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	HAL092182	A. BUILDING: _____ B. WING _____	R 10/08/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Wake County Department of Social Services conducted a follow-up survey and complaint investigation on October 3, 2018 through October 5, 2018 with an exit conference via telephone on October 8, 2018.	{D 000}		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure toilet seals were clean and in good repair in 4 shared resident bathrooms on the special care unit (SCU) and the women's shower room on the assisted living side of the facility; to assure baseboard tiles in 3 residents' rooms in the SCU were in good repair; and the walls and floors in 2 residents' rooms were kept clean and in good condition in the SCU. The findings are: Observations on the SCU on 10/03/18 from 10:35am until 11:04am revealed: -There was a thick brown build up along the edge of the floor where the floor meets the wall behind the toilet in room #302.	D 074		

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D 074	Continued From page 1 -The seal around the toilet was cracked and tannish brown in color in room #302. -There was a piece of mounting hardware on the wall above the head of the first bed in room #403 that had approximately one half inch screws protruding out and not attached to wall. -There was a baseboard tile loosened from the wall between the sink and toilet in room #403. -The toilet seal was cracked and tannish brown in color on the sides with a missing section of approximately 6 to 9 inches around the front of the base of the toilet in room #403. -The toilet seal around the base of the toilet in room #404 was built up and dark brown in color. -There was an area of cracked and missing baseboard tile approximately 5 inches in length by 1 inch in width along the floor between the sink and the toilet in room #410. -There were brown spatter type stains on the wall next to and behind the toilet in room #410. -There was a cracked and missing section of floor tile approximately 12 inches in length by 1 inch in width along the edge of the wall next to the sink in room #410. -There was no seal around the base of the toilet in room #410. Observation on the SCU on 10/04/18 at 7:59am revealed there was an area of missing floor laminate approximately 2 inches by 4 inches next to the transition plate at the exit door near room 400. Observation of the women's shower room on the 200 hall on 10/04/18 at 9:34am revealed there was black mold grime around the lower base of the toilet. Interview with a housekeeper on 10/04/18 at 11:00am revealed:	D 074		

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D 074	Continued From page 2	D 074		

-She had noticed the thick brown buildup along the edge of the floor behind the toilet in room #302 and had reported it to her supervisor a couple of days ago.
-The maintenance staff was working on all of the baseboards and was aware of room #400 and room #401.
-She had never noticed the hardware above the bed in room #403, but would report it on 10/04/18.
-The maintenance staff was supposed to be coming to repair the baseboard tile loosened from the wall in room #403.
-She had tried to clean the dark brown build up around the base of the toilet in room #404, but it did not come up.
-The cracked and missing tile and toilet seal in room #410 had been reported to maintenance, but she did not know exactly when it had been reported.

Interview with the maintenance staff on 10/04/18 at 11:58am revealed:
-She had started working at the facility in July 2018 and her work week was split between the facility and a sister facility.
-There were "a lot of projects" she was working on in the facility.
-She was not aware of concerns with cracked tiles and toilet seals on the SCU and was not aware of a work order for repair.
-She relied on staff to put in a work order for repair concerns.

Interview with the Special Care Coordinator (SCC) on 10/04/18 at 4:05pm revealed:
-She was not aware of the toilet seal and the brown build up on the floor in room #302.
-She was not aware of the missing baseboard in room #400 or the missing floor laminate in front of

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the exit door near room #400.
-The maintenance staff had removed the mounting hardware from above the bed in room #403 and repaired the loose tile between the sink and the toilet in room #403 since 10/03/18.
-She had already seen the loose tile in room #403 and had put in a work order.
-She thought she knew about the thick dark brown seal at the base of the toilet in room #404.
-She did not know about the cracked tiles and the toilet seal in room #410.
-She was going to let the maintenance staff know about the needed repairs on 10/04/18.
-She normally depended on staff to let her know if they see something that needed repair.
-There was not a process for anyone to go around room to room and check the condition of each room.
-She was going to incorporate environmental rounds into her routine.
-She had previously completed regular rounds in resident rooms just to make sure the rooms were clean and free of odors.

Interview with the Housekeeping Supervisor on 10/05/18 at 3:50pm revealed:
-She was aware of the repair concerns.
-Some of the concerns were new and some she knew about.
-She could not remember which repair concerns she was aware of, but knew the seals around the base of toilets was new.
-She had put work orders in for the repairs, some a few days ago and others a few weeks ago.
-The maintenance staff was not in the facility every day and had to work on repairs in the order they were requested based on when the work order was put in.
-She checked rooms after the room was deep cleaned; housekeepers deep cleaned three

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D 074	Continued From page 4 rooms every day and then informed the Supervisor which rooms had been deep cleaned. Telephone interview with the Executive Director on 10/08/18 at 11:59am revealed: -Staff had made her aware of the toilet seals and cracked tiles on the SCU. -She was made aware on 10/05/18 and put a work order in for the repairs.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 assure eight dining room chairs in the special care unit (SCU) and nine dining room chairs on the assisted living side were in good condition and good repair. The findings are: Observations on the SCU on 10/03/18 from 10:35am until 11:04am revealed: -There was a missing piece of baseboard approximately 3 inches by 3 four inches behind the door in room #400. -There was an area of baseboard approximately 18 inches in length that had loosened from the wall in room #401. Observations on the SCU on 10/04/18 at 9:31am	D 076		

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D 076	Continued From page 5	D 076		

revealed:
-There were eight chairs in the dining room with leather like seat coverings which were torn on the edges and cracked in the center, exposing the foam cushion underneath.
-There was one chair in the dining room that wobbled when pulled away from the table.

Interview with a personal care aide (PCA) on 10/04/18 at 10:57am revealed:
-She did not know how long the dining room chairs in the SCU had been torn, cracked and wobbly.
-She had not reported the condition of the chairs to anyone.

Interview with a housekeeper on 10/04/18 at 11:00am revealed:
-She had noticed the chairs were torn, cracked and wobbly, but had not reported the chairs to anyone.
-She was going to report the condition of the chairs to her supervisor on 10/04/18.

Interview with the Special Care Coordinator (SCC) on 10/04/18 at 4:05pm revealed:
-She knew the SCU needed some new furniture, but she did not know "it was this bad."
-She was going to remove the wobbly chair on 10/04/18 and check for any other that might be wobbly.
-She normally depended on staff to let her know if they see something that needed repair.
-She was going to incorporate environmental rounds into her routine.

Observations on the assisted living (AL) side on 10/05/18 at 3:35pm revealed there were nine chairs in the dining room where the leather like seat coverings were torn on the edges and

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D 076	Continued From page 6 cracked in the center exposing the foam cushion underneath. Interview with the Housekeeping Supervisor on 10/05/18 at 3:50pm revealed: -She was aware the facility needed new dining room chairs in the SCU and on the AL side. -She believed management had ordered new chairs. Telephone interview with the Resident Care Coordinator (RCC) on 10/08/18 at 10:46am revealed: -The chairs in the dining room on the AL side were in good condition, there were a "few scratches, but nothing critical about the chairs." -Twenty five chairs had been ordered last week for the dining rooms on the AL side and SCU. -The facility had "just ordered $5,000.00 worth of chairs so, I do not see what the problem is." Interview with the Assistant Executive Director on 10/05/18 at 5:12pm revealed: -She was aware of the torn and cracked dining room chairs. -She did not have an approval to order new dining room chairs. -The facility was in the process of remodeling and there was a process for each step in the remodeling process.	D 076		
{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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{D 079}	Continued From page 7 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 assure resident areas were free from hazards related to exposed, sharp metal edges of 3 air conditioning frames on the special care unit (SCU). The findings are: Observations on the SCU on 10/03/18 from 10:42am until 11:12am revealed: -There was an air conditioning unit set inside a metal frame with sharp edges protruding approximately four inches from the wall next to residents sitting area in the common room. -There were two air conditioning units set inside metal frames with sharp edges protruding approximately four inches from the wall next to residents sitting area in the dining room. Interview with a personal care aide (PCA) on 10/03/18 at 10:42am revealed: -She did not know how long the sharp edges of the air conditioner frame had been exposed. -Staff normally kept a stool in front of the air conditioner unit to keep residents away from it. Interview with the Special Care Coordinator (SCC) on 10/04/18 at 4:05pm revealed: -She had not noticed the frames around the air conditioner units in the common area and dining room on the SCU. -She could see where the edges were sharp and	{D 079}		

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{D 079}	Continued From page 8	{D 079}		

a potential hazard.
-She would see if there was anything to be done to cover the edges until covers were installed.
-She normally depended on staff to let her know if they see something that needed repair.
-There was not a process for anyone to go around room to room and check the condition of each room.
-She was going to incorporate environmental rounds into her routine.
-She had previously completed regular rounds in resident rooms to make sure the rooms were clean and free of odors.

Interview with the maintenance staff on 10/04/18 at 11:58am revealed:
-The air conditioning units were installed by a contractor and the contractor was supposed to place the covers over the metal frame.
-She did not know the details, but she had recently taken over placing protective plastic covers over the frames.
-She could not recall exactly when she started working on the air conditioner covers.

Interview with the Housekeeping Supervisor on 10/05/18 at 3:50pm revealed the new air conditioning units were under a contract when they were installed and the covers were supposed to be installed by the contactor, but now the maintenance staff was installing the air conditioner covers.

