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UNLIMITED POSSIBILITIES # 5	13931 THOMPSON ROAD MINT HILL, NC 28227

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 10-11, 2018	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 sampled staff (Staff D) was screened for Tuberculosis (TB) in compliance with control measures adopted by the Commission for Health Services upon hire. The findings are:	C 140		

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C 140	Continued From page 1 Review of Staff D's personnel record revealed: -Staff D was hired on 08/18/18 as Assistant Activity Coordinator. -A facility generated form, signed by the Licensed Health Professional Support (LHPS) Registered Nurse (RN), documented a TB test was administered to Staff D on 08/18/18. -There was no documentation the TB test result had been read by a nurse. -There was no documentation of any additional TB testing for Staff D. Interview with the Assistant Administrator on 09/11/18 at 1:45pm revealed: -"The LHPS Nurse administered the TB test on all employees when they were hired". -She thought the TB results for the test administered on 08/18/18 had been read by the LHPS nurse. -The LHPS Nurse and the Human Resources staff person had recently taken other positions. -She was currently responsible for assuring all requirements on new staff had been completed. -She thought the TB testing for all the present staff were current and complete. Interview with Staff D on 09/11/18 at 2:30pm revealed: -She had been tested for TB upon hire and the (LHPS) nurse checked her arm "a few days later". -The nurse stated the TB test was negative. -She did not see the nurse documenting the results of the TB test. Telephone interview with the Administrator on 09/11/18 at 4:30pm revealed: -He thought all staff had been screened for TB in accordance with the regulations. -Newly hired employees should receive the first step of the TB test during orientation, before	C 140		

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C 140	Continued From page 2 caring for the residents. -It was currently the Assistant Administrator's responsibility to ensure new employees have their results read and their second step TB screening completed. -He did not know the results from the first step of the TB screening was not documented for Staff D. Telephone interview with the LHPS nurse on 09/11/18 at 2:55pm revealed: -She had administered the first TB test for Staff D on 08/18/18. -She had examined the site of injection on 08/20/18. -The result of the TB test was a negative reading. -She did not know why she omitted documenting that information.	C 140		
C 190	10A NCAC 13G .0601 (c-2) Mangement And Other Staff 10A NCAC 13G .0601 Management And Other Staff (c) When the administrator or supervisor-in-charge is absent from the home or not within 500 feet of the home, the following shall apply: (2) For recurring or planned absences, a relief-supervisor-in-charge designated by the administrator shall be in charge of the home during the absence and in the home or within 500 feet of the home according to the requirements in Paragraph (b) of this Rule. The relief-supervisor-in-charge shall meet all of the qualifications required for the supervisor-in-charge as specified in Rule .0402 of this Subchapter with the exception of Item (4)	C 190		

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C 190	Continued From page 3 pertaining to the continuing education requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure there was an supervisor-in-charge in the facility or resided within 500 feet of the facility and staff present were unable to administer as needed medications for 5 of 5 residents. The finding are: Observation on 09/10/18 between 8:30am and 4:30pm revealed a medication aide (MA)/Supervisor-in Charge (SIC) and the Assistant Administrator were in the facility. Interview with the day shift SIC on 09/10/18 at 9:32am revealed: -She was a MA/SIC. -Her duties included cooking, serving meals, dispensing medications and housekeeping. -Her schedule was Monday - Friday 7:00am - 3:00pm. -The Administrator was not in the facility daily or on weekends. -The Assistant Administrator (AA) was not in the facility 7 days a week but was available via telephone 24/7 if needed. -The Assistant Administrator's office was located at the main house more than 500 feet from the facility. -A personal care aide (PCA) worked last night 11:00pm to 7:00am and he was the only staff member that needed the AA to come in if a PRN (as needed) medication or an issue arose, the AA was not within 500 feet of the facility.	C 190		

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C 190	Continued From page 4 -The PCA was not trained to pass medications. Review of Staff C's personnel record revealed: -He was a hired as a PCA on 07/23/18. -There was no documentation of the SIC application having been completed. -There was no reference letters to support his qualification as being a recommended candidate as a SIC. -The was no documentation he has taken and successfully completed the MA examination. -There was no documentation he had taken the 5 or 10 hour MA training. -There was documentation he completed PCA training 07/29/18. -There was documentation he had passed the high school graduation equivalency exam. Review of the staffing schedule revealed: -The PCA worked 11:00pm - 7:00am July 26-28, 2018. -The PCA worked 11:00pm - 7:00am in August, 3 nights a week, routinely. -The PCA worked 11:00pm - 7:00am in September, 3 nights a week, routinely. Review of 2 of 3 sampled resident's July and August 2018 eMARs revealed there were 4 PRN medications documented as administered on third shift when the PCA was not working. Interview with the Assistant Administrator on 09/11/18 at 3:11pm revealed: -She was responsible for the day to day operations of the facility. -She was the Assistant Administrator and a Medication Aide. -Her office was at the "main house" and that was greater than 500 feet away. -She lived "down the road" from the facility and	C 190		

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C 190	Continued From page 5 could be at the facility in 5 minutes, but was also more than 500 feet away. -The PCA could not carry out all of the required duties in the facility because of the need for medications to be administered. -She was aware the PCA was not allowed to give medications. -She knew the residents had PRN medication and 2 of the residents required a PRN medication to be given on 3rd shift because of behavioral issues. Telephone interview with the Administrator on 09/11/18 at 4:30pm revealed: -He was responsible for all of the day to day operations of the facility but delegated those responsibilities to the AA. -The Assistant Administrator was in contact with him on a daily basis. -He did not know all of the staff were not MAs. -It was the responsibility of the AA to fill in and or to administer medications if a staff member was not trained to do so. -The Assistant Administrator's office was located at the "main house" which was greater than 500 feet from the facility. -The Assistant Administrator lived 5 minutes from the facility which was greater than 500 feet from the facility. -He knew an Administrator or SIC was required to be within 500 feet of the facility.	C 190		
C 232	10A NCAC 13G .0801 (c) Resident Assessment 10A NCAC 13G .0801Residents Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition	C 232		

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C 232	Continued From page 6 using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being over a period of time such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	C 232		

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This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to assure an assessment was completed within 10 days following a significant change in the resident's condition for 1 of 3 residents, (Resident #3), who experienced a change in condition, related to transfers and ambulation.

