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	HAL017054	A. BUILDING: _____ B. WING _____	R 01/16/2019

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on January 9-11;14-16, 2019.	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, interviews, and record reviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair in 11 resident rooms and bathrooms, 2 hallway ceilings and the Assisted Living (AL) dining room ceiling. The findings are: Observation of the 500 hallway on 01/09/19 at 10:29am revealed: -The ceiling around the sprinkler head had been patched with plaster. -The plaster had cracked in six-ten-feet in multiple directions away from the sprinkler head and the plaster had been removed. -The ceiling had areas that were stained from water damage, had not been patched or repaired and remained unpainted.	D 074		

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D 074	Continued From page 1 Observation of the 500 hallway on 01/09/19 at 10:29am revealed: -The ceiling above room 616 had an area that was four feet by three feet foot that was partially covered with a piece of clear plastic. -The ceiling had plaster that had peeled and was hanging from the ceiling and was not covered; the ceiling was stained brown from water damage. Observation of the Assisted Living (AL) dining room ceiling on 01/09/19 at 1:00pm revealed the ceiling was damaged; the area was three feet by six and was covered in plastic. Observation of the bathroom for resident room #404 on 01/14/19 at 10:43AM revealed the grout had a dark brown stain and had separated from the base of the commode. Interview with the resident occupying room #404 on 01/14/19 at 10:43am revealed she knew the commode needed to cleaned and caulked; she did not know how long it had been stained. Observation of the bathroom for resident room #410 on 01/14/19 at 10:48am revealed the grout had a dark brown stain and had separated from the base of the commode. Observation of the bathroom for resident room #616 on 01/14/19 at 3:36pm revealed: -The grout had a dark brown stain and had separated from the base of the commode. -The wall beside the commode had a three feet by two feet area that had been patched and spackled; the area had not been sanded or painted. Interview with the resident occupying room #616 on 01/14/19 at 3:36pm revealed:	D 074		

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-The grout had been stained like that for years.
-The wall had been damaged when a resident fell and hit his head; he thought it was a "couple of months ago."
-He did not know why the repairs had not been finished.

Observation of the bathroom for resident room #612 on 01/14/19 at 3:38pm revealed there was no grout between the commode and the floor; the floor around the base of the commode was stained brown.

Observation of the bathroom for resident room #603, #604 and #605 on 01/14/19 between 3:39pm-3:41pm revealed:
-There was no grout between the commode and the floor; the floor around the base of the commode was stained brown.
-The screw that attached the commode to the floor was not cut off flush or capped at the base of the commode; the screw was sticking out of the base of the commode one-two inches.

Interview with the resident occupying room 604 on 01/14/19 at 3:41pm revealed:
-The grout had been stained like that for about one year.
-He had not told anyone it needed to be repaired; they saw it and should know it needed to be fixed.

Observation of the bathroom for resident room #501 on 01/14/19 at 3:44pm revealed:
-The grout had separated from the base of the commode; the grout and flooring around the base of the commode were stained dark brown.
-The screw that attached the commode to the floor was not cut off flush or capped at the base of the commode; the screw was sticking out of the base of the commode one-two inches.

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D 074	Continued From page 3 -The floor had separated at the seams across the entire length of the bathroom; beside the commode, the floor seams were separated approximately one half an inch. Interview with the resident occupying room 501 on 01/14/19 at 3:46am revealed his bathroom had been like that for a long time; he did not know how long his bathroom commode had needed caulking or his floor had been cracked. Observation of the bathroom for resident room #401 on 01/14/19 at 3:50pm revealed: -The laminated flooring was covered with a gray stain. -The grout was stained dark brown around the base of the commode. -The screw that attached the commode to the floor was not cut off flush or capped with the base of the commode; the screw was sticking out of the base of the commode one-two inches. Based on observations, interviews and record reviews it was determined the resident who resided in room #401 was not interviewable. Observation of the bathroom for resident room #102 on 01/14/19 at 3:52pm revealed: -The grout around the base of the toilet was stained dark brown. -There was a two-inch gap between the wall and flooring around the commode area that was three feet in length. -The screw that attached the commode to the floor was not cut off flush or capped with the base of the commode; the screw was sticking out of the base of the commode two-three inches. Interview with the resident occupying room #102 on 01/14/19 at 3:52pm revealed:	D 074		