Telephone interview with the Executive Director on 10/08/18 at 11:59am revealed:
-The maintenance staff had "not been at the community that long, maybe 90 days" and was not fully aware of all the work contracted to be done at the facility.
-The facility had received a quote for $42,000 for

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{D 079}	Continued From page 9 60 air conditioner casings which had been ordered and were being installed. Telephone interview with the Regional Director on 10/08/18 at 11:59am revealed the maintenance staff had put caulk and insulation around the air conditioner units in the SCU on 10/04/18 to protect the residents from the sharp edges.	{D 079}		
{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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide scheduled showers for 3 of 7 sampled residents (#3, #8, and #9) with resulting in offensive body odor for resident (#8) and two resident not receiving nail care resulting in long, dirty fingernails. The findings are: 1. Review of Resident #8's current FL-2 dated 05/29/18 revealed: -Diagnoses included acute on chronic respiratory failure, urinary tract infection, retention of urine, benign prostatic hyperplasia with urinary	{D 269}		

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retention, history of a cerebrovascular accident, Type II - diabetes, and hypertension.
-Resident #8 was semi-ambulatory.
-Resident #8 was incontinent of bladder and required personal care assistance with bathing and dressing.

Review of the Resident Register revealed Resident #8 was admitted on 07/27/17.

Review of Resident #8's care plan dated 05/29/18 revealed:
-Resident #8 was alert and oriented.
-Resident #8 was verbally abusive and resisted care (i.e. during times when the medication aide administered his medications).
-He was ambulatory with the use of a wheelchair.
-Resident #8 required extensive assistance with showering and tub bath on Mondays, Wednesdays, and Fridays.
-Resident #8 required extensive assistance daily with dressing and toileting (donning and removing clothes; pulling down, pulling up, and fastening pants during toileting; and transfer assistance with toileting).
-Resident #8 required extensive assistance daily with transferring.
-He had daily incontinence of bowel and performed his own catheter care (how often catheter care was performed was not specified).

Observation of Resident #8 on 10/03/18 at 9:42am revealed:
-Resident #8 was sitting in his wheelchair with his eyes closed in front of the facility.
-He was unshaven with a long graying beard and his hair was not combed.

Observation of Resident #8 on 10/03/18 at 3:40pm revealed:

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{D 269}	Continued From page 11 -Resident #8 was sitting in his wheelchair in his wheelchair watching television in the living room on the assisted living side of the facility. -Resident #8 had strong offensive body odor. -His beard was still long and straggly and his hair was still uncombed. -Resident #8 was wearing a dark gray hooded sweater with a zippered front, a red polo shirt, plaid gray and blue plaid shirt, black sweatpants, and black bedroom shoes with a Velcro closure on top. Interview with Resident #8 on 10/03/18 at 3:40pm revealed: -Staff helped him with his bath, getting dressed, and to the bathroom. -He was scheduled to get a shower three times a week. -He could not remember when he last had a shower. -He liked his beard long because of his religious beliefs. -He needed a haircut but he did not know when he was going to get one. Observation of Resident #8 on 10/04/18 at 8:00am revealed: -Resident #8 was sitting in his wheelchair in the dining room eating breakfast. -His hair was still uncombed. -Resident #8's body odor was more noticeable compared to 10/03/18. -Resident #8 was still wearing the dark gray hood sweater with the zippered front and red polo shirt he wore on 10/03/18. -There were several dried tan stains on the front of Resident #8's gray hooded sweater. -He had a pair of blue sweat pants with a white stripe on the side of the outside of each leg of the pants.	{D 269}		

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{D 269}	Continued From page 12 -Resident #8 had visible dressings bilaterally to both lower legs that were dated 10/03/18 and he wore his black bedroom shoes. -There was no drainage noted to the visible dressing areas of Resident #8's lower legs. Interview with Resident #8 on 10/04/18 at 8:00am revealed: -He had not had a bath or shower on 10/04/18. -He denied refusing to bathe on 10/04/18. -Resident #8 said, "They (staff) washed off my face and helped me put my clothes on; but that was all they did before I came in here for breakfast". Interview with a personal care aide (PCA) on 10/04/18 at 8:15am revealed: -Resident #8 needed staff to assist him with bathing and dressing because he was not able to stand for long periods of time. -The staff member was not sure if Resident #8 needed any help with shaving or combing his hair. -She had not noticed any body odor from Resident #8 on 10/04/18. -Resident #8 did have history of refusing showers and baths. -She was not sure when the last time Resident #8 had been given a shower by the staff. -Resident #8 was already up and dressed when the PCA arrived for work on 10/04/18 Interview with the LHPS nurse on 10/04/18 at 10:18am revealed: -Resident #8 did have a strong body odor. -She sprayed after Resident #8 left out in the chart room because of the odor. -Resident #8's body odor resulted from Resident #8's refusal to take showers and his bilaterally leg wounds.	{D 269}		

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-Resident #8 did not want to get his legs in the shower because of the dressings on his legs.
-Resident #8's body odor was noticeable.
-She did not know what else the staff could do if Resident #8 refused to take his showers.
-She did not know if staff offered Resident #8 bed baths instead of showers to accommodate his desire to keep his legs wounds dry.

Review of the facility shower schedule revealed Resident #8 was on the shower schedule for Mondays, Wednesdays, and Fridays during the first shift.

Review of Resident #8's October 2018 facility shower assessment reports revealed:
-Staff documented Resident #8 refused his shower and hair care on 10/01/18.
-There was no shower assessment report available for review for 10/03/18.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate the missing October 2018 shower assessment reports for Resident #8 for 10/03/18 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but the some of the shower reports were missing from the filing box.

Review of Resident #8's October 2018 charting notes from 10/01/18 through 10/04/18 revealed there was no documentation of any shower refusals by Resident #8.

Review of Resident #8's October 2018 electronic ADL record from 10/01/18 through 10/04/18

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revealed:
-It was documented staff provided extensive assistance with Resident #8 during bathing and showering 10/01/18 and 10/03/18.
-It was documented staff provided extensive assistance with a sponge bath for Resident #8 all other days during the first shift in October 2018.
-It was documented staff provided extensive assistance daily with Resident #8 for dressing during the first, second, and third shifts.
-It was documented staff provided limited daily assistance with Resident #8 for hair care during the first shift.
-It was documented staff provided extensive assistance daily with Resident #8 for toileting and transferring during the first, second, and third shifts.
-There was no documentation by staff of any refusals of personal care assistance by Resident #8 from 10/01/18 through 10/04/18.

Review of Resident #8's September 2018 facility shower assessment reports revealed:
-Staff documented Resident #8 refused his shower and hair care on 09/10/18, 09/12/18, 09/17/18, 09/19/18, 09/26/18, and 09/28/18.
-There were no facility shower assessment reports available for review for Resident #8 for 09/03/18, 09/05/18, 09/14/18, 09/21/18, and 09/24/18.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate the missing September 2018 shower assessment reports for Resident #8 for 09/03/18, 09/05/18, 09/14/18, 09/21/18, and 09/24/18 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care

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{D 269}	Continued From page 15 Coordinator's office (RCC), but some of the shower reports were missing from the filing box for Resident #8. Review of Resident #8's September 2018 charting notes from 09/01/18 through 09/30/18 revealed there was no documentation of any shower refusals by Resident #8. Review of Resident #8's September 2018 electronic ADL record from 09/01/18 through 09/30/18 revealed: -It was documented staff provided extensive assistance with Resident #8 during bathing and showering on 09/03/18, 09/05/18, 09/10/18, 09/12/18, 09/14/18, 09/17/18, 09/19/18, 09/21/18, 09/24/18, 09/26/18, and 09/28/18 during first shift. -It was documented Resident #8 was out the facility for an appointment on 09/07/18 and did not receive a shower. -It was documented staff provided extensive assistance with sponge bathing with Resident #8 all other days during the first shift in September 2018. -It was documented staff provided extensive assistance daily with Resident #8 for dressing during the first, second, and third shifts. -It was documented staff provided limited daily assistance with Resident #8 for hair care during the first shift. -It was documented staff provided extensive assistance daily with Resident #8 for toileting and transferring during the first, second, and third shifts. -There was no documentation by staff of any refusals of personal care assistance by Resident #8 from 09/01/18 through 09/30/18. Attempted review of August 2018 facility shower assessment reports for Resident #8 were not	{D 269}		

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available for review.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate the any of the missing August 2018 shower assessment reports for Resident #8 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but Resident #8's August shower reports were missing from the filing box.

Review of charting notes for Resident #8 from 08/01/18 through 08/31/18 revealed Resident #8 refused staff assistance with bathing on 08/12/18.

Review of Resident #8's August 2018 electronic activities of daily living (ADL) record from 08/01/18 through 08/31/18 revealed:
-It was documented staff provided extensive assistance with Resident #8 during bathing and showering on 08/01/18, 08/03/18, 08/06/18, 08/08/13/18, 08/15/18, 08/17/18, 08/20/18, 08/22/18, 08/24/18, 08/27/18, 08/29/18, and 08/31/18 during first shift.
-It was documented staff provided extensive assistance with a sponge bath with Resident #8 for all other days during the first shift in August 2018.
-It was documented staff provided extensive assistance daily with Resident #8 for dressing during the first, second, and third shifts.
-It was documented staff provided limited daily assistance with Resident #8 for hair care during the first shift.
-It was documented staff provided extensive assistance daily with Resident #8 for toileting and transferring during the first, second, and third

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shifts.
-There was no documentation by staff of any refusals of personal care assistance by Resident #8 from 08/01/18 through 08/31/18.