The findings are:

Review of Resident #3's current FL2 dated 10/31/17 revealed:
-Diagnoses included fronto-temporal dementia.
-His ambulatory status was independent without use of an assistive device.

Review of Resident #3's Resident Register revealed an admission date to the facility of 07/07/17.

Review of Resident #3's Care Plan dated 10/31/17 revealed:
-Resident #3 was independent with transfers.
-Resident #3 was independent with ambulation.

Observation on 09/10/18 at 8:45am revealed:
-Resident #3 was sitting at the kitchen table with his breakfast.
-Resident #3 was seated at the kitchen table until the remainder of the residents were directed to the living room.
-After two attempts, the medication aide (MA) transferred Resident #3 from a sitting to standing position, while supporting his back and right arm and pulling forward.
-The resident was very unsteady on his feet, had a shuffled gait, required support by the staff

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person and held on to the counter tops and furniture along the way.
-Several times, while walking from the kitchen table to the living room, his legs buckled at the knees.
-He was assisted into a straight back chair where he sat until lunch time.

Observation on 09/10/18 at 12:05pm revealed:
-Resident #3 was encouraged to transfer from a sitting position to a standing position by the MA for lunch.
-After several attempts, the resident stood and was unsteady and leaned on the staff for support.
-Resident #3 shuffled to the table very slowly, unsteady and grabbing the counter tops along the way, with staff supporting him.
-The MA assisted the resident by guiding him into his chair for his meal.

Review of Resident #3's Activities of Daily Living documentation for July 2018 revealed:
-The staff documented Resident #3 required assistance with all ambulation from 07/01/18 through 07/31/18.
-There was no category for the staff to document resident's level of assistance with transfers.

Review of Resident #3's Activities of Daily Living documentation for August 2018 revealed:
-The staff documented Resident #3 required assistance with all ambulation from 08/01/18 through 08/31/18.
-There was no category for the staff to document resident's needing assistance with transfers.

Review of the Activities of Daily Living documentation for September 2018 revealed:
-The staff documented Resident #3 required assistance with all ambulation from

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C 232	Continued From page 9 09/01/18-09/11/18. -There was no category for the staff to document resident's needing assistance with transfers. Review of the current Licensed Health Professional Support (LHPS) assessment dated 05/16/18 revealed no tasks related to ambulation and transfers by the staff were identified by the Registered Nurse (RN). Interview with the MA on 09/10/18 at 4:30pm revealed: -Resident #3 was ambulating independently when he was admitted up until the first of this year. -He required assistance of staff for safety when transferring and ambulating. -He did not attempt to transfer or ambulate on his own. -She documented in the Activities of Daily Living (ADL) binder the level of assistance the residents required, during her shift each day. -She reported to the caregiver on the next shift any changes in a resident's behavior or physical abilities. -She did not refer to the resident's Care Plan. -The Care Plans were kept in the resident's record in the Assistant Administrator's office. -This office was locked when she was not in the building. Interview with the Assistant Administrator on 09/11/18 at 11:35am revealed: -Resident #3 had required assistance with ambulation for about 4 months. -His primary care physician (PCP) ordered a wheelchair several months ago. -Due to his dementia, the wheelchair proved to be unsafe as he would lean forward and almost fell out at times. -The staff assisted Resident #3 with transfers and	C 232		

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C 232	Continued From page 10 ambulation since assistive devices were not recommended by the Assistant Administrator and the PCP. -Staff reported changes in a resident's condition to the Assistant Administrator or Resident Care Coordinator (RCC). -The RCC should have completed a new Care Plan based on Resident #3's change in ability to transfer and ambulate independently. -The LHPS nurse should have updated his assessment and included staff assistance with transfers and ambulation. -Staff received information on the resident's need through the ADL documentation, progress notes and verbal reports from the previous shift. Interview with the PCP on 09/11/18 at 3:30pm revealed: -He had been contracted as the PCP for this resident since April of 2018. -Resident #3 was not able to ambulate or transfer without the assistance of a staff person since he had been following this resident. -The staff assisted Resident #3 with transfers, ambulation, toileting, dressing and grooming. -His decline in ambulation was a progression of his dementia. It was not physiological. Interview with a family member on 09/12/18 at 5:30pm revealed it had been about 6 months since Resident #3 had ambulated independently.	C 232		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs,	C 243		

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C 243	Continued From page 11 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 2 of 3 sampled residents (Resident #1 and #2) who had falls that required visits to the emergency department and resulted in injuries. The findings are: 1. Review of Resident #1's current FL2 dated 07/15/18 revealed diagnoses included dementia with behaviors, pulmonary hypertension and was at risk for falls. Review of Resident #1's Care Plan dated 09/04/18 revealed: -Resident #1 required supervision with ambulation and locomotion. -Resident #1 required limited assistance with bathing, dressing, grooming and transfers. Review of Resident #1's progress notes revealed: -On 07/17/18 Resident #1 had two dime sized raised lumps on the top of the head without a cause documented. -On 07/26/18 Resident #1 received a head injury after a fall and was sent to the emergency room (ER). -On 07/27/18 Resident #1 was found in the living room floor and was sent to the ER. -On 07/30/18 the resident was unsteady with her gait and fell. Review of shift reports revealed: -On 08/05/18 Resident #1 was "very off balance". -On 08/08/18 Resident #1 was "very weak and	C 243		

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unsteady" and Resident #1 "would not stay in the bed".
-On 08/09/18 Resident #1 was "weak" and "almost fell with staff getting her up".
-On 08/17/18 Resident #1 was "very weak".

Review of Resident #1's Incident Reports/Accident Reports revealed:
-On 07/19/18 at 2:00pm, Resident #1 was found on the bathroom floor.
-On 07/26/18 at 8:11pm, Resident #1 was found on the living room floor.
-On 07/30/18 at 9:00am, Resident #1 was getting up, lost her balance and fell.