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D 074	Continued From page 4 -The commode and floor had been that way for several months; she did not know what had happened. -The housekeeper cleaned her room and bathroom every day. Observation of resident room #409 on 01/14/19 at 3:55pm revealed: -Three walls had numerous areas that had been repaired and spackled; some spackled areas had been sanded. -There was no grout around the base of the commode; there was a half of inch gap between the base of the commode and the floor. -The flooring was stained a dark brown around the base of the commode. Interview with the resident occupying room #409 on 01/14/19 at 3:55pm revealed: -She did not know what happened to the wall; the spackling repair had been that way "a long time." -She did not know why the commode had not been grouted, and the flooring was stained around the base of the commode; she did not know how long it had been stained. -Her room and bathroom were cleaned; she did not know how often they were cleaned. Interview with the Maintenance Director on 01/11/19 at 9:47am revealed: -He had been working at the facility since January 2018. -In July 2018 they had a problem with the sprinkler and it damaged the dining room ceiling. -They had obtained quotes on repairing the ceiling, but he did not think a final decision had been made. -The ceiling damage on the 500 hall happened in August 2018; he had been working on repairing the ceiling but did not have the materials to finish.	D 074		

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D 074	Continued From page 5 -The ceiling damage on the 600 hall happened on 01/01/19; he did not have the materials to repair the ceiling. -The company he had worked for did not renew their contract with the facility the week of 12/24/19; the facility hired him directly the same week. -The facility was still working out the details on purchasing materials. Interview with the housekeeper on 01/15/19 at 8:55am revealed: -She did not know what the brown stains were around the base of the commodes. -She knew there were a lot of commodes that needed to be caulked; she had reported this to the Maintenance Director and the Administrator. -She had tried to clean around the commodes, but it made the caulking crack. -The repairs in the rooms had been started; she thought they had not been finished because they did not have matching paint. Interview with the Maintenance Director on 01/15/19 at 9:53am revealed: -He was responsible for caulking. -The Administrator had mentioned a couple of rooms needed to be caulked. -He had not seen any that needed to be caulked. -He had caulked some on the 400 hall a month ago and the 600 hall in November 2018; he had not had time to finish. Interview with a medication aide (MA) on 01/15/19 at 5:00pm revealed: -The dining room ceiling had been damaged since May 2018. -She thought they had been without a maintenance worker for a while; she did not recall when or how long.	D 074		

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-The walls in the resident rooms had been patched for a while but had not been finished.
-The floor around the base of the commodes were "terrible; she thought maintenance was aware".

Interview with the Business Office Manager on 01/16/19 at 8:59am revealed:
-Maintenance was responsible for repairing the damaged ceilings in the dining room and hallways.
-She knew they had an air-conditioner leak and then the sprinkler system leaked; she thought it was within the past six-eight weeks.
-Maintenance was in the process of repairing the ceilings; she had instructed maintenance to tarp any holes that needed to be repaired.
-The Administrator was responsible for overseeing all maintenance requests and inputting them into the system.
-The dining room ceiling repairs had to be contracted out; the quotes had been submitted to corporate two-three weeks ago.
-She had walked through the facility with the local building inspector on 01/15/19; she knew there were commodes that needed to be caulked.
-Maintenance had been caulking commodes "here and there" and it was an ongoing project.
-She knew there were rooms that had been spackled at various stages; the room repairs had to be coordinated with residents being out of the room due to the smell.
-Repairs were an ongoing project.

