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D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services (DSS) conducted an annual, follow up and complaint survey on 05/16/18, 05/17/18, 05/21/18 and 05/22/18 with an exit conference via telephone on 05/25/18. The complaint investigation was initiated by the Robeson County DSS on 04/04/18.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings and floor were kept clean and in good repair for 4 resident rooms, 2 shared bathrooms, hallways, 1 common bathroom and the living room area as evidenced by scuff marks, dirt build up, peeling paint, bent door thresholds, floor stains, cracked and poorly placed linoleum tiles, gaps in bathroom caulking, loose baseboard stripping, multiple holes and chipped wood on doors; and aged plaster with cracks and gouge marks on walls. The findings are: Observations of resident room #1 on 05/16/18 at 10:44am and 11:03am revealed:	D 074		

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D 074	Continued From page 1 -The area of ceiling near the light that was closest to the closet had cracked dry wall patches. -There were 2 areas of dry wall spackle approximately 2 inches in diameter each above the bed to the left of the window. -There was a large unpainted, patched area of wall above the window approximately 3 ½ ft in length. -The air conditioning unit was dripping red liquid from a red colored patch on the lower right side. -There was a hole in the ceiling above the bed to the left of the window that was about ½ inch in diameter. -The frame above the entrance door to the room was loose from the wall with an approximate 1 inch gap between the trim wood and the frame where the nails were visible within the gap. Observations of the shared bathroom in resident room #1 on 05/16/18 at 10:57am revealed: -There was an approximately ¾ inch missing area of wall covering and trim on both sides of the light switch on the wall. -There were several areas missing grout where the shower wall met the floor with the largest area approximately ¼ inch wide and 12 inches in length and smaller areas of approximately ¼ inch width and 3 to 6 inches in length. Observations of resident room #2 on 05/16/18 at 10:39 am revealed: -There was a dark stain on the floor in front of the brown dresser that was approximately 2 feet in length. -The floor tiles in front of the brown dresser were lifted at the side seams for about 3 feet in 2 parallel lines. -There was a black stain approximately 3 inches by 1 inch next to the bed by the door.	D 074		

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D 074	Continued From page 2 Observations of the common bathroom on 05/16/18 at 10:44 am and 11:05am revealed: -The seam along the sink counter where the counter meets the wall had thick, loosened and cracked caulk. -There was a patched area of the corner wall near the commode that was ripped to expose the stud that was approximately 1 inch and a half in length. -The area behind the commode was patched with part of the patched area bubbled and part of the area cracked. -There was a black scuff mark approximately 7 inches from the floor that ran most of the length of the wall. -The seam along the tile floor where the floor meets the wall around the toilet area had thick, loosened and cracked caulk. Observation of Resident #2 on 05/17/18 at 3:26pm revealed: -The resident attempted to cross the dayroom threshold but his foot got stuck on the warped metal threshold. -The resident attempted to lift his foot higher to cross the metal threshold. -After approximately 8 attempts the resident was able to lift his leg high enough to cross into the day room. -The resident used his cane to balance himself while attempting to cross into the room. Interview with the Administrator on 05/21/18 at 3:50pm revealed: -Cleaning was done at night. -Day shift should not be cleaning. A second interview with the Administrator on 05/24/18 at 8:15am revealed: -Second shift was responsible for general	D 074		

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D 074	Continued From page 3 housekeeping including "incidental things like sweeping, checking for contraband, cleaning bathrooms, closets and dressers." -Second shift cleaned 1 to 2 rooms per day. -Second shift prepared the rooms for 3rd shift to clean. -Third shift washed the floors in the community bathroom and day room. -Third shift cleaned "whatever area second shift identified". Observations of resident room #4 on 05/16/18 at 10:44am revealed: -There were black and brown smudges covering an area of approximately 4 inches in width and expanding 12 inches above and 12 inches below the door knob. -The frame of the door around the door to the bathroom had a missing piece of wood approximately ½ inch in width and 3 inches in length and two screws protruding approximately ½ inch from the frame. -The frame of the door around the door to the closet had an area of approximately 1 inch in width and 3 inches in length of missing wood approximately 18 inches above the height of the door knob; and a second area of missing wood just above the height of the door knob that was approximately ½ inch in width and 3 inches in length. Observations of resident room #5 on 05/16/18 at 10:47am revealed: -There was a heavy accumulation of dirt build up on the floor behind the door into the room that was black in color and had streaks of lighter areas where the door rubbed the floor. -There were black and brown smudges and 5 holes inside an unpainted area above the door knob which was loose on the closet door.	D 074		

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D 074	Continued From page 4 -The floor was dirty with scattered blackened areas and gaps of approximately 1/8 inch between multiple floor tiles. -There was a cracked floor tile near the window that left a gap of approximately ½ inch. Observations of the shared bathroom between resident rooms #4 and #5 on 05/16/18 at 10:46am revealed: -The floor was dirty with scattered blackened areas and gaps of approximately 1/8 inch between multiple floor tiles. -The floor tiles at the entrance way from resident room #4 were warped and loose. -Approximately 9 inches of baseboard trim was loose from the wall closest to resident room #4. -There was a 3 by 3 inch square missing piece of tile from the floor behind the door to resident room #5. Observations of the living room on 05/16/18 at 11:22am revealed: -The transition plate on the floor in the doorway was bent and lifted from the floor between each nail set approximately 4 inches apart. -The linoleum was warped and bubbled for an area of approximately 2 feet in width and 3 feet in length at the entrance to the living room. -There were dirt and dust accumulations along the edges of the floor, in the corners and behind the door. -There was an area of warped baseboard covering that left a gap between the floor and the baseboard of approximately ½ inch in width and 2 inches in length. Interview with a medication aide (MA) on 05/16/18 at 11:09am revealed: -She was the only staff on duty on 05/16/18 because the cook had a family emergency.	D 074		

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D 074	Continued From page 5 -Normally there was a MA and a cook working 1st shift. -The condition of the floors had "not been long standing;" some of the floors had been stripped and buffed approximately six months ago. -The baseboards in resident rooms, bathrooms, kitchen, dining room and living room "probably just needed some new glue." -She was responsible for general cleaning when she worked 1st shift. -The 2nd shift staff did a more thorough cleaning of one resident room each day including making sure there was nothing on the floor. -The 3rd shift staff was responsible for cleaning common areas, resident bathrooms and mopping the floors. Interview with the Administrator on 05/18/18 at 11:30am revealed: -He was at the facility every day and went through the facility "all the time" checking the condition of the things. -The residents were constantly bumping into the walls with wheelchairs and that was how the floors and baseboards got damaged. -He had a maintenance person that came to the facility as needed for some repairs. -He could not recall the last time the maintenance person was at the facility. -He was generally the maintenance person and completed most repairs at the facility. -He had observed the concerns in resident rooms #1, #4 and #5, the common bathroom, kitchen, dining room and living room; none of the concerns were new to him. -He was continually making repairs and then the residents would "bang stuff up again."	D 074		

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D 176	Continued From page 6	D 176		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601Management Of Facilites (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the Administrator failed to assure responsibility for the total operation of the facility and compliance to state rules and regulations specific to personal care, health care referral and follow up, supervision, housekeeping and furnishings, personal care and other staffing, resident contracts, resident care plans, health care implementation, food service, activities, residents' rights, medication orders, medication administration, medication storage, controlled substances, pharmaceutical care, reporting accidents and incidents and examination and screening for controlled substances affecting all eleven residents in the facility.	D 176		

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D 176	Continued From page 7 The findings are: Confidential interview with a resident revealed the Administrator was "arrogant and disdainful and slept all day, leaned back in his chair with hands behind his head." Confidential interviews with three staff revealed: -The Administrator might be in the building every day, but he did not do anything except sleep in his office. -The Administrator did not check behind staff to make sure staff was doing what they were supposed to be doing. -Staff did not know the Administrator's responsibilities were because the staff had to do everything. Interview with the Administrator on 05/21/18 at 3:50pm revealed: -Regarding Licensed Health Professional Support (LHPS) recommendations: "If the recommendation is made it goes to the doctor, the doctor makes the eval [sic] and lets us know." -If blood sugar orders were changed to daily, "the LHPS nurse will contact the doctor and doctor will let you know ...we have nothing to do with that documentation ...that's what we be akin in that situation ...the doctor and pharmacy and are responsible." -In response to a facility system to monitor for signs of skin breakdown: "The (Department of Social Services worker) comes once a month ...the doctor comes once a month. -The policy on incontinent residents: "We rely on home health to assist us with an incontinence program. We try not to accept residents that are incontinent and how to appreciate their level of incontinence." -"The facility tells the doctor and the doctor orders	D 176		

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the supplies, home health supplies the business."
-In response to how does staff approve medications entered on the eMAR if they don't have the order: "The pharmacist has a license so he can write it like that. They are the top of the line here. They are liable for an incorrect order. We have 15 days."
-He did not have a response for what he was directly responsible for.

Interview with the Administrator on 05/22/18 at 10:30am and 11:00am revealed:
-In response to concerns identified at the facility: "These issues are outside our realm of responsibilities."
-He did not understand why "the focus was on a resident that was no longer here and things that were not happening now."

Interview with the Administrator on 05/22/18 at 4:00pm revealed:
-"There's a lot of paperwork, it's unfortunate that the paperwork has fallen on me. A top notch secretary would make this run so smooth and coherent."
-"We have an issue with filing. The LHPS and drug reviews should be on file."
-"I get very nervous, I stay nervous. Taking liabilities, short comings to house these people: derelicts, homeless are represented, lost their way."
-"You're the pillar to help them but you're subject to rules and regulations. That's what allows us to live together."

1. Based on observations, interviews and record reviews, the facility failed to provide personal care for 3 of 3 sampled residents (#1, #2 and #3) such as bathing, toileting, providing incontinence care and every two hour repositioning for Resident #3

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who had impaired mobility and required the use of wheelchair; and hand washing for Residents #2 and #3 with known behaviors of handling feces (#2) and ashtray waste (#1). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type A1 Violation)]

2. Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 2 of 3 sampled residents (#1 and #3) by delaying immediate transport to the emergency department (ED) for four days following notification of critical laboratory results indicating acute renal failure for Resident #3 and not identifying and reporting five pressure ulcers to the Nurse Practitioner (NP) for Resident #3; and by not reporting eight elevated blood pressures to the NP for Resident #1 and not scheduling a gastroenterologist referral appointment for Resident #1. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]

3. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 4 sampled residents who demonstrated need for increased supervision as evidenced by Resident #4, who had a history of Alzheimer's dementia and had wandered away from the facility on three known occasions; and Resident #1, who was known to fall asleep while smoking cigarettes, having numerous burn marks on his clothing. [Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)]

4. Based on observations and interviews, the facility failed to assure the walls, ceilings and floor were kept clean and in good repair for 4 resident rooms, 2 shared bathrooms, hallways, 1 common bathroom and the living room area as evidenced

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D 176	Continued From page 10 by scuff marks, dirt build up, peeling paint, bent door thresholds, floor stains, cracked and poorly placed linoleum tiles, gaps in bathroom caulking, loose baseboard stripping, multiple holes and chipped wood on doors; and aged plaster with cracks and gouge marks on walls. [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings 5. Based on observations and interviews, the facility failed to assure that 1st and 2nd shift staff were available to provide direct personal care and supervision to residents and were not assigned the primary responsibility of cooking the dinner meal every day and the lunch meal two to four days per week in addition to routine housekeeping tasks such as laundry and cleaning resident rooms and common areas. [Refer to Tag 186 10A NCAC 13F .0604(b) Personal Care & Other Staffing] 6. Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 resident contracts were completed adequately to include residents' signatures in designated areas and 1 of 3 resident contracts did not specify cost of care. [Refer to Tag 243 10A NCAC 13F .0704(a) Resident Contract, Information on Home & Resident Register] 7. Based on observations, interviews and record reviews, the facility failed to assure orders written by the Nurse Practitioner were implemented for 2 of 3 sampled residents (#1 and #2) including orders for daily diabetic urine testing and daily blood pressures for Resident #2, and a urine specimen for urinalysis culture and sensitivity for Resident #1. [Refer to Tag 276 10A NCAC 13F .0902(c) Health Care]	D 176		

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D 176	Continued From page 11 8. Based on observations and interviews, the facility failed to ensure the kitchen, dining and food storage area was clean, orderly and protected from contamination as evidenced by dirty drawers and cabinets, a dead bug, burnt and dirty cookware and broken serving dishes. [Refer to Tag 282 10A NCAC 13F .0904(a)(1) Nutrition & Food Service] 9. Based on observations and interviews the facility failed to assure an activity program for the residents that encouraged participation, socialization, mental stimulation, exercise and creativity. [Refer to Tag 315 10A NCAC 13F .0905(a) Activities Program] 10. Based on observations and interviews, the facility failed to assure two residents (#1 and #3) were treated with respect and dignity by the Administrator related to smoking behaviors. [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights] 11. Based on interviews and record reviews, the facility failed to assure multiple provider orders were in the residents records for 2 of 3 sampled residents (#1 and #3). [Refer to Tag 345 10A NCAC 13F .1002(b) Medication Orders 12. Based on observations, interviews and record review, the facility failed to assure medications were administered as ordered by the licensed provider for 1 of 3 sampled residents (#1) as evidenced by Ativan which was ordered once daily as needed, being administered twice a day routinely and being administered for 8 doses after an order to discontinue. [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration] 13. Based on observations and interviews, the	D 176		

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D 176	Continued From page 12 facility failed to assure medications, such as insulins, that were stored inside the kitchen food refrigerator were kept in a locked container. [Refer to Tag 383 10A NCAC 13F .1006(b) Medication Storage] 14. Based on observations, interviews and record reviews, the facility failed to assure there was an accurate accounting of a controlled substance for 1 of 2 sampled residents which resulted in a discrepancy in the documentation of 20 Ativan tablets for Resident #1. [Refer to Tag 392 10A NCAC 13F .1008(a) Controlled Substances] 15. Based on interviews and record reviews, the facility failed to assure documented actions taken based on the medication review for 1 of 2 sampled residents (#1) which included assuring the physician signed orders routinely every six months, staff completed proper documentation of controlled substances administration and counts, and physician ordered parameters for blood pressure reporting. [Refer to Tag 406 10A NCAC 13F .1009(b) Pharmaceutical Care] 16. Based on observations, interviews and record reviews, the facility failed to notify the county department of social services of an accident for 2 of 4 residents (#3 and #4) which resulted in injury to the residents that required emergency medical evaluation and medical treatment. [Refer to Tag 451 10A NCAC 13F .1212(a) Reporting of Accident & Incidents] The Administrator's failure to assure responsibility for the total operation of the facility and compliance to state rules and regulations resulted in significant non-compliance in the personal care of Resident #3 resulting in the development of five pressure injuries; health care referral and	D 176		

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D 176	Continued From page 13 follow up for Resident #3 where the pressure injuries went unreported to the Nurse Practitioner and developed into a stage III pressure injury on the left ischium and deep tissue injury on the left heel, and Resident #3 experienced a four day delay in emergency department evaluation and treatment for critical laboratory results indicating acute renal failure; and the supervision of Resident #4 who had a diagnoses of Alzheimer's dementia and wandering and did not have a supervision plan in place with an active railroad track within 150 feet of the facility. The failure of the Administrator to assure responsibility and compliance resulted in serious neglect of Residents #3 and #4 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 24, 2018.	D 176		
D 186	10A NCAC 13F .0604 (a-b-c) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (a) Adult care homes shall staff to the licensed capacity of the home or to the resident census. When a home is staffing to resident census, a daily census log shall be maintained which lists current residents by name, room assignment and date of admission and must be available for review by the Division of Facility Services and the county departments of social services.	D 186		

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D 186	Continued From page 14 (b) Homes with capacity or census of 12 or fewer residents shall comply with the following. (1) At all times there shall be an administrator or administrator-in-charge in the home or within 500 feet of the home with a means of two-way telecommunication. (2) When the administrator or administrator-in-charge is not on duty within the home, there shall be at least one staff member on duty on the first and second shifts and at least one staff member on call within the building on third shift. There shall be a call system connecting the bedroom of the staff member, who may be asleep on the third shift, with each resident's bedroom. (3) When the administrator or administrator-in-charge is on duty within the home on the first and second shifts and on call within the home on the third shift, another staff member (i.e., co-administrator, administrator-in-charge or aide) shall be in the building or within 500 feet of the home with a means of two-way telecommunication at all times. (4) The administrator shall prepare a plan of operation for the home (each home in a cluster) specifying the staff involved, their regularly assigned duties and the amount of time estimated to be spent for each duty. There shall be a current plan of operation on file in the home, available for review by the Division of Facility Services and the county department of social services. (5) At least 12 hours shall be spent daily providing for the personal services, health services, drug management, planned activities, and other direct services needed by the residents. These duties are the primary responsibility of the staff member(s) on duty on the first and second shifts; however, other help,	D 186		

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D 186	Continued From page 15 such as administrator-in-charge and activities coordinator may be used to assist in providing these services. (6) Between the hours of 9 p.m. and 7 a.m. the staff member on duty and the person on call may perform housekeeping and food service duties as long as a staff member can respond immediately to resident calls or the residents are otherwise supervised. The duties shall not hinder care of residents or immediate response to resident calls, disrupt residents' normal lifestyles and sleeping patterns, nor take a staff member out of view of where the residents are. (7) There shall be staff available daily to assure housekeeping and food service. (c) A cluster of homes with capacity or census of 12 or fewer residents shall comply with the following staffing: (1) When there is a cluster of up to six licensed homes located adjacently, there shall be at least one administrator or administrator-in-charge who lives within 500 feet of each of the homes with a means of two-way telecommunication at all times and who is directly responsible for assuring that all required duties are carried out in each home; and (2) In each of the homes, at least one staff member shall be on duty on the first and second shifts and at least one staff member shall be on call within the building during the third shift. There shall be a call system connecting the bedroom of the staff member, who may be asleep on the third shift, with each resident's bedroom. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that 1st and 2nd shift staff were available to provide direct personal care and	D 186		

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D 186	Continued From page 16	D 186		

supervision to residents and were not assigned the primary responsibility of cooking the dinner meal every day and the lunch meal two to four days per week in addition to routine housekeeping tasks such as laundry and cleaning resident rooms and common areas.

