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	HAL092182	A. BUILDING: _____ B. WING _____	R 06/27/2018

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OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 6/20- 6/22/18, 6/25- 6/26/18 with an exit conference via telephone on 6/27/18.	{D 000}		
{D 075}	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain a clean living area free from unpleasant odors in four shower rooms, two hallways, three shared bathrooms and a resident's room. The findings are: Observation of the entry area of the facility on 06/20/18 at 9:45am revealed a strong urine odor was noted at the entrance of the facility and throughout men's and women's halls. Observation of the entry area of the facility on 06/21/18 at 7:30am revealed a strong urine odor was noted at the entrance of the facility and throughout men's and women's halls. Observation of the entry area of the facility on 06/22/18 at 10:30am revealed a strong urine odor was noted at the entrance of the facility and throughout men's and women's halls.	{D 075}		

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{D 075}	Continued From page 1 Observation of the entry area of the facility on 06/25/18 at 2:00 pm revealed a slight urine odor was noted at the entrance of the facility and throughout men's and women's halls. Observation of the entry area of the facility on 06/26/18 at 8:30am revealed a slight urine odor was noted at the entrance of the facility and throughout men's and women's halls. Observation of room 208 on 06/20/18 at 9:45am revealed a strong urine odor was noted. Observation of room 208 on 06/21/18 at 7:35am revealed a strong urine odor was noted. Observation of room 208 on 06/22/18 at 10:35am revealed a strong urine odor was noted. Observation of room 208 on 06/25/18 at 2:00pm revealed a strong urine odor was noted. Observation of room 208 on 06/26/18 at 8:35am revealed a strong urine odor was noted. Observation on 06/21/18 at 11:25am of room 202 revealed: -There was a used incontinent pad in the side table. -The room smelled like urine. Observation of the shared bathroom on 06/20/18 at 10:00am between room 115 and room 117 revealed a strong urine odor. Observation of the shared bathroom on 06/20/18 at 10:19 am between room 111 and room 113 revealed a strong urine odor. Observation of the shower room next to room 107	{D 075}		

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{D 075}	Continued From page 2 on 06/20/18 at 10:22 am revealed a slight urine odor. Observation of the shared bathroom on 06/20/18 at 10:33am between room 105 and room 107 revealed: -There was a strong urine odor. -The trash can was filled with used incontinence pads. Observation of the shower room next to room 105 on 06/20/18 at 10:22 am revealed: -There was a strong urine odor. -There was urine in the commode. Observation of the shared bathroom on 06/20/18 at 11:05am between room 205 and room 207 revealed: -There was a strong odor of urine and feces. -The commode was approximately three-quarters full of toilet tissue and feces. Observation on 06/20/18 t 11:02pm of the shower room next to 203 revealed there was dried feces on the front of the commode. Interview with a resident on 06/20/2018 at 10:40 a.m. revealed: -The facility smelled "pissy" like "old pee". -The resident thought the facility needed better cleaning supplies or needed to use more of the supplies when they cleaned to get rid of the odors. Interview with a second resident on 06/26/18 at 1:15pm revealed: -Her room smelled like urine. -Her roommate urinated standing up and got urine on the bathroom floor. -The bathroom smelled like urine.	{D 075}		

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{D 075}	Continued From page 3 -The housekeepers cleaned the bathroom but it still smelled like urine. -She kept air fresheners in her room to help with the smell. Interview with a third resident on 06/26/18 at 1:25pm revealed: -"The smell is terrible in here" -His roommate used a urinal. -The urinal did not get emptied "sometimes all day and all night" which made the room smell. -"If you say anything about it, you are labeled a trouble maker". Interview with a fourth resident on 06/26/18 at 1:30pm revealed: -"Sometimes the smell bothers me". -"People are not being changed like they should be changed." -The facility was short staffed so it took up to an hour to change people at times which made the smell worse. Interview with a fith resident on 06/26/18 at 3:46pm revealed: -"It smells like pee all the time". -"It smells like crap all the time". -"There is (feces) in my bed right now and no one will come change the sheets." -"I asked over an hour ago for someone to help me change the sheets so now my room smells". Interview with a medication aid (MA) on 06/21/18 at 8:16am revealed: -The facility smelled like urine. -She thought the urine smell was due to 3rd shift not cleaning the wheelchairs properly. Interview with a second MA on 06/26/18 at 1:18pm revealed:	{D 075}		

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{D 075}	Continued From page 4 -The facility smelled bad. -"I think it has to do with the residents". -"The residents pee on the floor". Interview with a third MA on 06/21/18 at 8:04am revealed she "brought her own air fresheners" so she could "go behind the housekeepers". Interview with a fourth MA on 06/21/2018 at 8:16am revealed "it was not normal for poop to be all over like that". Interview with a personal care aide (PCA) on 06/26/18 at 1:55pm revealed: -The facility smelled like urine. -"They (the housekeepers) try to mop it (urine from the floors) but you have to find the source to get rid of it (the smell)". -"I don't think they know the source". -She cleaned the toilet seats before putting the residents on the commode because she did not think they were clean enough. Interview with a second PCA on 06/26/18 at 3:25pm revealed "it smells like urine pretty much all the time". Interview with a housekeeper on 06/20/18 at 10:50 am revealed: -She cleaned the facility with bleach. -She was usually assigned to clean the women's hall and the living room. -She cleaned the floors and dusted every day. -Once per week she did deep cleaning which consisted of cleaning the windows and blinds and taking items off shelves to dust. Attempted interview with a second housekeeper on 06/21/18 at 9:40am was unsuccesful.	{D 075}		

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{D 075}	Continued From page 5 Attempted interview with a third housekeeper on 06/26/18 at 1:30pm was unsuccesful. Interview with the housekeeping supervisor on 06/22/18 at 2:41pm revealed: -She noticed the urine smell. -The executive director did a daily walk through with her. -There were periods when the residents' incontinence products got changed that the smell was strongest. -Her staff was instructed to use "odor counteractive products" when the smell was strong. -The shower rooms were cleaned three times per day because "we try to hit the problem areas (the shower areas) first." -The housekeepers cleaned each room and bathroom every day. -A minimum of one room per hall was deep cleaned daily. -Usually three to four rooms per day were deep cleaned. -Deep cleaning consisted of cleaning the blinds and windows; wiping the walls, moving furniture to clean behind. -The housekeepers let her know when they were done with a deep clean so she could verify it was done. -There was no log to verify which rooms were cleaned. A second interview with the housekeeping supervisor on 06/26/18 at 9:35am revealed: -There was no written work schedule. -When she did a walk through with the Executive Director "we just point out areas that need deep cleaning." Interview with the resident care coordinator	{D 075}		

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{D 075}	Continued From page 6 (RCC) on 06/21/18 at 2:45pm revealed: -"The residents deserved things to be clean". -The housekeepers clean each bathroom every day. -The shower rooms were cleaned three times per day. -Cleaning the shower rooms meant cleaning the toilet, floors and showers. -The housekeepers mopped every room every day and as needed after spills. -He did rounds once per week and when he was the weekend manager on duty. Interview with the Executive Director (ED) on 06/26/18 at 4:08pm revealed: -She did "walk through" of the building "all the time". -There was no set time to walk through the building with the housekeeping supervisor. -She did random walk through with the housekeeping supervisor. -Deep cleaning included cleaning under beds and the blinds. A second interview with the ED on 06/26/18 at 3:19pm revealed: -She noticed a smell after personal care was done or when trash was being taken out. -She expected the facility to be odor free as much as was possible.	{D 075}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and	D 079		

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hazards;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain a clean living area free from hazards including live roaches and live ants in two residents' rooms, feces in three bathrooms, missing baseboards in two resident rooms, a missing outlet faceplate, cracked and dirty tiles in four shower rooms, two loose door knobs in resident rooms and a rusty drain.

The findings are:

Observation on 06/20/18 from 10:00am until 11:05am of the entryway, common living room, assisted living dining room and resident's rooms #101,111, 113, 115, 117, 203, 208 on 06/20/18 at 10am had approximately 25 live flies.

Observation of the shower room on 06/20/18 at 10:22am of the shower room next to room 107 revealed:
-There were dried black smears on the tiles.
-There was no toilet paper in the holder for the commode.
-The toilet paper holder was cracked.

Observations of the bathroom on 06/20/18 at 10:33am of room 105 revealed:
-There were dried brown spots on the tiles covering most of the wall behind the commode.
-The tiles were ripped and the backing was showing through under the light switch.
-The shower drain was rusted.