Interview with a medication aide (MA) on 10/04/18 at 8:44am revealed:
-Resident #8 required assistance with bathing and dressing.
-He was scheduled for showers on Mondays, Wednesdays, and Fridays during first shift.
-Resident #8 often refused to allow staff to give him a shower.
-Sometimes Resident #8 did have body odor because he refused his showers.
-Staff documented Resident #8's shower refusals on the shower assessment reports.
-She did not know if staff offered Resident #8 a sponge bath when Resident #8 refused a shower.
-Staff were trained to document baths and showers were provided on the ADL logs even when the residents refused their baths or showers.
-The PCAs and MAs reported to the Resident Care Coordinator (RCC) when Resident #8 refused his showers and personal care.
-She did not know if Resident #8 had refused assistance from staff with any of his personal care on 10//04/18.

Interview with the Executive Director (ED) on 10/04/18 at 2:50pm revealed:
-She was aware of Resident #8 refused to his bath and showers.
-Staff had problems with the resident refusing his personal care since she started working at the facility in May 2018.
-Different staff members tried repeatedly to get Resident #8 to shower during a shift and Resident #8 still refused.

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{D 269}	Continued From page 18 -The RCC would be able to explain what strategies staff had used to encourage Resident #8 to bathe when he refused. -Staff documented Resident #8's personal care refusals on the shower assessment reports and the reports were sent to the RCC's office. -She was not aware that he had any body odor on 10/04/18. Interview with the Regional Director on 10/04/18 at 2:50pm revealed: -The Assistant ED had tried to get Resident #8 to shower last weekend and Resident #8 refused. -He and the ED had tried to get Resident #8 to shower earlier on the morning of 10/04/18 and Resident #8 refused to shower even after they made several attempts including getting other staff to offer to assist Resident #8 with his shower. -Whenever Resident #8 refused his showers, staff was documented it on the shower assessment sheets and reported the refusal to the RCC. -He did not know of what else could be done about Resident #8's refusal for personal care without violating Resident #8's rights. -Resident #8 did have concerns about getting his leg wounds wet in the shower and believed his wounds may get worse if they got wet. -He did not know if the staff offered Resident #8 sponge baths when Resident #8 refused his showers. -Resident #8 "was very independent and set in his ways". -Resident #8's physician and mental health provider were both aware of Resident #8's refusals of bathing and personal care. -Resident #8 could be resistant to care and staff documented this shower refusals on the shower assessments sheets.	{D 269}		

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{D 269}	Continued From page 19 -The facility did not have a policy for notifying the physician about shower or bath refusals. -He was not sure when staff notified Resident #8's physician about his shower refusals. Interview with the RCC on 10/04/18 at 12:50pm revealed: -Resident #8 did require staff assistance with bathing, dressing, and grooming. -Resident #8 refused to bathe frequently but he was not sure what could be done to get Resident #8 to let staff help with his personal care. Interview with the Clinical Support Specialist on 10/04/18 at 4:15 p.m. revealed: -Staff had given Resident #8 a shower and changed his clothes on the afternoon of 10/04/18 after the concerns about Resident #8's personal care were discussed earlier. -The resident did have a history of refusing showers and personal care. -Staff documented on Resident #8's shower assessment reports when Resident #8 refused his showers. -The system would not let them document bath refusals and personal care refusals on Resident #8's ADL logs. -The staff had to document on the ADLs that staff had performed the personal care even when the residents refused. -There was little the staff could do when Resident #8 refused his personal care. -Somehow, the staff was able to get Resident #8 allow staff to assist him to get his personal care the afternoon of 10/04/18. Interview with Resident #8 on 10/04/18 at 4:50pm revealed: -Staff had bathed him earlier on the afternoon of 10/04/18.	{D 269}		

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{D 269}	Continued From page 20 -He did not specify if he was given a sponge bath or a shower. -Resident #8 denied previous refusals of showers or sponge baths. -"Sometimes, I don't like if they (staff) wake me up for a shower because I want to sleep." -He did not have a problem with his leg wounds and getting in the shower if staff wrapped his legs up so they did not get wet. Interview with Resident #8's physician's on 10/08/18 at 8:35am revealed: -Staff had not contacted the physician prior to 10/04/18 regarding Resident #8 refusing to shower or allowing staff to perform other personal care tasks. -His expectations was for the staff to attend to personal care needs of Resident #8 according his care plan. -The facility needed to handle their problem with getting Resident #8 to allow staff to help him with his bathing and other personal care needs. -If there was a problem with Resident #8 that caused infection to his leg wounds or if Resident #8 developed an infection as a result of refusing his baths and personal care, he expected for staff to contact him. Telephone interview with Resident #8's family member on 10/08/18 at 9:00am revealed: -The family member had visited Resident #8 several times and Resident #8 had an offensive body odor from not being bathed. -The family had spoken with a few PCAs and the PCAs told the family member that Resident #8 refused his showers when staff offered to assist him. -PCAs also reported to the family member that Resident #8 refused to change his clothes if his clothes got dirty.	{D 269}		

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{D 269}	Continued From page 21 -The family member believed there was more that the staff could do to make sure Resident #8 took baths and changed his clothes regularly. -The family member had picked Resident #8 up from the facility to attend a funeral a couple of months ago; Resident #8 "smelled so bad" the family member took Resident #8 to their home and gave Resident #8 a bath before they went to the funeral. -"If we are able to get him to bathe, the staff should be able to do something so that he does not smell like that." -She did not report this incident to ED; but she had complained to ED and other staff about Resident #8's personal hygiene on other occasions after the funeral. -The family member sometimes had to remind Resident #8 that he needed to let staff help him take a bath or change his clothes, or fix his clothes to be worn properly and Resident #8 did it. Telephone interview with the RCC on 10/08/17 at 11:05am revealed: -Staff were supposed to provide extensive assistance with Resident #8 during bathing and dressing. -Resident #8 needed staff assistance to wash his upper and lower body because Resident #8 was not able to do by himself. -Staff was also supposed to assist Resident #8 with dressing by helping to lift his arms and legs to guide into his clothing. -Resident #8 refused staff assistance often for showers. -He was not sure if staff offered Resident #8 sponge baths in lieu of showers when Resident #8 refused. -If the resident refused to bathe there was not anything else the staff could do.	{D 269}		

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{D 269}	Continued From page 22 -Staff documented all bath refusals for Resident #8 on the shower assessment reports and these reports were given to him. -Staff documented on the electronic ADL record providing Resident #8 assistance with personal care (bathing, dressing, nail care, etc.) according to his plan of care. 2. Review of Resident #9's current FL-2 dated 05/29/18 revealed: -Diagnoses included cellulitis of the feet, bilateral leg edema, morbid obesity, and stage 3 - chronic kidney disease. -Resident #9 was semi-ambulatory. -Resident #9 was incontinent of bladder and required personal care assistance with bathing and dressing. Review of the Resident Register revealed Resident #9 was admitted on 01/26/15. Review of Resident #9's care plan dated 05/24/18 revealed: -Resident #9 was alert, forgetful, and needed reminders. -Resident #9 had limited use of his upper extremities. -He was ambulatory with a walker in his room and used a wheelchair outside of his room. -Resident #9 required limited assistance with bathing and showering on Tuesdays, Thursdays, and Saturdays. -Resident #9 required limited assistance with nail care, dressing, and toileting (donning and removing clothes; pulling down, pulling up, and fastening pants during toileting). -Resident #9 required supervision daily with transferring. -He had occasional incontinence of bowel and bladder.	{D 269}		

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{D 269}	Continued From page 23 Observation of Resident #9 on 10/03/18 at 10:47am revealed: -Resident #9 was lying in bed watching television. -Resident was wearing a gray sweatshirt with black sweatpants and a white undershirt. -The fingernails on both of Resident #9's hands were long, chipped, and had black dirt caked under them. -The length of Resident #9's fingernails was approximately 1/4 of an inch long. -The fingernail of the fifth finger of Resident #9's left hand was badly chipped in the middle. Interview with Resident #9 on 10/03/18 at 10:47am revealed: -Staff assisted him with his bath every day. -Staff had not given him a bath today and he did not know why. -His showers were scheduled for Tuesdays and Thursdays. -Other days, staff "washed off" the resident in his room. -The staff cut his nails and the last time his nails were cut was about a week ago. -He dressed himself because staff did not help him dress. -"You have to do the best you can around here." Interview with a personal care aide (PCA) on 10/03/18 at 11:05am revealed: -Resident #9 was independent with most of his care but staff assisted him with bathing with washing his back and his feet. -Staff assisted Resident #9 with dressing if he asked them for help. -Resident #9 did occasionally refuse his showers and staff told the Resident Care Coordinator (RCC) about all bath refusals. -She was not sure when the last time Resident #9	{D 269}		

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refused his bath because he was scheduled for baths on third shifts.
-She had not noticed any problems with Resident #9's fingernails being dirty or long.
-Staff usually did nail care with the resident when the resident had their baths.

Observation of Resident #9 on 10/04/18 at 12:25pm revealed:
-Resident #9 was sitting in the dining room eating lunch.
-Resident was wearing the same gray sweatshirt with black sweatpants he had on 10/03/18.
-Resident #9's fingernails on both hands were still long and had black dirt caked under them.