The findings are:

Interview with the Administrator on 05/16/18 at 10:25am revealed:
-There were 10 residents in the building and one medication aide (MA) on duty on 05/16/18.
-There was usually a second staff, a cook, on duty for 1st shift, but the staff had a personal problem to attend to on 05/16/18.
-None of the 10 residents were involved in a day program, hospitalized or away at appointments on 05/16/18.

Observations on 05/16/18 from 10:25am until 11:09am revealed:
-Resident #4 was sitting in a chair on the porch.
-Resident #1 was sitting in a chair on the porch and had numerous holes in his sweat pants.
-There was a third resident on the porch seated in a wheel chair.
-There was a fourth resident lying down in the first bed in resident room #4.
-There was a fifth resident lying down in the first bed in resident room #5.
-At 10:52am, a sixth resident walked through the open yard behind the neighboring house of the facility.
-There was a seventh resident in a wheelchair in the hallway; and an eighth resident and Resident #2 in the living room area. (Nine residents were accounted for.)
-There was no staff outside with the residents.
-The MA was cooking food in the kitchen and

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D 186	Continued From page 17 there was no other staff observed in the building. Interviews with the MA on 05/16/18 from 11:09am through 11:56am revealed: -There was normally a second staff on duty for 1st shift who did all the cooking. -The MA normally worked from 7:00am until 2:00pm on Monday through Wednesday and Friday from 7:00am until 2:00pm, and 7:00am until 1:00pm on Saturdays; it was rare that she worked by herself. -The cook worked every Monday, Wednesday and Friday, the Administrator cooked on Tuesday and Thursday, and the MA cooked on the weekends. -There were ten total residents with nine residents present in the facility on 05/16/18; one resident was away from the facility at a day program that he attended Monday through Friday until 3:00pm. Interview with a MA on 05/21/18 at 10:34am revealed: -She was the only staff on all three shifts responsible for assisting residents with showering. -All residents were assisted with showering every Monday, Wednesday and Friday during 1st shift. Telephone interview with a second MA on 05/23/18 at 6:23pm revealed: -The 3rd shift MA was responsible for cleaning resident bathrooms, mopping the floors, cooking breakfast, checking residents' finger stick blood sugar levels and blood pressures, and passing morning medications every day. -The 1st shift MA was responsible for cleaning residents' rooms, making residents' beds, straightening closets, making sure nothing was on the floor and cooking lunch on the weekend.	D 186		

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D 186	Continued From page 18 -The 2nd shift MA was responsible every day for the 2:00pm snack and activity, medications, cooking the dinner meal and cleaning one resident room each day including washing clothes and bed linens. -All shifts were responsible for checking residents every two hours "to make sure they were where they were supposed to be." -"Once you get your routine down then the work gets done." Interview with the cook on 05/22/18 at 10:39am and 3:30pm (via telephone) revealed: -She was responsible exclusively for cooking the lunch meal daily and cleaning the kitchen. -She was also a MA and personal care aide (PCA) and "helped out with the residents by watching the building sometimes" and administered medications a few times per year to keep up her MA certification. -The main MA for 1st shift had "a lot to do," the MA was responsible for resident showers, cleaning in the facility, physician's orders, making appointments, follow up on the pharmacy reviews and resident care plans. -The MA would "try to put things in order," but whenever the MA was off and then came back to work "things were never where she left it." Observations on 05/16/18 from 3:00pm until 5:45pm revealed there was one MA on duty in the facility, the Administrator was in his office and there were no other staff observed. Observations on 05/17/18 from 2:30pm until 5:45pm revealed there was one MA on duty in the facility, the Administrator was in his office and there were no other staff observed. Observations on 05/21/18 from 3:15pm until	D 186		

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D 186	Continued From page 19 6:00pm revealed there was one MA on duty in the facility, the Administrator was in his office and there were no other staff observed. Observations on 05/21/18 from 4:00pm until 6:00pm revealed there was one MA on duty in the facility, the Administrator was in his office and there were no other staff observed. Telephone interview with the MA on duty at the facility on 05/24/18 at 7:53am revealed she was trying to complete personal care tasks for the residents and once the 3rd shift staff left, she would be working by herself for 1st shift. Interview with Administrator on 5/22/18 at 2:10pm revealed: -Staff completed hourly checks on all residents during the day time hours. -Staff completed checks on all residents every two hours during the night time hours after residents go to sleep. -Staff were allowed to sleep during the night, but were expected to get up every two hours to do checks on all residents. Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed: -The main MA for 1st shift was supposed to check resident records and make sure everything was in place. -The MA was supposed to go over one resident record per day making sure everything was ordered and check the medication administration records (MARs). -The MA's primary responsibility was resident care, medications and documentation. Telephone interview with the Administrator on 05/24/18 at 8:12am revealed:	D 186		

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D 186	Continued From page 20 -He was "talking to staff and verbally working on" an operations plan; he did not have anything "legible for review ...just notes on a notepad." -The staff knew what was supposed to happen each day. -The main MA on 1st shift "had her schedule pretty much down pat, so ask her about her job duties and the other ones, well ..." -There was a personal care person that came to work three days per week and was responsible for personal care and "general awareness of the resident". -General awareness of the resident meant, "One resident, the total package, the record was intact and medications and orders were intact." -He was trying to get it to where the personal care person worked four days per week and also talked to the rest of the staff about personal care. -The cooking staff came to work three days per week and was responsible for everything overall in the kitchen and the dining room. -The 2nd shift staff person was responsible for personal care for one resident, cleaning one to two residents' rooms which involved cleaning the floor, closet, clothes and straightening the clothes in the closet and dresser. -The 2nd shift staff person would let the 3rd shift staff person know which resident room they cleaned, so the 3rd shift staff person could finish cleaning that room. -The 3rd shift staff person was also responsible for cleaning "public areas" such as the hallways and common bathroom and "administrative things" such as reviewing blood sugar documentation and bringing any left out documentation to the Administrator's attention so that he could bring it to the staff's attention. Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care	D 186		

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D 186	Continued From page 21 Refer to Tag 270 10A NCAC 13F .0901(b) Supervision Refer to Tag 273 10A NCAC 13F .0902(b) Health Care Refer to Tag 276 10A NCAC 13F .0902(c) Health Care	D 186		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Infomation on Home and Resident Register (a) An adult care home administrator or administrator-in-charge shall furnish and review with the resident or responsible person information on the home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the home. The information shall include the following: (1) the resident contract to which the following applies: (A) the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees; (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet pursuant to G.S. 131D-2(a1)(4); (C) the contract shall be signed and dated by the administrator or administrator-in-charge and the resident or responsible person, a copy given to the resident or responsible person and a copy	D 243		

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D 243	Continued From page 22 kept in the resident's record; (D) the resident or responsible person shall be notified as soon as any change is known, but not less than 30 days before the change for rate changes initiated by the facility, of any changes in the contract and be provided an amended contract or an amendment to the contract for review and signature; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly. Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled resident (#2 and #3) contracts were completed to include residents' signatures in designated areas and 1 of 3 (#3) resident contracts did not specify cost of care. Review of Resident #3's current FL-2 dated 3/6/17 revealed: -Diagnoses included change in mental status, cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension. -Resident #3 was intermittently disoriented, had speech limitations and difficulty communicating verbally.	D 243		

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D 243	Continued From page 23 Review of Resident #3's contract revealed: -Resident was admitted to facility on 10/30/2014. -Facility contract was in the resident's record. -The contract was not signed and dated by Resident #3 in designated areas. -A "Statement of Policies and Procedures at Admission" checklist was signed by resident, but was not dated. -The contract did not specify cost of care for Resident #3. Interview with Resident #3 on 04/19/18 at 11:45am revealed: -Resident #3 managed his own finances. -Resident #3 was informed verbally at admission by the Administrator that his cost of care at the facility was $1250 monthly. -Resident #3 wrote a check to the facility for $1250 monthly. -The facility paid his pharmacy bill each month from the $1250. Interview with the Administrator on 05/17/18 at 5:25pm revealed the Administrator was not aware that Resident #3's cost of care charge was not written on contract. Refer to interview with the Administrator on 05/17/18 at 5:25pm. Review of Resident #2's current FL-2 dated 11/17/17 revealed: -Diagnoses included cerebrovascular accident with right side flaccidity, hypertension, anemia, hyperlipidemia, and diabetes mellitus. -No information was provided regarding Resident #5's orientation level. -Resident #5 had impaired speech.	D 243		

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D 243	Continued From page 24 Review of Resident #2's contract revealed: -Resident was admitted to facility on 04/22/12. -Facility contract was in the resident's record. -The contract was not signed and dated by Resident #2 in designated areas. -A "Statement of Policies and Procedures at Admission" checklist was signed by resident, but was not dated. -The contract specified cost of care for Resident #2. Based on interviews, record reviews and observations, Resident #2 was not interviewable. Refer to interview with the Administrator on 05/17/18 at 5:25pm. Interview with the Administrator on 05/17/18 at 5:25pm revealed: -A contract was competed with residents at admission. -He was responsible for reviewing and completing contracts with residents. -A "Statement of Policies and Procedures at Admission" checklist was signed by residents at admission acknowledging that all the information in contract was reviewed with them. -The Administrator informed residents at time of admission the cost of care charges and reviewed the entire contract with them. -Cost of care was usually written on resident contracts.	D 243		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal	D 269		

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care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide personal care for 3 of 3 sampled residents (#1, #2 and #3) such as bathing, toileting, providing incontinence care and every two hour repositioning for Resident #3 who had impaired mobility and required the use of wheelchair; and hand washing for Residents #2 and #3 with known behaviors of handling feces (#2) and ashtray waste (#1).

The findings are:

1. Review of Resident #3's current FL-2 dated 3/6/17 revealed:
-Diagnoses included change in mental status, cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension.
-Resident #3 was intermittently disoriented, non-ambulatory and incontinent of bowel and bladder.
-Resident #3 had speech limitations and difficulty communicating verbally.
-Resident #3 needed assistance with bathing and dressing.

Review of Resident #3's undated assessment and care plan revealed:
-Resident #3 was ambulatory with a walker and a wheelchair and had limited strength and range of

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motion in his upper extremities.
-Resident #3 was occasionally incontinent of bowel and bladder and was sometimes disoriented.
-Resident #3 needed extensive assistance with toileting, ambulation, transfers, bathing and dressing.
-The care plan was signed by the Nurse Practitioner (NP) on 02/14/17.

Review of a Nurse Practitioner (NP) visit summary for Resident #3 dated 01/19/18 revealed there was an order for a motorized wheelchair due to mobility limitation and insufficient upper extremity strength to propel a wheelchair.

Review of hospital records dated 02/12/18 through 02/26/18 for Resident #3 revealed:
-On 02/12/18, Resident #3 reported to the emergency department (ED) via emergency medical services (EMS) with abnormal lab values.
-Resident #3 complained of heel pain, had blisters on each heel and swelling to his left leg.
-On 02/14/18, Resident #3 had a consultation for wound care where a Nurse Practitioner (NP) documented Resident #3 had the following wounds on admission to the hospital:
-A stage III pressure injury to his left ischium (hip) which measured 3 x 3 x 0.1 centimeters (cm), had a moist, pinkish-yellow wound bed, a scant amount of serosanguineous drainage and nonblanchable erythema.
-A deep tissue injury to his left heel was measured 4 x 4 cm which was not open and dark purple in color.
-Two stage II pressure injuries to his right heel measuring 1 x 1 cm on his medial heel and 2 x 2 cm on his lateral heel; both were fluid filled, un-open blisters.

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D 269	Continued From page 27 -A stage I pressure injury to his sacral area that measured 8 x 8 cm. Interview with Resident #3 on 05/21/18 at 1:34pm revealed: -He spent his day at the facility sitting in his wheelchair on the porch. -Staff assisted him with incontinence care, dressing and transferring from his bed to his wheelchair at 6:00am, incontinence care at 12:00pm, and incontinence care at 6:00pm when transferring from his wheelchair to his bed. -Staff did not check and/or change him for incontinence care or help with changing his position overnight (from 6:00pm until 6:00am). -His whole bed would be wet when he woke up in the morning. -He had a shower every two days at the facility except on Fridays because there was only one staff that gave showers and Friday was her day off. -There were only two staff that helped him with incontinence care. -He never refused to let staff help him. -Before he left the facility, he had bedsores and needed to go to the doctor. Telephone interview with Resident #3's family member on 05/22/18 at 9:46am revealed: -She visited Resident #3 three to four times each week. -Resident #3 would just sit in his wheelchair all day until 6:00pm. -Resident #3 had bedsores that were found when he went to the hospital in February 2018. -Family members talked to the Administrator "all the time about keeping clean clothes on him (Resident #3) and keeping him clean". Telephone interview with a second family member	D 269		

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D 269	Continued From page 28 for Resident #3 on 05/22/18 at 9:50am revealed: -The first time he visited the facility and saw Resident #3 was a few days before Resident #3 went to the hospital (02/10/18) , and Resident #3 was "a mess." -Resident #3 "looked like he had not been bathed, his clothes were dirty, he was curled up in his wheelchair ...his feet were swollen like basketballs". -Resident #3 did not have anything protective on his feet like foam booties, he had a gel cushion seat that a family member brought him and that was it. -Resident #3 went to the hospital two or three days after the first time the family member visited the facility and the hospital found wounds on his bottom and both of his heels when Resident #3 was admitted. -The kind of sores Resident #3 had "did not develop overnight or in two days, it took weeks or months probably". Interview with a medication aide (MA) on 05/22/18 at 11:30am revealed: -Resident #3 was showered every Monday, Wednesday, Friday and anytime he urinated on himself. -Resident #3 was incontinent, but he would not tell staff when he had urinated; staff "would have to walk up on him and smell it." -"He hardly ever refused" any personal care assistance. -Resident #3 had a spot on his buttock that he scratched all the time; the spot would heal and then he would "dig it up." -Resident #3 had a gel cushion seat for his wheelchair and protective heel booties to keep his skin from breaking down. -Resident #3 "did not have a stage II ulcer" when he left the facility.	D 269		

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D 269	Continued From page 29 Telephone interview with a second MA on 05/22/18 at 10:00pm revealed: -Resident #3 was incontinent more at night, had a bowel movement in his bed daily and used a urinal during the day. -A while back he had some wounds, but those healed; he had some booties for his feet to prevent wounds from reoccurring, "but that was it." -When she would come to work in the morning, Resident #3's whole bed was wet and she would have to change his linens every day. -She had not seen any wounds on Resident #3 before he went to the hospital in February 2018. Telephone interview with a third MA on 05/23/18 at 6:23pm revealed: -Approximately a year ago, Resident #3 used a walker to assist with standing so that she could provide incontinence care, she could not remember when Resident #3 stopped using the walker. -Resident #3 would "use his one good hand" to help the MA because he was a "big man," and sometimes the Administrator would help with getting Resident #3 up from the wheelchair if the Administrator was at the facility. -If she was working by herself, then she had to take care of Resident #3 by herself. -Approximately a year ago, Resident #3 had a small area "on his bottom" that healed. -The MAs had a cream they put on Resident #3's "bottom" and they turned and repositioned him every two hours to keep his skin from breaking down. -Some days when she came to work for second shift, Resident #3 would be on the porch in his wheelchair and some days he would be lying down in his bed; "from time to time" she would	D 269		

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have to get Resident #3 up from his bed for dinner.
-Resident #3 also had protective heel booties and a cushion for his chair to prevent skin breakdown.
-Resident #3 had swelling to his feet most of the time; she tried to keep his feet elevated on pillows when he was in the bed.