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D 079	Continued From page 8 -The sink drain was rusted. -There was a black substance in the caulking behind the sink that was approximately 5 inches in length. -There was dried feces on the wall. Observations on 06/20/18 at 10:36am of the shower room next to room 103 revealed: -There was no toilet paper. -There was a brown, dried substance on the wall to the left that was approximately ½ inch in diameter. -The shower drain was cracked. Observations on 06/20/18 at 10:45am of the shared bathroom between room 101 and room 103 revealed: -The floor drain was rusty and missing the cover. -The shower faucet had rust dripping from where it came out of the wall. Observation on 06/20/18 at 10:46am of room 103 revealed the door knob was loose and coming away from the door. Observation on 06/20/18 at 11:02am of the shower room next to 211 revealed: -The grout between the floor and the wall was cracked and brown. -The floor tile grout was cracked and had holes in approximately a four foot line. -The shower stall had black marks on the floor to the left of the drain. Observation on 06/20/18 at 11:05am of the shower room next to 203 revealed: -The toilet seat was broken and shifted to the right. -The grout for the floor tiles in the shower stall was black.	D 079		

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D 079	Continued From page 9 Observations on 06/20/18 at 11:16am in room 203 revealed: -There was an area approximately 8 inches long where base board was missing in an area close to the door. -There was a hole in the floor next to the window bed that was approximately 1 inch in diameter. Observation on 06/21/18 at 9:35am of the shower room closest to room 105 revealed: -The front of the commode had dried feces. -The shower seat had dried feces on the left side of the seat. Observation on 06/21/18 at 9:35am of the shower room closest to room 105 revealed: -The tile threshold for the shower had a missing section of tile approximately 3 inches in length. -The area around the base of the commode had black build up. -The front of the commode had dried feces. -The shower seat had dried feces on the left side. Observation on 06/21/18 at 9:39am of the shower room closest to room 107 revealed: -The grout around the base of the commode was cracked. -There was rust staining on the tile under the sink drain. Interview on 06/21/18 at 10:40 a.m. with the resident assigned to room #210 revealed: -The resident had lived at the facility for appproximately four months. -The baseboards were missing when she moved in. Observation on 06/21/18 at 11:25am of room 202 revealed:	D 079		

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-There was a used incontinent brief that smelled of urine in the side table.
-There was small bag that had dried red-brown crumbled substance resembling bacon bits in the side table.
-There was approximately 10 pieces of wrapped and unwrapped candy in the side table.
-There were various other items in the side table including: 2 Lotion bottles, a package of toothpicks, dirty clothes, a hairbrush, wrapped and used straws.

Observation on 06/21/18 at 11:25am of room 202 revealed approximately 15 dead roaches and approximately 5 live roaches in the resident's bedside table.

Observation on 06/26/18 at 10:20am of the shared bathroom between room 111 and room 113 revealed:
-There was dried feces on the floor.
-There was dried feces on the toilet seat lid.
-There was dried feces smeared on the face of the commode.

Observation on 06/26/18 at 1:20pm of room 108 revealed:
-There were approximately 30 live ants on the floor near the air conditioning unit.
-There were live ants under the bed closest to the window.

Observation on 06/26/18 at 10:11am of room 115 revealed the baseboard was pulled away from the wall area next to the closet.

Observation on 06/26/18 at 1:20pm of room 108 revealed:
-The wall outside of the closet that was closest to the window was scraped and the dry wall was

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exposed.
-The corner of the wall outside of the closet that was closest to the door was dented and the dry wall was split and exposed.
-There was a scrape along the inside of the bathroom door with missing paints chips that was approximately 18 inches in length.
-The door knob face plate was loose and pulled away from the door.

Observation on 06/26/18 at 1:41pm of room 113 revealed:
-The faceplate was missing from the electrical outlet.
-The lamp was on the floor.
-The lampshade was missing.

Interview with a medication aide (MA) on 06/21/18 at 8:16am revealed "the flies here are terrible".

Interview with a second MA on 06/21/18 at 9:30am revealed:
-"I just give showers in here".
-"I saw the toilet and the shower" (needing repairs).
-"I tell the main people about it". (the maintenance issues)
-The exterminator came once per month.
-The exterminator sprayed each room when he came.
-She cleaned out the resident's drawers "once in a while" or "whenever they need it."

Interview with the business manager on 06/21/18 at 11:20am revealed:
-There was a book that the facility used to record issues for the exterminator.
-The exterminator looked in that book on every visit.

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-There was a "room sweep" once a day which included the personal care aides (PCA) to clean out resident's closets and drawers.
-The MA were responsible for monitoring the clean out.

Interview with the resident care coordinator (RCC) on 06/21/18 at 2:45pm revealed:
-The exterminator "had a routine in coming" although he was unsure of the schedule.
-The PCA organize the rooms.
-He did rounds once per week or when he was the weekend Manager on Duty.

Interview with the exterminator on 06/21/18 at 3:40pm revealed:
-He sprayed for insects at the facility one time per month.
-The facility would call the pest control dispatch if there was a problem between visits.
-He did not think that the facility had called in a problem since his last routine visit.
-He usually responded to dispatch calls within 24-72 hours.
-Once a month treatment was a "general room inspection" and spray treatment.
-The facility staff wrote issues in a notebook that he reviewed each visit.
-Sometimes he could not locate the notebook or it was available.
-He "coordinated with staff to open drawers" in resident rooms.
-"The problem usually comes from the resident".

Interview with a maintenance worker on 06/23/18 at 2:34 pm revealed:
-He is not the usual maintenance worker.
-He had not been in the facility for about six months.
-If a staff member needed a repair he or she

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would tell the executive director (ED).
-The request for repair was put into the computer system so the maintenance worker got a work order notification.
-He was able to repair some requests "on the spot" without having to fill out a form.
-The ED would check if the work was done correctly.
-The maintenance supervisor double checked the work once per week or once every other week.

Interview with the house keeping supervisor on 06/23/18 at 2:41pm revealed:
-Her main priority was "resident safety".
-The housekeepers "asked permission to clean inside the furniture" when they noticed a smell.
-That happened during a deep cleaning.
-The exterminator came once per month.
-Maintenance had a log to request repairs.
-The maintenance worker came once per week.
-The facility was working on replacing floors, tiles, commodes and toilet seats, drywall and baseboards.
-She was unaware of the live roaches in the resident's side table.

A second interview with the housekeeping supervisor on 06/26/18 at 9:35am revealed:
-There was no written work schedule.
-When she did a walk through with the Executive Director "we just point out areas that need deep cleaning."

Interview with the district facilities manager on 06/26/18 at 10:24am revealed:
-There was no maintenance worker for the building.
-He was working on hiring a permanent worker.
-There were "fill in" workers scheduled weekly.
-Maintenance was available 24 hours per day.

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D 079	Continued From page 14 -Requests for maintenance "go right to my phone". -The housekeeping supervisor and the executive director were able to input requests for repairs. -He knew about the broken tiles in the shower rooms "a couple of weeks or a month ago". -If the repair was small, it would be fixed on site. -If it was larger repair, a contractor would be called. -A contractor would usually come to the facility within a week. -He came to this facility every two weeks to do spot checks. -During his monthly walk through he looked at the halls, resident rooms, mechanical rooms, life safety and cosmetic needs. -"There were some issues". Interview with the Executive Director (ED) on 06/26/18 at 4:08pm revealed: -She did "walk through" of the building "all the time". -There was no set time to walk through the building. -She did random walk through with the housekeeping supervisor. -Deep cleaning included cleaning under beds and the blinds. -The facility did not "go through resident drawers due to resident rights". -"We can't make them (the residents) clean it out (their rooms)." Interview with the regional director of operations on 06/26/18 at 4:08pm revealed: -"As long as we are treating for pests we are following the rule". -"The roaches could have just happened".	D 079		

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D 117	Continued From page 15	D 117		
D 117	0A NCAC 13F .0311 (h) Other Requirements 0A NCAC 13F .0311 Other Requirements (h) In facilities licensed for 7-12 residents, an electrically operated call system shall be provided connecting each resident bedroom to the live-in staff bedroom. The resident call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of the resident lying on the bed. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure an electrically operated call bell system was operable for 1 of 7 resident rooms (Room 210). The findings are: Observation in resident room #210 on 06/20/2018 at 10:40 a.m. revealed there were two color coated electrical wires that were exposed leading from the end of the call bell that was not protected with an outer sheath. Interview with Resident #5 (who lived in room #210 alone) on 6/20/2018 at 10:40 a.m. revealed: -The call bell had not worked right for about 3 weeks. -She told the maintenance person a couple of days ago about the call bell, however he had not come yet to repair it. Interview with a contracted maintenance provider on 06/21/2018 at 11:24 a.m. revealed: -He was in the building today (06/21/2018)	D 117		

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D 117	Continued From page 16	D 117		

working on a repair in another resident's room and was told by staff "about 15 minutes ago" to repair the call bell in room #210 today (06/21/2018).
-The cord to the call bell looked like it had been pulled which caused the wires to separate in the internal compartment of the hand held device.
-The wires inside of the hand held call bell did not have a good connection and that would cause the call system not to work properly when the hand held device was pressed by the resident.

Interview with Resident #5 on 6/21/18 at 3:25pm revealed:
-She had a history of a cerebral vascular accident (CVA) with left-sided paralysis.
-She was wheel-chair bound and required assistance with transfers from her wheelchair to the bed and from her wheelchair chair to bathroom commode.
-The resident used the call light in her room to summon staff to her room when she needed to go to the bathroom.
-When she pressed the button, at times the light would not light up outside her door.
-One of the maintenance staff had started repairing the cord about 2 weeks ago, which was frayed near the button, but did not finish the repair.
-The call light would work briefly but then stop working.
-The call light was not working properly at this time. She had been trying to press the button to turn on the light for about 10 minutes but the light would only come on for a few minutes and then turn back off.

Observation on 6/21/18 at 3:35pm revealed:
-The call light cord was frayed with exposed wires near the end.