Telephone interview with Resident #1's physician on 09/10/18 at 9:10am revealed:
-He was aware of the falls.
-When the facility called him about the falls he ordered every hour safety checks for 12 hours on every fall.
-On 07/26/18, he had ordered vital signs and checks, every hour for 24 hours on Resident #1 because of the head injury.
-Resident #1 was to have increased supervision, also after the Physical Therapist spoke with him on 08/14/18 in relation to the resident's severe dementia and being her physically able to get up out of her chair or bed and fall because her decreased cognitive ability.
-He expected the facility to increase the supervision on Resident #1 because of her frequent falls and she was identified as having increased fall risk.
-He expected the facility to follow the Post-Fall every 1 hour checks for 12 hours because of the risk of decreased level of consciousness, increased pain from injury and or brain bleed especially with the residents after a head injury.
-The facility did not follow their Post-Fall Safety

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C 243	Continued From page 13 Checks. Review of Resident #1's safety check sheet revealed there were no sheets filled out for Resident #1 after every fall. Review of Resident #1's Post-Fall Head Injury Vital Sign form revealed there was no form filled out for Resident #1 on 07/26/18 for the head injury, for every hour for 12 hours or 24 hours. Review of the Resident #1's Post-Fall Safely Reports for Shift One, Shift Two and Shift Three Reports revealed there were no reports completed for any of the falls. Telephone interview with Resident #1's Physical Therapist on 09/10/18 at 12:38pm revealed: -Resident #1 received physical therapy 08/01/18 - 08/14/18. -Resident #1 was discharged from physical therapy because she reached her maxim potential due to her severe dementia. -Resident #1 was unable to follow commands and was considered a risk for falls. -It was her recommendation Resident #1 needed increased supervision because Resident #1 was strong enough to get out of the bed or chair on her own but she lacked the capability of understanding the safety issues. Interview with the Assistant Administrator on 09/11/18 at 3:11pm revealed: -Resident #1 was at an increased risk for falls due to the dementia. -Resident #1 received physical therapy but was unable to complete it due to dementia she was unable to follow commands. -Resident #1 was to have every one hour safety checks for 12 hours implemented after every fall	C 243		

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and documented in the Fall Book.
-He did not know the every one hour safety checks were not being done.

Refer to the review of the facility fall policy.

Refer to interview with the Resident Care Coordinator (RCC) on 09/10/18 at 4:30pm.

Refer to interview with the Assistant Administrator on 09/11/18 at 3:11pm.

Refer to telephone interview with the Administrator on 09/11/18 at 4:30pm.

2. Review of Resident #2's current FL2 dated 10/31/17 reveled diagnoses included Alzheimer's dementia, hypertension, anxiety and falls.

Review of Resident #2's Care Plan dated 10/31/17 revealed:
-Resident #2 required limited assistance with ambulation and transfers.
-Resident #2 required extensive assistance with toileting, bathing, dressing and grooming.

Review of Resident #2's Nurse's Notes revealed there were no entries about falls.

Review of shift reports dated 07/01/18 revealed Resident #2 fell and was sent to the ER.

Review of Resident #2's Incident Reports/Accident Reports dated 07/01/18 revealed at 5:30pm Resident #2 was found on the floor of the bedroom complaining of right hip pain and Resident #2 was transported to the ER.

Review of Resident #2's ER discharge summary revealed Resident #2 was treated in the ER on

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C 243	Continued From page 15 07/01/18 for a fall, tooth avulsion (the complete dislocation of the tooth from its socket due to a trauma), and a urinary tract infection. Telephone interview with Resident #1's physician on 09/10/18 at 9:10am revealed: -He was aware of Resident #2's fall. -The fall dated 07/01/18 was considered a head injury and Resident #2 should have the every one hour checks for 24 hours and documenting on the Post-Fall Head injury sheet for his review on his next visit. -He did not have documentation of any Post-Fall documentation sheets in his record for Resident #2. -He expected the facility to increase supervision by implementing the Post-Fall policy which included every 1 hour checks for 12-24 hours because of the risk of decreased level of consciousness, increased pain from injury and or brain bleed especially after a fall with a head injury. -The facility did not follow their policy in regards to the post fall procedures. Review of Resident #2's Safety Check Sheet revealed: -There was a safety check filled out for Resident #2 on 07/09/18 with hourly safety checks from 7:00am to 1:00pm, a total of 7 safety checks. -There was no safety check sheet completed for the 07/01/18 fall. Review of Resident #2's Post-Fall Head Injury Vital Sign form revealed there was no form filled out for Resident #1 on 07/01/18 for the head injury, for every hour for 12 hours. Review of the Resident #2's Post-Fall Shift One, Shift Two and Shift Three Report revealed there	C 243		

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C 243	Continued From page 16 were no reports completed for any of the falls. Refer to the review of the facility fall policy. Refer to interview with the Resident Care Coordinator (RCC) on 09/10/18 at 4:30pm. Refer to interview with the Assistant Administrator on 09/11/18 at 3:11pm. Refer to telephone interview with the Administrator on 09/11/18 at 4:30pm. _____ Review of the facility fall policy revealed: -It was their policy 911 was to be called and resident sent to the ER for evaluation for all head injuries or other injuries. -A nurse's note was to be written on all falls. -An Incident Report/Accident Report was to be filled out on all falls. -A Post-Fall Safety Check Intervention or a Post-Fall Head Injury Vital Sign Documentation form were to be filled out and followed along with documentation every hour for 12 hours. -A Shift one, two and three report was to be documented after every fall. Interview with the Resident Care Coordinator (RCC) on 09/10/18 at 4:30pm revealed: -She was responsible for making sure the Incident Reports were filled out and the every 1 hour safety checks for 12 hours were completed with each fall. -She was to check weekly for completion of the Incident Reports and safety check documentation. -She checked the Incident Reports weekly but did not check the safety check sheets because they were in a different book and they should have been with the Incident Reports.	C 243		