Telephone interview with a representative of the home health (HH) agency on 05/24/18 at 12:12pm revealed:
-The HH nurse (HHN) documented a visit with Resident #3 at the facility on 02/07/18, the resident was at risk for skin breakdown for impaired mobility and apparently had actual breakdown on and off and edema in both of his legs.
-The HHN documented that she educated the staff on turning and positioning Resident #3 every two hours and elevating the resident's legs for pressure relief and to decrease swelling.
-The HHN visit notes refer to Resident #3 repeatedly being in his wheelchair when the HHN was trying to get him out of the chair more often.
-In response to the time frame a stage III pressure ulcer developed, the HH representative responded, an area was more prone to skin breakdown if there had been breakdown before and the skin breakdown could be worse because of previous damage.

Attempted interviews with Resident #3's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.

Upon request on 05/21/18 at 9:30am personal care assistance records were not available for review for Resident #3.

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D 269	Continued From page 31 Interview with the Administrator on 05/21/18 at 3:50pm and 05/23/18 at 2:30pm via telephone revealed: -No one reported Resident #3's wounds to him. -Usually HH would come and see Resident #3 and the doctor would come once per month. -He was afraid to say anything about what came from the hospital, it had "been a long time ago". -Resident #3 was non-ambulatory, he could not do anything. -"We were with him as much as could be done," Resident #3 would ask to go to the toilet. -The policy on incontinent residents was that the facility "relied on home health to assist us with an incontinent program, we try not to accept residents that are incontinent and how to appreciate their level of incontinence." -Resident #3 "would tell us if he had to go to the bathroom ...we would not abuse him to feel if he was wet." -We have a 30 minute to 1 hour check to see what residents need, Resident #3 "was abusive and aggressive about his privacy." -Staff put Resident #3 on the commode every 30 minutes. -There was no current resident that could not say when they're wet. -When a resident told staff they were wet, staff assisted them; "We don't check, but wait for them to tell us." -Residents were checked at night every 2 hours, and it "depended on what level of incontinence of how we check them." -For Resident #3 "most of the waterworks happened between 4:00-5:00am, so let's go in at 4:00am, sometimes (Resident #3) worked with them and sometimes he didn't." -Personal care that was provided was not documented unless a resident had personal care provisions, "If we are not compensated for it, then	D 269		

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we don't document."
-Staff still provided personal care assistance and "we try and prompt them (residents) more to participate in the program".
-Staff saw Resident #3's skin 2-3 times per day, if the staff had seen a wound, they would have documented it; if Resident #3 had a wound, he was sure staff would have seen it.
-The system for monitoring residents at risk for skin breakdown was that the county Department of Social Services (DSS) worker came to the facility once per month and the doctor came once per month.
-"Seventy percent of residents that were "problematic" received HH services two to three times per week access to (home) health: toileting, empty urinal, put in bed. The assurity of him getting out of the bed."
-He helped residents and the staff does by observing residents; he had observed Resident #3's skin.
-He thought Resident #3's foot wound was healed, "If I'm not mistaken his foot was healed."
-He did not think Resident #3 had any wounds.

Refer to telephone interviews with the Administrator on 05/23/18 at 2:30pm and 05/24/18 at 8:12am.

2. Review of Resident #1's current FL-2 dated 10/02/17 revealed:
-Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.
-Resident #1 was intermittently disoriented, ambulatory with assistance and continent of bowel and bladder.
-Resident #1 needed moderate assistance with

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D 269	Continued From page 33 bathing and dressing and set up for meals. Review of Resident #1's current care plan dated 03/07/18 revealed: -Resident #1 was receiving medications for mental illness and/or behaviors and had a history of mental illness and substance abuse. -Resident #1 was receiving services for mental health and substance abuse; the name of the agency was documented, but there was no provider name or contact number. -Resident #1 was ambulatory, had occasional bowel and bladder incontinence and was sometimes forgetful and disoriented. -Resident #1 needed limited assistance with toileting, extensive assistance with bathing and grooming and was totally dependent on staff for dressing. -The care plan was signed by the Nurse Practitioner (NP) on 03/15/18. Observations of Resident #1's hands on 5/16/18 at 12:58pm revealed the resident's nails were approximately ¼ inch in length and had a thick black substance under each nail on each hand. Interview with Resident #1 on 05/16/18 at 12:58pm revealed it was dirt under his nails; he did not know when his nails were last clean and cut. Resident #1 declined additional observations of his hands on 05/17/18, 05/21/18 and 05/22/18. Interview with the Administrator on 05/16/18 at 12:58pm revealed Resident #1's feet were done when "the people were here (at the facility) last week," but he did not know when Resident #1's hands had been taken care of.	D 269		

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D 269	Continued From page 34 Interview with a medication aide (MA) on 05/21/18 at 9:26am and 10:34am revealed: -Resident #1's nails were black because he would dig in the ashtray. -She had cleaned Resident #1's hands twice already on the morning of 05/21/18, but the resident's nails were black again from digging in the ashtray. -Staff tried to keep the ashtray empty to keep Resident #1 from digging in the ashtray. -There was no shower schedule or written schedule for residents' care needs. -She assisted all 10 residents with showers every Monday, Wednesday and Friday; she was the only staff person that did resident showers. -Residents were shaved, given haircuts and nail care if needed at the time of their shower. Interview with Resident #1's Nurse Practitioner (NP) on 05/17/18 at 10:58am revealed: -Residents that had mental health issues all had their "quirks and not being messed with" was Resident #1's quirk. -Resident #1 refused to have his nails trimmed regularly. -She did not have a comment on the cleanliness of Resident #1's hands and nails. Interview with the Administrator on 05/23/18 at 1:20pm revealed: -His hand washing expectations was for hand washing to be done early in the morning and after a resident used bathroom. -"We're giving consideration before eating to use soap and hand towels." Refer to interview with Administrator on 5/22/18 at 2:10pm. Refer to telephone interviews with the	D 269		

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D 269	Continued From page 35 Administrator on 05/23/18 at 2:30pm and 05/24/18 at 8:12am. 3. Review of the FL-2 dated 11/17/17 for resident #2 revealed: Resident #2's diagnosises were cerebrovascular accident with right side flaccidity, anemia, hypertension, diabetes mellitus and hyperlipidemia. Resident was incontinent of bowel and bladder. The care plan for Resident #2 dated 02/15/18 revealed: -The resident was total care on staff for grooming and personal hygiene. -The resident required extensive assistance for his toileting. -The resident required limited assistance for his ambulation. -No other care needs were listed on the care plan for personal hygiene, toileting or ambulation. Interview with resident #2's family member on 05/22/18 at 8:35am revealed: -The resident wore incontinence briefs. -The facility gave the resident wipes to clean himself between showers. -The resident was unable to clean himself well with the wipes. -The resident was having issues with accidents. -The resident used to go to occupation therapy but stopped going several years ago. -The Administrator said the occupational therapy services ended. a) Observation of Resident #2 on 05/16/18 at 10:40am revealed he had an empty pill bottle held in his right hand. Interview with a medication aide (MA) on	D 269		

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D 269	Continued From page 36 05/17/08 at 5:25pm revealed: -The resident kept the bottle in his hand all the time. -He took the bottle out of his hand during showers. -He slept with the bottle in his hand. -The resident wore an adult diaper. -She was not sure if the resident was able to wash his hands after going to the bathroom or cleaning up after using an adult diaper. Interview with a family member on 05/21/18 at 6:36pm revealed: -She did not remember how long the resident had been holding the bottle in his hand. -She did not remember who gave him the bottle to hold. -The resident "needed something to hold" to help with his hand spasms. Interview with a second family member on 05/22/18 at 8:35am revealed: -The resident had 7 strokes. -The resident had been holding that bottle for 1-2 years. -The Administrator said Resident #2 could get a bath daily and the resident agreed to this. -The resident was not getting a bath daily. -The resident had to clean himself with wipes between showers. -The resident had trouble cleaning himself with wipes between showers because of his physical limitations -The facility did not wash the resident's hands or the bottle to her knowledge. Interview with a second MA on 05/21/18 at 5:00pm revealed: -The resident used the bottle to help with hand spams.	D 269		

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-He started using the bottle before he was admitted to the facility.
-Sometimes the resident washed his hands and sometimes he did not after using the bathroom.
-She seldom washed his hands for him.
-She washed his hands only if his hands were tired.
-He took the bottle into the shower with him.
-The medication aide supervisor washed the resident's hands.

Interview with the medication aide supervisor on 05/21/18 revealed showers are given Mondays, Wednesdays and Fridays.

A second interview with the medication aide supervisor on 05/22/18 at 9:35am revealed:
-The resident's hand had spasms when he did not hold the bottle.
-She washed the bottle when she gave the resident a shower.
-The resident showered 3x per week.
-The resident washed his hands but did not remove the bottle when he washed.
-She used sanitizer on his hands before meals.
-She did not sanitize or wash his hands May 16-17 and May 21-22, 2018 but she did not know why.
-She was busy when the resident was in the shower last time so she did not wash his hands.

Interview with the resident on 5/22/18 at 10:44am revealed he washed his hands before meals.

Observations of Resident #2 on 05/22/18 at 10:48am revealed the resident did not wash his hands after using the bathroom.

Observations of Resident #2 on 05/22/18 at 11:32am revealed the resident did not wash his

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hands after using the bathroom.

Interview with Resident #2 on 05/22/18 at 10:57am revealed:
-He wanted to be cleaned daily.
-He asked the facility staff to take the bottle out of his hand to clean his hand and the bottle.
-He is satisfied with being showered 3 times per week.

Interview with Resident #2 on 05/22/18 at 2:50pm revealed the resident sometimes needed help in the bathroom.

Observation of resident #2 and another resident on 5/22/18 at 11:50am revealed:
-Resident #2 and another resident got sanitizer on their hands before lunch but no other residents were offered sanitizer.
-The bottle did not get removed from resident #2's hand to apply the sanitizer.

Interview with the Administrator on 05/21/18 at 11:07am revealed:
-The resident showers 4-5 times per week.

Interview with the Administrator on 05/22/18 at 10:30am revealed:
-Most residents showered 3 times per week but can get showered more if the resident chooses to do that "if they submit to more showers".
-"Most residents were satisfied with 2 or 3 showers per week because there's not much activity."
-Residents can use washcloths in between showers to get "washed up in the morning".

Interview with the Administrator on 05/23/18 at 1:20pm revealed:
-His expectation was for hand washing to be

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D 269	Continued From page 39 done early in the morning and after residents use the bathroom. -The bottle for resident #2 should be washed daily. -"We're giving consideration before eating to use soap and hand towels." (b) Interview with Resident on 05/22/18 at 2:50pm revealed: -He was continent of bowel and bladder. -He could toilet himself but sometimes needed help. Interview with a medication aide (MA) on 05/17/18 at 3:28pm revealed: -Resident #2 wore an incontinent brief. -The resident could go to the bathroom himself. -The resident's bowels "sneak surprise" him and he had accidents at times. -This behavior had been the same for 5 years. -She did not always understand what Resident #2 was saying. Interview with the Administrator on 05/21/18 at 3:50pm revealed: -The facility "relied on home health to assist us with an incontinence program". -"We try to not accept residents that are incontinent and how to appreciate their level of incontinence". -"If the incontinence goes, on the doctor will work with occupational therapy (to create a toilet schedule)". -A toilet schedule had been tried with Resident #2 in the past but he "feels like we are vexing or bothering him." -All current incontinent residents were able to communicate their needs. -The facility waited until the residents asked for help if they were soiled.	D 269		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 40 -None of the incontinence issues with residents were documented "unless they have a personal care provision and the facility is compensated for it". Review of the resident's progress notes in the medical record revealed: -There was a note from the nurse practitioner on 03/15/18 reporting resident has frequent incontinence and difficulty getting to the bathroom. -There was a note from the resident's doctor on 02/06/18 to encourage resident to void every 2-3 hours. Another interview with administrator on 05/23/18 at 1:20pm revealed: -The first step for referring a resident to an outside provider would be for facility staff to inform the administrator of the need for service. -The administrator would follow up on "procedures and times for doctor procedures that may be required". Review of progress notes for Resident #2 revealed there was no documentation that the facility spoke to the providers regarding the resident handling feces or the need for a bathroom schedule. Refer to interview with Administrator on 5/22/18 at 2:10pm. Refer to telephone interviews with the Administrator on 05/23/18 at 2:30pm and 05/24/18 at 8:12am. _____ Interview with Administrator on 5/22/18 at 2:10pm revealed: -Staff completed hourly checks on all residents	D 269		

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D 269	Continued From page 41 during the day time hours. -Staff completed checks on all residents every two hours during the night time hours after residents go to sleep. -Staff were allowed to sleep during the night, but were expected to get up every two hours to do checks on all residents. Telephone interviews with the Administrator on 05/23/18 at 2:30pm and 05/24/18 at 8:12am revealed: -The MA's primary responsibility was resident care, medications and documentation. -The staff knew what was supposed to happen each day. -The main MA on 1st shift "had her schedule pretty much down pat, so ask her about her job duties and the other ones, well ..." -There was a personal care person that came to work three days per week and was responsible for personal care and "general awareness of the resident". -General awareness of the resident meant, "One resident, the total package, the record was intact and medications and orders were intact." -He was trying to get it to where the personal care person worked four days per week and also talked to the rest of the staff about personal care. -The 2nd shift staff person was responsible for personal care for one resident, cleaning one to two residents' rooms which involved cleaning the floor, closet, clothes and straightening the clothes in the closet and dresser. Refer to Tag 186 10A NCAC 13F .0604(b) Personal Care and Other Staffing The facility failed to provide personal care including bathing, incontinence care and every two hour repositioning for Resident #3 who was	D 269		

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D 269	Continued From page 42 wheelchair bound, which resulted in the resident being admitted to the hospital from the facility with a stage III decubitus ulcer on his left ischium (hip), a deep tissue injury on his left heel, two stage II decubitus ulcers on his right heel and a stage I decubitus ulcer on his sacrum. The failure of the facility to provide personal care for Resident #3 resulted in serious neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 24, 2018.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 4 sampled residents who demonstrated need for increased supervision as evidenced by Resident #4, who had a history of Alzheimer's dementia and had wandered away from the facility on three known occasions; and Resident	D 270		

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D 270	Continued From page 43 #1, who was known to fall asleep while smoking cigarettes, having numerous burn marks on his clothing. The findings are: 1. Review of Resident # 4's current FL2 dated 10/23/17 revealed: -Diagnoses included dementia, Manic Bipolar Disorder, hypertension and gastro-esophageal reflux disease. -No information was provided regarding orientation level. -Resident #4 was ambulatory. Review of Resident # 4's Care Plan dated 07/20/17 revealed: -He functioned independently in ambulation and locomotion. -Care Plan was signed by a physician. -There was no documentation of wandering behaviors or the resident's cognitive abilities. Review of Resident # 4's Incident Report dated 07/07/17 revealed: -Resident #4 walked off from the facility after breakfast on 07/07/17. -The time was not documented. -The medication aide (MA) was unable to locate Resident #4 in facility. -The MA searched the outside premises and was unable to locate Resident #4. -The Administrator was notified. -The Administrator found Resident #4 and returned him to facility. -Time of return was not documented on the Incident Report. -Resident #4 had no injuries. Review of Resident # 4's Incident Report dated	D 270		

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D 270	Continued From page 44 08/31/17 revealed: -Incident occurred on 08/31/17 at 7:35am. -The MA was giving other residents showers. -The MA stopped showers to do a check on Resident #4. -Resident #4 could not be located on the premises. -The MA attempted contact with the Administrator. -At 8:15am Resident #4 was observed in the vehicle with the "out going" MA. -No other information was provided. Review of Resident # 4's Incident Report dated 04/12/18 revealed: -The incident occurred on 04/12/18 at 10:20am. -The MA checked on residents and could not locate Resident #4. -Another resident stated that Resident #4 was seen walking down railroad tracks. -The MA contacted the Administrator immediately and a search began for Resident #4. -The Administrator returned to facility at 1:30pm with Resident #4. -Resident #4 had an injury to the right lower ear lobe area. Review of prescription orders, Nurse Practitioner (NP) visit notes and Report of Health Services to Residents forms for Resident # 4 revealed: -There was no documentation in the record of the incident on 04/12/18. -There was no documentation of the facility physician being notified of the incident. -There was no documentation of Resident #4 having wandering tendencies. Interview with the MA on 05/22/18 at 10:05am revealed: -She worked at the facility on 04/12/18.	D 270		

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D 270	Continued From page 45 -She checked on residents about 10:20am and could not locate Resident #4. -Another resident stated that Resident #4 was seen walking down the railroad tracks directly across from the facility. -She did hourly checks during the day hours at facility. -It had not been an hour since she had last seen Resident #4. -She could not see Resident #4 from the facility. -She contacted the Administrator immediately and a search began for Resident #4. -She was unable to participate in the search because she could not leave the facility unsupervised. -The Administrator returned to the facility at 1:30pm with Resident #4. -Resident had scratches on his ear lobe area. -He appeared to be oriented. -The ear area was cleaned. -Resident #4 appeared to be fine. -She completed an Incident Report documenting the incident. Interview with a second MA on 05/22/18 at 3:05pm revealed: -She was called by Administrator on 04/12/18 to assist in looking for Resident #4 around 10:30am since she was in town transporting. -She immediately began looking for Resident #4 by riding in the areas surrounding the facility and she searched for about 45 minutes then returned to facility. -She was unable to locate Resident #4. -The Administrator found Resident #4 very close to the facility around 1:30pm near the railroad tracks. -She observed Resident #4 had a couple of light scratches on his ear lobe area. -She observed that Resident #4 appeared "to be	D 270		

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oriented" when he was found.
-This was the first time that she was aware of Resident #4 wandering away from the facility.
-Hourly checks are done on all residents during the day time hours.