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D 117	Continued From page 17 -When the button was pressed, the light only stayed on for 1-3 seconds. Interview with a corporate manager on 06/21/2018 at 11:35 a.m. revealed he gave the resident assigned to resident room #210 a whistle to use as a back up to the hand held call bell. Interview with a personal care aide (PCA) on 06/21/2018 at 4:18 p.m. revealed: -The call light indicator on the outside of resident room #210 was messed up. -She noticed yesterday (06/20/2018) when the light over the doorway of resident room #210 came on it made a "zinging" noise. -She had not reported what she had observed with the call light over the doorway of resident room #210. Observation on 6/21/18 at 4:30pm revealed the call light above the door of room 210 lit up without problem and the cord to the call system was repaired.	D 117		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record	{D 269}		

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{D 269}	Continued From page 18 reviews, the facility failed to provide personal care assistance (assistance with transfer to the bathroom commode) in accordance with the care plan for 1 of 7 residents sampled (Resident #5) who was wheelchair bound. The findings are: .Review of Resident #5's FL-2 dated 05/08/18 revealed: - Diagnoses included dysphagia, hemiplegia, essential primary hypertension, epilepsy and chronic obstructive pulmonary disease (COPD). -The resident was wheelchair bound and semi-ambulatory. Review of Resident #5's care plan dated 1/16/18 revealed the resident required extensive assistance with transfers and toileting. Interview with Resident #5 on 6/21/18 at 10:45am revealed: -The resident had a history of cerebral vascular accident (CVA) and had left-sided paralysis. -The resident was non-ambulatory and required assistance with all transfers including on and off the commode. -Even though the call light did not work properly, she had managed to turn on the light after repeatedly trying and had been waiting for more than 10 minutes for staff to take her to the bathroom. -The medication aide (MA) came into her room and told the resident to turn the light off and someone would come and help her to the bathroom, but no one came. The call light would not come back on because it needed to be repaired. Observation made on 6/21/18 from 10:45am to	{D 269}		

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{D 269}	Continued From page 19 11:05am revealed no staff came in the resident's room to assist her to the bathroom. Interview with a medication aide on 6/21/18 at 11:10am revealed: -She had informed the personal care aide (PCA) about an hour ago Resident #5 needed assistance to go to the bathroom. -She thought the PCA had already taken the resident to the bathroom. Interview with the PCA on 6/21/18 at 11:15am revealed: -She had not taken the resident to the bathroom because she had been giving another resident a shower. -The PCA did not assist Resident #5 to the bathroom when she finished with the shower because she had taken the resident to the bathroom earlier this morning, but did not remember the time. -The PCA would assist Resident #5 to the bathroom at this time. -The PCA usually assisted residents who required assistance to the bathroom about every 2 hours and more often if they asked. Interview with a corporate manager on 6/21/18 at 12:30pm revealed: -When residents request assistance to the bathroom, they should not have to wait over 30 minutes. -The resident's call light was being repaired today and he would follow-up with staff to make sure they are answering lights promptly and providing for the residents' needs.	{D 269}		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision	{D 270}		

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{D 270}	Continued From page 20 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 B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 8 sampled residents (Resident #1) who had a diagnosis of dementia and had numerous burn marks and holes on his clothing. The findings are: Review of Resident #1's current FL-2 dated 5/29/18 included diagnoses of urinary tract infection, hypertension, dementia, anemia and history of cerebral vascular accident. Observation of Resident #1 on 6/20/18 at 10:30am revealed: -Resident #1 was in a wheelchair. -The resident had his left leg amputated above the knee and was unable to move his left arm and hand. -Resident was wearing a pair of gray sweat pants. -The sweat pants had several small, round holes on the crotch and upper thigh area on the front of the pants and the holes appeared to be cigarette burns where the edges of the holes were a darker shade of black. Observation of Resident #1 on 6/21/18 at 9:32am	{D 270}		

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{D 270}	Continued From page 21 revealed resident #1 was wearing a pair of tan khaki pants that had several small, round holes of various sizes on the crotch area on the front of the pants and the holes appeared to be cigarette burns where the edges of the holes were a darker shade of black. Interview with Resident #1 on 06/21/18 at 9:30am revealed: -"That's probably a new hole (in my pants)". -"It's from the ash (falling off the cigarette)". -"I doubt it's from today". -"Basically every time I smoke I burn a hole." Observation of Resident #1 on 6/25/18 at 2:32pm revealed: -Resident was wearing a different pair of gray sweat pants. -The pants had multiple small, round holes of various sizes on the crotch on the front of the pants. -The holes appeared to be cigarette burns where the edges of the holes were a darker shade of black. Interview with a medication aide (MA) on 06/21/2018 at 3:11pm revealed: -"The resident smoked a lot". -The ashes fell off the resident's cigarettes and burned his clothes. -The resident had "wore out clothes" so she did not know which holes were from burns and which were from being old. -She did not know why she did not tell the doctor about the burn holes. -No one on staff sat with the resident while he smoked. Interview with another MA on 06/21/2018 at 3:30pm revealed:	{D 270}		

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{D 270}	Continued From page 22 -Resident #1 liked to smoke. -"They (administration) don't tell me what's going on" -"They (administration) just tell me to watch resident #1. Interview with a third MA on 06/23/2018 at 3:15pm revealed: -Resident #1 smokes "a least twelve times per day". -The resident smoked the cigarettes "down to the butt" and "had a long ash". -Some of the resident's clothes had burns, "especially the sweatpants". -Resident #1 smoking habits were "talked about by the previous administration" in meetings but he did not know if there were measures put in place for Resident #1 smoking. -The process for reporting issues was the CNA tells the MA, who tells the RCC who then tells the ED. Interview with a fourth MA on 06/26/18 at 11:03am revealed: -Resident #1 smoked "a lot". -The holes in the resident's pants could have been "wear and tear". -She did notice the holes in the resident's pants. -She did not report the holes to anyone. Interview with the guardian for Resident #1 on 06/26/18 at 9:57am revealed: -He had been the guardian for Resident #1 for four years. -He saw Resident #1 every ninety days. -The facility contacted him last week to tell him the resident had "pinprick holes" in his pants from smoking. -He was unaware the resident was dropping hot ashes and had burn holes in his pants.	{D 270}		

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{D 270}	Continued From page 23 Interview with the resident care coordinator (RCC) on 06/21/18 at 2:45pm revealed: -He was aware Resident #1 smoked. -He was aware that Resident #1 had burn holes from cigarettes. -"The ashes might burn him." "I am a smoker and sometimes I burn myself". -He was not sure if the doctor was aware resident #1 had burn holes from cigarettes. -"Anyone can see the holes". -The resident was not burning his skin so he was not concerned about the holes. -Supervision had not been increased for Resident #1. Interview with the executive director on 06/25/18 at 4:26pm revealed: -Any resident can smoke regardless of diagnosis. -"There's always someone to watch". -Resident #1's pants have been that way for a long time" (with the holes). Interview with the physician's assistant on 06/26/18 at 12:05pm revealed: -He had not been notified about the burn marks on the resident #1's pants. -"The facility never expressed concern about it". _____ The failure to supervise Resident #1 while he was smoking resulted in the resident dropping ashes from his cigarette which burned holes in the resident's clothes and placed the resident at risk of burning himself. This failure was detrimental to the safety and welfare of the resident and constitues a Type B Violation. _____	{D 270}		

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{D 270}	Continued From page 24 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/25/2018 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2018.	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 2 of 7 sampled residents (Residents #4 and #5) by delaying immediate transport to the emergency department (ED) for Resident #5 who complained of food stuck in her esophagus for at least 24 hours; failed to contact the primary care provider for Resident #4 who had increased generalized weakness with left sided weakness; and was unable to eat for at least three days; and failed to schedule a nephrologist appointment, as ordered by the primary care provider, for Resident #4. The findings are: 1.Review of Resident #5's FL-2 dated 05/08/18	{D 273}		

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{D 273}	Continued From page 25 revealed: - Diagnoses included dysphagia, hemiplegia, essential primary hypertension, epilepsy and chronic obstructive pulmonary disease (COPD). -There was an diet order for mechanical soft foods. Interview with Resident #5 in 06/21/18 at 10:45am revealed: -The resident ate meals independently without assistance, but had left-sided paralysis from a previous stroke. -About 2 months ago (April 2018) Resident #5 was eating dinner in the facility's dining room and swallowed a chunk of stew beef that did not go all the way down, The meat got stuck in her esophagus. -The resident tried to drink tea and water to help swallow the meat but it did not help. -The resident tried to stick her finger down her throat to vomit the meat up but the meat remained stuck. -When the resident informed the Resident Care Coordinator (RCC) and a personal care aide (PCA) she was choking, both told her she was not choking because she was able to talk. -Another PCA gave her bread, tea and water in the dining room but the resident spit up the water. -The staff transported the resident to her room because they told her she should not be sticking her finger down her throat in the dining room. -The staff (could not remember names) asked the resident if she wanted to go to the emergency room (ER) but she refused because she thought she would eventually swallow the food. -The resident continued to attempt to swallow water and tea during the evening but she could not swallow and only spit it up. She continued to stick her finger down her throat to attempt to get the food up but only water and tea came back up.	{D 273}		

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{D 273}	Continued From page 26 -The resident attempted to swallow her evening medications, but the pills came back up. -The resident continued to spit up water throughout the evening and the food remained lodged in her esophagus. -The resident did not know if 3rd shift staff was aware of the incident. -The next day the resident continued to spit up water and food when she attempted to drink and eat breakfast. -She did not eat lunch do to unable to swallow. -The MA on 1st and 2nd shift did not attempt to administer the resident medications. -The resident told MAs on 1st and 2nd shifts on the next day she needed to go to the hospital because the food remained stuck in her throat, but was told, "no" because she had refused to go to the hospital the previous day. The resident called the local emergency medical service (EMS) around 5:00pm and was transported to a local ER. -X-rays taken in the ER showed a big piece of meat on the left of the resident's center, upper chest. -The resident was administered IV medications to attempt to relax her muscles so the food would slide down her esophagus without success. -An endoscopy was performed and the food, including the stew beef was pulled from the resident's esophagus and the resident was discharged from the ER back to the facility on the same evening. The procedure was uncomfortable and left the resident's throat sore/painful. -The ER physician informed the resident she had a stricture in her esophagus and she could have asphyxiated on the food in her esophagus when she laid down in bed. -The resident had a 2nd episode of difficulty swallowing food about a month ago, but the staff gave her bread and water and the food went	{D 273}		

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{D 273}	Continued From page 27	{D 273}		

down eventually. The resident was sent to the ER for evaluation and no food was impacted in her esophagus.