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C 243	Continued From page 17 -The Assistant Administrator was to check behind her as well to make sure all of the Incident Reports and safety checks were completed. Interview with the Assistant Administrator on 09/11/18 at 3:11pm revealed: -The medication aide (MA) was responsible for implementation of the Incident/Accident Report and the post fall documentation including implementing the safety checks every hour for 12 hours. -The every hour safety check for 12 hours consisted of "laying eyes" on the resident and making sure their needs were met to decrease falls. -The Resident Care Coordinator (RCC) was responsible for making sure the Incident/Accident report were filled out and the safety checks were imitated after every fall. -When the physician was notified, he could give any "extra" orders needed or would instruct them to follow the ER's orders. Telephone interview with the Administrator on 09/11/18 at 4:30pm revealed: -All falls were to have an Incident/Accident Report completed along with the Post-Fall Safety Check Intervention. -The Post-Fall Safety Check Intervention was the every one hour checks for 12 hours which assured the resident had their "needs were met and they were comfortable and in a safe position". -The MA could initiate and the RCC and Assistant Administrator were responsible for making sure all forms and documentation were completed with every fall. -He did not know the documentation was not being done after every fall.	C 243		

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C 243	Continued From page 18 The facility failed to provide supervision for residents in accordance with the residents' current symptoms related to frequent and recurrent falls as evidenced by 2 of 3 sampled residents, with one fall documented with a head injury (Resident #1), and a fall documented with a head injury which included a tooth avulsion (Resident #2). The failure of the facility to provide supervision for the residents resulted in the increased risk of for injury including decreased level of consciousness, increased pain from injury and//or brain bleed especially with the residents after a head injury and considered this was detrimental to the safety, health and welfare of the residents and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2018.	C 243		
C 283	10A NCAC 13G .0904 (e-3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Therapeutic Diets in Family Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by:	C 283		

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C 283	Continued From page 19 Based on observations, interviews and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets for 2 of 3 sampled residents with a physician's order for a mechanical soft (MS) ground diet (Resident #2) and a no added salt diet (Resident #1). The findings are: 1. Review of Resident #'2's FL2 dated 10/31/17 revealed: -Diagnoses included Alzheimer's dementia and gastroesophageal reflux disease. -There was an order for a regular diet. Review of the Discharge Summary of a subsequent hospitalization on 03/29/18, for Resident #2, revealed there was a diagnosis of aspiration pneumonia. Review of a subsequent physician's order dated 09/06/18 revealed a mechanical soft, ground diet with nectar thickened liquids. Observation of the kitchen area on 09/10/18 at 8:45am revealed there was no therapeutic diet list posted. Interview with the medication aide (MA) on 09/10/18 at 8:48 revealed: -She cooked the breakfast and noon time meals for the residents. -The most current menu should be displayed in the plastic stand on the kitchen countertop. -The menu for this week had not been posted yet. -All the residents were on a regular diet. -There were no residents on a therapeutic diet. -For breakfast she prepared eggs, bacon, toast and an apple slice.	C 283		

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C 283	Continued From page 20 -She did not contact her supervisor for clarification of the menu. -The supervisors were shopping for groceries, and she prepared "what she thought was best." Interview with the Assistant Administrator on 09/10/18 at 9:50am revealed: -The MAs on each shift prepared the meals for the residents. -The menus were displayed on the kitchen countertop in a plastic display stand. -The menu for this week was behind the menu for last week. -The menu for the therapeutic diets (Diet Extensions) were located behind the weekly menus. -She did not currently have anyone on a therapeutic diet. -She did not know the MA did not follow the menu this morning for breakfast. -She did not know the MA did not know where to access the current menu or the Diet Extensions. -She did not know where the current list with the physician ordered diets was located. -The Resident Care Coordinator (RCC) was responsible for updating the diet sheet. -She had been responsible for updating the diet list based on orders received from the physician in the absence of a RCC. Review of the facility's Diet Extension menu for mechanical soft ground breakfast on 09/10/18 revealed a moistened whole wheat pancake, scrambled eggs and a mechanically soft fruit. Observation of the lunch meal service on 09/10/2018 at 12:30pm revealed: -Resident #2 was served a whole baked chicken breast, dry toast, rice pilaf, and mixed vegetables. -The MA prepared the meal and added the	C 283		

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thickener to the resident's beverages.
-The Assistant Administrator was contacted and the meal was removed from the resident's place setting.

Review of the facility's Diet Extension menu for lunch on 09/10/18 revealed ground chicken with gravy, mechanically soft rice pilaf, seasoned zucchini, moistened bread and soft fruit.

Interview with the MA on 09/10/18 at 1:15pm revealed:
-She thought all the residents were on a regular diet.
-She did not know Resident #2 was on a therapeutic diet.
-She was not trained to prepare any therapeutic diet meals.
-She did not know how to prepare mechanically soft ground meat.
-She did not know what to moisten the bread with.
-She did not know how to serve rice pilaf as mechanically soft.
-She did not know where to access the menus for a therapeutic diet.
-There was a diet list in the kitchen drawer which had a list of the Resident's diets.

Review of the Resident diet list kept in a binder in the kitchen drawer revealed:
-The diet list was last updated in May 2018.
-The diet list of May 2018 listed Resident #2 as a Regular diet.
-The diet list had been updated in May 2018 by the Assistant Administrator.

Interview with the Assistant Administrator on 09/10/18 at 3:20pm revealed:
-There was a handwritten list with the residents

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C 283	Continued From page 22 and their physician ordered diets in a binder in the kitchen drawer. -She had been responsible for updating the list, in the absence of a staff person in the RCC position. -She had last updated the list in May 2018. -She did not know Resident #2 was on a mechanically soft ground diet. -She had not seen the most current diet order in the resident's record. -She did not know if she or the RCC had filed the order in the resident's record. -The current RCC was responsible for updating the diet list as new orders were received from the physician. -Orders should be reviewed by the Assistant Administrator or the RCC before filing in the resident's record. Based on observation and record review, it was determined Resident #2 was not interviewable. Telephone interview with the responsible family member on 09/10/18 at 9:05am was unsuccessful. Interview with the Office Manager of the primary care physician (PCP's) office on 09/11/18 at 4:30pm revealed: -The physician changed the diet from a regular diet to a mechanically soft ground diet on 09/06/18. -This change in diet was due to reports the resident was coughing while eating, and had a history of aspiration pneumonia. Refer to the telephone interview with the Administrator on 09/11/18 at 4:30pm. 2. Review of Resident #'1's FL2 dated 07/15/18 revealed:	C 283		