Interview with a third MA on 05/22/18 at 3:50pm revealed:
-She was made aware upon her arrival at the facility on 04/12/18 that Resident #4 had been missing from the facility for three hours, but was back at the facility.
-Resident #4 had never wandered away from facility when she was working.
-She observed Resident #4 had a scratch on one of his ear lobes.
-Staff are required to do hourly checks on all residents during the day time hours and two hour checks once residents go to sleep.

Interview with Resident #4's family member on 05/22/18 at 4:05pm revealed:
-She was notified on 04/12/18 around 10:30am that resident had walked away from facility.
-Facility also notified local law enforcement.
-Facility called her a couple of hours later on 04/12/18 and stated that they had located Resident #4 close to the rail road tracks across from the facility.
-She had concerns about Resident #4 walking away from the facility because of his age as well as his physical and mental state.
-She had concerns about him not being supervised properly if he was able to walk away that easily.
-She expressed these concerns to the Administrator after the incident occurred on 04/12/18.
-She was not aware of any other incidents when he wandered away from facility.

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D 270	Continued From page 47 Interview with Resident #4's family member on 05/23/18 at 8:05pm revealed: -There was one or two times in the fall of 2017 in which Resident #4 left the facility and went to town or to his nephew's shop, but he was more physically and mentally able at that time to do so. -The Administrator met with her and Resident #4 after these two incidents in 2017 in reference to Resident #4 leaving facility without notifying anyone. -The resident did not leave the facility again until the incident on 04/12/18. -Resident #4's should not leave facility alone now due to his physical and mental condition. Attempted interviews with Resident #4's NP on 05/17/18 at 11:00am, 05/18/18 at 3:44pm, 05/22/18 at 9:45am and 05/23/18 at 4:50pm were unsuccessful. Interview with Clinical Organizer for Resident #4's NP's office on 05/23/18 at 4:50pm revealed Resident #4's NP notes reflected that the facility notified the NP on 04/16/18 that Resident #4 had wandered away from the facility on 04/12/18 and was found. Interview with Administrator on 05/22/18 at 2:10pm revealed: -He received a call from MA who was on duty at facility on 04/12/18 around 10:20am stating Resident #4 left the facility walking. -He immediately headed to facility, but was about 30 minutes away. -He called a second Med Aide, who was in route to facility, and she began an immediate search for Resident #4 in the area surrounding the facility. -He called Resident #4's family member as well as the local police department and informed them	D 270		

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that resident had walked away from the facility and they were searching for him.
-Resident #4 had asked him earlier that day about going to town and Administrator told him he would take him to town that afternoon.
-He searched the different routes to town from facility and then returned to the facility.
-He located Resident #4 about 100 yards from the facility, sitting in the shade on an embankment near the rail road tracks around 1:30pm.
-Resident #4 did not "appear disoriented, but stated he was tired so he was resting. "
-Resident #4 had a "scratch on his hand and on his ear lobe that was bleeding a little."
-He and staff cleaned the scratched area.
-Resident #4 did not complain of any pain and stated he was fine.
-Resident #4 was oriented when found and "knew exactly where he was."
-There was only one other incident when Resident #4 walked away from facility which was in November, 2017.
- Resident #4 left the facility stating that he was "going walking."
-He witnessed Resident #4 leaving the facility walking on this occasion and followed him until resident got tired and agreed to get in the truck with him.
-Staff completed hourly checks on all residents during the day time hours.
-Staff completed checks on all residents every two hours during the night time hours after residents go to sleep.
-There was no plan put in place to have increased supervision for Resident #4.

Interview with Administrator on 05/23/18 at 5:00pm revealed:
-He had forgotten about the incident on 07/07/17

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and 08/31/18 involving Resident #4 leaving the facility.
-Resident #4 did not go "far from the facility."
-Resident #4 did not sign out on 07/07/17 or 08/31/17.
-Resident #4 was found quickly both times.
-Resident #4 expressed a desire to go to town prior to the incidents.
-He did consider increasing supervision for Resident #4.

Observations on 05/21/18 at 11:15am revealed:
-A rail road track was located an estimated 150 feet from the front of the facility.
-A commercial train came by the facility on the railroad track.
-Resident #4 was sitting on the front porch of the facility unsupervised.
-There was an alarm on the front and back doors of the facility.
-The alarm on the front door was turned off.

Observations on 05/22/18 at 1:40pm revealed:
-A commercial train came by facility on the railroad track.
-Resident #4 was sitting on the front porch of the facility unsupervised.
-The alarm on the front door was turned off.

Observations of Resident #4 on 05/21/18 and 05/22/18 revealed:
-He was very hard of hearing.
-He walked very slowly with an unstable gait and shuffled while ambulating.
-He was able to engage in conversation if spoken to very loudly.
-He appeared confused when asked about past events.

Interview of Resident #4 on 05/22/18 at 1:55pm

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revealed:
-He was oriented to name and place, but not time.
-He knew the facility's name and the Administrator's name.
-He knew the town he lived in.
-He did not know the current month or day.
-He was aware that he was not supposed to leave the facility without informing staff or the Administrator.
-He could not recall leaving the facility without informing staff or the Administrator.
-He could not recall leaving the facility on 04/12/18 and being close to the rail road tracks.

2. Review of Resident #1's current FL-2 dated 10/02/17 revealed:
-Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.
-Resident #1 was intermittently disoriented, ambulatory with assistance and continent of bowel and bladder.
-Resident #1 needed moderate assistance with bathing and dressing and set up for meals.

Observations of Resident #1 on 5/16/18 at 10:20am revealed:
-Resident was wearing a pair of black sweat pants.
-The sweat pants had multiple small, round holes on the crotch and upper thigh area on front and back of pants.
-The holes appeared to be cigarette burns where the edges of the holes were a darker shade of black and appeared to have a plastic like texture.

Interview with Resident #1 on 5/16/18 at 10:25am

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revealed:
-He smoked cigarettes on the porch of facility.
-There were just usually just other residents on the porch smoking.
-Sometimes staff was on the porch with him, but most of the time staff were inside of facility.
-He dropped cigarettes on his pants sometimes when he smoked.
-Sometimes he fell asleep and dropped a cigarette on his pants and sometimes the cigarette just fell out of his hand on his pants.
-The holes on the front of sweat pants were cigarettes burns.
-The holes on back of sweat pants were not cigarettes burns, but were just holes form being old.
-He liked to wear these pants best because they are old and comfortable.

Interview with a medication aide (MA) on 05/16/18 at 12:24pm revealed all of Resident #1's pants had burn holes in them from the resident burning his pants while smoking cigarettes.

Interview with a medication aide (MA) on 05/17/18 at 10:05am revealed:
-Resident #1 chain smoked and when he did not have cigarettes, he went out in the ashtray to find a cigarette butt with "any little bit of white on it" to smoke.
-Resident #1 did not always pay attention while he was holding a cigarette and would not realize when it had burned all the way down to the filter.

Interview with a medication aide (MA) on 05/17/18 at 11:45am revealed everything she tried to get Resident #1 to do like taking a shower, changing his clothes and washing his hands, she had to bribe him with cigarettes.

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D 270	Continued From page 52 Review of the facility's undated Smoking Policy and Procedure revealed: -It was the intent of the facility to provide an environment to allow those residents, who wished to smoke the opportunity to do so in a safe environment, with optimal safety to themselves, other residents, volunteers, visitors and staff members. -The staff would conduct an assessment upon admission to establish the frequency and guidelines for each resident who wished to smoke. -Any restrictions would be noted in the resident's record. -Smoking privileges would be addressed in the care plan. Review of a Resident Smoking Assessment for Resident #1 dated 03/20/14 revealed: -Staff marked "no" the resident was oriented to person, place and time. -Staff marked "yes" the resident demonstrated dexterity to manage small objects with both hands. -Staff marked "yes" the resident was able to hold a cigarette without dropping. -Staff marked "yes" the resident's smoking regimen was included in the care plan. Upon request there were no further Resident Smoking Assessments completed for Resident #1 after 03/20/14. Review of Resident #1's undated care plan and the care plan dated 03/07/18, both signed by the NP on 03/15/18, revealed there was no documentation of Resident #1's smoking privileges, restrictions or need for supervision. Interview with a medication aide (MA) on	D 270		

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D 270	Continued From page 53 05/22/18 at 11:30am revealed she did not put things like supervision for smoking on care plans and was unaware that supervision needs should be documented on the care plan. Observations of Resident #1's hands and clothing with the Administrator on 05/16/18 at 12:54pm revealed: -Resident #1 had brown and white marks on the tips of his right and left thumbs, index and middle fingers which were greater on the right hand. -There was a pea sized black area resembling an old blister on the inside of his left index finger. -There was a new burn mark on Resident #1's shirt on the part that covered his lower abdomen area that was black and singed around the edges, but no hole in the shirt. -Resident #1 had on dark gray sweat pants with numerous holes with singed edges on the front and the back from the waist area to the crotch of the pants. -Resident #1 stated to the Administrator, "I did not burn myself, I just held the cigarette too close." Interview with the Administrator on 05/16/18 at 12:50pm revealed: -"Well, are those really burn holes? Are those even his (Resident #1) pants? Has he (Resident #1) actually even burned himself?" -Resident #1 did not actually have burn holes in his pants, those were just holes. -"It was not his (Resident #1) to smoke, well it is his (Resident #1) right, but I'm not going to put staff to watch him smoke 24/7." -He did not see a problem or risk of Resident #1's handling of cigarettes while smoking if the resident had not actually burned himself. Observation on 05/16/18 at 4:28pm revealed: -Resident #1 was on the back porch smoking a	D 270		

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D 270	Continued From page 54 cigarette. -There was no staff outside in the back of the facility. -Staff left the kitchen area saying, "Where's (name of Resident #1)? Is anyone out there with him (Resident #1)?" -Staff then went outside on the back porch area with Resident #1. Interview with Resident #1's Nurse Practitioner (NP) on 05/17/18 at 10:58am revealed: -She understood the concern for the burns for Resident #1 and felt the resident needed more supervision when he was smoking cigarettes. -She was going to start Resident #1 on a medication to help decrease his nicotine cravings because the resident's high nicotine consumption was already a concern for contributing to his high blood pressure. -Resident #1 had a history of non-compliance and was not going to wear a smoking blanket, but "maybe we can get him to smoke less and staff to supervise him when he was outside." Interview with the Administrator on 05/17/18 at 11:35am, 2:35pm and 3:17pm revealed: -"You have elevated this situation to where he (Resident #1) is a danger to himself and I can't support that." -Staff could not stay with Resident #1 while he was outside "continually chain smoking" and he thought he could offer Resident #1 the option of standing while smoking outside so that he did not fall asleep with a cigarette in his hand or drop a cigarette in his lap. -If Resident #1 was sitting outside then he would have to be supervised by staff. -He was concerned that if Resident #1 continued to be "subject to all these checks and harassment, his schizophrenia might get worse".	D 270		

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D 270	Continued From page 55 -Staff conducted hourly checks of all residents at the facility and documented the checks on a check sheet. -Resident #1 had a mental health provider (MHP) that looked at whether or not the resident was harming himself. -The MHP had ordered some medications to help Resident #1 relax and until the Administrator had indications that Resident #1 was harmful to himself, "there was nothing more (the MHP) could do". -"I will be saddled with this responsibility when y'all [sic] leave and that's why we need to make an assessment of what's going on here." -The facility needed "to do a physical assessment every four to eight hours to see if" Resident #1 was "harming himself." -He planned for staff to observe Resident #1's "handing of his tobacco products over the next 10 days to see if there was any indication he's (Resident #1) abusing himself." -He had called and left a message for the MHP and the fire marshal, but he was not sure if they had any input into the matter of Resident #1's smoking concerns. -The Nurse Practitioner (NP) was going to contact the MHP to collaborate on medications to help decrease the number of cigarettes Resident #1 smoked and the resident's behaviors when he did not have a cigarette. -He, the staff and the NP had "given a lot of consideration to this situation because it was not okay for him (Resident #1) to burn his clothes". -He thought Resident #1 was "burning his clothing intentionally to see if anyone was paying any attention to him, it was not accidental". -Staff contacted the Administrator first and then the MHP or the NP; the NP was the primary care provider for all residents at the facility. -Any of the staff were able to contact the MHP or	D 270		

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D 270	Continued From page 56 the NP when there were concerns about a resident. -There was "record on him and all of this, that's what we're going to have to figure out." -Staff did not document resident concerns or discussions about resident concerns in the resident record. Attempted interview with Resident #1's MHP on 05/18/18 at 1:09pm was unsuccessful. Attempted interview with Resident #1's responsible person on 05/18/18 at 1:14pm was unsuccessful. Further attempted interviews with Resident #1's NP on 05/18/18 at 3:44pm and 05/22/18 at 9:45am were unsuccessful. _____ The facility failed to provide supervision for two residents (#1 and #4) in need of increased supervision. The facility's failure to provide increased supervision for Resident #4 who had a diagnoses of Alzheimer's dementia and had wandered away from the facility three times with an active railroad approximately 150 feet from the facility, placed Resident #4 at substantial risk for serious harm. The facility's failure to provide increased supervision for Resident #1 who was known to fall asleep while smoking cigarettes, drop lit cigarettes in his lap and had numerous burn marks in his clothing, placed Resident #1 at substantial risk to burn himself. The failure of the facility to supervise Residents #1 and #4 resulted in substantial risk of serious physical injury of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/16/18 with amendments on 05/17/18 and 05/22/18, for this	D 270		

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D 270	Continued From page 57 violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 24, 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 referral and follow up for the acute and routine health care needs of 2 of 3 sampled residents (#1 and #3) by delaying immediate transport to the emergency department (ED) for four days following notification of critical laboratory results indicating acute renal failure for Resident #3 and not identifying and reporting five pressure ulcers to the Nurse Practitioner (NP) for Resident #3; and by not reporting eight elevated blood pressures to the NP for Resident #1 and not scheduling a gastroenterologist referral appointment for Resident #1. The findings are: 1. Review of Resident #3's current FL-2 dated 3/6/17 revealed: -Diagnoses included change in mental status,	D 273		

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cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension.
-Resident #3 was intermittently disoriented, non-ambulatory and incontinent of bowel and bladder.
-Resident #3 had speech limitations and difficulty communicating verbally.
-Resident #3 needed assistance with bathing and dressing.

a. Interview with Resident #3 on 05/21/18 at 1:34pm revealed before he left the facility (02/12/18), he was tired, not feeling well, and needed to go to the doctor's.