Interview with the Administrator on 01/16/19 at 5:51pm revealed:
-Maintenance requests were put into the impulse computer system which generated a work order
-If she had been told of any maintenance needs she put them into the impulse maintenance

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D 074	Continued From page 7 system. -She did not know there were multiple commodes that needed to be caulked; no one had told her the commodes and floors looked bad. -She had made rounds in resident rooms two-three weeks ago; she did not look at commodes. -She noticed rooms had been prepped but not finished out; they had not been put into the impulse maintenance system. -The dining room ceiling had been damaged a couple of months ago; it had been put into the impulse maintenance system. -She had just found out last week they were not using the impulse maintenance system.	D 074		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to assure all the components of the call light system were operating as designed to assure residents' calls were received by staff and responded to in a timely manner in the Assisted Living unit (ALU) for 4 of 4 sampled residents (#7, #8, #9, and #20) with special care needs that included blindness (#7 and #9), a resident that had a cerebrovascular accident and left side paralysis (#8), and a resident with a colostomy	D 119		

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D 119	Continued From page 8 that needed frequent changes (#20). The findings are: Observation during the initial tour of the facility on 01/09/19 at from 10:00am to 11:15am revealed: -Thirty-eight residents resided in the ALU. -The ALU floor plan consisted of a main hallway that was more than fifty feet long. -There were two hallways adjacent off the main hallway. -The longest hallway adjacent to the main hallway was the hallway with resident rooms 500 and 600. -These rooms were not visible from the main hallway. -Each resident room had a call system activated light that was located outside the room near the upper part of door frame. -The lights were part of the call bell system, signaling staff when a resident needed help. -The lights did not illuminate when the call bell was activated. -Residents #7, #8, and #9 resided on the 600 hallway. -The residents' rooms were more than forty-six to seventy-one feet away from the nurse station where the call bell alarm sounded. Observation on 01/09/19 at 4:48pm revealed: -There were two staff were sitting in the nurses' station for over three minutes. -There call bells ringing. -The staff did not respond to the call bells. -The lights outside the residents' rooms doors were not working and did not illuminate. Observation on 01/10/19 at 9:48am revealed: -The call bells were ringing for up ten minutes with no staff was present in the nurse' station to respond to the needs of the residents.	D 119		

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D 119	Continued From page 9 -Outside of the nurse station it was difficult to hear the call bell ringing due to the noise with residents and staff in the hallway. -The lights outside the residents room doors were not illuminated. Observation on 01/15/19 at 12:41am revealed: -There were no staff was in the nurse' station for three minutes as four residents' call bells were ringing. -Staff were observed come in and out of the nurse station, but the alarms continued to sound for more than fifteen minutes. -The lights outside the residents' room doors were not illuminated when the call bell was activated. 1. Review of Resident #7's current FL2 dated 01/03/19 revealed: -Diagnoses included depression, glaucoma, degenerative joint disease, fracture of humerus, macular degenerative. -The resident was semi-ambulatory with the use of an electric wheel-chair. Review of Resident #7's Care Plan dated 06/07/18 revealed: -Resident #7 vision was "very limited (blind)." -Resident #7 was sometimes disoriented, but had adequate memory. -Resident #7 required extensive assistance with bathing/showering. -Resident #7 required limited assistance with ambulation, transfers to the toilet, dressing and cutting food. -The resident required supervision with transfers. Observation of Resident #7 and her room on 01/09/19 at 11:28am revealed: -Outside of Resident #7's room near the top of	D 119		

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the door frame was a light that was covered with a white plastic covering.
-Upon entering Resident #7's room, the resident was observed sitting in a lounge chair.
-Resident #7 was blind.
-On the floor, near the chair where Resident #7 was sitting was a plastic box.
-There was a string with one end tucked inside the box and the other end attached to the call bell system on the wall.
-When Resident #7 tried to reach for the cord she had to feel several times before finding the cord.
-The cord was not long enough to reach the resident's bed.
-The call bell system was in the off position.
-At 11:31am the resident pulled the call bell.
-The light outside Resident #7's room door did not illuminate when the call bell was activated.
-It could not be determine how staff knew Resident #7 needed personal care assistance.
-At 12:07pm no staff had come to assist the resident.