Review of an EMS report dated 4/29/18 revealed:
-At 5:13pm, EMS services were requested by Resident #5.
-EMS was dispatched to the facility and upon arrival, Resident #5 was sitting on the side of her bed complaining of a sore throat.
-The resident was upset because the facility staff did not do the Heimlich maneuver or even offer to do so.
-The resident stated she had been spitting up since yesterday (4/28/18) and she had not been able to sleep.
-The resident stated she ate bacon and eggs for breakfast but spit it back up because the food would not go down. She stated she wanted to be checked out at the hospital.
-The resident was transported to a local ER.

Review of a local hospital ER Provider Note dated 4/29/18 revealed:
-Resident #5's chief complaint was the resident called EMS from the facility stating that she had choked on beef stew yesterday. The patient was angry that staff did not offer 'Heimlich" yesterday so she called to have herself brought here.
-Resident #5 presented for evaluation of possible food bolus. The resident was unable to drink water or hold anything down. The resident was eating beef stew yesterday and since then she had chest pressure mid chest and unable to tolerate anything by mouth. She was unable to tolerate fluids at this time. Will get chest x-ray and call GI (gastrointestinal).
-At 7:15pm GI tried IV Glucagon first before going to EGD (esophagogastroduodenoscopy), but after 1 hour, the patient's status was unchanged

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and was taken to endoscopy suite.
-Resident #5 was placed on oxygen via nasal cannula and intubated after IV medication was administered and the scope was advanced to the second portion of the duodenum. A large amount of food debris with black liquid was noted in the esophagus with food bolus impaction in the lower esophagus from an esophageal stricture which was relieved.
-The resident was discharged back to the facility.

Review of electronic medication administration record (eMAR) "Charting Notes" revealed:
-On 4/28/18 at 10:38pm, the 2nd shift MA documented Resident #5 was seen putting her fingers in her throat making herself throw up food during dinner in the dining room. And later after giving her the night medication doing the same thing. Staff saw her put medication in her mouth and swallowed but later started to put her finger in her mouth to make herself throw up the medication. She had medication on the floor and in her bed.
-On 4/29/18 at 6:36pm, the same 2nd shift MA documented Resident #5 "called 911 herself. She stated she was vomiting and did not feel well. Resident was transported to [a local hospital].

Interview with a 1st shift MA on 6/21/18 at 2:35pm revealed:
-She did not know anything about Resident #5 choking.
-She did not know if the resident had asked to go to the ER.
-The RCC would know about any problems the resident was having.

Interview with a 2nd shift PCA on 6/22/18 at 3:20pm revealed:
-She was working the evening Resident #5

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choked while eating dinner, but she did not remember the date.
-Resident #5 complained food was stuck in her throat while in the dining room.
-The resident could not swallow the food or get the food up even when she stuck her finger down her throat to attempt to vomit the food up.
-The RCC asked the resident if she wanted to go to the ER but the resident refused.
-The resident tried to get the food up at least 2 more times on 2nd shift without success.
-The resident did go to the ER the next day but the PCA was off and did not know what time the resident went.

Interview with a 2nd shift MA on 6/25/18 at 3:35pm revealed:
-On 4/28/18 on 2nd shift, the MA observed Resident #5 putting her fingers in her mouth trying to vomit several times during the shift (in the dining room during dinner and after dinner).
-The resident was attempting to vomit food eaten at dinner.
-The MA administered the resident's bedtime medications, but when she checked on the resident later in her bedroom, the partially "melted' medications (pills) were on her bed. The resident did not tell her why the medication was on her bed.
-The MA did not report the resident's behaviors to the primary care provider (PCP).
-The MA did not remember if Resident #5 asked to go the ER on 4/29/18.
-On 4/29/18, 2nd shift, the resident complained of vomiting and not feeling well, but the MA did not know if the PCP was contacted to report the changes.
-Later on 2nd shift, the MA observed an EMS vehicle in the front of the facility. Resident #5 had called 911 and the EMS there to transport the

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resident to the ER.
-The MA sent the necessary paperwork with the resident to the ER.
-If a resident had any changes, such as choking, the resident would be sent to the ER or problems reported to the PCP by the RCC or MAs.

Interview with the RCC on 6/25/18 at 4:55pm revealed:
-The MA should have sent the resident to the ER on 4/28/18 after the resident complained of food stuck in esophagus.
-He did not know if the resident asked staff to send her to the ER the next day (4/29/18).
-Resident #5 had a episode of coughing while eating breakfast on 5/25/18. The resident stated she felt something in her throat.
-The staff gave her water and bread and the RCC the PCP and called 911 and sent her to the ER.
-She was evaluated and sent back to the facility, she was ok.

Interview with Resident #5's PCP on 6/26/18 at 12:10pm revealed:
-The facility staff had not reported Resident #5 had food impaction in her esophagus on 4/28/18 or 4/29/18.
-Since both dates were on a weekend, the call would have been answered by his on-call service, but there had not been any record of a call from the facility regarding the resident's swallowing difficulty.
-The facility should have called the on call provider or should have sent her to a local ER for evaluation the 1st day the resident complained of food impacted in her esophagus.

Interview with the Administrator on 6/26/18 revealed:
-She was not aware of Resident #5's choking

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episode on 4/28/18 or of the resident calling EMS the next day because she was not working in the facility during that time.
-Staff should call the residents' PCP or send the residents to the ER for evaluation for acute medical changes

2. Review of Resident #4's current FL-2 dated 05/29/2018 revealed:
-Diagnoses included shortness of breath, asthma, chronic obstructive pulmonary disease, hypertension, hypokalemia, polysubstance abuse, hypercholesterolemia, and congestive heart failure.
-The orientation section was blank.

Review of resident #4's current Assessment and Care Plan signed and dated 05/29/2018 revealed:
-The resident was oriented and had an adequate memory.
-There was documentation the resident had a history of substance abuse and had "episodes" where he went out of the facility on leave and consumed too much alcohol and was sent to the hospital but returned without any changes.

a. Interview with Resident #4 on 06/22/2018 at 10:20 a.m. revealed:
-He had an incident in May 2018 when his "sugar got low", was weak and he thought he had a stroke.
-He pressed his call light for help the morning he was so weak.
-A personal care aide (PCA) responded to the call light, he told her he was weak and needed the MA.
-He then called 911 himself.
-He had not eaten anything for 5 days and had told the RCC and a MA (named) that he was not able to eat.

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{D 273}	Continued From page 32 -He asked the resident care coordinator (RCC) a day or so before going to the hospital to get some blood work or urine test done. -The RCC told him he was weak because he had not eaten anything. Review of a local county emergency medical service (EMS) incident report for Resident #4 dated 05/17/2018 revealed: -EMS arrived at 7:40 a.m. to find the resident sitting upright in his bed. -The resident had an abnormal gait, slurred speech, left and right sided weakness and facial droop. -The primary impression was hypoglycemia (not diabetic). -Staff reported that the resident called 911 himself and were unsure what his complaint was. -The resident's speech was difficult to understand. -The resident stated that he had not felt well since yesterday (05/16/2018) and felt he was having a stroke. -The resident stated that he had not eaten since Sunday because he was prescribed an antibiotic that "depressed" his appetite. -The resident's finger stick blood sugar (FSBS) was found to be 32mg/dl and the resident was not known to be a diabetic. -Intravenous therapy was started and the resident was given Dextrose 10% (an intravenous sugar solution), improvement was noted and a recheck of the residents FSBS was 130 mg/dl. -The resident admitted to feeling much better, speech and coordination improved to baseline. -The resident was transferred to the local emergency room (ER). Review of Resident #4's local ER provider note on 05/17/2018 revealed:	{D 273}		

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{D 273}	Continued From page 33 -The time of service in the ER was at 8:07 a.m. -The chief complaint was hypoglycemia. -The resident reported that he was unable to get up or talk. -The History and Physical Information included the resident went to another local emergency room approximately 2 weeks ago for alcohol intoxication and was diagnosed with a yeast urinary tract infection and was discharged with Fluconazole (a medication used to treat fungal infections) and since he had taken that medication, he had lost his appetite. -For the last 4 days, the resident reported having nothing to eat or drink except for water. -The resident reported that he was too weak to stand last night (05/16/18) and again this morning (05/17/2018). -The resident reported that staff at the facility repeatedly told him his vital signs were normal. Review of a discharge summary from the local hospital for Resident #4 dated 05/18/2018 revealed: -The admission date was 05/17/2018 and discharge date was 05/18/2018 -Discharge diagnoses included hypoglycemia and chronic kidney disease, stage III. -There was documentation that included the resident's hospital course by problems included acute on chronic kidney disease with an acute kidney injury, a creatinine level of 4.4 on admission associated with acidemia and hyperkalemia (a blood test to check kidney functions with a normal range of 0.67-1.20 mg/dl). -With intravenous therapy, the resident's creatinine level improved on discharge to 3.5 mg/dl with stable electrolytes. -The resident should follow-up with outpatient nephrology.	{D 273}		