Confidential interview with a staff member revealed:
-Resident #9 did most of his baths and showers on his own.
-"He liked to try to do things for himself."
-Staff had reminded Resident #9 to ask for assistance when he needed help.
-Resident #9 has refused to take his bath or shower on occasion.
-Staff documented all bath refusals on the bath assessment sheets and these sheets were turned in to the RCC.
-Resident #9's nail care should be done when Resident #9 got his bath.
-She was not sure when Resident #9 last had a shower or nail care.
-She was not sure when the last time Resident refused his shower or his nail care.

Review of the facility shower schedule revealed Resident #9 was on the shower schedule for Tuesdays, Thursdays, and Saturdays during third shift.

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Review of Resident #9's October 2018 facility shower assessment reports revealed staff documented Resident #9 refused his shower and nail care on 10/02/18.

Attempted telephone interview with the personal care aide who documented Resident #9's shower and nail care refusals from 10/02/18 at 8:45am was unsuccessful due to staff was not available by phone.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate the missing 10/02/18 shower assessment report for Resident #9 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but some of the shower reports were missing from the filing box for Resident #9.

Review of Resident #9's October 2018 charting notes from 10/01/18 through 10/04/18 revealed there was no documentation of any shower refusals by Resident #9.

Review of Resident #9's October 2018 electronic ADL record from 10/01/18 through 10/04/18 revealed:
-It was documented staff provided limited assistance with Resident #9 with bathing and showering on 10/02/18 and 10/04/18.
-It was documented staff provided limited assistance with a sponge bath for Resident #9 for 10/01/18 and 10/03/18 during the first shift in October 2018.
-It was documented staff provided limited assistance daily with Resident #9 for dressing

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during the first, second, and third shift.
-It was documented staff provided limited assistance with Resident #9 for nail care during the first shift by assisting to clean, cut, trim, and file Resident #9 fingernails.
-It was documented staff provided limited daily assistance with Resident #9 for toileting during the first, second, and third shifts.
-There was no documentation of any refusals of personal care by staff on Resident #9's electronic ADL record from 10/01/18 to 10/04/18.

Review of Resident #9's September 2018 facility shower assessment reports revealed:
-Staff documented Resident #9 refused his shower and nail care on 09/08/18, 09/11/18, 09/15/18, 09/20/18, 09/25/18, and 09/27/18.
-There were no facility shower assessment reports available for review for Resident #9 for 09/01/18, 09/04/18, 09/06/18, 09/13/18, 09/18/18, 09/22/18, and 09/29/18.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate the missing September 2018 shower assessment reports for Resident #9 for 09/01/18, 09/04/18, 09/06/18, 09/13/18, 09/18/18, 09/22/18, and 09/29/18 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but some of the shower reports were missing from the filing box for Resident #9.

Attempted telephone interview on 10/08/18 at 8:45am with the personal care aide who documented Resident #9's shower and nail care refusals on 09/08/18, 09/11/18, 09/15/18, 09/20/18, 09/25/18, and 09/27/18 was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 269}	Continued From page 27 unsuccessful due to staff unavailability by phone. Review of Resident #9's September 2018 charting notes from 09/01/18 through 09/30/18 revealed there was no documentation of any shower or nail care refusals by Resident #9. Review of Resident #9's September 2018 electronic activities of daily living (ADL) record from 09/01/18 through 09/30/18 revealed: -It was documented staff provided limited assistance with Resident #9 with bathing and showering on 09/01/18, 09/04/18, 09/06/18, 09/08/18, 09/11/18, 09/13/18, 09/15/18, 09/18/18, 09/20/18, 09/22/18, 09/25/18, 09/27/18, and 09/29/18 during first shift. -It was documented staff provided limited assistance with Resident #9 with a sponge bath all other days during the first shift in September 2018. -It was documented staff provided limited assistance daily with Resident #9 for dressing during the first, second, and third shifts. -It was documented staff provided limited assistance weekly with Resident #9 for nail care during the first shift on 09/04/18, 09/11/18, 09/18/18, and 09/25/18. -It was documented staff provided limited assistance daily with Resident #9 for toileting and daily supervision of transferring during the first, second, and third shifts. -There was no documentation of any refusals of personal care by staff on Resident #9's electronic ADL record from 09/01/18 to 09/30/18. Interview with the Executive Director (ED) on 10/04/18 at 2:50pm revealed: -Resident #9 was mostly independently with his personal care. -Resident #9 could do most of his own bathing	{D 269}		

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{D 269}	Continued From page 28	{D 269}		

without staff assistance.
-He had a history of refusing showers and baths when the staff offered to assistance.
-She did not know of any problems with Resident #9's nail care.

Interview with the Regional Director (RD) on 10/04/18 at 2:50pm revealed:
-Resident #9 had a history of refusing showers and personal care.
-Resident #9 was not going to allow staff to provide any personal care for him until he was ready.
-The facility did not have a specific policy regarding resident refusing personal care.
-Staff reported any refusals to the RCC who contacted the resident's physician after 3 refusals of personal care.

Interview with the RCC on 10/04/18 at 12:50pm revealed:
-Resident #9 did need some staff assistance with bathing, dressing, and grooming.
-Resident #9 had history of refusing his showers.
-The staff was responsible to provide nail care for Resident #9 during his baths and showers.
-He was not sure when nail care was last done with Resident #9.

Interview with the Clinical Support Specialist on 10/04/18 at 4:15 p.m. revealed:
-She did not understand the concern with Resident #9's personal care.
-Resident #9 was independent and had the right to refuse baths if he liked when staff offered to assist.
-She was not sure who was responsible for Resident #9's nail care.

Observation of Resident #9 on 10/05/18 at

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{D 269}	Continued From page 29 5:37pm revealed: -Resident #9 was sitting in his wheelchair in his room. -Resident #9 was wearing a red sweatshirt and gray pants. -Resident #9's fingernails on both hands were still long, chipped, and had black dirt caked under them as they were on 10/03/18. -The fingernail of the fifth finger of Resident #9's left hand still had the same chipped area first seen on 10/03/18. Interview with Resident #9 on 10/05/18 at 5:37pm revealed: -Staff had promised to cut his fingernails; but his nails had not been cut yet. -Staff helped him with a sponge bath on 10/05/18 and helped him change his clothes. -Staff did not normally help with his bathing and dressing unless he called and asked for help. Interview with Resident #9's physician's on 10/08/18 at 8:35am revealed: -Staff had not contacted the physician prior to 10/04/18 regarding Resident #9 refusing to shower or allowing staff to perform other personal care tasks. -His expectations was for the staff to attend to personal care needs of Resident #9 according his care plan. -The facility needed to handle their problem with getting Resident #9 to allow staff to help him with his bathing, nail care, and other personal care needs. -If a Resident #9 developed an infection as a result of refusing his baths or nail care then he expected staff to contact him. Telephone interview with the RCC on 10/08/17 at 11:05am revealed:	{D 269}		

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{D 269}	Continued From page 30 -He had assisted Resident #9 with a bath and changed his clothes on the morning of 10/04/18. -He could not remember if he provided nail care to Resident #9 during the bath. -Staff were supposed to provide limited assistance with Resident #9 bathing and dressing by helping to lift his arms and legs or washing the areas Resident #9 could not reach. -It was hard sometimes for staff to get Resident #9 to take a shower. -If the resident refused to bathe or to let staff to provide nail care, there was not anything else the staff could do. 3. Review of Resident #3's current FL-2 dated 05/29/18 revealed: -Diagnoses included acute bronchitis, chronic airway obstruction, epilepsy, and depression. -Resident #3 was continent of bladder and bowel. Review of Resident #3's care plan dated 06/18/18 revealed: -Resident #3 was oriented. -Resident #3 was ambulatory with a wheelchair or a walker. -Resident #3 required limited assistance with bathing and dressing. -He required limited assistance with toileting (i.e., remove and pull up pants, and hygiene after toileting). -Resident #3 required supervision with transferring. Observation of Resident #3 on 10/03/18 at 11:22am revealed: -Resident #3 was sitting in his wheelchair in his room. -Resident #3's fingernails were approximately ¼ inch long, yellowed, with black dirt caked under the nails of both hands.	{D 269}		

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{D 269}	Continued From page 31 -Resident #3 was wearing a gray and orange plaid shirt with black jeans. Interview with Resident #3 on 10/03/18 at 11:22am revealed: -He can could not walk more than seven feet or walk more than three minutes because of he had weakness related to his blood pressure. -Resident #3 used his wheelchair to ambulate throughout the facility. -Staff was supposed to give him a shave earlier but he had not gotten his shave yet. -It was hard to get staff to help him when he needed it so he tried to do "for himself a lot". -Staff did assist him sometimes with bathing. -He usually did his own baths and showers. -He was supposed to get a shower 3 days a week. -He went to the shower without any assistance from staff sometimes because it took too long for staff to help with his shower. -He wheeled himself to the shower stall and transferred himself to the shower chair. -He had not complained about having to wait for staff to assist him with getting his showers to anyone at the facility. -He had a shower on 10/02/18 and his fingernails were last cut about a one and half weeks ago by staff at the facility. Interview with a personal care aide (PCA) on 10/03/18 at 11:45am revealed: -Resident #3 did a lot of his personal care by himself. -She did not assist Resident #3 with any of his personal care unless he asked her to. -She did not know what type of assistance Resident #3 needed with his any of personal care needs. -She had not noticed any problems with Resident	{D 269}		