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C 283	Continued From page 23 -Diagnoses included dementia with behaviors and pulmonary hypertension.. -There was an order for a Regular diet with no added table salt. Observation of the kitchen area on 09/11/18 at 8:15am revealed there was no therapeutic diet list posted. Review of the facility's therapeutic diet menu (Diet Extension menu) for breakfast on 09/11/18 revealed: -There was cold cereal, a banana, whole grain toast with margarine and milk. -No added salt, or table salt was to be offered. Observation of the breakfast meal service on 09/11/18 at 8:10am revealed Resident #1 was served cold cereal, whole grain toast with margarine and 6 ounces of milk. Review of the resident's diet list kept in a binder in the kitchen drawer revealed: -The diet list was last updated in May 2018. -Resident #1's diet was listed as Regular with no restrictions. Interview with the MA on 09/11/18 at 8:55am revealed: -She did not know Resident #1 was on a "no added table salt" diet. -She had not seen a current list of residents and their physician ordered therapeutic diets posted for guidance. -The most current diet list, kept in a drawer in the kitchen, was last updated in May 2018, and listed all residents as having regular diet orders. Based on observation and record review, it was determined that Resident #1 was not	C 283		

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C 283	Continued From page 24 interviewable. Interview with the Assistant Administrator on 09/10/18 at 3:20pm revealed: -There was a handwritten list with the residents and their physician ordered diets in a binder in the kitchen drawer. -She had been responsible for updating the list, in the absence of a staff person in the RCC position. -She had last updated the list in May 2018. -She did not know Resident #1 was on a "no added salt" diet. -She had not seen the most current order in the resident's record. -She did not know if she had filed the most current FL2 in the resident's record. -The current RCC was responsible for updating the diet list as new orders were received from the physician. -Orders should be reviewed by the Assistant Administrator or RCC before filing in the resident's record. Refer to the phone interview with the Administrator on 09/11/18 at 4:30pm. _____ Interview with the Administrator on 09/11/18 at 4:30pm revealed: -He did not know the physician ordered diets were not current on the facility diet sheet. -He did not know the specific diets of each resident. -He relied on the Assistant Administrator to be responsible for the resident's clinical needs. -The Assistant Administrator was responsible for overseeing the diet orders and updating the diet sheet. -He expected the MAs to be trained to review the diet sheet before serving the resident's their	C 283		

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C 283	Continued From page 25 meals.	C 283		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure a therapeutic diet was served as ordered by the resident's physician to 1 of 2 sampled residents, (Resident #2), with a physician's order for a mechanical soft ground diet and nectar thickened liquids. The findings are: Review of Resident #'2's FL2 dated 10/31/17 revealed: -Diagnoses included Alzheimer dementia and gastroesophageal reflux disease. -There was an order for a regular diet. Review of the Discharge Summary of a hospitalization on 03/29/18 revealed: -Diagnoses included aspiration pneumonia and dysphagia. -The discharge orders, signed by a licensed provider, were for a mechanical soft diet and nectar thickened liquids. Review of the physician orders dated 05/17/18	C 284		

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C 284	Continued From page 26 revealed an order for a regular diet and nectar thickened liquids. Review of a subsequent physician's order dated 09/06/18 revealed -There was a continuation for the order for nectar thickened liquids. -There was an order for a mechanical soft ground diet. a. Interview with the Assistant Administrator on 09/10/18 at 9:50am revealed: -The MAs on each shift prepared the meals for the residents. -The menus were displayed on the kitchen countertop in a plastic display stand. -The menu for this week was behind the menu for last week. -The therapeutic menu, the Diet Extension menu, was located behind the weekly menus. -The facility did not currently have anyone on a therapeutic diet. Review of the facility's therapeutic diet menu, (Diet Extension menu), for mechanical soft ground diets, to be served at lunch on 09/10/18 revealed ground chicken with gravy, mechanically soft rice pilaf, seasoned zucchini, moistened bread and soft fruit. Observation of the lunch meal service on 09/10/18 at 12:30pm revealed: -Resident #2 was served a baked chicken breast (not ground), dry toast, rice pilaf, and mixed vegetables. -The medication aide (MA) prepared the meal and the nectar thickened liquid in the resident's beverages. -The meal was removed from the resident's place setting before the resident could eat, and the	C 284		

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C 284	Continued From page 27 Assistant Administrator was contacted. -Twenty minutes later, the resident was served a second meal with mechanically soft ground chicken, mechanically soft rice pilaf, seasoned zucchini, moistened bread and soft fruit. -The MA was assisted by the Assistant Administrator in preparing the mechanical soft ground diet for Resident #2. An interview with the medication aide (MA) on 09/10/18 at 1:15pm revealed: -She did not know the resident was on a mechanical soft ground diet. -She did not know where the Diet Extension menus were located for therapeutic diets. -She had not been trained on the preparation of a mechanically soft ground diet. -She did not know how to prepare mechanically soft ground meat. -She did not know what to moisten the bread with. -She did not know how to serve rice pilaf as mechanically soft. Observation of the resident's Diet List kept in the kitchen drawer in a binder revealed: -The Diet List was dated May 2018. -The Diet List dated May 2018 listed Resident #2 as a Regular diet. A second interview with the Assistant Administrator on 09/10/18 at 3:20pm revealed: -There was a handwritten list with the physician ordered diets for the residents in a binder. -The binder was kept in the kitchen drawer. -She was responsible for updating the Diet List based on the current physician orders. -She received the orders from the physicians and sent them to the pharmacy. -She had last updated the Diet List in May 2018.	C 284		