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{D 273}	Continued From page 34 Review of Resident #4's computer generated Charting Notes labeled "Well Care Notes" revealed: -There were entries on 05/09/2018, 05/11/2018, 05/12/2018, two entries on 05/13/2018 and 05/15/2018 documented by two medication aides (MAs) with documentation that included the resident continued to be on antibiotic therapy, doing good, no complaints, no signs of adverse reaction and would continue to monitor. -There was an entry documented by a MA dated 05/16/2018 at 12:05 p.m. that the resident was complaining of being weak on his left side and had not eaten in 3 days. -There was a second entry (the same MA that documented the entry on 05/16/2018 at 12:05 p.m.) dated 05/17/2018 at 12:05 p.m. that the resident called 911. The resident said that he may have had a stroke. The resident was also complaining of being weak on his left side. The resident was sent to the hospital. Vital signs were blood pressure 160/63, pulse 87, respirations 20 and temperature 97. Interview with a MA on 06/26/2018 at 11:03 a.m. revealed: -The entries made on 05/16/2018 and 05/17/2018 were documented by her. -Resident #4 complained the 1st day (05/16/2018), but he did not want to go to the hospital. It was offered. Resident #4 said he didn't eat, however, it was reported in shift change from the prior MA that he had eaten. -Resident #4 refused her offer of food on 05/16/2018. -She offered to buy Resident #4 something from the store but he said no. -The resident said he was feeling a little weak. She did not take Resident #4's vital signs that day (05/16/2018). The resident was able to stand.	{D 273}		

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{D 273}	Continued From page 35 This was about lunch time. -She reported the left side weakness in shift change and thought she told the RCC on 05/16/2018. -On 05/17/2018, Resident #4 rang his call bell. The resident said he had left side weakness and trouble standing. He was sitting up on his bed. -She went to get the RCC. We (The MA and the RCC) asked what the trouble was, then we called 911 after doing Resident #4's vital signs, the operator said they (911) had already been called. The resident's vital signs were normal. -Resident #4 called 911 himself. -Resident #4 mentioned at the time he had not eaten in 3 days. -She called the primary care provider (PCP) as soon as emergency medical services (EMS) took Resident #4 out of the facility. It was a "for your information" call. -She did not get any information in shift change that something was wrong with Resident #4 when she started her shift. Interview with the RCC on 06/26/2018 at 4:06 p.m. revealed: -He did not remember an incident of Resident #4 not eating in May 2018, but remembered the resident was on an antibiotic and that could have caused stomach upset. -He was not sure what type of infection Resident #4 had when he was treated with an antibiotic in May 2018. A second interview with the RCC by telephone on 06/26/2018 at 4:07 p.m. revealed: -When there were changes with any of the residents, the MAs were responsible for contacting the PCP immediately. -Resident #4 had left sided weakness and had not eaten in 3 days in May 2018. The reason was	{D 273}		

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because Resident #4 was on an antibiotic and not eating which had upset his stomach.
-He remembered the incident with Resident #4 on 05/16/2018 because the resident asked him for lab work.
-The MA had informed him on 05/16/2018 that the resident had not eaten and was having left sided weakness.
-Resident #4 informed him (on Wednesday, 05/16/2018) that he had stopped eating the prior Sunday or Monday.
-Resident #4's vital signs were taken on 05/16/2018, his vitals were normal, no signs and symptoms, and "everything was normal."
-He reported Resident #4's complaints and that the resident's vital signs were normal on 05/16/2018 to the PCP. He did not document that he contacted the resident's PCP.

Telephone Interview with Resident #4's PCP on 06/26/2018 at 12:59 p.m. revealed:
-He was not aware of any issues Resident #4 was having with the inability to eat or complaints of left sided weakness prior to the resident's hospital stay from 05/17/2018 - 05/18/2018.
-It sounded "like something I need to be addressing".
-He visited the facility every Tuesday. If Resident #4 had not been eating, then he should have seen him on that Tuesday (05/15/2018) and could have evaluated him.
-Resident #4's blood sugars could have dropped from not eating and if Resident #4 was not eating then he probably was not drinking which likely contributed to dehydration and the kidney injury.
-It was not unusual for Resident #4 to call 911 himself and he had done this in the past.

Telephone interview with the Administrator on 06/26/2018 at 4:40 p.m. revealed:

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{D 273}	Continued From page 37 -She was not aware of any issues with Resident #4 not eating or having weakness prior to his hospital admission on 05/17/2018. -She expected for the residents' PCPs to be contacted immediately for any changes or concerns involving the residents. -The MAs, special care unit coordinators (SCUC) and the RCC were responsible for contacting the residents' PCP and were supposed to document the contact. b. Review of an physician's order written on a local hospital Discharge Instruction form for Resident #4 revealed: -The dates of the hospitalization were from 05/17/2018 - 05/18/2018. -A section of the form had been highlighted in yellow with documentation that included the resident was hospitalized for low blood sugar. It was important to follow-up with the resident's primary care provider (PCP) Monday to get "your numbers rechecked" and would also suggest going to a kidney doctor. -There was a handwritten order signed and dated on 05/22/2018 by the resident's PCP to "refer to nephrology as per recommendations" under the yellow highlighted section. Interview with Resident #4 on 06/22/2018 at 10:25 a.m. revealed -He was hospitalized in May 2018 for a low blood sugar. -He had not seen a nephrologist after his hospitalization in May 2018. Interview with the transportation person on 06/25/2018 at 4:00 p.m. -She was responsible for scheduling and canceling appointments and referrals for the residents.	{D 273}		

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{D 273}	Continued From page 38 -All resident physician's orders for outside medical appointments or referrals were first given to the Resident Care Coordinator (RCC) or the Special Care Unit Coordinator (SCUC), a copy was made of the order, and the copy of the order was given to her to schedule the appointment. -She had never received Resident #4's order for a nephrology referral dated 05/22/2018. -When a PCP wrote an order for a referral, the order was usually dictated on a visit note instead of a hospital discharge instruction form. Interview with the RCC on 06/25/2018 at 5:10 p.m. revealed: -He was not sure if Resident #4 had seen a nephrologist from the order written 05/22/2018 but would follow up on it. -Resident #4's PCP could have made the nephrology appointment. Telephone interview with the RCC on 06/26/2018 at 4:07 p.m. revealed: -"Maybe I missed" Resident #4's order written on 05/22/2018 for a nephrology referral. -He had spoken with the transportation person yesterday (06/25/2018) and told her to schedule Resident #4's nephrologist appointment. -The facility used a folder system called a "bucket system" to track all orders. -When a referral or medical appointment was made, a copy was given to the transportation person and once the appointment was made, the transportation person verbally reported to him when the appointment was scheduled and time of the appointment date and time was written on the order. -Orders for a medical appointments/referrals were not complete or ready to file until confirmation is received from the transportation person that the appointment was scheduled.	{D 273}		

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{D 273}	Continued From page 39 Telephone interview with the Administrator on 06/26/2018 at 4:40 p.m. revealed: -All orders should be processed using the "bucket system" to avoid any orders from falling through the cracks. -She expected follow-up to be done when the order was written on 05/22/2018 for Resident #4 to be referred to a nephrologist. Telephone Interview with Resident #4's PCP on 06/26/2018 at 12:59 p.m. revealed: -He expected for all of the residents' orders to be carried out. -He ordered a nephrology referral on 05/22/2018 after Resident #4 was hospitalized for an acute kidney injury. -It was the responsibility of the facility to make sure the nephrology referral for Resident #4 was done. _____ The facility failed to assure the acute health care needs were provided for Resident #5 who had complaints of food being stuck in her throat for at least 24 hours and required an endoscopy to remove a food bolus impaction from her esophagus after the resident called 911; and, for Resident #4 who had not eaten for 3 days and had complaints of weakness and unable to stand and required a hospital admission after the resident called 911. This noncompliance placed both residents at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/26/2018 for	{D 273}		

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{D 273}	Continued From page 40 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 27, 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 following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to implement physician orders for 1 of 8 residents sampled (Resident #1) with an order for a hand roll to be placed in his left hand and replaced every other day. The findings are: Review of Resident #1's current FL-2 dated 5/29/18 revealed: -Resident #1 with diagnoses including urinary tract infection, hypertension, dementia, anemia and history of cerebral vascular accident and physician's orders for a treatment for a rolled washcloth to be placed in left hand and to be replaced every other day. -Resident #1 had a physician's order of a rolled	D 276		

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D 276	Continued From page 41 washcloth to be placed in the resident's left hand and replace every other day. -There was no documentation of subsequent order to discontinue the use of the rolled washcloth. -Review of April 2018 Medication Administration Record (MAR) for Resident #11 revealed physician's orders for a treatment for a rolled washcloth to be placed in left hand and to be replaced every other day. -Review of April 2018 MAR for Resident #1 revealed the rolled washcloth as a treatment that was completed fifteen times from 7:00am to 2:59pm on 4/1/18 to 4/29/18. -Review of May 2018 MAR for Resident #1 revealed physician's orders for a treatment for a rolled washcloth to be placed in left hand and to be replaced every other day. -Review of May 2018 MAR for Resident #1 revealed the rolled washcloth as a treatment that was completed sixteen times 7:00am to 2:59pm on 5/1/18 to 5/31/18. -Review of June 2018 MAR for Resident #1 revealed physician's orders for a treatment for a rolled washcloth to be placed in left hand and to be replaced every other day. -Review of June 2018 MAR for Resident #1 on 6/21/18 revealed the rolled washcloth as a treatment that was completed ten times 7:00am to 2:59pm on 6/2/18 to 6/20/18. Interview with Resident #1 on 06/21/18 at 3:47pm revealed:	D 276		