Telephone interview with a family member for Resident #3 on 05/22/18 at 9:50am and 05/24/18 at 6:55am revealed:
-Resident #3 went to the hospital (02/12/18) two or three days after the first time the family member visited the facility (02/09/18 or 02/10/18).
-Resident #3's "feet were swollen like basketballs" on 02/09/18 or 02/10/18.
-Resident #3 seemed groggy, his face was "drawn" and pale, he "just didn't look healthy and slept a lot.
-Resident #3 reported to the family member having had blood in his urine.
-Resident #3 was "so out of it" that at the hospital, he did not remember seeing the family member a few days before at the facility.

Review of a Nurse Practitioner (NP) visit summary for Resident #3 dated 01/19/18 revealed:
-There was an order for a urinalysis, culture and sensitivity.
-The visit note did not indicate the reason for the urine specimen and did not document any

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D 273	Continued From page 59 complaints from Resident #3. Review of a lab report for Resident #3 revealed: -The report date was 02/08/18, although it was documented the collection date was 01/26/18 and the receive date was 01/31/18. -Next to comments, "Critical Alert (BUN)" was documented. (BUN is for blood urea nitrogen which is used to measure kidney function.) -The BUN result was 121 with a reference range of 5-25. -The serum creatinine result was 3.19 with a reference range of 0.50-1.30. (Creatinine is used to measure kidney function.) Telephone interview with the Clinical Organizer for Resident #3's NP's office on 05/23/18 at 1:22pm revealed: -According to the record at the doctor's office, the NP's last visit with Resident #3 was on 01/19/18 and a urine specimen was ordered because the resident complained about burning and pain with urination; there was no blood work ordered on 01/19/18. -The laboratory work for Resident #3 was ordered on 01/25/18 according to the record at the doctor's office. -Sometimes the phlebotomist went to the facility one day per week, so any orders were done on that day each week unless the order was written as STAT which was done as soon as possible. -Usually, the NP placed an order for laboratory work in the system at the doctor's office, the phlebotomist went out and drew the blood work and sent the specimens to the laboratory. -The laboratory sent results to the doctor and the doctor would make a comment on the results which were kept in the record at the doctor's office. -Resident #3 was no longer active with the	D 273		

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doctor's office, so there was no record of any comment by the NP in regards to the critical BUN and creatinine results on 02/08/18.
-Critical laboratory results were reported to the doctor's office by the laboratory.
-On 02/08/18, the laboratory notified another Clinical Organizer at the doctor's office about Resident #3's critical BUN and creatinine results.
-The Clinical Organizer notified the NP and contacted (name of MA) at the facility on 02/08/18.
-The Clinical Organizer instructed the facility MA to send Resident #3 to the ED on 02/08/18.

Review of a Report of Health Services to Residents form for Resident #3 revealed on 02/12/18 staff documented, "Got a text from (name of NP) to send (name of resident) out by EMS (emergency medical services). He is in acute renal failure. His BUN was 121 and his creatinine was 3.19. He needs to be sent out immediately."

Review of the hospital discharge summary dated 02/26/18 for Resident #3 revealed:
-Resident #3 presented to the ED on 02/12/18 with diagnoses of acute kidney injury and unspecified anemia.
-Resident #3 appeared "slightly dehydrated...and very debilitated".

Telephone interview with the named MA on 05/24/18 8:26am revealed:
-She did not remember getting a call from the doctor's office on 02/08/18 regarding Resident #3 having had critical laboratory results and needing to go to the ED immediately.
-She was notified via text message by the NP on 02/11/18 at 7:19pm that Resident #3 needed to be sent to the ED.

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-She was not at the facility and asked the NP if the morning of 02/12/18 would by okay and the NP replied via text the morning was okay.
-Resident #3 was sent out the next morning (02/12/18) at 7:22am.

Attempted interviews with Resident #3's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.

Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed:
-He was unable to say if he was aware or not of the doctor's office notifying the facility on 02/08/18 of Resident #3 having had critical laboratory results and needing to be sent to the emergency room.
-He could not think back that far to remember "the scenario" and if it took from 02/08/18 until 02/12/18 to send Resident #3 to the ED.
-He was sure if the doctor's office called and said send Resident #3 to the ED, the facility would have called for a stretcher and sent the resident within two hours.

b. Interview with Resident #3 on 05/21/18 at 1:34pm revealed:
-Before he left the facility (02/12/18), he had bedsores and needed to go to the doctor's.
-Staff was aware that he had bedsores, two MAs and the Administrator had seen the sores.
-Staff placed a patch over the bedsore on his bottom every week, the patch was changed two days before he went to the hospital.

Telephone interview with Resident #3's family member on 05/22/18 at 9:46am revealed:
-She visited Resident #3 three to four times each week.

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-Resident #3 would just sit in his wheelchair all day until 6:00pm.
-Resident #3 had bedsores that were found when he went to the hospital in February 2018.
-Family members talked to the Administrator "all the time about keeping clean clothes on him (Resident #3) and keeping him clean".

Telephone interview with a second family member for Resident #3 on 05/22/18 at 9:50am and 05/24/18 at 6:55am revealed:
-The first time he visited the facility and saw Resident #3 was a few days before Resident #3 went to the hospital (02/10/18) , and Resident #3 was "a mess."
-Resident #3 "looked like he had not been bathed, his clothes were dirty, he was curled up in his wheelchair".
-Resident #3 reported to the family member and that his feet hurt.
- The hospital found wounds on Resident #3's bottom and both of his heels when the resident was admitted (02/12/18).
-The kind of sores Resident #3 had "did not develop overnight or in two days, it took weeks or months probably".

Review of hospital records dated 02/12/18 through 02/26/18 for Resident #3 revealed:
-On 02/12/18, Resident #3 reported to the emergency department (ED) via emergency medical services (EMS) with abnormal lab values.
-Resident #3 complained of heel pain, had blisters on each heel and swelling to his left leg.
-On 02/14/18, Resident #3 had a consultation for wound care where a Nurse Practitioner (NP) documented Resident #3 had the following wounds on admission to the hospital:
-A stage III pressure injury to his left ischium which measured 3 x 3 x 0.1 centimeters (cm),

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had a moist, pinkish-yellow wound bed, a scant amount of serosanguineous drainage and nonblanchable erythema.
-A deep tissue injury to his left heel which measured 4 x 4 cm which was not open and dark purple in color.
-Two stage II pressure injuries to his right heel measuring 1 x 1 cm on his medial heel and 2 x 2 cm on his lateral heel; both were fluid filled, un-open blisters.
-A stage I pressure injury to his sacral area that measured 8 x 8 cm.

Review of a Report of Health Services to Residents form for Resident #3 revealed on 02/05/18 staff documented a verbal order for "Bacitracin 2% apply to area (location was not indicated) twice daily and cover with a bandaid [sic] until healed."

Telephone interview with a medication aide (MA) on 05/24/18 8:26am revealed:
-The Bacitracin was for "the area on his (Resident #3) butt [sic] because he had a tear of his skin."
-It was a tear and Resident #3 never had a pressure ulcer that she knew of.

Interview with a MA on 05/21/18 at 9:26am and 05/22/18 at 11:30am revealed:
-Resident #3 had a spot on his buttock that he scratched all the time; the spot would heal and then he would "dig it up."
-Resident #3 "did not have a stage II ulcer" when he left the facility.

Telephone interview with a second MA on 05/22/18 at 10:00pm revealed:
-A while back he had some wounds, but those healed.
-She had not seen any wounds on Resident #3

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D 273	Continued From page 64 before he went to the hospital in February 2018. Telephone interview with a third MA on 05/23/18 at 6:23pm revealed: -The MA did not know anything about Resident #3 having had wounds on his bottom and his heels when he left the facility and went to the hospital. -Approximately a year ago, Resident #3 had a small area "on his bottom" that healed. -Resident #3 did not have anymore wounds anywhere since a year ago that the MA could remember. Review of a Report of Health Services to Residents forms dated 12/20/17, 01/10/18, 01/17/18, 01/31/18 and 02/07/18 for Resident #3 revealed: -The home health nurse (HHN) documented that Resident #3 was seen for an assessment and lab draw with each visit. -There was no documentation of any details of the assessment including skin integrity and the presence or absence of lower extremity edema completed for Resident #3. -Telephone interview with Resident #3's HHN on 05/21/18 at 3:22pm revealed: -She did not have access to her notes for Resident #3 because he had been discharged from home health. -She had mainly been seeing Resident #3 weekly for collecting laboratory specimens, but she always checked his skin whenever she collected blood work. -Resident #3 had problems in the past with a stage II pressure ulcer on his buttock and a stage II pressure ulcer on his heel which would heal over and then come back again. -Her last visit with Resident #3 was in February 2018 for blood work and the resident did not have	D 273		

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any wounds and to her knowledge, Resident #3 was not sick.
-Resident #3 would give staff a hard time about being changed; staff would tell her that Resident #3 would have incontinent episodes and not tell the staff.
-Resident #3 would develop wounds really quickly and from one week to the next week, she would come in and find he had developed a wound.
-No one at the facility had contacted her with concerns that Resident #3 had developed pressure ulcers.
-The facility did not call her and alert her to any concerns, she would only find out when she got to the facility.
-She was not able to say how a stage III pressure ulcer and deep tissue injury could develop without anyone at the facility seeing it.

Telephone interview with a representative of the home health (HH) agency on 05/24/18 at 12:12pm revealed:
-The HH nurse (HHN) documented a visit with Resident #3 at the facility on 02/07/18, the resident was at risk for skin breakdown for impaired mobility and apparently had actual breakdown on and off and edema in both of his legs.
-The HHN documented that she educated the staff on turning and positioning Resident #3 every two hours and elevating the resident's legs for pressure relief and to decrease swelling.
-There was no documentation in the call logs at the HH agency of the facility calling with concerns related to Resident #3 having issues with skin breakdown after the HHN saw the resident on 02/07/18.
-In response to the time frame a stage III pressure ulcer developed, the HH representative responded, an area was more prone to skin

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breakdown if there had been breakdown before and the skin breakdown could be worse because of previous damage.

Telephone interview with the Clinical Organizer for Resident #3's NP's office on 05/23/18 at 1:22pm revealed:
-She did not see any notes about Resident #3 having wounds or any skin concerns from 01/01/18 through 02/13/18.
-There was a note dated 01/19/18 by the NP that Resident #3 complained of burning and pain with urination.
-The doctor's office expected to be notified for any changes in the resident's condition or any concerns about the resident.

Interview with Resident #3's NP on 05/17/18 at 10:45am revealed:
-She was the NP and Resident # 3 was her patient.
-She had seen Resident #3 two times, once in December 2017 and once January 2018.
-She did not have the exact dates with her at this time.
-Resident #3 did not have any wounds or skin break downs when she examined him.
-She looked at his buttocks area and heels during the two visits with Resident #3.
-Resident #3 had swelling in his feet so she increased his Lasix and treated him for a urinary tract infection.
-She didn't have time to talk because she had patients to see.

Attempted interviews with Resident #3's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.

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D 273	Continued From page 67 Interview with the Administrator on 05/21/18 at 3:50pm and 05/23/18 at 2:30pm via telephone revealed: -No one reported Resident #3's wounds to him. -Usually HH would come and see Resident #3 and the doctor would come once per month. -In response to the documented pressure ulcers on admission to the hospital, he was afraid to say anything about what information came from the hospital, it had "been a long time ago". -Resident #3 was non-ambulatory, he could not do anything. -Staff saw Resident #3's skin 2-3 times per day, if the staff had seen a wound, they would have documented it; if Resident #3 had a wound, he was sure staff would have seen it. -The system for monitoring residents at risk for skin breakdown was that the county Department of Social Services (DSS) worker came to the facility once per month and the doctor came once per month. -He helped residents and the staff does by observing residents; he had observed Resident #3's skin. -He thought Resident #3's foot wound was healed, "If I'm not mistaken his foot was healed." -He did not think Resident #3 had any wounds. 2. Review of Resident #1's current FL-2 dated 10/02/17 revealed diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia. a. Review of an order written on a prescription for Resident #1 revealed an order signed by the Nurse Practitioner on 10/23/17 to check vital signs (VS) daily, there were no written reporting	D 273		

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D 273	Continued From page 68 parameters. Review of prescription orders, Nurse Practitioner visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order or clarification order for reporting parameters for the VS checks. Review of Resident #1's March 2018 VS log revealed: -On 03/02/18, a BP of 157/109 was documented. -On 03/16/18, a BP of 148/102 was documented. -On 03/30/18, a BP of 144/107 was documented. -There was no documentation the Nurse Practitioner (NP) was notified of the BPs on 03/02/18, 03/16/18 and 03/30/18. Review of Resident #1's April 2018 VS log revealed: -On 04/01/18, a BP of 154/102 was documented. -On 04/05/18, a BP of 154/104 was documented. -On 04/13/18, a BP of 154/141 was documented. -On 04/26/18, a BP of 149/114 was documented. -There was no documentation the NP was notified of the BPs on 04/01/18, 04/05/18, 04/13/18 and 04/26/18. Review of Resident #1's May 2018 VS log revealed on 05/10/18, a BP of 180/91 was documented and there was no documentation the NP was notified. Telephone interview with a medication aide (MA) on 05/23/18 at 10:26pm revealed: -There might have been one day when she checked Resident #1's BP and the BP was high. -She had checked Resident #1's BP and documented the result on 04/13/18 as 154/141. -If she had contacted the NP, she would have documented that on the VS log sheet.	D 273		

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D 273	Continued From page 69 -Sometimes the BP cuff gave false high readings, which she knew because she would check the BP and then the doctor would come and check the BP and it would be a different result. -She had not reported a problem with the BP cuff because most of the time "it was good" meaning the BP cuff did not consistently give false readings. -Normally if a resident's BP was high when she checked, she would tell the next MA coming on duty because her shift ended at 8:00am before the doctor's office opened. Interview with a second MA on 05/22/18 at 3:30pm revealed: -If she was not mistaken, if a BP was greater than 170/100 or 130/90, she would call the doctor. -Resident #1 and another resident tended to have high BPs. -The MA was supposed to document in the comment on the electronic medication administration record (eMAR) or on the BP log. Review of Resident #1's March, April and May 2018 eMARs revealed there was no documentation the NP was notified of the elevated on 03/02/18, 03/16/18, 03/30/18, 04/01/18, 04/05/18, 04/13/18, 04/26/18 and 05/10/18. Interview with a third MA on 05/22/18 at 4:02pm revealed: -Residents BPs were checked in the morning by the MA on duty. -The MA was supposed to contact the Nurse Practitioner (NP) if a resident's BP was high or low; high meant over 160/98 and low was when the top number was 95 or below. -If staff had called about a resident's BP being high or low, the NP would check that resident's	D 273		

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D 273	Continued From page 70 BP herself when she was at the facility. Telephone interview with a fourth MA on 05/22/18 at 10:00pm revealed if there was an order to contact the doctor if a BP was over a certain limit or if the BP was not normal like 153/122, MAs were supposed to call the doctor immediately and document on the flow sheet (VS log). Telephone interview with the Clinical Organizer for Resident #1's NP's office on 05/23/18 at 1:22pm revealed: -She did not see any notation of notification from the facility of Resident #1 having had elevated BP such as 143/114 on 04/26/18 and 159/141 on 04/13/18. -The provider would have expected facility staff to notify the doctor's office if the result was outside the written parameters or abnormal. -She could not see in the notes if the NP reviewed VS logs while at the facility. Attempted interviews with Resident #1's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed: -The NP set the parameters for reporting BP results and the parameters were documented in the log book. -He expected staff to document contact with the NP in the log book and in the comments on the eMAR if the BP results were outside the "norm". -The book was shared with the NP when they came to the facility. -He could not say if he had reviewed the VS logs; he reviewed the logs "from time to time" which was "maybe once a week".	D 273		

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D 273	Continued From page 71 b. Review of hospital discharge instructions dated 10/02/17 for Resident #1 revealed: -There were instructions under "Follow up appointments" to see a named gastroenterologist (GI) in two weeks for fatty liver disease and mild hepatic encephalopathy. -The "Follow up appointments" area on the form was highlighted. Interview with a medication aide (MA) on 05/21/18 at 9:26am revealed: -She thought the hospital was going to make the GI appointment. -She never called back to the hospital to follow up on the GI appointment. -Resident #1 did not see a GI doctor following his discharge form the hospital on 10/02/17. -She was going to notify Resident #1's Nurse Practitioner (NP) and see what the NP wanted to have done. Attempted interviews with Resident #3's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Interview with the Administrator on 05/21/18 at 3:50pm revealed: -All of the staff were responsible for reading any doctor's orders for the residents. -The main MA on 1st shift was responsible for "coordinating the orders." -MAs and personal care aides (PCAs) were "qualified to make appointments. -In response to hospital discharge orders for referrals, the Administrator stated, "Over the next ten days they are taken care of." Telephone interview with the Administrator on	D 273		