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C 284	Continued From page 28 -She did not know Resident #2 was on a mechanically soft ground diet. -She made rounds with the physicians when they came to the facility to ensure orders were documented and sent to the pharmacy. -She did not know how she missed this change in Resident #2's diet order from the physician. -She was in the process of training the Resident Care Coordinator (RCC) to assume these responsibilities. Review of the Diet Extension menu for breakfast service, on 09/11/18, for mechanical soft ground diet, revealed: -The abbreviation "DYS" under cold cereal, mechanically soft banana, whole grain toast "MS", juice and milk at ordered thickness. -There was no legend explaining "DYS" and "MS" for the food preparer. Observation of the breakfast meal served on 09/11/18 at 8:00am revealed: - Resident #2 was served cold cereal with 4 ounces of milk, a banana cut into nickel size pieces and toast softened with milk. -The cereal was not fully immersed and "mushy" in the bowl. -The banana was firm. -The resident was intermittently coughing during the meal. -She ate 100% of her cereal and banana and 50% of her toast. Interview with the MA on 09/11/18 at 8:15am revealed: -She did not know what "DYS" cold cereal was. -She thought cutting the banana was sufficient since it was a soft fruit. -She did not know what "MS" was in reference to. -She had not been trained in the Diet Extension	C 284		

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C 284	Continued From page 29 menu preparation. Interview with the Registered Dietician for the facility menus on 09/11/18 at 8:45am revealed: -She had completed an In Service training with the previous management regarding the diet extensions, within the past year. -Due to limited space on the printed Diet Extension menu chart, she had informed the management the recipes for the therapeutic diet meals should be printed for the staff preparing the meal. This would provide the meal preparer the information she needed. -She did not remember who she spoke to regarding these topics. -The recipes outlined the instructions to prepare a mechanical soft ground diet. -The meal preparer could utilize a blender or a food processor to ground the meal as necessary. -The abbreviations are also listed on the recipes. -"DYS is an abbreviation for dysphagia diet, a slight variation of the mechanical soft ground texture for some foods, in some literature." -The DYS recommended cereal is a hot cereal, such as cream of wheat. However, if a cold cereal is used it must be fully immersed and saturated in the liquid used, to a "mushy" texture. Interview with the Office Manager of the primary care physician (PCP's) office on 09/11/18 at 4:30pm revealed: -The physician changed the diet from a regular diet back to a mechanically soft ground diet on 09/06/18. -This change in diet was due to reports the resident was coughing while eating, and had a history of aspiration pneumonia. Interview with the second shift MA on 09/11/18 at 3:35pm revealed:	C 284		

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C 284	Continued From page 30 -She was informed today during shift change, from the first shift MA, Resident #2 was on a mechanical soft ground diet. -She did not know Resident #2 was on a therapeutic diet prior to 09/11/18. -She could not find the facility diet sheet that was updated to reflect the change in Resident #2's diet in the binder. -She could not find the recipe for the mechanical soft ground diet for the evening meal. Observation of the meal preparation on 09/11/18 at 4:00pm revealed: -The MA was preparing the supper meal service for Resident #2. -She did not know if the mayonnaise added to the bread of the tuna sandwich was enough to moisten the bread, per mechanical soft diet instructions. -The recipe detailing the preparation of the menu items for the evening meal had not been provided to her. Telephone interview with the Administrator on 09/11/18 at 4:30pm revealed: -He did not know the specific diets of each resident. -He relied on the Assistant Administrator to be responsible for the resident's clinical needs, including their diets. -The Assistant Administrator was responsible for overseeing diet orders and updating the diet list. -He expected the MAs to be trained to review the diet sheet before serving the resident's their meals, to be trained in meal preparation, including reading the recipes provided. -He expected the Assistant Administrator and RCC to provide the staff with this training and the tools needed to provide the residents with the diets ordered by their physicians.	C 284		

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C 284	Continued From page 31 Based on observation and record review, it was determined Resident #2 was not interviewable. Attempted telephone interview with Resident #2's responsible family member on 09/10/18 at 4:10pm was unsuccessful. b. Review of a physician's order dated 07/11/18 revealed there was an order for nectar thickened liquids. Interview with the MA on 09/10/18 at 11:30am revealed: -There were 5 residents currently at the facility, one of which received a thickener in her liquids. -She added thickener to Resident #2's water, given with her medications, and any other liquids the resident received. -The resident's daughter brought the thickener to the facility when she observed her mother coughing during meals. -"I have asked for an order from the primary care physician (PCP) as to the consistency (of the thickener), but have not seen one yet." -"I try not to make it too thick for the resident." Observation of the MA on 09/10/11 at 11:35am revealed: -The MA was preparing medications for Resident #2. -She filled a 4 ounce cup with water and added 2 level tablespoons of the thickener to the water. -The MA did not refer to the directions for preparation based on the consistency highlighted on the thickener container. -The water was of a "pudding" consistency. Interview with the Assistant Administrator on 09/10/11 at 12:15pm revealed:	C 284		

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C 284	Continued From page 32 -The order for nectar thickened liquids for Resident #2 was on the eMAR. -The thickener was ordered through the facility pharmacy based on the physician's order of 07/11/18. -The staff had been trained in July 2018 regarding the proper administration of thickener, using the directions on the canister as a reference guide. -The staff had been instructed on the difference between the lower case "t" (teaspoon) and uppercase "T" (Tablespoon) when measuring the thickener. -She did not know the MA was not administering the proper amount of thickener for nectar thickened consistency. -She did not know the MA was not referring to the chart on the back of the thickener canister. Review of the directions on the thickener canister revealed: -Scoop and level off the recommended amount of the beverage thickener. -For nectar thickened consistency, 3 1/2 - 4 teaspoons of thickener should be added to 4 ounces of water. Observation of breakfast on 09/11/18 at 8:10am revealed: -The MA measured 1 teaspoon of thickener into the cereal bowl filled with 6 ounces of milk. -The MA measured 2 1/2 teaspoons of thickener in a 6 ounce cup with apple juice. -The MA measured 2 1/2 teaspoons of thickener in an 8 ounce cup with water. -The MA used the measuring spoon provided by the manufacturer. -The spoon provided a measured teaspoon on one end and a measured tablespoon on the opposite end.	C 284		