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D 276	Continued From page 42 -"I used to have a grip (in my hand) but I can't use my hand so it kept falling out." -"It hurt my hand to use it." -He had not used the washcloth roll in a "long time". Interview with a personal care aide on 06/21/18 at 3:18pm revealed Resident #1 did not have a hand roll order. Interview with a second personal care aide on 06/21/18 at 3:19pm revealed Resident #1 did not have a hand roll order. Interview with a medication aide on 06/26/18 at 11:03am revealed: -The resident has an order for a hand roll. -"We put it (the wash cloth) in (his hand) but he takes it out." -For the most part he does not have the handroll in his hand. Observation of Resident #1 on 06/20/2018 at 10:24am showed resident without hand roll. Observation of Resident #1 on 06/21/2018 at 7:35am showed resident without hand roll. Observation of Resident #1 on 06/21/2018 at 9:30am showed resident without hand roll. Observation of Resident #1 on 06/21/2018 at 3:47pm showed resident without hand roll. Observation of Resident #1 on 06/23/2018 at 3:30pm showed resident without hand roll. Interview with the resident care coordinator on 06/21/18 at 2:45pm revealed he was unfamiliar with resident #1 using the hand roll.	D 276		

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D 276	Continued From page 43 Interview with the executive director on 06/26/18 at 4:40 pm revealed: -She expected the facility staff to follow up on doctor orders. -If a resident had seven days of consecutive treatment refusals, the resident care coordinator, special care coordinator or medication aide should have contacted the doctor. Interview with physician's assistant on 06/26/18 at 2:00 pm revealed: -The contractures and poor muscle tone of Resident's #1 hand could lead to bacteria growth in the palm of the resident's hand due to the warm and dark environment. -He was unaware that the resident was not using the hand roll. -He expected his orders to be followed by the facility.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to assure ice was free from contamination related to a build-up of wet black, brown and pink thick mold-like substance in the ice machine.	D 283		

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D 283	Continued From page 44 The findings are: Observation of the ice machine in the kitchen on 06/20/18 at 3:10pm revealed: -There was a heavy build-up of a wet pink, brown and black mold like substance on the lower portion of the white shield and a heavier concentration of a black and brown mold-like substance on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine. -There was black substance surrounding the front panel section of the ice machine where the ice cubes are formed. Observation of the cleaning schedule on 06/20/18 revealed: -The ice machine cleaning was listed as monthly. -The instructions for cleaning the ice machine was listed as empty the ice machine, clean bottom and sides of the ice machine then rinse thoroughly. -There were no instructions for cleaning the inside of the ice machine. Interview with dietary manager on 06/20/18 at 3:10pm revealed: -She worked for the facility about a month. -She was out for two weeks on medical leave and returned to work this week. -The ice machine was cleaned once per month. -She cleaned the ice machine when she first started working at the facility. -There was a cleaning schedule. -The cleaning schedule did not include cleaning inside the ice machine. -She did not know to clean in the front panel or inside the ice machine.	D 283		

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D 283	Continued From page 45 Interview with a cook on 06/21/18 at 8:20am revealed: -She worked at this facility for four years. -She had been a cook for over forty years. -She and the manager were the two people that cleaned the ice machine. -She never cleaned inside the ice machine. -She would "just wipe it down when I went by". Interview with a second cook on 06/21/18 at 8:38am revealed: -He had worked for the facility about a month. -He was not trained on how to clean the ice machine. Interview with a third cook on 06/22/18 at 4:45pm revealed today was his first day of work. --- The facility failure to keep the ice machine clean resulted in the build up of wet pink, brown and black mold-like substance which placed the residents at risk of receiving contaminated ice. This failure was detrimental to the health and welfare of the residents and constitues a Type B Violation. --- The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/2018 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2018.	D 283		

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{D 310}	Continued From page 46	{D 310}		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to follow physician order for thickened beverages for 1 of 2 residents (Resident #11) during meals. The findings are: Review of diet order clarification for Resident #11 dated 03/26/18 revealed a puree diet with honey thick liquids based on the most recent speech assessment. Review of the licensed health professional support review dated 05/03/18 revealed Resident #11 a puree diet with honey thick liquids. Review of diet order list posted in the kitchen dated 06/20/18 revealed the resident was on a puree diet with honey thick liquids. Interview with dietary manager on 06/20/18 at 3:10pm revealed: -The resident care coordinator or the special care coordinator gave her an updated diet order list once per week or when a change occurred. -Dietary staff should have been reviewing the diet	{D 310}		

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{D 310}	Continued From page 47 list before every meal. Observation of Resident # 11 on 06/21/18 at 7:30am revealed: -The resident had puree meal with a glass of thickened milk, a mug of thickened coffee and a mug of coffee without thickener. -The resident was drinking the coffee without thickener. An interview with a medication aide (MA) on 06/21/18 at 8:04am revealed: -Her job in the dining room included making sure "all the people have what they need" and "making sure no one chokes". -"Just by being here we know who has what diet". An interview with a second MA on 06/21/18 at 8:16am revealed: -The residents "fix their own coffee". -The dietary aides preset the resident beverages "they just put it on the table". -She was trying to "even out the coffee" for resident #11 because the resident does not like thickened coffee that "he has to chew". -She was aware that Resident #11 was on thickened beverages. -She did not mention that the resident does not like thickened coffee to the resident care coordinator. Observation of Resident #11 on 06/21/18 at 5:00pm revealed resident drinking a coffee without thickener. An interview with a third MA on 06/21/18 at 3:30pm revealed: -Residents raise their hand to get coffee. -Residents can help other residents get coffee. -MA can go in the kitchen to review the diet list if	{D 310}		

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{D 310}	Continued From page 48 he or she is unsure who is on a special diet. Observation of a cook on 06/21/18 at 5:00pm revealed: -She filled an 8 oz mug with approximately 6 oz. of regular coffee -She opened the packet of honey thick coffee drink mix. -She sprinkled some thickener into the mug and mixed with a spoon. -She lifted the spoon to see how thick the coffee was. -She repeated these steps two more times. -She folded the packet of the remaining thickener and put it back on the shelf. Interview with a cook on 06/21/18 at 5:10pm revealed: -She had worked at the facility for "three or four months" as both a MA and cook. -Residents could get their own coffee or she would get it for them. -She knew how to make the thickened coffee. -She had never been trained to make thickened coffee. -"I just add the powder by eyeball" and look for a "thin syrup" consistency. -She thought the mug was 16 oz. in capacity. - She thought the powder should have been added to coffee. -She did not know the instructions on the packet of thickener was to add the entire packet into 6 oz. of hot water. A second interview with the dietary manager on 06/25/18 at 3:15pm revealed: -She thought everyone had been trained on preparing thickened liquids. -An in-service on thickened liquids was given days ago.	{D 310}		

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{D 310}	Continued From page 49	{D 310}		

-"Everyone knows who is (on) thickened (beverages)".
-Resident #11 got his own coffee.
-The dietary staff will "take it (the coffee without thickener) if we see it".
-She told the RCC about resident #11 drinking the coffee without thickener.
-She was not sure if the doctor knew the resident drank coffee without thickener.
-As tolerated meant that if the resident drank the coffee without thickener it was ok.
-If the resident "got froggy" in his voice she would "take the coffee and get the MA".
-The resident got to choose what as tolerated meant.

Interview with the resident care coordinator on 06/21/18 at 2:45pm revealed:
-The dietary staff made and served the thickened beverages.
-"It is not ok for residents to serve coffee" (to themselves).
-Resident #11 "gets upset with the thick coffee".
-"We say he had to have (the thickened coffee) because that's the order" (from the physician).
-He never saw the resident with coffee without thickener.

Interview with the primary care physician office supervisor on 06/25/18 at 3:32pm revealed:
-Resident 11 was on a nectar thick liquid diet after having "multiple choking incidents".
-The speech therapist give the physician the diet order recommendations.

Interview with the speech therapist on 06/25/18 at 3:41pm revealed:
-The resident's current diet was puree with nectar thick liquids.
-The resident was on the diet because he had

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{D 310}	Continued From page 50	{D 310}		

swallowing deficiencies and esophagus issues.
-Resident #11 was at "great risk for aspiration".
-The facility can "step down" a resident to a thicker liquid consistency if needed but should not have given him thinner liquids.
-The resident should not have gotten coffee without thickener.

Interview with the physician's assistant on 06/26/18 at 12:05pm revealed:
-The resident was at risk for silent aspiration due to swallowing issues.
-The speech therapist assessed the resident for diet textures.
-He followed the speech therapist's recommendations.
-He expected the facility to follow orders as written.

Interview with executive director on 06/26/18 at 4:26pm revealed:
-An in-service for thickened liquids was given on 06/19/18.
-She taught the in-service along with the regional director of operations.
-In-services were done when she felt there was a need to have one.
-Her expectation was that the facility followed orders as written.

The failure to follow the physician's order for thickened beverages, resulted in Resident #11 drinking the coffee without thickener which placed the resident at risk of choking. This failure was detrimental to the health, safety and welfare of the resident and constitues a Type B Violation.