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{D 269}	Continued From page 32 #3 having dirty fingernails or needing to be shaved. Review of the facility shower schedule revealed Resident #3 was on the shower schedule for Mondays, Wednesdays, and Fridays during the second shift. Review of Resident #3's October 2018 facility shower assessment reports revealed Resident #3 refused his shower on 10/01/18 and 10/03/18. Review of Resident #3's charting notes revealed there was no documentation of any shower refusals by Resident #3 from 10/01/18 through 10/05/18. Review of Resident #3's October 2018 electronic ADL log from 10/01/18 through 10/05/18 revealed: -It was documented staff provided limited assistance with Resident #3 with bathing and showering on 10/01/18 and 10/03/18 during second shift. -It was documented staff provided limited assistance with Resident #3 with a sponge bath on 10/02/18 and 10/04/18 during the second shift in September 2018. -It was documented staff provided limited assistance daily with Resident #3 for dressing during the first, second, and third shifts. -It was documented staff provided extensive assistance with nail care for Resident #3 during first shift on 10/01/18. -It was documented staff provided limited assistance daily with Resident #3 for toileting and daily supervision of transferring during the first, second, and third shifts. -There was no documentation of any refusals of personal care by staff on Resident #3's electronic	{D 269}		

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{D 269}	Continued From page 33 ADL record from 10/01/18 to 10/05/18. Review of Resident #3's September 2018 facility shower assessment reports revealed: -Staff documented Resident #3 refused his shower and nail care on 09/12/18, 09/14/18, 09/19/18, 09/24/18, 09/26/18, and 09/28/18. -There were no facility shower assessment reports available for review for Resident #3 for 09/03/18, 09/05/18, 09/10/18, 09/17/18, and 09/21/18. Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed: -The facility was unable to locate Resident #3's missing shower assessment report for 09/03/18, 09/05/18, 09/10/18, 09/17/18, and 09/21/18 used by staff to manually document personal care. -Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but some of the shower reports were missing from the filing box for Resident #3. Review of Resident #3's charting notes revealed there was no documentation of any shower refusals by Resident #3 from 09/01/18 through 09/30/18. Review of Resident #3's September 2018 electronic ADL log from 09/01/18 through 09/30/18 revealed: -It was documented staff provided limited assistance with Resident #3 with bathing and showering on 09/03/18, 09/05/18, 09/10/18, 09/12/18, 09/14/18, 09/17/18, 09/19/18, 09/21/18, 09/24/18, 09/26/18, and 09/28/18 during second shift. -It was documented staff provided limited assistance with Resident #3 with a sponge bath	{D 269}		

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all other days during the second shift in September 2018.
-It was documented staff provided limited assistance daily with Resident #3 for dressing during the first, second, and third shifts.
-It was documented staff provided extensive assistance weekly with nail care for Resident #3 during the first shift on 09/03/18, 09/10/18, 09/17/18, and 09/24/18.
-It was documented staff provided limited assistance daily with Resident #3 for toileting and daily supervision of transferring during the first, second, and third shifts.
-There was no documentation of any refusals of personal care by staff on Resident #3's electronic ADL record from 09/01/18 to 09/30/18.

Review of the Resident #3's August 2018 facility shower assessment sheet revealed:
-Resident refused his shower on 08/10/18, but staff was able to give a shave to Resident #3.
-There were no other shower assessment sheets available for August 2018 for Resident #3.

Interview with the facility's Regional Nurse Consultant on 10/05/18 at 10:15am revealed:
-The facility was unable to locate Resident #3's missing shower assessment report for 08/01/18, 08/03/18, 08/06/18, 08/08/18, 08/10/18, 08/13/18, 08/15/18, 08/17/18, 08/20/18, 08/22/18, 08/24/18, 08/27/18, 08/29/18, and 08/31/18 used by staff to manually document personal care.
-Staff were supposed to file the shower assessments in a box in the Resident Care Coordinator's office (RCC), but some of the shower reports were missing from the filing box for Resident #3.

Review of Resident #3's charting notes revealed there was no documentation of any shower

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{D 269}	Continued From page 35 refusals by Resident #3 from 08/01/18 through 08/31/18. Review of Resident #3's August 2018 electronic activities of daily living (ADL) record from 08/01/18 through 08/31/18 revealed: -It was documented staff provided limited assistance with Resident #2 during bathing and showering on 08/01/18, 08/03/18, 08/06/18, 08/08/18, 08/10/18, 08/13/18, 08/15/18, 08/17/18, 08/20/18, 08/22/18, 08/24/18, 08/27/18, 08/29/18, and 08/31/18 during second shift. -It was documented staff provided limited assistance daily with a sponge bath with Resident #3 for all other days during the second shift in August 2018. -It was documented staff provided limited assistance daily with Resident #3 with dressing during the first, second, and third shifts. -It was documented staff provided extensive assistance weekly with nail care for Resident #3 during the second shift on 08/06/18, 08/13/18, 08/20/18, and 08/27/18 -It was documented staff provided supervision daily with Resident #3 with toileting during the first, second, and third shifts. -There was no documentation of any refusals of personal care by staff on Resident #3's electronic ADL record from 08/01/18 to 08/31/18. Confidential interview with a staff member revealed: -Resident #3 has refused baths and showers occasionally. -He complained that he does not feel good and staff just leaves him alone. -Staff documented all Resident #3's bath refusals on his bath assessment sheets and these sheets were turned in to the Resident Care Coordinator (RCC).	{D 269}		

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{D 269}	Continued From page 36 -Resident #3's nail care should be done when Resident #3 got his bath. -The staff was not sure if nail care was provided for Resident #3 since the resident refused his showers. Observation of Resident #3 on 10/04/18 at 12:30pm revealed: Resident #3 was sitting in his wheelchair in the dining room. -Resident #3's fingernails were still ¼ inch long, yellowed, with black dirt caked under the nails of both hands. -Resident #3 was still wearing his gray and orange plaid shirt with black jeans that he was wearing on 10/03/18. Interview with the Executive Director (ED) on 10/04/18 at 2:50pm revealed: -She was not aware there was an issue with Resident #3 not taking baths, changing his clothes, or having long dirty fingernails. -She had only seen Resident #3 wearing a white shirt and khaki pants most of the time. -The RCC would have better insight on what is being done with Resident #3's personal care. -It was expected for staff to provide personal care to Resident #3 according to his plan of care. Interview with the Regional Director (RD) on 10/04/18 at 2:50pm revealed: -Resident #3 was independent and he could do his own baths and change his own clothes. -He was not sure about who was responsible for cleaning and cutting Resident #3's fingernails. -The RCC could look at the care plan for more details. -If Resident #3 refused to change his clothes or bathe then he was not sure what else could be done without violating Resident #3's rights.	{D 269}		

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{D 269}	Continued From page 37 -The facility did not have a specific policy regarding resident refusing personal care. -The facility had notified Resident #3's physician about his resistance to personal care (time not specified). Interview with the RCC on 10/04/18 at 12:50pm revealed: -Resident #3 did require staff assistance with bathing, dressing, and grooming. -Resident #3 did have a history of bath refusals. -He did not know when Resident #3's fingernails were last cut or cleaned. Interview with the Clinical Support Specialist on 10/04/18 at 4:15 p.m. revealed: -The RCD did not know why there were concerns about Resident #3 receiving personal care (bathing, nail care, and changing clothes). -Resident #3 had his fingernails cut by staff on the afternoon of 10/04/18. -The RCD did not know who had cut Resident #3's nails. -Resident #3's fingernails were a little long before they were cut but she did not see anything wrong with them. Observation of Resident #3 on 10/05/18 at 5:40pm revealed: -Resident #3 was sitting in his wheelchair in his room. -Resident #3's fingernails had been cut, but they were still yellowed with black dirt caked under all them -Resident #3 was wearing a white shirt with dark gray pants. Interview with Resident #3 on 10/05/18 at 5:40pm revealed: -Someone had cut his fingernails on 10/04/18.	{D 269}		

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{D 269}	Continued From page 38 -No one cleaned under his fingernails. -He took a shower last night during the second shift. -Staff did not assist him with getting his shower or getting dressed after his shower. Interview with Resident #3's physician's on 10/08/18 at 8:35am revealed: -Staff had not contacted the physician prior to 10/04/18 regarding Resident #3 refusing to shower or allowing staff to cut his fingernails. -His expectations was for the staff to attend to personal care needs of Resident #3 according his care plan. -The facility needed to handle their problem with getting Resident #3 to allow staff to help him with his bathing, nail care, and other personal care needs. -If a Resident #3 developed an infection as a result of refusing his baths or nail care then he expected staff to contact him. The facility's failure to provide scheduled showers and assistance with changing clothing for Resident #9 resulted in offensive body odors; Residents #8 and Resident #3, who were not showered as scheduled and not provided nail care resulted in long nails with caked dirt under them. This noncompliance was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/21/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2018.	{D 269}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 276}	Continued From page 39	{D 276}		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure implementation of a floor mat and bed alarm for 1 of 5 sampled residents (#2) on the special care unit with a history of falls. The findings are: Review of Resident #2's current FL-2 dated 05/01/18 revealed diagnoses included Alzheimer's dementia, diabetes mellitus, hypertension, osteoporosis, depression and gastro esophageal reflux disease. Review of a Physician's Assistant (PA) visit note dated 07/04/18 for Resident #2 revealed: -The PA documented Resident #2 was seen on 07/04/18 following a visit to the emergency department (ED) due a fall out of bed early in the morning on 07/04/18. -Resident #2 did not sustain any injury and had a negative computed tomography (CT) scan. -Staff reported concern that Resident #2 had cold	{D 276}		