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C 284	Continued From page 33 -The spoon ends were marked with a lowercase "t" and an uppercase "T". -The directions on the back of the canister explained the difference between the "t" and the "T" -The MA did not refer to the directions on the canister before preparing the thickened liquids. -The MA was not referring to the different liquids which required differing amounts of thickener. -The MA was confusing the "t" teaspoon and "T" tablespoon when mixing the thickener with the liquid. -The MA did not measure the ounces in the cups she used to administer the liquids. -The liquids prepared by the MA were of a thin consistency, not a nectar consistency. -The liquids needed to be prepared again with the proper nectar consistency. Review of the thickener directions for 4 ounces of liquid for nectar thickened consistency revealed: -Six ounces of milk should have 6-7 teaspoons of thickener. -Six ounces of apple juice should have 5-6 teaspoons of thickener. -Eight ounces of water should have 7-8 teaspoons of thickener. Interview with the Assistant Administrator on 09/11/18 at 9:15am revealed: -She did not know the MA was not following the physician's order for Resident #2 to receive thickened liquids of a nectar consistency. -The MA had been trained in July 2018 to refer to the canister of thickener for the type of liquid, the quantity of thickener and the consistency in the preparation of the order. -She would be conducting an In Service for all the MA's on the proper administration of thickener.	C 284		

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C 284	Continued From page 34 Telephone interview with the PCP on 09/10/18 at 11:26am revealed: -He did not know the thickener was not being administered as ordered. -He expected the facility to administer his orders as directed. -He had ordered the mechanical soft ground diet and thickened liquids due to her diagnoses of dysphagia and aspiration pneumonia and reports of coughing when eating and drinking. -A resident who had the diagnosis of dysphagia, and had difficulty swallowing, could aspirate on thin liquids. Phone interview with the guardian on 09/10/18 at 4:01pm was unsuccessful. _____ The facility failed to prepare and serve a mechanical soft ground diet and nectar thickened liquids to Resident #2 who had a history of aspiration pneumonia. The failure of the facility to provide the physician ordered therapeutic diet and nectar thickened consistency in the beverages she was served was detrimental to the resident's health, safety and welfare and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2018.	C 284		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a	C 288		

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C 288	Continued From page 35 program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure a program of activities was implemented, to promote the resident's active involvement, was provided for 5 of 5 residents. The findings are: Interview with the Activity Assistant Coordinator (AAC) on 09/10/18 at 9:45am revealed: -She was recently hired as an assistant to the Activity Director. -She worked Monday and Tuesday, when the Activity Director was not working. -She had a" holistic background" and worked with aromatherapy and massage therapy. -The Activity Director created the activity calendar each month. -She followed the calendar of activities when she worked. Observation on 09/10/18 at 9:15am revealed: -The AAC was in the living room with the residents. -She put a program on the television that highlighted landscape scenery, architectural structures and grocery items. -There was no interaction between the residents, the staff and the televised scenes. Observation on 09/10/18 at 10:30am revealed: -The activity listed on the calendar at 10:00am was "Life Skill - Groceries" -From 10:00am to 11:00am the staff put away the groceries and there was no involvement with the residents regarding groceries at this time.	C 288		

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C 288	Continued From page 36 Observation on 09/10/18 at 11:15am revealed: -"Exercise" was listed on the calendar at 11:00am as an activity. -The AAC engaged one resident in marching in place for a few minutes. The remainder of the residents were not involved in any activity. Observation on 09/10/18 at 11:40am revealed: -"Color Creations" was listed on the calendar at 11:30am as an activity. -One resident was coloring a picture in an adult coloring book by herself. -The remainder of the residents were sitting or sleeping in their chairs in the living room. -No attempt to involve the other residents was noted. Observation on 09/10/18 at 1:00pm revealed there was no Bingo offered to the residents, as listed on the calendar. Observation on 09/10/18 at 3:40pm revealed: -At 3:30 there was no "Porch sitting", listed as an activity, due to an impending rain. -No alternate activity was provided for the residents. Observation on 09/11/18 at 10:00am revealed: -"Coffee and Friends" was listed on the calendar as an activity at 10:00am. -The residents were all seated in the living room with the television on and with no engagement by the staff. Observation on 09/11/18 at 10:30am revealed: -"Balloon Volley" was on the calendar from 10:30-11:00am. - The MA played "Balloon Volley" with the residents for 20 minutes, between 10:30 and	C 288		

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C 288	Continued From page 37 10:50am. Observation on 09/11/18 at 11:00am revealed: -The activity listed on the calendar at 11:00am was "Reminiscing." -The staff did not engage the residents at this time. -The residents continued to sit in the living room with the television on. -The residents were directed to the lunch table at 12:00pm. Observation on 09/11/18 at 1:55pm revealed: -The "Pandora Visit Pet Therapy" did not arrive as scheduled from 1:30-3:30pm on the calendar. -No alternate activity was provided for the residents. Interview with the Assistant Administrator on 09/11/18 at 2:01pm revealed: -The Activity Director created the Activity Calendar each month. -The new staff position created (AAC) was to add a holistic approach to activities and a continuity of engagement when the Activity Director was off. -She did not know why the AAC did not follow the calendar. -She did not know why some activities were not offered. -She did not know why the Pet Therapy volunteers did not arrive today. -There were some "Life Skills" activities listed on the calendar that were not activities for the resident's to participate in. Review of the Calendar posted for September 2018 revealed 13 hours of activities listed per week. Telephone interview with the Activity Director on	C 288		

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C 288	Continued From page 38 09/11/18 at 2:35pm revealed: -She created the activity calendar each month. -The AAC had a "holistic" background and could spread her activities throughout the calendar. -The AAC had some flexibility in following the activities on the calendar when she was off. -She had forgotten to tell the Acting Administrator the Pet Therapist had canceled this week. -She had not planned another activity. -She "dropped the ball in some ways" this week. Telephone interview withe the AAC at 2:55pm on 09/11/18 was unsuccessful. Telephone interview with the Administrator on 09/11/18 at 4:30pm revealed: -He did not know some of the activities on the calendar were not being initiated. -He did not know the residents were not engaged or stimulated during the day. -He knew the AAC was recently hired and may still be learning her role. -The Assistant Administrator should be overseeing the training of the AAC when the Activity Director was off. Telephone interview with Resident #3's family member on 09/12/18 at 5:30pm revealed: -He would like to see his loved one more active during the day. -He would like to see Resident #3 more engaged in activities for dementia residents who are more advanced in their disease process.	C 288		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the	C 330		

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preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 sampled residents (#3) related to not receiving oxygen at 2 liters per minute (LPM) via nasal cannula (NC) continuously.