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{D 310}	Continued From page 51 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/21/2018 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2018	{D 310}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Type A2 Violation Based on observations, record reviews and interviews, the facility failed to administer medication in accordance with the physician's orders for 3 of 10 sampled residents as evidenced by staff giving a resident an empty inhaler for almost 2 weeks (#9) and failed to administer medications as ordered for 2 residents observed during the medication passes including errors with a laxative (#4) and eye drops (#10). The findings are:	{D 358}		

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{D 358}	Continued From page 52 1. Review of Resident #9's current FL-2 dated 05/01/2018 revealed: -Resident #9's diagnoses included Alzheimer's disease. -An order for Advair Diskus 250-50mcg to be taken one puff twice a day (used to prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease (COPD)). Review of the medication list attached to Resident #9's FL-2 revealed: -Resident #9 had a diagnoses of acute respiratory failure with hypoxia. -Resident #9 was sometimes disoriented. -Resident #9's level of care was for the Special Care Unit (SCU). Review of Resident #9's Charting Note documentation by MCM on 05/23/2018 at 5:36pm revealed Resident #9 "stated that he didn't feel well. Started complaining of problems with breathing and displaying paleness. Resident went out to hospital." Interview with the Memory Care Manager (MCM) on 06/25/2018 at 4:35pm revealed: -Resident #9 was sent to the hospital due to having trouble breathing. -MAs are responsible for reordering medications. -She wish that the medication aides (MAs) would tell her if they do not reorder the medication. -Medications are reordered on the computer by clicking the order request button. Review of Resident #9's Physician encounter note dated 05/29/2018 revealed: -The resident was sent to the hospital for unremitting shortness of breath (SOB).	{D 358}		

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{D 358}	Continued From page 53 -Per report following incident, it was revealed that the resident's Advair Diskus was empty and it was uncertain how long it had been empty prior to the COPD exacerbation. -COPD exacerbation was due to an empty Advair Diskus being administered to the resident. -Staff was instructed to "pay attention to what they're doing". Interview with Resident #9 on 06/26/2018 at 10:20am revealed: -Resident #9 was having a hard time breathing along with SOB. -"I was out of my inhaler". -I kept telling them "I wasn't getting nothing out" of the inhaler. -"They said yes you are" -He told staff three days prior to having to be taken to the ED that his Advair Diskus was empty. -He did not feel the mist from the Advair Diskus in his mouth when using diskus. Interview with the Primary Care Provider (PCP) on 06/26/2018 at 12:05pm revealed: -Resident #9 has a diagnosis of COPD. -Resident #9 was sent to the hospital for COPD exacerbation. -PCP confirmed that staff giving Resident #9 an empty Advair Diskus was directly related to hospital visit on 05/23/2018. -"I expect when I give an order for medicines I expect them to be given as ordered". Review of Resident #9's May 2018 electronic Medication Record (eMAR) revealed there was an entry for Advair Diskus one puff twice daily and staff documented medication as administered for all days in May 2018 except the afternoon of 05/23/2018 when Resident #9 was in the hospital.	{D 358}		

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{D 358}	Continued From page 54 Interview with the MCM on 06/26/2018 at 11:30 am revealed: -Medication cart reviews are to be done twice a week by the MA. -MAs are to turn the medication cart in to MCM when completed. -Medication cart reviews were not being done due to "we were supposed to start a new way but it wasn't being done". -Medication cart reviews started back in June 2018. Telephone interview with facility pharmacy regarding Resident #9 on 06/25/2018 at 5:05pm revealed: -Advair Diskus, sixty doses, were dispensed on 03/06/2018, 04/10/2018, and 05/24/2018. -Sixty doses was a thirty day supply. -Medication was ordered for 1 puff twice per day. -Advair Diskus refills had to be requested from facility and are not dispensed automatically. Based on interview and record review, Resident #9 was administered an empty inhaler for almost 2 weeks. 2. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 4:00 p.m. medication passes on 06/20/2018 and the 8:00 a.m. medication passes on 06/21/2018. a. Review of Resident #4's current FL-2 dated 05/29/2018 revealed: -Diagnoses included shortness of breath, asthma, chronic obstructive pulmonary disease, hypertension, hypokalemia, polysubstance abuse, hypercholesterolemia, and congestive heart failure. -There was an attached "Physician's Order" of	{D 358}		

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{D 358}	Continued From page 55	{D 358}		

current orders as of 05/09/2018 for the resident's medications signed by the primary care provider (PCP) on 05/29/2018.

Observation of the medication aide (MA) on 06/21/2018 revealed:
-At 7:52 a.m., the MA measured 17 grams of Polyethylene Glycol powder at eye level using the containers cap marked with an indicated line for 17 grams, then mixed the measured medication in approximately 8 ounces of water and stirred it until it was dissolved.
-At 7:54 a.m., the MA walked away from the cart and entered Resident #4's room with the prepared medications.
-Resident #4 was lying in bed with his eyes closed and moved to an upright position as the MA entered the room.
-At 7:55 a.m., the MA gave the Polyethylene Glycol mixed in water to Resident #4 and the resident used the water mixed with the Polyethylene Glycol to swallow his pills.
-Resident #4 drank all of the water mixed with the Polyethylene Glycol.

Review of Resident #4's subsequent medication orders revealed there was not an order for Polyethylene Glycol (a medication used for constipation) 17gm/dose powder mixed with 8 ounces of water or other fluid.

Review of Resident #4's June 2018 electronic medication administration record (eMAR) revealed:
-There was an entry for Polyethylene Glycol 17gm/dose powder, one unit daily, mix with 8 ounces of water or other fluid scheduled to be administered at 8:00 a.m.
-There was documentation Polyethylene Glycol had been administered from 06/01/2018 through

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{D 358}	Continued From page 56 06/21/2018 at 8:00 a.m. Interview with Resident #4 on 06/22/2018 at 10:20 a.m. revealed: -He did not think he was supposed to take laxatives anymore but he knew he got the medication (Polyethylene Glycol) yesterday (06/21/2018). -He did not need laxatives and had loose stools from the dose yesterday. Interview with the MA on 06/21/2018 at 10:55 a.m. revealed she was not aware that there was not a current order for Polyethylene Glycol and she gave medications based on the eMAR. Interview with the Regional Clinical Director and the RCC on 06/22/2018 at 10:45 a.m. revealed: -The RCC had been in his position since 04/24/2018. -The RCC had printed off Resident #4's Physician Orders with the resident's medications and the PCP was supposed to sign the orders the same day the medication orders were printed, however, the PCP did not sign the order the same day. -Because there was a delay in the PCP signing the order, the order for the Polyethylene Glycol ordered on 05/28/2018 was not included. -A clarification order was obtained on 06/21/2018 for Polyethylene Glycol 17 gram in 8 ounces of fluid daily. -Going forward, the residents' current medication orders would only be printed off on the same day the physician would be at the facility to sign the order. Telephone interview with Resident #4's PCP on 06/26/2018 at 12:59 p.m. revealed: -He updated all medication orders every 6 months for the residents at the facility and made	{D 358}		

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{D 358}	Continued From page 57	{D 358}		

medication changes and modifications multiple times in between.
-He expected for all medications to be given as ordered.

Telephone interview with the Administrator on 06/25/2018 at 4:40 p.m. revealed:
-A 10% chart audit was done quarterly by the licensed health professional support (LHPs) nurse, clinical support specialist, Administrator or the care managers (RCC and special care unit coordinator).
-The RCC was new to the position and had Resident #4's orders pre-printed a day or two prior to the PCP signing the orders. The PCP did not sign Resident #4's orders until later.

b. Review of Resident #10's current FL-2 dated 05/29/2018 revealed:
-Diagnoses included seizures, repeated falls, muscle weakness and alcohol dependence.
-There was an attached "Physician's Order" of current orders as of 05/09/2018 for the resident's medications signed by the primary care provider on 05/29/2018.

Observation of the medication aide (MA) on 06/20/2018 revealed:
-The MA removed Besivance 0.6% (used to treat bacterial infections of the eyes) from the medication cart.
-At 3:37 p.m., the MA entered Resident #10's room, put on a pair of gloves and told the resident it was time for his eye drops.
-At 3:38 p.m., while the resident was lying in a flat position with a small pillow underneath the resident's head, the MA pulled the left lower eyelid down to form a pocket and administered the eye drop making contact with the surface of the eye.