Interview with Resident #7 on 01/09/19 at 11:29am revealed:
-Resident #7 said she was waiting to go to the bathroom.
-"I have been waiting for over 30 minutes to go to the bathroom.
-"The girl came in once, but she left again, stating "she would be back."
-It often took thirty minutes or longer for staff to answer her call bell.
-She knew what time staff left her room because she checked her watch.
-Her watch verbally told her the time, date, month and year.
-She could not take herself to the bathroom, and had been feeling weak in her legs.
-She was afraid to stand without staff assistance

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for fear she might fall.
-Staff complained that she should call them earlier, but it did not matter what time she pulled her call bell, they still took a long time to come.
-When she was in bed she usually had to yell for help because the call bell cord did not reach her bed.
-Someone would come soon to take her to lunch because it was almost 12:00pm.
-At 12:10pm, after prompting the personal care aide (PCA) came to assist Resident #7.

A second interview with Resident #7 on 01/16/19 at 11:09am revealed:
-She could not walk well and her balance was off.
-When she had to go to the bathroom or she wanted water it sometimes took staff a long time to come so, she yelled for staff to come assist her.

Interview with Resident #7's guardian on 01/15/19 at 1:30am revealed:
-Resident #7 was blind and she needed staff to help her with toileting, dressing, showering/bathing, helping to meals, and other things like getting water.
-When Resident #7 had to use the bathroom she needed staff assistance, because she could not get out of the recliner into the wheelchair.
-Resident #7 had told him that sometimes it took facility staff up to thirty minutes before they came to assist her.
-Resident #7 told him she sometimes had to holler loud to get staff attention to help her.
-Resident #7 told him another resident heard her yelling and was able to get staff to help.
-He was not sure how many times this had happened.
-The facility have not said anything to him regarding checking on Resident #7 more

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frequently because she was blind.
-He did not know the new Administrator and had not had any discussions with her regarding Resident #7 waiting a long time for staff to assist her.
-Resident #7 was alert and able to speak for herself and she had tried to talk with the Administrator, but she was always out of her office or busy.
-The facility was short staffed, and the care that staff provided to Resident #7 had deteriorated over the years.

Interview with another resident's family member on 01/10/19 at 9:25am revealed:
-She had a family member at the facility.
-She visited her family member every other day.
-She knew that Resident #7 was blind.
-Some times when she came to see her family member she heard Resident #7 yelling from her room.
-The Resident's door was usually closed, but she could still hear the resident yelling.
-The resident was yelling for staff to come and help her.
-She observed staff causally walking down the hallway saying "Oh' it's [named resident]."

Interview with a first shift medication aide (MA) on 01/09/19 at 12:07pm revealed:
-She was not surprised that Resident #7 had waited more than thirty minutes to go to the bathroom.
-When the resident pulled the cord, the call bell system sounded to a computer that was in the nurses' station.
-The staff had to go to the computer to view which resident, by room number was calling for help.
-If there were no staff in the nurse station, staff

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had no way of knowing when residents called for assistance.
-There were lights outside of each resident room.
-The lights were broken and had not worked for more than one year.
-If the lights worked that would help staff to identify quicker when a resident called for help.

Interview with the Physician Assistant (PA) from Resident #7's Primary Care Physician's office on 01/11/19 at 10:50am revealed:
-Resident #7 was blind and needed staff assistance with most of the activities of daily living, like dressing, showering, toileting, assistance to the dining room and almost everything.
-He did not know the facility's structure or how many staff were on duty per shift, but thought a resident should not have to wait thirty minutes for staff to take her to the bathroom.
-Resident #7 had not shared with him that it took staff a long time to assist her.