The findings are:

Review of Resident #3's current FL2 dated 05/12/16 revealed diagnoses included Alzheimer's dementia, hypertension, and anxiety.

Review of Resident #3's physician's orders dated 03/29/18 revealed an order for oxygen at 2 LPM via NC continuously.

Review of Resident #3's subsequent physician order's revealed:
-An order dated 05/17/18 for oxygen at 2 LPM via NC continuously.
-An order dated 07/17/18 for oxygen at 2 LPM via NC continuously to be changed to PRN (as needed).
-An order dated 08/22/18 for oxygen at 2 LPM via NC continuously.

Observation of Resident #3 on 09/10/18 at 9:22am revealed:
-Resident #3 was assisted to the living room from

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C 330	Continued From page 40	C 330		

the kitchen via wheelchair by the MA and transferred to the sofa.
-Resident #3 was not wearing oxygen at the time.

Observation of Resident #3 on 09/10/18 at 12:05pm revealed:
-Resident #3 was transferred to the wheelchair by the Activities Coordinator.
-Resident #3 began to self-propel herself around the facility.
-Resident #3 was short of breath.
-Resident #3 did not have on oxygen.

Observation of Resident #3's bedroom on 09/10/18 at 10:00am revealed an oxygen concentrator with oxygen tubing connected and the machine was off.

Review of Resident #3's July, August and September 2018 electronic Medication Administration Record (eMAR) and the electronic Treatment Record (eTAR) revealed no order transcribed for oxygen 2 LPM via NC continuously.

Interview with a MA on 09/10/18 at 9:40am revealed:
-Resident #3 had an order for oxygen at 2 LPM continuously after being discharged from the hospital for pneumonia and hypoxemia in March.
-Resident #3 was not on oxygen anymore.
-Resident #3's oxygen order was discontinued in July.

Telephone interview with Resident #3's physician on 09/10/18 at 11:26am revealed:
-On 03/29/18 Resident #3 was discharged from the hospital with a diagnoses of pneumonia, acute hypoxia, and respiratory failure.
-Resident #3 was sent home on oxygen 2 LPM

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	FCL060135	A. BUILDING: _____ B. WING _____	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNLIMITED POSSIBILITIES # 5	13931 THOMPSON ROAD MINT HILL, NC 28227

(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
C 330	Continued From page 41	C 330		

via NC continuously.
-Resident #3 was oxygen dependent.
-On 07/17/18 he tried to wean Resident #3 off of the oxygen and changed the oxygen 2 LPM via NC to PRN but Resident #3's oxygen saturations dropped to 90% on room air on 2 different visits to the facility on 07/24/18 and 08/07/18.
-He wanted to keep Resident #3's oxygen saturation (the percentage of hemoglobin binding sites in the bloodstream occupied by oxygen.) above 94% at all times.
-He expected the facility to check Resident #3's oxygen saturation using their O2 saturation (SAT) machine and put Resident #3 on oxygen 2 LPM via NC after 07/17/18 if her SATs were less than 94% on room air.
-He noted in his records that an order was written to check Resident #3's oxygen saturation every shift, PRN and keep above 94% while oxygen was PRN.
-On 08/22/18 after a 3rd visit with Resident #3 at the facility the resident's oxygen saturation was 91% on room air so he wrote an order for oxygen at 2 LPM via NC continuously.
-He did not discontinue the oxygen order at all.
-He did not know Resident #3 was not getting oxygen at all since 07/17/18.

Interview with the Assistant Administrator on 09/10/18 at 4:22pm revealed:
-Resident #3 was on oxygen 2 LPM via NC continuously since discharged from the hospital in March 2018.
-The oxygen was discontinued in July 2018 by the physician.
-She did not know the oxygen at 2 LPM via NC was changed to PRN in July 2018.
-She did not know the physician changed the oxygen order to 2 LPM via NC continuously on 08/22/18 because Resident #3's oxygen SATs

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C 330	Continued From page 42	C 330		

were less than 94% on room air.
-She reviewed the order dated 07/17/18 and checked the eMAR and verified the other orders were implemented or discontinued but the oxygen was not transcribed onto the eMAR as PRN and she did not know why the order was not included on the eMAR.

Observation of Resident #3 on 09/10/18 at 4:22pm revealed the Resident Care Coordinator (RCC) checked Resident #3's oxygen saturation which was 93% on room air.

Interview with the RCC on 09/10/18 at 4:22pm revealed:
-The oxygen 2LPM via NC continuously was discontinued on 07/17/18.
-She was responsible for verifying all transcribed orders on the eMAR were correct every month and when new orders came in.
-After reviewing the order dated 07/17/18, she did not know why some of the orders were implemented or discontinued but the oxygen was not implemented as PRN.

Interview with the Administrator on 09/11/18 at 4:30pm revealed:
-He did not know Resident #3 was still on oxygen.
-The Assistant Administrator and the RCC were responsible for receiving, implementing and clarifying all orders as wells as checking the eMARs/eTARs monthly for accuracy.
-The RCC was responsible for entering, changing or discontinuing the orders on the eMAR.
-The Assistant Administrator would walk around with the physician to make sure she received any new orders, and if a family member took a resident to the physician the Assistant Administrator and the RCC would inquire about any new orders written on the resident with the

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C 330	Continued From page 43 family member and or the physician.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, and in compliance with rules and regulations as related to Personal Care and Supervision, and Nutrition and Food Service. The findings are: 1. Based on observation, interviews, and record review the facility failed to provide supervision for 2 of 3 sampled residents (Resident #1 and #2) who had falls that required visits to the emergency department with injuries. [Refer to Tag C00243, 10A NCAC 13F .0901 Personal Care and Supervision. (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure a therapeutic diet was served as ordered by the resident's physician to 1 of 2 sampled residents, (Resident #2), with a physician's order for a mechanical soft ground diet and nectar thickened liquids. [Refer to Tag C00284, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service. (Type B Violation)].	C 912		

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