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	HAL092182	A. BUILDING: _____ B. WING _____	R 10/08/2018

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{D 276}	Continued From page 40 symptoms. -Under "Medical Decision Making" the PA documented "will implement physical therapy (PT) for dementia-oriented muscle reconditioning and balance training." -Under "Plan" the PA documented "PT for dementia-oriented muscle reconditioning and balance training due to fall." -The visit note was electronically signed by the PA. Review of a PA visit note dated 09/04/18 for Resident #2 revealed: -The PA documented Resident #2 was seen on 09/04/18 and staff reported the resident was sent out the morning of 09/04/18 at 5:30am after a fall out of bed and sustained a bleeding injury to her forehead. -In the hospital, Resident #2's forehead wound was closed with Dermabond (medical glue) and no intracranial injury was detected. -Under "Medical Decision Making" the PA documented "I recommended hospice provide patient with fall mat and alarm system if not already ordered." -The visit note was electronically signed by the PA. Review of an accident/injury report dated 09/04/18 at 5:12am for Resident #2 revealed: -Staff documented Resident #2 was discovered lying on the floor. -Resident #2 had a laceration and staff applied gauze to stop the bleeding. -Resident #2 was sent to the ED and the PA and Power of Attorney (POA) were notified. Review of emergency department discharge instructions dated 09/04/18 for Resident #2 revealed Resident #2 was evaluated in treated for	{D 276}		

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{D 276}	Continued From page 41 a fall with a head injury and forehead laceration. Observation on 10/04/18 at 3:32pm revealed: -Resident #2 was sleeping in her bed. -There was no alarm visible on Resident #2's bed. -There was a floor mat on the floor in front of Resident #2's bed. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Interview with a medication aide (MA) on 10/04/18 at 3:34pm revealed: -Resident #2 had a bed alarm when the resident was up front on the assisted living (AL) side, but had not had a bed alarm while on the SCU. -Resident #2 started declining when she was on the AL side. -Resident #2 would get up during the night, one night the resident got up around 4:00am and fell. -Resident #2's fall happened approximately one to two months ago and the resident got a floor mat after that fall. -Staff knew Resident #2 got up at night, so staff checked Resident #2 every 30 to 45 minutes. Interview with the Special Care Coordinator (SCC) on 10/04/18 at 3:58pm revealed: -The section under "Medical Decision Making" was a recommendation, not an order. -Usually if the PA wanted something like a bed alarm, he would have written an order in the "Plan" section. -She had put the floor mat in place and moved Resident #2's bed around on her own without an order. -Resident #2 had not had a fall since she put the floor mat in place and moved the bed around.	{D 276}		

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{D 276}	Continued From page 42 -Resident #2 was at high risk for falls so the resident was usually in the common area with a PCA to keep an eye on her and other residents who were at high risk for falls. -Resident #2 was only in her bed if she was very sleepy during the day and at night. Telephone interview with the PA on 10/08/18 at 8:37am revealed: -He had written in his visit note dated 09/04/18 for Resident #2 the recommendation for hospice order a bed alarm and floor mat. -Resident #2 was receiving hospice services and therefore hospice handled orders for medical equipment. -Normally he wrote the recommendation and then the SCC contacted hospice to get the equipment. Telephone interview with a hospice nurse on 10/08/18 at 9:29am revealed: -The hospice nurse that visited Resident #2 at the facility would probably not have seen the recommendation written by the PA. -Hospice had already ordered and put in place a fall mat for Resident #2 on 07/31/18. -If the PA was requesting a bed alarm, an order would have needed to have been faxed to hospice. -Hospice did not have an order for a bed alarm for Resident #2 and did not have any contact from the facility regarding a bed alarm since 09/04/18. Telephone interview with the SCC on 10/.08/18 at 1:27pm revealed: -Usually when the PA wanted the SCC "to do something he put in the plan." -The PA did not always discuss the outcome of each visit with residents, most of the time he just wrote it in his note.	{D 276}		

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{D 276}	Continued From page 43 -She did not remember if she had requested the fall mat from hospice or not, but she knew Resident #2 had fell and she put the floor mat in place and moved the resident's furniture around in her room. -Resident #2 fell and sustained a head laceration on 09/04/18 with a floor mat in place because Resident #2's bed was in the middle of the floor and there was space on both sides of the resident's bed. -The floor mat was only on one side of the bed. -After Resident #2 fell on 09/04/18 was when she moved the furniture around in Resident #2's bed and pushed one side of Resident #2's bed against the wall and placed the floor mat in front of the resident's bed. Telephone interview with the Executive Director on 10/08/18 at 2:03pm revealed: -The PA documented orders for the SCC to carry out under the plan section of his visit note; the bed alarm was not written under the plan section of the PA visit note. -If there was space on both sides of the bed, the bed should have been pushed up against the wall with the floor mat in front of the bed. -The clinical support team reviewed charts quarterly to assure orders had been implemented.	{D 276}		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals.	D 297		

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D 297	Continued From page 44 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were served food that was appealing, not overcooked, and served hot. The findings are: Confidential interviews with seven residents revealed: -The food served at the facility tasted bland and unseasoned. -Most of the time, the food was served overcooked and cold when it was served to residents. -The dietary staff cooked all of the meals early and the meals were ready at least an hour and a half before it was to be served. -The dietary staff did not keep the food warm after it was cooked. -The residents' plates were made at least 15 minutes before it was timed for the meal to be served and the plates were not placed in a warmer. -The residents' plates "were already plated and placed at the residents' tables at 4:30pm even though dinner was not served until 5:00pm". -The residents' plates were not covered when they were sent out from the kitchen early. -There was not enough staff to serve all the residents in the dining room and the residents' "food would be served even colder". -The facility frequently ran out of food at all three meals and then the dietary staff had to "sub out" the food item with whatever the staff could find in the kitchen. -It had last happened at lunch on 10/02/18 when residents were supposed to be served a turkey croquette.	D 297		

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D 297	Continued From page 45 -Residents received "a bunch of dry burned stuffing and no meat". -A resident complained and the staff gave the resident a turkey and cheese sandwich. -The resident did not get any other food items besides the turkey and cheese sandwich during lunch on 10/02/18. -Residents had been served "a badly burned ham and stuffing casserole" for dinner on 10/02/18. -There was no ham in the casserole; just burnt stuffing. -The residents did not complain about the casserole served for dinner on 10/02/18 and they did not eat the casserole. -A resident hated the food at the facility, "I don't like the food here; if you want to call it food ...it has no taste; like eating cardboard." -Residents reported they had complained about the food at the facility to the current and previous executive director and to the dietary staff several times over the last couple of months. -Nothing had changed since they had made their complaints. Confidential interviews with an additional seven residents revealed: -There had been several times that meat was on the menu and the facility didn't serve meat (date unknown). -A resident had been served "chicken that was so dry" a few weeks ago that the resident "couldn't bite it, chew it or swallow it (date and time unknown)." -For lunch, on 10/02/18, the resident was served one cold hotdog on a bun with mustard, ketchup and potato chips. -There was no chili, fruit, or any other sides served. -On 10/02/18, the facility served eggs, oatmeal and strawberries.	D 297		

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-Bacon was on the menu for breakfast on 10/02/18, but the facility didn't serve bacon to everyone.
-Residents in the SCU were served first and the AL residents were always served last.
-There wasn't enough staff to serve everyone at the same time to prevent the food from being cold.
-Normally there isn't enough staff to help with serving food in the SCU or AL.
-The only reason there was enough staff there was enough staff in the dining room on 10/03/18 was because the survey team was here.
-A resident ate noodles, from their personal stash, most of the time because the food was cold and it had no flavor.
-The resident didn't eat any food on the evening of 10/02/18 because it was cold, and it didn't look appealing to eat.
-The chicken salad served for lunch on 10/03/18 was loose and running in the resident's plate.

Observation of the lunch meal on 10/03/18 at 12:25 p.m. revealed:
-One resident requested chicken salad and the dietary staff served the resident chicken salad with lettuce and tomato.
-The chicken salad was loose running into the other food in the middle of the resident's plate.