Interview with a personal care aide (PCA) on 01/11/19 at 10:18am revealed:
-Resident #7 was blind and was dependent on facility staff to assist her with toileting, taking her to meals, dressing, showering/bathing.
-She checked Resident #7 every two hours.
-It was difficult to hear the call bell, but she had not been instructed to assist the resident more often than every two hours.

Interview with the housekeeper on 01/15/19 at 11:00am revealed:
-Sometimes when she was cleaning rooms on the 500 and 600 hallways, she heard Resident #7 yelling for staff to come and help her.
-When she heard the resident yelling she informed staff the resident needed help.

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D 119	Continued From page 14 Interview with a second shift medication aide (MA) on 01/15/19 at 5:43pm revealed: -Resident #7 needed help getting dressed, bathing and going to the bathroom. -When Resident #7 activated the call bell cord for staff assistance sometimes staff did not know. -The light outside the rooms did not work and unless she was near the nurses' station she had no way of knowing Resident #7 needed help. -The light had not worked for more than one year. -She had heard Resident #7 yelling for staff to come and help her because staff did not respond to the call bell. -The facility policy was to check on residents every two hours. Interviews with four residents on 01/16/19 from 9:40am to 11:10am revealed: -One resident heard Resident #7 yell for help at least two times per week. -When she heard Resident #7 yell for help, she went to get staff to help the resident. -A second resident heard Resident #7 yell for help. -Resident #7 "hollered loud" through her closed door. -She heard Resident #7 yell and holler for help sometimes twice per day, on all shifts. -A third resident heard Resident #7 yell for help, but did not know what was going on with the resident. -A fourth resident heard somebody yell for staff to help. -If he could help the resident he would, but he was blind also. Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am.	D 119		

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D 119	Continued From page 15 Refer to interview with a first shift medication aide (MA) on 01/11/19 at 9:55am. Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am. Refer to interview with a resident on 01/16/19 at 8:45am. Refer to interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm. 2. Review of Resident #9's current FL2 dated 07/16/18 revealed: -Diagnosis included legal blindness. -The resident was intermittently disoriented. -Ambulatory status was semi-ambulatory. Review of Resident #9's Care Plan dated 11/29/17 revealed: -The resident was blind, ambulatory with assistive device, had limited range of motion. -Resident #9 required extensive assistance with bathing/showering and oral care. -Resident #9 required limited assistance with dressing, ambulation and transferring. Review of the LHPS evaluation and quarterly report in Resident #9's record revealed: -The nurse documented the resident was blind and required extensive assistance with bathing. Observation of Resident #9's room on 01/15/19 at 10:02am revealed: -The resident was in his room lying in bed. -The call bell system was at the foot of the bed. -The cord attached to the system was not close enough for the resident to reach when in bed. -The call bell was activated at 10:03am. -The light outside Resident #9's room did not	D 119		

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illuminate.
-At 10:15am a staff person came and pushed the call bell in the off position.

Interview with Resident #9 on 01/15/19 at 10:03am revealed:
-He was blind and needed staff assistance with getting in and out of bed, going to the bathroom, getting dressed and going to meals.
-He was told the call bell did not work.
-When he needed staff help he had to keep yelling until someone heard him.
-Sometimes it took a while for staff to come, but he was not sure about the amount of time he waited because he did not see the time.

Interview with the personal care aide (PCA) on 01/11/19 at 10:18am revealed:
-Resident #9 was blind and needed staff assistance with bathing and toileting, and assistance to the dining room.
-She conducted incontinence checks on Resident #9 every two hours and assisted the resident's well-being.
-If resident #9 waited too long he would yell for help.

Interview with the housekeeper on 01/15/19 at 11:00am revealed:
-Sometimes when she was cleaning rooms on the 500 and 600 hallways, she heard Resident #9 yelling for staff to help him.
-When she heard the resident yelling she informed staff the resident needed help.
-Resident #9 was blind and needed staff assistance getting in and out of bed and maybe to use the bathroom.

