizer in the dishwasher during the cleaning cycles for 3 days and clean utensils stored upright in a dishwasher caddy. [Refer to Tag 0283, 10A NCAC 13F .0904 (a) (2) Nutrition and Food Service (Type B Violation)].

3. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 10 residents (#6) observed during the medication pass who received a fast acting insulin one hour before receiving a meal and for 1 of 5 sampled residents (#4) who received 11 doses of a blood pressure medication after the medication was discontinued and did not receive a second blood pressure medication as ordered. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration

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D912	Continued From page 47 (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from neglect in the area of Nutrition and Food service (feeding assistance). The findings are: Based on observations, interviews and record reviews, the facility failed to provide assistance with meals that promoted dignity and respect for 1 of 2 sampled residents (Resident #3) with a diagnosis of dementia and in a special care unit, who fell two times while recieving feeding assistance and sustaining injury in both instances. [Refer to Tag 312, 10A NCAC .0904(f)(2) Nutrition and Food Service (A1 Violation)].	D914		