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{D 358}	Continued From page 58 -After the drop was administered, the resident kept his left eye closed. -The MA waited approximately a minute or two and gently dapped below the resident's lower left lid with the tissue. Review of Resident #10's subsequent medication orders revealed there was not an order for Besivance 0.6% eye drops to be administered. Review of Resident #10's June 2018 electronic medication administration record (eMAR) revealed: -There was a computer printed entry for Besivance 0.6%, instill one drop in left eye four times daily with scheduled administration times at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. -There was documentation Besivance 0.6% was administered four times daily from 8:00 a.m. on 06/01/2018 through 06/20/2018 at 4:00 p.m. Interview with the MA on 06/20/2018 at 5:05 p.m. revealed: -He was not aware Resident #10's Besivance 0.6 % was not on the current FL-2 dated 05/29/2018 or the attached "Physician's Order" . -Contact would be made with Resident #10's PCP to clarify the order. Review of a "Physician's Order" with current orders as of 06/20/2018 at 5:23 p.m. revealed: -There was an order for Besivance 0.6% instill one drop in left eye four times daily with scheduled administration times at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. -The PCP provider signed the order at 5:39 p.m. on 06/20/2018. Interview with Resident #10 on 06/22/2018 at 8:48 a.m. revealed:	{D 358}		

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{D 358}	Continued From page 59 -He was taking eye drops because he had cataract surgery to his left eye about 2 months ago. -He thought he had been receiving eye drops in his left eye since the cataract was removed. -His vision had improved since cataract surgery. Interview with the Regional Clinical Director and the RCC on 06/22/2018 at 10:45 a.m. revealed: -The RCC had printed off Resident #10's physician medication orders and the PCP was supposed to sign the orders the same day the medication orders were printed, however, the PCP did not sign the orders that day. -Because there was a delay in the PCP signing the order the most current medication orders, the orders to restart Besivance 0.6% one drop four times daily ordered on 05/16/2018 was not included. -Going forward, the residents' current medication orders would only be printed off on the same day the physician would be at the facility to sign the order. Telephone interview with a technician with Resident #10's ophthalmologist on 06/26/2018 at 2:30 p.m. revealed: -Resident #10 was seen in the office on 06/22/2018. -Besivance 0.6% one drop to the left eye four times a day was discontinued. Telephone interview with the Administrator on 06/25/2018 at 4:40 p.m. revealed: -A 10% chart audit was done quarterly by the licensed health professional support (LHPs) nurse, clinical support specialist, Administrator or the care managers (RCC and special care unit coordinator). -The RCC was new to the position and had	{D 358}		

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{D 358}	Continued From page 60 Resident #10's orders pre-printed a day or two prior to the PCP signing the orders. The PCP did not sign Resident #10's orders until later. _____ The facility's failure to administer medications as ordered resulted in Resident #9 experiencing unrelieved shortness of breath that required emergency room care as a result of staff giving the resident an empty inhaler for almost 2 weeks of the medication used to prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease. The failure of the facility to administer medications as ordered to Resident #9 placed the resident at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/26/2018 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 27, 2018. Surveyor: King, Johnpaul	{D 358}		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents	D 375		

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D 375	Continued From page 61 who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 1 resident sampled (#4) who self-administered an inhaled medication (used to treat asthma) had a physician'' order to self-administer the medication. The findings are: Review of Resident #4's current FL-2 dated 05/29/2018 revealed: -Diagnoses included shortness of breath, asthma, chronic obstructive pulmonary disease, hypertension, hypokalemia, polysubstance abuse, hypercholesterolemia, and congestive heart failure. -There was an attached "Physician's Order" of current orders as of 05/09/2018 for the resident's medications signed by the primary care provider (PCP) on 05/29/2018. -There was an order for Albuterol Sulfate (used to treat asthma) 0.083%/2.5mg/3ml, inhale contents of one ampule by a nebulizer twice daily. Review of Resident #4's current Assessment and	D 375		

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D 375	Continued From page 62	D 375		

Care Plan signed and dated 05/29/2018 revealed the resident was oriented and had an adequate memory.

Observation of the medication aide (MA) on 06/21/2018 revealed:
-At 7:56 a.m., the MA asked Resident #4 did he want her to add the ampule of Albuterol Sulfate to the nebulizer's chamber and the resident responded, no.
-The MA placed the ampule of Albuterol on the nightstand beside the nebulizer machine and left the room.

Interview with the MA on 06/21/2018 at 7:56 a.m. revealed:
-Resident #4 liked to do his nebulizer treatments himself.
-It was common for Resident #4 to add the ampule of Albuterol to the medicine chamber of the nebulizer and the resident would administer the medication himself.
-She would come back in about 10 minutes to make sure Resident #4 had completed the treatment..

Review of Resident #4's June 2018 electronic medication administration record (eMAR) revealed:
-There were two computer printed entries for Albuterol Sulfate 0.083%/2.5mg/3ml, inhale contents of one ampule by a nebulizer twice daily, scheduled to be administered at 8:00 a.m. and 8:00 p.m. One entry was marked as discontinued on 06/06/2018 with documentation the medication had been administered from 06/01/2018 at 8:00 a.m. through 06/06/2018 at 8:00 a.m. The second computer printed entry for Albuterol Sulfate was documented as administered from 06/06/2018 at 8:00 p.m. through 06/20/2018 at

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D 375	Continued From page 63 8:00 p.m. -There were initials with a circle for the 8:00 a.m. administration of Albuterol Sulfate on 06/21/2018 with additional documentation that the resident refused the medication on 06/21/2018 at 8:00 a.m. under the section labeled "Exceptions". Interview with Resident #4 on 06/21/2018 at 8:25 a.m. revealed: -He occasionally did not take Albuterol Sulfate using the nebulizer unless he was having "a breathing attack when he woke up in the mornings". -On 06/21/2018 at 8:25 a.m., he was sleepy and was going back to sleep. A second interview with the MA on 06/21/2018 at 10:55 a.m. revealed: -She had worked at the facility for 5 years. -Some days Resident #4 would allow her to put the Albuterol Sulfate in the medicine chamber of the nebulizer and other days the resident would not. -She left the Albuterol Sulfate at Resident #4's bedside for approximately 3 to 4 minutes before she went back in to check on him. -Resident #4 refused to take the Albuterol Sulfate this morning so she removed the ampule from his room and returned it to the medication cart. -She had always allowed the resident to self-administer the Albuterol Sulfate if he requested to perform himself, "he can become very fussy". -She thought that it was alright for Resident #4 to self-administer the Albuterol Sulfate using the nebulizer because that was his right to do so. -She was not sure if the resident care coordinator (RCC) was aware she allowed Resident #4 to self-administer Albuterol Sulfate because the RCC was new to the position.	D 375		

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D 375	Continued From page 64 -She had observed Resident #4 self-administer Albuterol Sulfate using the nebulizer and the resident took slow deep breaths to inhale the medication until the medication was dissolved. -She always went back to Resident #4's room to check to see if he had taken then Albuterol Sulfate so she could check the medication off in the eMAR. -Resident #5 had never refused the Albuterol Sulfate before today (06/21/2018). -She was not sure if Resident #4 had been assessed to correctly self-administer Albuterol Sulfate using a nebulizer. -She would follow up to see if Resident #4's primary care provider would write an order to self-administer the Albuterol Sulfate. -No other residents at the facility self-administered medication except for Resident #4. Interview with the Regional Clinical Director on 06/21/2018 at 5:00 p.m. revealed: -Resident #4 did not have an order to self-administer Albuterol Sulfate. -Staff were aware that no medications should be self-administered unless the resident had a self-administration assessment for medications and treatments completed by a nurse and a current PCP's order to self- administer medication. -She had completed the self -administration assessment today (06/21/2018) and received a verbal order from Resident #4's PCP for the resident to self-administer the nebulizer treatments. A second interview with Resident #4 on 06/22/2018 at 10:20 a.m. revealed: -He had asked about an order for self-administering his Albuterol Sulfate when he first came to live at the facility.	D 375		

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D 375	Continued From page 65 -He wanted to self-administer his nebulizer treatments and had been doing so independently long before he came to live at the facility. Telephone interview with Resident #4's PCP on 06/26/2018 at 12:59 p.m. revealed: -Resident #4 was prescribed Albuterol sulfate to treat asthma. -Albuterol Sulfate was used to open the airway to allow greater oxygenation. -It was important that the medication was used properly. -When Resident #4 came to the facility, he thought the resident had requested to keep Albuterol Sulfate at his bedside and he thought he had approved that, but that was a few years ago. -Resident #4 had not had any pulmonary exacerbations that he was aware of. -He would expect for an assessment to be completed prior to any resident self-administering medications to assure the resident was able to perform independently. Telephone interview with the Administrator on 06/25/2018 at 4:40 p.m. revealed: -She was not aware of any residents self-administering medication in the facility. -Before a resident could self-administer medication, there should be a physician's order and a screening filled out to assess the residents' ability to self- administer any medication and both should be done yearly.	D 375		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	{D912}		

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{D912}	Continued From page 66 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure each resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, health care, nutrition and food service, and medication administration. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 8 sampled residents (Resident #1) who had a diagnosis of dementia and had numerous burn marks and holes on his clothing. [Refer to Tag 270, 10A NCAC 13F .0901 Personal Care and Supervision (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 2 of 7 sampled residents (Residents #4 and #5) by delaying immediate transport to the emergency department (ED) for Resident #5 who complained of food stuck in her esophagus for at least 24 hours; failed to contact the primary care provider for Resident #4 who had increased generalized weakness with left sided weakness; and was unable to eat for at least three days; and failed to schedule a nephrologist appointment, as ordered by the primary care provider, for Resident #4. [Refer to Tag 273, 10A NCAC 13F .0902 Health	{D912}		

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OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D912}	Continued From page 67 Care (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews the facility failed to follow physician order for thickened beverages for 1 of 2 residents (Resident #11) during meals. [Refer to Tag 310 , 10A NCAC 13F .0904 Nutrition and Food Service (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure ice was free from contamination related to a build-up of wet black, brown and pink thick mold-like substance in the ice machine. [Refer to Tag 283 , 10A NCAC 13F .0904 Nutrition and Food Service (Type B Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to administer medication in accordance with the physician's orders for 3 of 10 sampled residents as evidenced by staff giving a resident an empty inhaler for almost 2 weeks (#9) and failed to administer medications as ordered for 2 residents observed during the medication passes including errors with a laxative (#4) and eye drops (#10). [Refer to Tag 358, 10A NCAC 13F .1004 Medication Administration (Type A2 Violation)].	{D912}		