Interview with a second shift medication aide (MA) on 01/15/19 at 5:40pm revealed:

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D 119	Continued From page 17 -Resident #9 was blind and needed staff assistance with dressing and making sure he was cleaned after toileting, and getting in and out of bed. -When the PCA's assisted a resident with going to bed they should make sure the cord to the call bell system was near the resident. -The cord to Resident #9's call bell was not long enough, so when the resident wanted help he yelled or beat on the wall with his cane. Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am. Refer to interview with a first shift medication aide (MA) on 01/11/19 at 9:55am. Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am. Refer to interview with a resident on 01/16/19 at 8:45am. Refer to interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm. 3. Review of Resident #20's current FL2 dated 09/28/18 revealed: -Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia. -The resident had "colostomy." Review of Resident #20's Resident Register revealed the resident was admitted to the facility on 10/05/18. Review of Resident #20's record revealed there was no Care Plan.	D 119		

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D 119	Continued From page 18 Observation of Resident #20 in his room on 01/16/18 at 3:58pm revealed: -Resident #20's room was less than twenty feet from the nurse station. -There was a light outside the room door near the upper part of the door frame. -The light did not work when the call bell was alarmed. -Resident #20 was sitting in a wheelchair. -He was able to maneuver himself around the room in the wheelchair. -He was able to reach the call bell cord when in the wheelchair. -Resident #20's bed was to the left of room about four feet from doorway entrance to the room. -At the foot of the bed was the call bell system. -There was a white cord that was three and one-half feet long attached to the system. -If the resident was lying in bed with his head at the top of the bed he would not be able to reach the cord to the call bell. Interview with Resident #20 on 01/16/19 at 11:35am revealed: -When he was not in bed he was in a wheelchair. -He was able to wheel himself around the room. -He needed staff assistance with caring for his colostomy, getting in and out of the wheelchair to the bed and getting out of bed into the wheelchair. -If he was in the wheelchair and wanted to get in bed he pulled the call bell. -It sometimes took staff thirty minutes or half a day to respond when he pulled the call bell. -When in the bed he could not reach the call bell cord so he yelled for staff to come and help him. -Sometimes it took so long for staff to come and help, he got tired of waiting and tried to get himself. -Sometimes he was successful and sometimes	D 119		

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he fell to the floor.
-When staff came to the room to assist him they argued asking him why he was yelling and he did not like to be yelled at.

Interview a personal care aide (PCA) on 01/16/19 at 12:53pm revealed:
-Resident #20 activated his call bell, but he did not know how long the bell was ringing before he came to the room.
-He had been employed at the facility since May 2018 and the light outside Resident #20 room had not worked since that time.
-He checked on Resident #20 every two hours, which was the facility's policy.
-If he knew the resident was calling for help he assisted the resident.

Interview with Resident #20's roommate on 01/16/19 at 4:11pm revealed:
-Staff did not come when he and Resident #20 pulled the call bell.
-When Resident #20 fell he had to yell for help.
-He had resided at the facility since 2016.
-When he first came to the facility the light outside the rooms worked.
-It had been over one year since the lights stopped working.

Interview with the medication aide (MA) on 01/16/19 at 4:01pm revealed:
-Resident #20's room had a light outside the door.
-The lights had been broken for over one year.
-There was a call bell cord in the room for residents to call for staff assistance.
-Sometimes staff did not know Resident #20 needed assistance, if they did not hear the call bell.