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D 273	Continued From page 72 05/23/18 at 2:30pm revealed: -The facility policy for referrals was that if a referral was ordered by the NP, the facility tried to get the resident to their appointment. -The facility tried to mentally prepare residents for their appointments because the resident "might have an attitude and say he's not going". The facility failed to assure immediate transport to the emergency department (ED) for Resident #3 after being notified by the Nurse Practitioner's (NP's) office of critical laboratory results which resulted in Resident #3 experiencing a four day delay in ED treatment for acute kidney injury and failed to notify the NP of wounds developing on Resident #3 who was wheelchair bound and had a history of previous pressure ulcers which resulted in Resident #3 developing a stage III pressure on the left hip, two stage II pressure ulcers on the right heel, and a deep tissue injury on his left heel which were found on admission to the hospital. The facility's failure to seek emergency room treatment immediately and report wounds immediately to the NP resulted in serious neglect of Resident ##3 and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/18 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 24, 2018.	D 273		
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	D 276		

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D 276	Continued From page 73 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 assure orders written by the Nurse Practitioner were implemented for 2 of 3 sampled residents (#1 and #2) including orders for daily diabetic urine testing and daily blood pressures for Resident #2, and a urine specimen for urinalysis culture and sensitivity for Resident #1. The findings are: Review of the FL-2 dated 11/17/17 for resident #2 revealed: -Resident #2's diagnosis was cerebrovascular accident with right side flaccidity, anemia, hypertension, diabetes mellitus and hyperlipidemia. -Special care factors listed were to have blood pressure and blood sugar testing done daily. Review of the FL-2 dated 04/12/18 for resident #3 revealed special care factors were to have blood pressure and blood sugar testing done daily. Review of Resident #2's care plan dated 02/15/18 revealed: -There were handwritten instructions written on the care plan to check blood sugar and blood pressure weekly.	D 276		

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D 276	Continued From page 74 -The care plan was signed by the medication aide supervisor and the family nurse practitioner. Review of the Licensed Health Professional Support (LHPS) quarterly review dated 05/08/18 revealed the personal care tasks that were to be provided included fasting blood sugars to be checked daily. Review of Resident #2's diabetic monitoring flow sheet for March, April and May 2018 revealed blood sugars were checked weekly. Interview with a medication aide on 05/23/18 at 3:34pm revealed: -She was unaware the FL-2 had been updated in April. -The Administrator was responsible for "getting" the FL-2. -The Administrator would "pass" the FL-2 to the medication aide supervisor if there are orders to be changed or updated. -The Administrator would "let people know of the changes. He tells us verbally and shows us the FL-2". Interview with medication aide supervisor on 05/21/18 at 11:46am revealed: -She faxed any changes or updates to the physician's office. -The physician's office faxed changes or updates to the pharmacy to add to the medication administration record (MAR). -She followed up on all physician orders to be sure they were being done. -She had good communication with the doctor's office. -Resident #2's "blood sugars are never elevated". -The resident's blood sugars were ordered to be checked daily until 01/31/18 when the order was	D 276		

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D 276	Continued From page 75 changed to being checked every Wednesday. Interview with a staff member from the facility pharmacy on 05/23/18 at 3:38pm revealed: -She did not see the order for daily blood pressure or blood sugar checks. -An order was received on 05/30/18 for weekly blood sugar checks. Interview with administrator on 05/21/18 at 11:07am revealed: -If the blood sugar and blood pressures were to be checked daily, the Licensed Healthcare Personnel nurse would contact the physician directly. -The physician would then contact the facility to let them know of any changes or updates. -The medication aide supervisor processed most of the physician orders. -"We have nothing to do with that documentation". -"That's what we be akin to in that situation". -"The doctor and pharmacy are responsible" for the paperwork. -"Everyone is supposed to read doctor orders". -He reviewed doctor reports weekly and "chews them down to a smaller list" for the staff. -Orders seldom go right to the pharmacy. -Most order changes come directly from the electronic medication administration record (eMAR). -"The pharmacist has a license so he can write it like that" "They (pharmacists) are the top of the line here. They are liable for incorrect orders". Review of the Licensed Health Professional Support (LHPS) quarterly review dated 02/02/18 revealed: -The personal care tasks that were to be provided	D 276		

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D 276	Continued From page 76	D 276		

included fasting blood sugars to be checked daily.
-The recommendation was written by the LHPS nurse to have the blood sugar checked daily.

Interview with staff from the physician's office on 05/23/18 at 1:20pm revealed:
-There were no orders changing the blood sugar checks from daily to weekly.
-Orders could be written while the provider was in the facility or could be sent to the facility and/ or the pharmacy electronically.

Attempted interviews with mental health provider on 05/15/18 at 1:09pm and 05/18/18 at 1:09pm were unsucessful.
Attempted interviews with primary care provider on 05/18/18 at 3:44pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.

2. Review of Resident #1's current FL-2 dated 10/02/17 revealed diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.

Review of a Report of Health Services to Residents form for Resident #1 dated 03/15/18 revealed an order signed by the Nurse Practitioner (NP) for a STAT (immediately) urinalysis, culture and sensitivity (UA, C&S).

Review of laboratory results for Resident #1 revealed there were no results for a UA, C&S.

Interview with a medication aide (MA) on 05/21/18 at 11:20am revealed anything the NP ordered like laboratory specimens, the doctor's office sent someone out to the facility for them to

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D 276	Continued From page 77 do. Telephone interview with the Clinical Organizer for Resident #3's NP's office on 05/23/18 at 1:22pm revealed: -Usually, the NP placed an order for laboratory work in the system at the doctor's office, the phlebotomist went out and drew the blood work and sent the specimens to the laboratory. -She did not see any record of an order or results for a UA, C&S for Resident #1 dated 03/15/18. Attempted interviews with Resident #3's NP on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed he expected staff to follow through on things like that (a UA, C&S for Resident #1) and he was not aware that it had not been done.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen, dining and food storage area was clean, orderly and protected from contamination as evidenced by dirty drawers and cabinets, a dead bug, burnt and dirty cookware and broken serving dishes.	D 282		

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D 282	Continued From page 78 The findings are: Observations of the kitchen on 05/16/18 at 11:09am revealed: -The silverware drawer had dried liquid stains and debris inside. -The inside of the dishwasher had rust staining. -One of the wooden fruit bowls was cracked and missing the lip. -The cabinet shelf for the pots and pans was scarred and had black residue. -Two pots estimated to be 4 quarts each had brown grease burned onto the walls and bottom of the pot. -One pot estimated to be 2 quarts was missing the handle and had black scorched stains inside and outside of the pot. -The lower cabinet to the left of the stove had a sticky film covering the inside shelf and there was a dead bug stuck in the residue. -The bottom corner to the left of the stove had black grease build up on the side of the stove and the front of the base board stripping. -The drawer to the right of the stove had dried food stains and debris in it. -The bottom of the pantry had grease and food debris build up in the back corners. -There were two shelves in the refrigerator that had dried food build up. -The deep fryer had a sticky residue on the outside with a hair stuck to the side. -The crock pot had a rusted dent in the side. -The upper cabinet to the right of the stove had dried food and drink stains on the bottom, sides and door. -Inside the cabinet to the left of the sink was dried food debris on the inside trim and on the lazy Susan. -Inside the sink cabinet was dried food debris on	D 282		

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D 282	Continued From page 79 the door and hinge, and parts of the pressed board wood was exposed. -There was dried brown liquid and black debris on and under the sink pipes. Observations of the dining room on 05/16/18 at 10:56am revealed: -There were scrapes and peeling paint on the walls where the tabletops touched the dining room walls on all three tables. -The plastic table wrap was missing and bubbled in places on the dining room table in the back right corner. -The shoe moulding was pulled away from the wall under the air conditioning unit. -The shoe moulding was pulled away from the wall on the corner behind the table to the right. -The flooring to the left of the kitchen door had gray stains on 7 tiles. -The area in front of the first table on the right had gray splash stains on 4 tiles. -There was dark build up on both sides of the hallway leading to the back door that was approximately 5 feet in length. -There was black build up in the corner near the back door. -The floor going out of the back door was cracked in several places and one piece of the tile was missing that was about an inch in diameter. -The metal threshold between the hall and the day room was warped and lifted in parts. Interview with the cook on 05/17/18 at 9:23a revealed: -She worked Monday, Wednesday and Fridays from 10am-2pm. -She "was supposed to keep it (the kitchen) straight and clean". -All of the facility staff worked in the kitchen. -There was a cleaning list.	D 282		

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D 282	Continued From page 80 -The administrator checked her work 1-2 times per week. -She was not sure who checked the other kitchen workers cleaning. -"Some things do be over sighted. No one's perfect". -She would tell the administrator that the pots needed to be replaced or would just throw them away herself as needed. -The wooden fruit bowls were broken because they were put in the dishwasher by other staff members but should be hand washed only. -She had "spoken to the staff about (hand washing the fruit bowls) but it had been a minute ago" when she did. -She did clean the dishwasher but it looked that way "because it was just old". Interview with the Administrator on 05/16/18 at 12:07pm revealed: -The kitchen staff was responsible for cleaning the stove, refrigerator, cabinets, lazy Susan, pots, pans, disposal and dishwasher. -There is a deep cleaning schedule for the kitchen staff to follow. -The kitchen staff works 4-5 hours per day. -He did a cleaning inspection of the kitchen with the cook on Monday mornings. -He failed to look under the pantry shelves during the inspections. -The pantry dirt looked like more than build up. -There needed "more precautions to be done" for the cleaning. -"We are falling behind on the cleaning". -The kitchen is "not as clean as it could be especially with how much time staff has in here to clean". -The kitchen "should be maintained better". -Some pots needed to be thrown away. -"This one (pot) can't even be used".	D 282		

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D 282	Continued From page 81 -He was in charge of buying new pots. -The cook told him if the pots need to be replaced. -No one told him the pots were not in good condition. -Looking at the pots was part of the weekly inspection that he did with the cook. -"Everyone here knows the rules". -"The shelves need cleaning. Yeah, that's right. They should bring that to my attention". -"That's something to be concerned about. The pantry has been neglected". Observation of the administrator on 05/16/18 at 12:15 pm revealed he threw away one of the blackened pots. Interview with the administrator on 05/21/18 at 3:50pm revealed: -"(The cook) failed to do her job." -"I do check behind the staff one time per week. I look at the cabinets in a different way". -"The roach in there (the cabinet) looked like he'd been there awhile."	D 282		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.	D 315		

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D 315	Continued From page 82 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure an activity program for the residents that encouraged participation, socialization, mental stimulation, exercise and creativity. The findings are: Interview with a resident 05/16/18 at 11:44 am revealed: -The "facility doesn't take anyone anywhere". -"(The medication aide supervisor) is the only person to do anything." -"Administration doesn't give a "(expletive) (to what we do during the day). -The residents smoke or watch TV all day. -"The facility offers Bingo but hardly anything else". Interview with a resident's family member on 05/22/18 at 8:35am revealed: -"(The resident) does nothing all day." -"There's not a lot for him to do". Interview with a resident on 05/16/18 at 10:35am revealed there was nothing to do except sit outside on the porch or watch television. Telephone interview with a medication aide (MA) on 05/23/18 at 6:23pm revealed: -She worked as a MA on 1st and 2nd shifts. -The 2nd shift MA was responsible for doing activities with residents when the 2:00pm snack was passed out. -She usually played bingo or cards with the resident and worked hard to get them involved in whatever activity was going on.	D 315		

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D 315	Continued From page 83 Observation of activities on 05/16/18 at 3:00pm revealed: -A game of Bingo was offered. -Four residents were playing Bingo while 2 residents sat on the sofa in the same room but did not participate. -The game stopped at 3:50pm. Observation of activities on 05/17/18 at 3pm revealed: -A game of Bingo was offered. -The game stopped after 15 minutes because the MA got called away to supervise a resident. -The MA was the only staff member on duty. Interview with the administrator on 05/23/18 revealed: -The second shift MA is responsible for doing activities. -The facility is continually trying to find activities that are interesting. Observation on 05/16/18 from 1:00pm to 3pm revealed the dance activity did not occur. Observation on 05/18/18 from 1:00pm to 3pm revealed the art activity did not occur. Observation on 05/21/18 from 10:00am to 12am revealed the puzzle activity did not occur. Observation on 05/22/18 from 10:00am to 12am revealed the card activity did not occur.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to assure two residents (#1 and #3) were treated with respect and dignity by the Administrator related to smoking behaviors.

The findings are:

1. Review of Resident #3's current FL-2 dated 3/6/17 revealed:
-Diagnoses included change in mental status, cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension.
-Resident #3 was intermittently disoriented, non-ambulatory, had speech limitations and difficulty communicating verbally.

Interview with Resident #3 on 04/19/18 at 11:45am revealed:
-The Administrator grabbed a cigar out of his hand, crumbled the cigar and threw it in the trash on one occasion, but he could not remember when it happened.
-The Administrator told him he wasn't supposed to be smoking inside of the facility and he wasn't smoking inside of the facility.
-The Administrator stole cookies and a shirt out of his bedroom drawer.
-The Administrator only took his "stuff" and didn't bother other residents' "stuff."
- The Administrator took all of his cigars and kept the cigars in his office.
-He never got his cigars back.
-He felt as if the Administrator was "being mean."

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D 338	Continued From page 85 Observations of Resident #3 on 04/19/18 at 11:45am revealed: -Resident was in a wheelchair. -Resident had no use of one arm. -Resident was oriented. Interview with the Administrator on 05/14/18 at 2:25pm revealed: -He found lit cigars in Resident #3's clothing drawer on two occasions. -He only took the two lit cigars out of Resident #3's drawer. -He kept the two cigars in his office until Resident #3 asked for them when he was going out to smoke. -Resident #3 received both cigars back and smoked them. -He never took cookies or any food items from Resident #3. -He never took a shirt or any clothing from Resident #3. -He would never take any of the residents' personal belongings. -Resident #3 walked in the facility with a lit cigar in his hand on one occasion. -He grabbed the cigar out of resident's hand, but was not "rough" in doing so. -He told resident that he could not smoke inside of the facility. -He did not give Resident #3 an opportunity to give him the cigar prior to taking it from the resident. -He had never been disrespectful to Resident #3. 2. Review of Resident #1's current FL-2 dated 10/02/17 revealed: -Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic	D 338		

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respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.
-Resident #1 was intermittently disoriented and ambulatory with assistance.

Observations of Resident #1 on 5/16/18 at 10:20am revealed:
-Resident was wearing a pair of black sweat pants.
-The sweat pants had multiple small, round holes on the crotch and upper thigh area on front and back of pants.
-The holes appeared to be cigarette burns where the edges of the holes were a darker shade of black and of a plastic like texture.

Interview with Resident #1 on 5/16/18 at 10:25am revealed:
-He smoked cigarettes on the porch of facility.
-There were just usually just other residents on the porch smoking, sometimes staff was on the porch with him, but most of the time staff were inside of facility.
-He dropped cigarettes on his pants sometimes when he smoked.
-Sometimes he fell asleep and dropped a cigarette on his pants and sometimes the cigarette just fell out of his hand on his pants.
-The holes on the front of sweat pants were cigarettes burns.
-The holes on back of sweat pants were not cigarettes burns, but were just holes form being old.
-He liked to wear these pants best because they are old and comfortable.

Observations of Resident #1's hands and clothing with the Administrator on 05/16/18 at 12:54pm revealed:
-Resident #1 had on dark gray sweat pants with

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D 338	Continued From page 87 numerous holes with singed edges on the front and the back from the waist area to the crotch of the pants. -The Administrator was standing over Resident #1 and asking the resident repeatedly in a scolding tone, "Are those your pants? Whose pants you got on? Those are not even your pants." -There was no pause between questions and Resident #1 was not given the opportunity to answer. -Resident #1 stated to the Administrator, "I did not burn myself, I just held the cigarette too close." Interview with the Administrator on 05/16/18 at 12:50pm revealed: -"Well, are those really burn holes? Are those even his (Resident #1) pants? Has he (Resident #1) actually even burned himself?" -Resident #1 did not actually have burn holes in his pants, those were just holes. -"It was not his right (Resident #1) to smoke, well it is his (Resident #1) right, but I'm not going to put staff to watch him smoke 24/7." -He was not being demeaning to Resident #1, he was trying to "ascertain what was going on."	D 338		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure multiple provider orders	D 345		

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were in the residents records for 2 of 3 sampled residents (#1 and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 10/02/17 revealed diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.

a. Review of Resident #1's current FL-2 dated 10/02/17 revealed there was an order for Metformin 500mg daily. (Metformin used to lower blood sugar levels.)