Observations of the kitchen on 10/03/18 at 2:40pm revealed:
-There were trays of white meat baking in the oven; the meat had a dry, lightly tan coating as it cooked.
-There was a pan of cooked rice covered with aluminum foil on the stove top; the stovetop burner was not on.
-There was a pan of mixed vegetables including green beans and corn loosely covered with

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D 297	Continued From page 47 aluminum foil and simmering in the stove top. Interview with the cook on 10/03/18 at 2:46pm and 4:40pm revealed: -She was preparing the dinner meal for 10/03/18. -Once the meal was finished cooking each item would be placed on the food warming table until it was served. -Most of the time she started preparing the dinner meal as soon as the cleanup from the lunch meal was completed which was usually about 2:00pm to 2:30pm. Observations during the breakfast meal on 10/04/18 at 7:39am revealed: -The cook was placing eggs, bacon and toast on each plate then handing the plate of food to the dietary aide. -The dietary aide placed the plate of food on an unheated serving cart until the cart was full (12 plates). -Once the cart was full the dietary aide took the cart to the dining room to serve the uncovered plates of food to residents. -There was no steam visible from the plates of food being served to residents. Observations during the lunch meal on 10/04/18 from 12:08pm until 12:29pm revealed: -The cook placed barbequed meat, lima beans, mixed vegetables and sweet potatoes on each plate then handing the plate of food to the dietary aide who added a piece of corn bread. -The dietary aide placed the plate of food with visible steam on an unheated serving cart until the cart was full (12 plates). -It took from 12:08pm until 12:13pm to prepare 12 plates and place them on the cart. -Once the cart was full the dietary aide took the cart to the dining room to serve the plates of food	D 297		

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D 297	Continued From page 48 to residents. -There was no steam visible from the plates of food being served to residents. -The second cart of 12 plates was served to residents at 12:20pm. -The third cart of plates was served to residents at 12:29pm. Interview with a second cook on 10/05/18 at 10:35am revealed: -The lunch was going to be ham sandwiches, vegetable soup and pineapple chunks. -The lunch meal was completely prepared at 10:35am on 10/05/18. -She usually started preparing the dinner meal right after the lunch cleanup right around 2:00pm to 2:30pm. -If it was "something like a pork loin, that would slow cook all day." -She used her meat thermometer to check and make sure the meats were cooked properly and then placed the cooked food on the warming table until it was time to serve. Interview with the second cook on 10/05/18 at 3:29pm revealed: -There was one cook and two dietary aides working in the kitchen, but starting the week of 10/08/18 there would be two cooks and two dietary aides. -As soon as food was thoroughly cooked, the food was placed on the steam table and the cook then prepped the pureed and mechanical soft foods. -The normal process for serving the food was the cook plated the food and hand the plates to the dietary aide who placed the food on the cart. -She was not aware of any complaints regarding the quality, or taste of the meals served to residents.	D 297		

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-There were alternatives daily for each meal if a resident did not like the meal that was served.
-She thought she did a "pretty good job of getting the food out" and served to residents.
-From the time she opened the door to the kitchen to the time when all the residents were served usually took 20 to 25 minutes.

Interview with the Executive Director (ED) on 10/04/18 at 12:35pm revealed either she or the Assistant Executive Director supervised the cook in the absence of a dietary manager.

Telephone interview with the Resident Care Coordinator (RCC) on 10/08/18 at 11:11am revealed he had not received any complaints about the food served to residents, if he had he would have brought the concern to the ED in the morning meeting.

Interview with the Assistant Executive Director on 10/05/18 at 5:12pm revealed:
-There was only resident that had complaints about the food that she was aware of.
-The resident would sometimes say he did not want what was being served and wanted a steak instead.
-She knew residents preferred the way home cooked meals were seasoned and prepared, but that was not feasible given all the different diets that had to be served.
-The cook plated food and the staff brought food out to the residents.
-She was not aware of food being served overcooked or cold.
-She did not know when the cooks starting making the dinner meal, usually when she went back there about 2:00pm to 3:00pm the meal was "under way."
-She did not know anything about the dinner meal

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D 297	Continued From page 50 being nearly completely cooked at 2:50pm on 10/03/18. Telephone interview with the ED on 10/08/18 at 11:59am revealed: -There was a resident council meeting every month, she had attended the last two meetings and there were no complaints about the food served at the facility. -She was happy to provide an alternative to residents for any meal. -She had simmered vegetables all day and did not see the how that would make the vegetables overcooked. -As long as the food was at the right temperature when the food was served it was okay. Telephone interview with the Regional Director on 10/08/18 at 11:55am revealed: -He was working in the kitchen on 10/03/18 to help serve the lunch meal because when meals were served to residents it was "all hands on deck." -All staff were expected to assist with serving meals to residents and were available for residents to report any concerns or complaints about the food.	D 297		
{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	{D 358}		

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{D 358}	Continued From page 51 and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews and record reviews, the facility failed to administer three diabetic medications (Bydureon injections, Tradjenta and glipizide), an antihypertensive (amlodipine), a mood stabilizer (lamotrigine), an antacid (famotidine) and a supplement (calcium with vitamin D) as ordered by the licensed prescriber for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 05/01/18 revealed: -Diagnoses included Alzheimer's dementia, diabetes mellitus, hypertension, osteoporosis, depression and gastro esophageal reflux disease. -Medication orders included glipizide 7.5mg daily, amlodipine 5mg daily, calcium with vitamin D 600mg-400mg daily, famotidine 20mg daily at bedtime, lamotrigine 100mg daily and Tradjenta 5mg daily. a. Review of Resident #3's August, September and October 2018 electronic medication administration records (eMARs) revealed: -There was an entry for Tradjenta 5mg daily. (Tradjenta is used to lower blood sugar levels.) -Staff documented Tradjenta 5mg was administered daily at 8:00am 08/01/18 through 10/04/18 except on 09/04/18, for a total of 64	{D 358}		

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{D 358}	Continued From page 52 doses. Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There was a bubble pack with a pharmacy label that included Resident #2's name, instructions for Tradjenta 5mg daily and that 30 tablets were dispensed on 08/09/18. -There were 19 tablets remaining in the bubble pack. -There was a second bubble pack with a pharmacy label that included Resident #2's name, instructions for Tradjenta 5mg daily and that 30 tablets were dispensed on 09/02/18. -There were 29 tablets in the bubble pack. -There was a third bubble pack with a pharmacy label that included Resident #2's name, instructions for Tradjenta 5mg daily and that 30 tablets were dispensed on 09/29/18. -There were 30 tablets in the bubble pack. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 30 tablets of Tradjenta dispensed on 08/09/18, 09/02/18 and 09/29/18. b. Review of Physician's orders dated 07/18/18 for Resident #2 revealed an order for glipizide 10mg daily. (Glipizide is used to lower blood sugar levels.) Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed: -There was an entry for glipizide 10mg daily. -Staff documented glipizide 10mg was administered daily at 8:00am 08/01/18 through 10/04/18 except on 09/04/18, for a total of 64 doses.	{D 358}		

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{D 358}	Continued From page 53 Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There was a bubble pack with a pharmacy label that included Resident #2's name, instructions for glipizide 10mg daily and that 30 tablets were dispensed on 08/15/18. -There were 21 tablets remaining in the bubble pack. -There was a second bubble pack with a pharmacy label that included Resident #2's name, instructions for glipizide 10mg daily and that 30 tablets were dispensed on 09/12/18. -There were 26 tablets remaining in the bubble pack. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 30 tablets of glipizide 10mg dispensed on 07/16/18, 08/15/18 and 09/12/18. c. Review of a prescription order dated 07/23/18 for Resident #2 revealed an order for Bydureon 1mg subcutaneously (SQ) weekly. (Bydureon is used to lower blood sugar levels.) Review of Resident #2's July 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Bydureon 1mg inject below the skin weekly. -Staff documented one dose was administered on 07/31/18 at 8:00am. Review of Resident #2's August 2018 eMAR revealed: -There was an entry for Bydureon 1mg inject below the skin weekly. -Staff documented four doses were administered	{D 358}		

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{D 358}	Continued From page 54 on 08/07/18 at 8:00am, 08/14/18 at 8:00am, 08/21/18 at 8:00am and 08/28/18 at 8:00am. Review of Resident #2's September 2018 eMAR revealed: -There was an entry for Bydureon 1mg inject below the skin weekly. -Staff documented three doses were administered on 09/11/18 at 8:00am, 09/18/18 at 8:00am, and 09/25/18 at 8:00am. Review of Resident #2's October 2018 eMAR revealed: -There was an entry for Bydureon 1mg inject below the skin weekly. -Staff documented a dose was administered on 10/02/18 at 8:00am. Observation of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There was a box of Bydureon injections with a pharmacy label that included Resident #2's name, instructions to inject 1mg below the skin weekly and that four injections of 2mg/ml had been dispensed on 07/24/18. -The box contained one prepackaged injection which included a syringe prefilled to a marked line, a vial of white powder and a mixing and administration needle. -Each prepackage injection kit indicated that it was a single dose tray. -There was a second box of Bydureon injections with a pharmacy label that included Resident #2's name, instructions to inject 1mg below the skin weekly and that four injections of 2mg/ml had been dispensed on 08/25/18. -The box contained three prepackaged injections, each included a syringe prefilled to a marked line, a vial of white powder and a mixing and administration needle.	{D 358}		

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{D 358}	Continued From page 55 Interview with medication aide (MA) on 10/05/18 at 10:53am revealed: -She was not at work most of the time Resident #2 was scheduled to receive the Bydureon injections (1st shift at 8:00am). -She normally worked 2nd shift and had come in early on 10/05/18. -She did not have any problems administering medications to Resident #2, medications were administered according to what was on the eMAR. -As far as she knew, all of Resident #2's medications came from the facility contracted pharmacy. -She could not really say why there would be an excess of medication for Resident #2. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed: -The original order date for Bydureon was 07/24/18 and 4 injections were dispensed on 07/24/18. -There were another 4 Bydureon injections dispensed on 08/24/18 and there were no other dispenses of Bydureon. Review of a Physician's Assistant (PA) visit note dated 07/24/18 for Resident #2 revealed: -The PA documented Resident #2's finger stick blood sugar (FSBS) for the past 24 days showed 87% of readings were greater than 200 despite increasing glipizide from 5mg to 10mg last month. -Under "Medical Decision Making" the PA documented "Bydureon would be added for additional diabetes mellitus type 2 control due to persistent poor control status post glipizide increase." -Under "Plan" the PA documented "Bydureon	{D 358}		

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{D 358}	Continued From page 56	{D 358}		

2mg/ml SQ injection every week."
-The visit note was electronically signed by the PA.