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D 119	Continued From page 20 Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am. Refer to interview with a first shift medication aide (MA) on 01/11/19 at 9:55am. Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am. Refer to interview with a resident on 01/16/19 at 8:45am. Refer to interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm. 4. Review of Resident #8's current FL2 dated 01/25/18 revealed: -Diagnoses included stroke (left side weakness), type 2 diabetes, Chronic Obstructive Pulmonary Disease, acute kidney injury, obstructive sleep apnea, and hypertension. -The resident was non-ambulatory with wheelchair. Review of Resident #8's Care Plan dated 01/16/18 revealed: -The resident was ambulatory with an assistive device (wheelchair), but had limited range of motion. -Resident #8 required extensive assistance with bathing/showering, dressing, transfers, and cutting up food. -Instructions to staff were to assist Resident #8 so that he transferred safely to and from bed and to the wheelchair due to having left sided weakness, unsteady gait and decreased range of motion. Observation of Resident #8 in his room on 01/10/19 at 11:09am revealed:	D 119		

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-The resident's room was at the end of the 600 hallway.
-There was a call light located by the upper part of the door frame.
-The room was more than seventy-one feet from the nurse station.
-The resident was sitting in a wheelchair and was unable to move his left side.
-There was a call bell system with pull cord on the wall that could be activated and alarmed at the nurses' station.
-The light on the wall outside the room did not work when the call bell was activated.

Interview with Resident #8 on 01/10/19 and 01/16/19 at 11:09am and 10:45am revealed:
-He could not get out of bed, or get dressed without staff assistance and needed staff assistance with cutting up food.
-He needed staff help when he got up in the morning.
-He also called staff when he did not feel good.
-Sometimes it took staff twenty to twenty-five minutes when he called for assistance using the call bell.

Interview with a medication aide (MA) on 01/16/19 at 10:10am revealed:
-The personal care aides (PCAs) were responsible for assisting Resident #8 to the bathroom, with showers and dressings.
-Resident #8 was checked every two hours for incontinent.
-If the resident wanted staff he had to pull the call bell cord.

Interview with a PCA on 01/16/19 at 10:25am revealed:
-Resident #8 was checked on every two hours.
-The resident was assisted with transfers out of

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bed and with toileting.
-Resident #8 was checked on every two hours for incontinent care.
-Resident #8 was taken to the bathroom at least three times per shift.
-Resident #8's room was located at the back of the building.
-When he pulled the call bell cord it sounded to a computer that was located at the nurses' station.
-If staff was near the nurses' station and heard the call bell they had to go check the computer see the room number that needed assistance.
-There was a problem with staff hearing and knowing the residents pulled their call bell cord.
-Resident #8's room was a long distance from the nurses' station.
-You also had to turn off the main hallway to see Resident #8's room.
-Sometimes the only way to know if a resident was calling for help was for staff to hear the call bell and tell you, or a resident yelled for staff.
-There was a call light near the upper part of the door frame outside of each residents room.
-The light had not worked since he started working at the facility four months ago.

Interview with a second PCA on 01/11/19 at 10:18am revealed:
-She checked on Resident #8 every two hours for incontinence.
-The call bell system was hard to hear unless you were standing or at the nurses' station.

Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am.

Refer to interview with a first shift medication aide (MA) on 01/11/19 at 9:55am.

Refer to interviews with two family members on

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D 119	Continued From page 23 01/11/19 at 11:00am and 11:15 am. Refer to interview with a resident on 01/16/19 at 8:45am. Refer to interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm. _____ Interviews with two family members on 01/11/19 at 11:00am and 11:15 am revealed they visited family members almost daily, "This place needs management, and staff needed training because staff did not know how to help the residents." Interview with a PCA on 01/10/19 at 10:51am revealed: -She could not hear the alarm from one end of the hall to the other end of the hall. -The only way he knew a resident needed help was to hear the call bell alarm. -The system told him what room to go to. -Whoever heard the call bell alarm should respond. -He had to go to the nurse station to view the computer screen and what resident needed help. -To disarm the system he had to go to the resident's room. -It was hard to hear the call bell system unless he was near the nurse station. -There were lights outside each resident room, but they did not work. -The lights had not worked since he started working at the facility in October 2018. Interview with a first shift medication aide (MA) on 01/11/19 at 9:55am revealed: -The problem with residents not getting care was the call bell system was not fully operational. -The call bell system was inconvenient because if	D 119		