Review of Resident #1's March, April and May 2018 electronic medication administration record (eMAR) revealed there was an entry for Metformin 1000mg twice daily which was documented as administered 03/01/18 through 05/17/18.

Review of prescription orders, Nurse Practitioner (NP) visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Metformin 1000mg daily.

Review of an electronic prescription order from the NP for Resident #1 received from the pharmacy dated 01/08/18 revealed an order for Metformin 1000mg twice daily.

b. Review of Resident #1's March, April and May 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Ellipta 100/62.5/25mcg inhaler one puff daily. (Ellipta is used to treat

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symptoms of chronic obstructive pulmonary disease.)
-Staff documented administering the Ellipta 20 of 31 days in March 2018, 20 of 30 days in April 2018, and 11 of 17 days in May 2018.

Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ellipta 100/62.5/25mcg inhaler one puff daily.

Review of an electronic prescription order from the pulmonary physician for Resident #1 received from the pharmacy dated 02/12/18 revealed an order for Ellipta 100/62.5/25mcg inhaler one puff daily.

c. Review of Resident #1's March, April and May 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Ativan 0.5mg daily as needed (PRN) for agitation. (Ativan is used to treat anxiety.)
-Staff documented administering 26 doses in March 2018, 7 doses in April 2018, and no doses in May 2018.

Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ativan 0.5mg daily PRN for agitation.

Telephone interview with a pharmacy technician on 05/22/18 2:34pm revealed the original order date for Ativan 0.5mg daily PRN was on 01/26/18 and was discontinued on 04/10/18.

Upon request the order to start and stop Ativan 0.5mg daily PRN for agitation for Resident #1 was not available for review.

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D 345	Continued From page 90 d. Review of Resident #1's April and May 2018 electronic medication administration record (eMAR) revealed there was an entry for Ativan 1mg twice daily which was documented as administered 04/27/18 through 05/17/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ativan 1mg twice daily. Review of an electronic prescription order from the mental health provider (MHP) for Resident #1 received from the pharmacy dated 04/23/18 revealed an order for Ativan 1mg twice daily. e. Review of Resident #1's April and May 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Ativan 1mg daily as needed (PRN) for agitation on the April 2018 eMAR. -Staff documented administering one dose on 04/15/18. -There was no entry for Ativan 1mg daily PRN on the May 2018 eMAR. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ativan 1mg daily PRN. Telephone interview with a pharmacy technician on 05/22/18 2:34pm revealed the original order for Ativan 1mg daily PRN was on 04/10/18 and then discontinued on 04/23/18. Review of an electronic prescription order from the MHP for Resident #1 received from the	D 345		

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pharmacy dated 04/23/18 revealed an order to discontinue Ativan 1mg daily as needed (PRN).

Upon request the order to start Ativan 1mg daily PRN for Resident #1 was not available for review.

f. Review of Resident #1's April and May 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Ventolin inhaler two puffs four times daily as needed (PRN). (Ventolin is used to treat excessive coughing and shortness of breath.)
-Staff documented administering one dose on 03/12/18, one dose on 04/25/18 and no doses in May 2018.

Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ventolin inhaler two puffs four times daily PRN.

Review of an electronic prescription order from the pulmonary physician for Resident #1 received from the pharmacy dated 02/12/18 revealed an order for Ventolin inhaler two puffs four times daily PRN.

Attempted interviews with Resident #1's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.

Refer to telephone interview with a pharmacy technician on 05/22/18 2:34pm.

Refer to interview with the medication aide (MA) on 05/21/18 at 11:20am.

Refer to telephone interview with the Clinical

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CROMARTIE SPRING VILLAGE REST HOME	508 WORTH STREET SAINT PAULS, NC 28384

(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 345	Continued From page 92 Organizer for the NP's office on 05/23/18 at 1:22pm. Refer to telephone interview with the Administrator on 05/23/18 at 2:30pm. 2. Review of Resident #3's current FL-2 dated 3/6/17 revealed: -Diagnoses included change in mental status, cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension. a. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Zaroxolyn 2.5mg every Monday and Thursday 30 minutes before Lasix. (Zaroxolyn is used to remove excess fluid from the body.) -Staff documented administering on 02/01/18, 02/05/18, 02/08/18 and 02/12/18. Review of prescription orders, Nurse Practitioner (NP) visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Zaroxolyn 2.5mg every Monday and Thursday 30 minutes before Lasix. Upon request the order for Zaroxolyn 2.5mg every Monday and Thursday 30 minutes before Lasix for Resident #3 was not available for review. b. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Remeron 15mg daily at bedtime. (Remeron is used to treat depression and insomnia.)	D 345		

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D 345	Continued From page 93 -Staff documented administering from 02/10/18 through 02/11/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Remeron 15mg daily at bedtime. Upon request the order for Remeron 15mg daily at bedtime for Resident #3 was not available for review. c. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Procardia XL 60mg daily. (Procardia XL is used to treat high blood pressure and chest pain.) -Staff documented administering 02/01/18 through 02/12/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Procardia XL 60mg daily. Upon request the order for Procardia XL 60mg daily for Resident #3 was not available for review. d. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Protonix 40mg twice daily. (Protonix is used to treat acid reflux symptoms.) -Staff documented administering 02/01/18 through 02/12/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for	D 345		

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D 345	Continued From page 94 Protonix 40mg twice daily. Upon request the order for Protonix 40mg twice daily for Resident #3 was not available for review. e. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Zantac 150mg twice daily. (Zantac is used to treat acid reflux symptoms.) -Staff documented administering 02/01/18 through 02/12/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Zantac 150mg twice daily. Upon request the order for Zantac 150mg twice daily for Resident #3 was not available for review. f. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed: -There was an entry Vitamin C 500mg daily. (Vitamin C is a supplement.) -Staff documented administering 02/01/18 through 02/12/18. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Vitamin C 500mg daily. Upon request the order for Vitamin C 500mg daily for Resident #3 was not available for review. g. Review of Resident #3's February 2018 electronic medication administration record (eMAR) revealed:	D 345		

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D 345	Continued From page 95 -There was an entry Senna 8.6mg daily as needed (PRN) for constipation. (Senna is used to treat constipation.) -There were no doses documented as administered. Review of prescription orders, NP visit notes and Report of Health Services to Residents forms for Resident #3 revealed there was no order for Senna 8.6mg daily PRN for constipation. Upon request the order for Senna 8.6mg daily PRN for constipation for Resident #3 was not available for review. Telephone interview with the Clinical Organizer for Resident #3's NP's office on 05/23/18 at 1:22pm revealed the NP's last visit note for Resident #3 had a current medication list which included the following: Zaroxolyn 2.5mg every Monday and Thursday 30 minutes before Lasix, Remeron 15mg daily at bedtime, Procardia XL 60mg daily, Protonix 40mg twice daily, Zantac 150mg twice daily, Vitamin C 500mg daily and Senna 8.6mg daily PRN for constipation. Telephone interview with a pharmacy technician on 05/24/18 at 1:36pm revealed there was a signed physician's order dated 12/14/17 which included the following medications: Zaroxolyn 2.5mg every Monday and Thursday 30 minutes before Lasix, Remeron 15mg daily at bedtime, Procardia XL 60mg daily, Protonix 40mg twice daily, Zantac 150mg twice daily, Vitamin C 500mg daily and Senna 8.6mg daily PRN for constipation. Attempted interviews with Resident #3's NP on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful.	D 345		

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D 345	Continued From page 96 Refer to telephone interview with a pharmacy technician on 05/22/18 2:34pm. Refer to interview with the medication aide (MA) on 05/21/18 at 11:20am. Refer to telephone interview with the Clinical Organizer for the NP's office on 05/23/18 at 1:22pm. Refer to telephone interview with the Administrator on 05/23/18 at 2:30pm. _____ Telephone interview with a pharmacy technician on 05/22/18 2:34pm revealed: -Some physicians send orders via electronic prescriptions and some send via fax. -Most of the prescription orders from the facility came to the pharmacy via fax. -The pharmacy then enters the order onto the eMAR. -The facility did not get a copy of the order if the order was faxed. -A copy of the order was usually sent to the facility with the medication delivery. Interview with the medication aide (MA) on 05/21/18 at 11:20am revealed: -She was responsible for provider orders for the residents. -When the Nurse Practitioner (NP) or mental health provider (MHP) came to facility to see residents, if there were any orders the NP or the MHP would tell the MA what the new orders were and fax the written order to the pharmacy. -She did not approve new orders on the eMAR until the medication was delivered to the facility which was usually the next day after the order was sent to the pharmacy by the NP or MHP.	D 345		

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D 345	Continued From page 97 -She did not always have a hard copy of new orders for the resident's record. -She compared the medication that was delivered with the order on the eMAR and with what the NP or MHP had told her about the new order. -She did not know how she would know if an order was entered incorrectly by the pharmacy. Telephone interview with the Clinical Organizer for the NP's office on 05/23/18 at 1:22pm revealed: -The NP sometimes wrote orders while at the facility and sometimes the NP had orders sent from the doctor's office directly to the pharmacy in the form of electronic prescriptions. -Orders were sent electronically from the doctor's office to the facility and the pharmacy. Interview with the Administrator on 05/21/18 at 3:50pm revealed in regards to orders that go right to pharmacy: "It's very seldom done like that. If it is done like that and we see on the eMAR we call the pharmacy to clarify. The MA calls the pharmacy to get copy of the MD orders. Should call right away." Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed: -He expected the MAs to be responsible and assure orders were in the residents' records. -He expected residents' records to be in order. -Every 10 days the 1st shift MA was to check the residents' records to make sure everything like medication orders and documentation was in place, he also checked "periodically to make sure everything was going on."	D 345		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 98 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: Based on observations, interviews and record review, the facility failed to assure medications were administered as ordered by the licensed provider for 1 of 3 sampled residents (#1) as evidenced by Ativan which was ordered once daily as needed, being administered twice a day routinely and being administered for 8 doses after an order to discontinue. The findings are: Review of Resident #1's current FL-2 dated 10/02/17 revealed: -Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia. Review of Resident #1's March 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Ativan 0.5mg daily as needed (PRN) for agitation. (Ativan is used to treat anxiety.) -Staff documented administering Ativan 0.5mg at	D 358		

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D 358	Continued From page 99 8:12am and 6:55pm on 03/12/18 and 8:13am and 6:52pm on 03/26/18. Review of Resident #1's April 2018 eMAR revealed: -There was an entry for Ativan 0.5mg daily PRN for agitation. -Staff documented administering 7 doses once daily between 04/01/18 and 04/21/18. Review of a controlled drug record (CDR) for Resident #1 revealed: -There was a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 02/26/18. -Staff documented administering Ativan 0.5mg at 7:00am and 7:00pm on 03/05/18, 03/09/18, 03/12/18, 03/16/18, 03/19/18 and 03/26/18. Review of a controlled drug record for Resident #1 revealed: -There was a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 03/26/18. -Staff documented administering Ativan 0.5mg at 7:00am and 7:00pm on 03/30/18 and 04/02/18. Review of Resident #1's March and April 2018 eMARs and the CDRs dated 02/26/18 and 03/26/18 revealed there were eight occasions between 03/05/18 and 04/02/18 when staff documented administering Ativan 0.5mg twice daily to Resident #1. Observation of medications on hand for Resident #1 on 05/22/18 at 2:09pm revealed there was a bubble pack with a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 03/26/18 and there were 13 tablets remaining.	D 358		

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D 358	Continued From page 100 Review of prescription orders, Nurse Practitioner visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ativan 0.5mg daily PRN for agitation. Telephone interview with a pharmacy technician on 05/22/18 2:34pm revealed the original order date for Ativan 0.5mg daily PRN was on 01/26/18 and was discontinued on 04/10/18. Upon request the order to start and stop Ativan 0.5mg daily PRN for agitation for Resident #1 was not available for review. Review of Resident #1's April 2018 eMAR and the CDR dated 03/26/18 revealed Resident #1 received eight doses of Ativan after 04/10/18, for example: on 04/11/18, 04/13/18 and 04/14/18 at 7:00pm according to the CDR; and on 04/17/18 at 7:25am and 04/21/18 at 8:01am according to the eMAR. Telephone interview with a medication aide (MA) on 05/23/18 at 6:23pm revealed: -She did not know why Ativan was documented as being administered twice daily for the PRN. -Anytime a resident was given a PRN controlled drug, the MA documented on the CDR and the eMAR, "so they don't mess up and give it too early". -She had told other MAs to "do it that way" and she knew "it was something we have to work on because the eMAR and the book (CDRs) got to match". -She did not know if the Administrator was aware of the discrepancies between the eMARs and the CDRs.	D 358		

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D 358	Continued From page 101 Attempted interviews with Resident #1's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Telephone interview with the Clinical Organizer for Resident #1's NP's office on 05/23/18 at 1:22pm revealed the NP did not order the Ativan for Resident #1. Attempted interview with Resident #1's MHP on 05/18/18 at 1:09pm was unsuccessful. Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed: -He could not say that he personally had reviewed CDR for Resident #1, he did review the CDR "from time to time, maybe once a week". -Whenever he saw a difference between the CDR and the eMAR he would talk the MAs about it. -He had not observed MAs administering medications or completing the controlled drug count at change of shift "as much as he would have liked to, but had done it in the past".	D 358		
D 383	10a NCAC 13F .1006 (g) Medication Storage 10a NCAC 13F .1006 Medication Storage (g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.	D 383		

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D 383	Continued From page 102 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications, such as insulins, that were stored inside the kitchen food refrigerator were kept in a locked container. The findings are: Observations on 05/16/18 at 11:26am and 05/17/18 at 9:04am revealed: -There was a black box inside the refrigerator inside the facility kitchen that had multiple vials and pens of residents' insulins. -The box was ajar and unlocked revealing a gap of approximately one inch between the lid and the container. Interview with a medication aide (MA) on 05/16/18 at 11:28am revealed: -The lock on the insulin storage box "just broke the other day and won't lock". -The Administrator was supposed to get a new lock. -She did not have a response to what day the Administrator was notified and ordered a new box. Observations on 05/16/18 at 11:29am revealed the MA interrupted the interview to walk in a fast pace to the Administrator's office. Interview with the Administrator on 05/16/18 at 11:30am revealed he, "ah, talked with the ah, pharmacy uh, yesterday," about getting a new lock box for the insulins. Interview with the Administrator on 05/17/18 at 2:25pm revealed: -He had not heard back from the pharmacy about the lock box for the insulins.	D 383		

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D 383	Continued From page 103 -He was pretty sure he spoke with the pharmacy last Thursday (05/10/18) or Tuesday (05/15/18) of this week or yesterday (05/16/18). -He thought the lock on the box had been broken "over the last week". Telephone interview with a pharmacy technician on 05/18/18 at 3:30pm revealed: -She had a note on her desk dated 05/16/18 that the facility requesting a new lock box for the insulins. -This was the first request from the facility. -She did not have a lock box on hand, but had placed an order for a new one for the facility. Observation on 05/17/18 at 3:15pm revealed the maintenance person was working on repairing the lock to the insulin lock box at the front desk in the facility. Interview with the maintenance person on 05/17/18 at 3:15pm revealed the Administrator had contacted him on 05/17/18 and requested he fix the lock on the insulin lock box and he had just fixed it.	D 383		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record	D 392		

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D 392	Continued From page 104	D 392		

reviews, the facility failed to assure there was an accurate accounting of a controlled substance for 1 of 2 sampled residents which resulted in a discrepancy in the documentation of 20 Ativan tablets for Resident #1. (Ativan is used to treat anxiety.)

The findings are:

Review of Resident #1's current FL-2 dated 10/02/17 revealed:
-Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.

Review of prescription orders, Nurse Practitioner visit notes and Report of Health Services to Residents forms for Resident #1 revealed there was no order for Ativan 0.5mg daily PRN for agitation.

Telephone interview with a pharmacy technician on 05/22/18 2:34pm revealed the original order date for Ativan 0.5mg daily PRN was on 01/26/18 and was discontinued on 04/10/18.

Review of Resident #1's March 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Ativan 0.5mg daily as needed (PRN) for agitation.
-Staff documented administering 26 doses between 03/01/18 and 03/31/18.

Review of Resident #1's April 2018 eMAR revealed:
-There was an entry for Ativan 0.5mg daily PRN for agitation.