Review of a PA visit note dated 08/21/18 for Resident #2 revealed:
-The PA documented Resident #2's FSBS for the past 20 days showed 70% of readings were greater than 200 despite the addition of Bydureon last month.
-Under "Medical Decision Making" the PA documented "Lantus would be added for additional diabetes mellitus type 2 control due to persistent poor control status post glipizide increase and addition of Bydureon."
-Under "Plan" the PA documented "Lantus 10 units SQ injection daily at bedtime."
-There was a hand written entry that the Lantus was discontinued and changed to Basaglar.
-The visit note was electronically signed by the PA.

Review of a PA visit note dated 09/04/18 for Resident #2 revealed:
-The PA documented under diagnoses codes, after diabetes mellitus type 2 "57% less than 200 past 30 days."
-There was no other notation regarding Resident #2's diabetes and/or related medications.
-The visit note was electronically signed by the PA.

Telephone interview with the PA on 10/08/18 at 8:37am revealed:
-He had added the Bydureon to Resident #2's medication regimen because the resident's FSBS levels remained high.
-He had first increased the glipizide for Resident #2, then added the Bydureon and then added Lantus (a long acting insulin used to lower FSBS

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

levels) because Resident #2's FSBS levels remained high.
-The Lantus was changed to Basaglar because of insurance issues. (Basaglar is a long acting insulin used to lowere FSBS levels.)
-He had not discontinued Bydureon for Resident #2 and was not aware of Resident #2 refusing Bydureon.
-If Resident #2 was not getting her diabetic medications (Tradjenta, glipizide, Bydureon and Basaglar) as he had ordered them and he increased Resident #2's medications unaware the resident was not receiving the medications and then Resident #2 actually received all of the medications as ordered, Resident #2 would be at risk for her FSBS levels dropping too low.

d. Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed:
-There was an entry for amlodipine 5mg daily. (Amlodipine is used to treat high blood pressure.)
-Staff documented amlodipine 5mg was administered daily at 8:00am 08/01/18 through 10/04/18 except on 09/04/18, for a total of 64 doses.

Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed:
-There was a bubble pack with a pharmacy label that included Resident #2's name, instructions for amlodipine 5mg daily and that 30 tablets were dispensed on 08/30/18.
-There were 20 tablets remaining in the bubble pack.
-There was a second bubble pack with a pharmacy label that included Resident #2's name, instructions for amlodipine 5mg daily and that 30 tablets were dispensed on 09/29/18.
-There were 30 tablets in the bubble pack.

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{D 358}	Continued From page 58 Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 30 tablets of amlodipine 5mg dispensed on 07/31/18, 08/30/18 and 09/29/18. e. Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed: -There was an entry for lamotrigine 100mg daily. (Lamotrigine is used to treat mood disorders.) -Staff documented lamotrigine 100mg was administered daily at 8:00am 08/01/18 through 10/04/18 except on 09/04/18, for a total of 64 doses. Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There was a bubble pack with a pharmacy label that included Resident #2's name, instructions for lamotrigine 100mg daily and that 30 tablets were dispensed on 07/24/18. -There was one tablet remaining in the bubble pack. -There was a second bubble pack with a pharmacy label that included Resident #2's name, instructions for lamotrigine 100mg daily and that 30 tablets were dispensed on 08/17/18. -There were 19 tablets remaining in the bubble pack. -There was a third bubble pack with a pharmacy label that included Resident #2's name, instructions for lamotrigine 100mg daily and that 30 tablets were dispensed on 09/12/18. -There were 30 tablets in the bubble pack. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 30 tablets of	{D 358}		

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{D 358}	Continued From page 59 lamotrigine 100mg dispensed on 07/24/18, 08/17/18 and 09/12/18. f. Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed: -There was an entry for famotidine 20mg daily at bedtime. (Famotidine is used to treat acid reflux.) -Staff documented famotidine 20mg was administered daily at 8:00pm 08/01/18 through 10/04/18 for a total of 64 doses. Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There was a bubble pack with a pharmacy label that included Resident #2's name, instructions for famotidine 20mg daily and that 30 tablets were dispensed on 08/30/18. -There were 7 tablets in the bubble pack. -There was a second bubble pack with a pharmacy label that included Resident #2's name, instructions for famotidine 20mg daily and that 30 tablets were dispensed on 09/29/18. -There were 30 tablets in the bubble pack. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 30 tablets of famotidine 20mg dispensed on 07/31/18, 08/30/18 and 09/29/18. g. Review of Resident #2's August, September and October 2018 electronic medication administration records (eMARs) revealed: -There was an entry for Calcium with Vitamin D 600mg-400mg twice daily. (Calcium with vitamin D is a nutritional supplement.) -Staff documented Calcium with Vitamin D 600mg-400mg twice daily was administered daily at 8:00am and 8:00pm 08/01/18 through 10/04/18	{D 358}		

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{D 358}	Continued From page 60 at 8:00am except on 09/04/18 at 8:00am, for a total of 128 doses. Observations of medications on hand for Resident #2 on 10/04/18 at 3:45pm revealed: -There were two bubble packs with pharmacy labels that included Resident #2's name, instructions for Calcium with Vitamin D 600mg-400mg twice daily and indicated 60 tablets were dispensed on 10/03/18 in two bubble packs. -There were 30 tablets in each bubble pack. -There was a third bubble pack with pharmacy label that included Resident #2's name, instructions for Calcium with Vitamin D 600mg-400mg twice daily and indicated 60 tablets were dispensed on 10/03/18 in two bubble packs. -There were 26 tablets remaining in the bubble pack. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed there were 60 tablets of calcium with vitamin D 600mg-400mg dispensed on 07/05/18, 08/04/18, 09/03/18 and 10/03/18. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Telephone interview with the Pharmacist at the facility contracted pharmacy on 10/05/18 at 9:40am revealed: -The facility was on an anniversary refill cycle which meant a medication was automatically refilled on the monthly anniversary after the original fill date, approximately every 28 days from the original date the order was written. -The anniversary refill cycle applied to scheduled	{D 358}		

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{D 358}	Continued From page 61	{D 358}		

oral medications and did not include injections, narcotics, liquids, creams and as needed medications.
-Facility staff were also able to request medication refills by hitting the refill button on the electronic medication system, pulling the label and attaching to a faxed refill request or hand writing a refill request.

Telephone interview with the PA on 10/08/18 at 8:37am revealed:
-It seemed odd that Resident #2 would have an excess of medications including the amlodipine, glipizide, Tradjenta, lamotrigine, famotidine and calcium with vitamin D.
-He was not aware of Resident #2 refusing any of her medications.

Interview with the Special Care Coordinator (SCC) on 10/05/18 at 11:00am revealed:
-Medications for the residents came from the pharmacy.
-The facility received medications on an automatic refill cycle.
-She did not know why Resident #2 would have excess medications.
-She was not aware of Resident #2 refusing medications.
-Staff were expected to report medication refusal directly to the SCC.

Interview with the SCC on 10/05/18 at 12:24pm revealed:
-MAs administered medications according to the physician's order.
-Medication refills were requested by the MA mashing the reorder button on the eMAR.
-There was a monthly batch of medications delivered to the facility, but sometimes they did run out of medications.

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{D 358}	Continued From page 62 Interview with the Executive Director (ED) on 10/05/18 at 12:24pm revealed: -Resident #2 was receiving hospice services. -Any medications ordered by hospice were supplied every two weeks. -Care Managers conducted weekly medication cart audits to assure correct medications for each resident. -There were Regional Clinical Support staff that also worked with staff quarterly and as needed to assure medication compliance. Interview with the Regional Nurse Consultant on 10/05/18 at 12:24pm revealed: -The Regional Director was investigating Resident #2's medications and specifically the Bydureon injections. -The facility was trying to figure out what happened. The failure of the facility to administer a glucose lowering injection medication (Bydureon) to Resident #2 as ordered by her Physician's Assistant (PA) resulted in the PA adding an additional glucose lowering injection medication (Basaglar) for Resident #2, therefore placing the resident at substantial risk of severe and life threatening hypoglycemia (low blood sugar) which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/05/18 for this violation.	{D 358}		
{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:	{D912}		

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{D912}	Continued From page 63 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 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 medication administration and personal care and supervision. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to provide scheduled showers for 3 of 7 sampled residents (#3, #8, and #9) with resulting in offensive body odor for resident (#8) and two resident not receiving nail care resulting in long, dirty fingernails [Refer to Tag 269, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to administer three diabetic medications (Bydureon injections, Tradjenta and glipizide), an antihypertensive (amlodipine), a mood stabilizer (lamotrigine), an antacid (famotidine) and a supplement (calcium with vitamin D) as ordered by the licensed prescriber for 1 of 5 sampled residents (#2) [Refer to Tag 358, 10A NCAC 13F .1004 Medication Administration (Unabated Type A2 Violation)].	{D912}		