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D 392	Continued From page 105 -Staff documented administering 7 doses between 04/01/18 and 04/21/18. Review of a controlled drug record (CDR) for Resident #1 revealed: -There was a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 02/26/18. -Staff documented administering 31 tablets from 03/02/18 through 03/27/18 and that there were no tablets remaining. -Staff documented administering one tablet on 03/28/18 at 7:00am when the count was documented as zero on 03/27/18. Review of a controlled drug record for Resident #1 revealed: -There was a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 03/26/18. -Staff documented administering 17 tablets from 03/29/18 through 04/23/18 and that 13 tablets remained. -On the 16th line from the top, there was a subtraction of one tablet with no signature, time or date (between 04/17/18 at 7:00am and 04/21/18 at 7:00am). Review of Resident #1's March and April 2018 eMARs and the CDRs dated 02/26/18 and 03/26/18 revealed: -There were 20 discrepancies in documentation resulting in 18 tablets documented as administered on the controlled drug log that were not on the eMAR such as 03/05/18 at 7:00am, 03/09/18 at 7:00am, 03/16/18 at 7:00am, 03/19/18 at 7:00am and 7:00pm, 03/30/18 at 7:00am and 04/02/18 at 7:00am. -There was two doses on the eMAR that were not on the controlled drug log: 03/01/18 at 7:05pm	D 392		

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and 04/06/18 at 8:13am.
-There was no dose documented on the eMAR between 04/17/18 at 7:25am and 04/21/18 at 7:00am to account for the unsigned, undated entry on the CDR.

Observation of medications on hand for Resident #1 on 05/22/18 at 2:09pm revealed there was a bubble pack with a pharmacy label which had Resident #1's name and indicated 30 tablets of Ativan 0.5mg were dispensed on 03/26/18 and there were 13 tablets remaining.

Based on observations of medications on hand and review of March and April eMARs and CDRs dated 02/26/18 and 03/26/18; a total of 60 tablets of Ativan 0.5mg were dispensed, 13 tablets remained on hand, and 33 tablets were documented as administered on the eMARs verses 48 tablets on the CDRs leaving a difference of 15 tablets yet there were 20 discrepancies in documentation between the eMARs and CDRs.

Interview with a medication aide (MA) on 05/22/18 at 2:09pm revealed the MAs were supposed to count off on controlled drugs each shift change; the count was not documented.

Telephone interview with a second MA on 05/23/18 at 6:23pm revealed:
-Anytime a resident was given a PRN controlled drug, the MA documented on the CDR and the eMAR, "so they don't mess up and give it too early".
-She had told other MAs to "do it that way" and she knew "it was something we have to work on because the eMAR and the book (CDRs) got to match".
-She did not know if the Administrator was aware

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D 392	Continued From page 107 of the discrepancies between the eMARs and the CDRs. Telephone interview with a pharmacy technician on 05/23/18 at 11:03am revealed there were 30 tablets of Ativan 0.5mg daily PRN dispensed on 01/26/18, 02/26/18 and 03/26/18. Attempted interviews with Resident #3's Nurse Practitioner (NP) on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Telephone interview with the Clinical Organizer for Resident #3's NP's office on 05/23/18 at 1:22pm revealed the NP did not order the Ativan for Resident #1. Attempted interview with Resident #1's MHP on 05/18/18 at 1:09pm was unsuccessful. Telephone interview with the Administrator on 05/23/18 at 2:30pm revealed: -He could not say that he personally had reviewed CDR for Resident #1, he did review the CDR "from time to time, maybe once a week". -Whenever he saw a difference between the CDR and the eMAR he would talk the MAs about it. -He had not observed MAs administering medications or completing the controlled drug count at change of shift "as much as he would have liked to, but had done it in the past".	D 392		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or	D 406		

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appropriate health professional has been informed of the findings when necessary.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure documented actions taken based on the medication review for 1 of 2 sampled residents (#1) which included assuring the physician signed orders routinely every six months, staff completed proper documentation of controlled substances administration and counts, and physician ordered parameters for blood pressure reporting.

The findings are:

Review of Resident #1's current FL-2 dated 10/02/17 revealed:
-Diagnoses included schizophrenia exacerbation, altered mental status, history of chronic obstructive pulmonary disease, asthma, hypoxic respiratory failure, hypertension, diabetes mellitus type 2 and hyperlipidemia.

a. Review of the Consultant Pharmacist's Medication Regimen Review summary dated 03/01/18 through 03/09/18 revealed there was a "general note" where the pharmacist documented, "Please make sure physician's orders were signed routinely every six months."

Review of Resident #1's April and May 2018 electronic medication administration records (eMARs) revealed there were entries for Metformin 1000mg twice daily (for blood sugar management), Ellipta inhaler one puff daily (for obstructive pulmonary disease), Ativan 1mg twice daily, 1mg daily as needed (PRN) and 0.5mg PRN (for anxiety) and Ventolin two puffs four

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D 406	Continued From page 109 times daily PRN (for asthma). Review of prescription orders, Nurse Practitioner (NP) visit notes and Report of Health Services to Residents forms for Resident #1 revealed: -There was no six month review of medication orders signed by the NP. -There were no orders for Metformin, Ellipta, Ativan and Ventolin. Upon request on 05/17/18 and 05/21/18, the facility's copy of the medication review and follow up actions taken by the facility regarding physician signed medications every six months was not available for review. b. Review of the Consultant Pharmacist's Medication Regimen Review summary dated 03/01/18 through 03/09/18 revealed: -There was a "general note" where the pharmacist documented "Please make sure that controlled substance counts were documented properly for declining inventory...please make sure everyone was signing at shift change every shift change...Lots of holes noted." -"In auditing PRN (as needed) controlled substance documentation it was noted that count sheets are being documented on however the MAR (medication administration record) did not match the documentation ...Please follow up with staff." Review of Resident #1's March and April 2018 eMARs and the controlled drug records (CDRs) dated 02/26/18 and 03/26/18 revealed: -There were 20 discrepancies in documentation for Ativan 0.5mg daily as needed (PRN), resulting in 18 tablets documented as administered on the controlled drug log that were not on the eMAR such as 03/05/18 at 7:00am, 03/09/18 at 7:00am,	D 406		

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D 406	Continued From page 110 03/16/18 at 7:00am, 03/19/18 at 7:00am and 7:00pm, 03/30/18 at 7:00am and 04/02/18 at 7:00am. -There was two doses on the eMAR that were not on the controlled drug log: 03/01/18 at 7:05pm and 04/06/18 at 8:13am. Interview with a medication aide (MA) on 05/22/18 at 2:09pm revealed the MAs were supposed to count off on controlled drugs each shift change; the count was not documented. Interview with a MA on 05/24/18 at 8:26am revealed she was not aware of any problems with the CDRs or counts, although she had talked with the staff about documenting consistently on the eMAR and the CDR. Telephone interview with a second MA on 05/23/18 at 6:23pm revealed: -Documenting on the eMAR and the CDR was something MAs had to work on because the eMAR and the CDRs had to match. -She did not know if the Administrator was aware of the discrepancies between the eMARs and the CDRs. Upon request on 05/17/18 and 05/21/18, the facility's copy of the medication review and follow up actions taken by the facility regarding controlled substance administration and count documentation was not available for review. c. Review of the Consultant Pharmacist's Medication Regimen Review summary dated 03/01/18 through 03/09/18 revealed there was a "general note" where the pharmacist documented, "Please make sure that parameters for blood sugar or blood pressure/pulse state to notify the provider for greater than or less than	D 406		

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D 406	Continued From page 111 values...please have provider sign notification and file in the chart." Review of prescription orders, Nurse Practitioner (NP) visit notes and Report of Health Services to Residents forms for Resident #1 revealed: -There was a prescription order from the NP dated 10/23/17, to check vital signs (VS) daily, there were no written reporting parameters. (VS include blood pressure, heart rate, respiratory rate and temperature.) -There was no order or clarification order for reporting parameters for the VS/blood pressure checks. Review of Resident #1's March, April and May 2018 VS log revealed: -There were eight diastolic blood pressure results greater than 100 documented. -There was no documentation the NP was contacted for blood pressure reporting parameters. Interview with the 1st shift MA on 05/24/18 at 8:26am revealed blood pressure parameters had not been written by the NP for Resident #1. Upon request on 05/17/18 and 05/21/18, the facility's copy of the medication review and follow up actions taken by the facility regarding documentation of physician ordered blood pressure parameters was not available for review. Telephone interview with the Pharmacist on 05/18/18 at 7:25pm revealed: -She was responsible for completing the medication review every quarter at the facility, her last visit to the facility was in March 2018. -Upon completion of the review, she discussed concerns with the staff and faxed and emailed a	D 406		

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D 406	Continued From page 112 copy of the summary to the facility. Interview with a third MA on 05/22/18 at 3:30pm revealed: -The 1st shift MA and the Administrator were responsible for facility matters such as the pharmacy review. -The Pharmacist sends the report to the facility and then the 1st shift MA faxes the report to the to the NP. -If the NP did not send the report back signed to the facility, then the 1st shift MA would put it in the NP's folder for the NP to sign on her monthly visit to the facility. Interview with the 1st shift MA on 05/24/18 at 8:26am revealed: -She was responsible for follow up on any recommendations from the pharmacy review. -She had never been trained on what to do, but had taught herself. -She sent the medication review summary to the NP via fax. -The Administrator was aware of the recommendations from the pharmacy review and the time and effort required by the first shift MA to address the concerns. Attempted interviews with the facility's NP on 05/18/18 at 1:09pm, 05/22/18 at 9:45am and 05/23/18 at 1:22pm were unsuccessful. Interview with the Administrator on 05/22/18 at 4:00pm revealed: -The Pharmacist emailed the pharmacy review to the facility and the 1st shift MA looked at the pharmacy review. -The staff knew the pharmacy review was available, he kept a copy in his office and placed a second copy on the bulletin board for staff.	D 406		

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D 406	Continued From page 113 -The 1st shift MA "took the major part of the review, she looked at procedures to be followed and moved forward with it." -"Any medication d/c's (discontinued) or like that, she'll consult the doctor ...she'll talk directly with the pharmacy and it clears out from there." -"We continue to have discussions and make notations about the concerns." -"The pharmacy sends right to the doctor, they confer and we're left with finality and clarity." -In response to action taken by the facility to address the concerns documented on the medication review, the Administrator said, "The doctor has been here 2-3 times since then, I don't think the review should have been an issue."	D 406		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to notify the county department of social services of an accident for 2 of 4 residents (#3 and #4) which resulted in injury	D 451		

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D 451	Continued From page 114 to the residents that required emergency medical evaluation and medical treatment. The findings are: Review of Resident # 4's current FL2 dated 10/23/17 revealed: -Diagnoses included dementia, Manic Bipolar Disorder, hypertension and gastro-esophageal reflux disease. -No information was provided regarding orientation level. -Resident was ambulatory. Review of Incident Report dated 03/29/18 revealed: -Incident occurred on 03/29/18 at 3:05pm. -The Medication Aide (MA) was administering medications and a resident informed her that Resident #4 was on the ground. -Resident #4 met Med Aide at the front door. -Resident #4 stated that he had fallen. -There were visible signs of injury to the top, left side of Resident #4's head extending to his forehead. -The MA checked vital signs and contacted the paramedics at 3:10pm. -Resident #4's blood pressure was 131/77 and pulse was 77. -Paramedics arrived at 3:30 p.m. -Resident #4 was transported to the Emergency Room. Interview with the MA on 05/22/18 at 10:05am revealed: -She was on duty and completed the Incident Report dated 03/29/18. -She did not fax the Incident Report dated 03/29/18 to the Department of Social Services. -She gave the Incident Report to the	D 451		

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D 451	Continued From page 115 Administrator on 03/29/18. -It was the Administrator's responsibility to fax Incident Reports to the Department of Social Services. -She had never been instructed by the Administrator to fax Incident Reports to the Department of Social Services. -She assumed the Administrator had faxed the Incident Report dated 03/29/18 to the Department of Social Services. Interview with Administrator on 05/21/18 at 10:10am revealed: -Incident Reports were completed at facility when an incident or accident occurred. -He reviewed the Incident Report dated 03/29/18. -He did not fax the Incident Report dated 03/29/18 to the Department of Social Services. -The MA on duty was responsible for faxing the Incident Report to the Department of Social Services. -Incident Reports were supposed to be faxed the day of the incident to the Department of Social Services. -He thought the MA had faxed the Incident Report dated 03/29/18 to the Department of Social Services on 03/29/18. -He will address this with the MAs at facility to ensure they are aware that it is their responsibility to fax all Incident Reports to the Department of Social Services on the same day of the incident. 2. Review of Resident #3's current FL-2 dated 3/6/17 revealed: -Diagnoses included change in mental status, cerebral vascular accident, diabetes mellitus, lower extremity edema, history of falls and systolic hypertension. -Resident #3 was intermittently disoriented, non-ambulatory and incontinent of bowel and	D 451		

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bladder.
-Resident #3 had speech limitations and difficulty communicating verbally.
-Resident #3 needed assistance with bathing and dressing.

Review of an accident/incident report for Resident #3 dated 12/14/17 revealed:
-Staff documented Resident #3 was found face down on the floor in his bedroom at 9:20am.
-Resident #3 reported trying to pick up a battery off of the floor.
-Resident #3 had a "visible injury to his forehead (scrape of skin)".
-Staff documented Resident #3 refused medical attention, antibiotic ointment was applied after cleaning (the wound) and the Administrator assisted staff with helping Resident #3 back to his wheelchair.
-The report was not signed by a medication aide (MA) or the Administrator.

Review of an emergency department (ED) discharge sheet for Resident #3 dated 12/14/17 revealed:
-Resident #3 was seen for a fall from a wheelchair.
-Diagnoses included contusion of the back and abrasion of the scalp.

Telephone interview with a MA on 05/24/18 at 6:43pm revealed:
-She could not remember the events of a year ago and if she had filled out the accident/incident report, then she did whatever she wrote on the report.
-She could not remember any details of Resident #3 falling out of his wheelchair and whether or not she faxed the form to the Department of Social Services (DSS).

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D 451	Continued From page 117 Interview with a DSS worker on 05/22/18 at 5:00pm revealed: -She had not been notified by the facility that Resident #3 fell and was sent to the ED on 12/14/18. -She had not received a copy of the accident/incident report dated 12/14/18 for Resident #3. Interview with the Administrator on 05/17/18 at 2:35pm revealed: -Any resident concerns were documented on accident/incident report forms and kept in his office. -The accident/incident reports were completed by the MAs and "we all send them to DSS". -The MA sent the accident/incident report to DSS via fax or the MA gave the report to the Administrator and he faxed the report.	D 451		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to management of the facility, personal care, health care referral and follow up and supervision of residents. The findings are:	D914		

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D914	Continued From page 118 1. Based on observations, interviews and record reviews, the Administrator failed to assure responsibility for the total operation of the facility and compliance to state rules and regulations specific to personal care, health care referral and follow up, supervision, housekeeping and furnishings, personal care and other staffing, resident contracts, resident care plans, health care implementation, food service, activities, residents' rights, medication orders, medication administration, medication storage, controlled substances, pharmaceutical care, reporting accidents and incidents and examination and screening for controlled substances affecting all eleven residents in the facility. [Refer to Tag 176 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation)] 2. Based on observations, interviews and record reviews, the facility failed to provide personal care for 3 of 3 sampled residents (#1, #2 and #3) such as bathing, toileting, providing incontinence care and every two hour repositioning for Resident #3 who had impaired mobility and required the use of wheelchair; and hand washing for Residents #2 and #3 with known behaviors of handling feces (#2) and ashtray waste (#1). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care (Type A1 Violation)] 3. Based on observations, interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 2 of 3 sampled residents (#1 and #3) by delaying immediate transport to the emergency department (ED) for four days following notification of critical laboratory results indicating acute renal failure for Resident #3 and not identifying and reporting five pressure ulcers to the Nurse Practitioner (NP) for Resident #3; and	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078082	A. BUILDING: _____ B. WING _____	R 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROMARTIE SPRING VILLAGE REST HOME	508 WORTH STREET SAINT PAULS, NC 28384

(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
D914	Continued From page 119 by not reporting eight elevated blood pressures to the NP for Resident #1 and not scheduling a gastroenterologist referral appointment for Resident #1. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)] 4. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 4 sampled residents who demonstrated need for increased supervision as evidenced by Resident #4, who had a history of Alzheimer's dementia and had wandered away from the facility on three known occasions; and Resident #1, who was known to fall asleep while smoking cigarettes, having numerous burn marks on his clothing. [Refer to Tag 270 10A NCAC 13F .0901(b) Supervision (Type A2 Violation)]	D914		