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D 119	Continued From page 24 "you heard the alarm you had to go to the nurses' station to see the computer and identify the resident room number." -The call bell alarm system was not attached to pagers or cell phones for staff to immediately identify the residents that needed help. -The lights outside the residents' rooms had not worked for over one year. -When the lights worked it was easier to identify residents that needed assistance because staff were able see the light. -The call bell alarm system had only been working for three to four months. -Prior to the call bell system the facility gave the residents hand bells, but due to the facility's size and floor plan design the hand bells were worse than the current call bell system. -When there was only one MA and one PCA, the PCAs were left alone on the floor and it took a long time for staff to assist the residents. -The Administrator was in the facility two to three days per week, but she did not assist staff on the floor with personal care to the residents. Interview with a resident on 01/16/19 at 8:45am revealed: -He had heard residents calling out for assistance at night and no staff responded; he had gone to the nurses' station himself to get the staff and all the staff were in the office "just cutting up." -He had seen staff asleep at the desk when a resident had been calling out for assistance. -He had seen a male resident in the hall naked, and he could not find anyone to assist the resident. -He had heard the male resident call out for assistance and no one responded; he did not recall the last time this happened it was "not long ago."	D 119		

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D 119	Continued From page 25 Interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm revealed: -Staff did not know when the call bell system was alarming. -The Administrator was in the facility two to three days per week. -They could never respond quick enough to a resident asking for help by pulling the call bell cord because they were always busy assisting other residents. -Also you had to be near the nurses' station to hear the system alarming. The facility failed to assure all components of the call bell system was operating as designed to assure residents calls were received by staff and responded to in a timely manner which resulted in personal care and services not being provided for the residents needing ambulation and transfer assistance getting in and out of bed and toileting (#7, #8, #9 and #20), for two residents that were blind and required assistance with activities of daily living (#7 and #9), and a resident needing personal care with a colostomy (#20). The facility's failure was detrimental to the residents' safety and welfare and constitutes a Type B Violation. The facility provided a plan of protection on 01/11/19 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2019.	D 119		
D 127	10A NCAC 13F .0403(c) Qualifications Of Medication Staff	D 127		

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D 127	Continued From page 26 10A NCAC 13F .0403 Qualifications Of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 medication aides sampled (B) completed six hours of continuing education annually related to medication administration. The findings are: Review of Staff B, personal care aide (PCA), medication aide's (MA) personnel record revealed: -Staff B was hired on 06/22/16. -There was documentation of two continuing education units (CEU) related to medication administration in Staff B's personnel record for 2018. -There were no CEU's for 2017 that were passed related to medication administration. Interview with the Business Office Manager on 01/15/19 at 5:46pm revealed: -She was responsible for personnel records. -She thought Staff B had completed her annual CEUs. -The MAs were responsible for completing their annual CEUs on the computer system. -She had a spreadsheet to keep track of staff	D 127		

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D 127	Continued From page 27 CEUs. -She usually reviewed the spreadsheet at least monthly; she had not reviewed the spreadsheet since early December 2018. Interviews with the Administrator on 01/16/19 at 5:51pm revealed: -The Business Office Manager was in charge of the personnel records. -The Business Office Manager was responsible for making sure the MA had the required 6 hours of CEU annually. -The Business Office Manager assigned the training, scheduled training, sent reminders for training and audited the training records. -She did not audit personnel records. -She expected the Business Office Manager to keep the personnel records in order. -She expected the MAs to complete their required training. Attempted interview with Staff B on 01/16/19 at 5:32pm was unsuccessful.	D 127		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty	D 188		

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D 188	Continued From page 28 for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 39 shifts for 13 days from December 2018 - January 2019.	D 188		

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D 188	Continued From page 29 The findings are: Interview with a Resident 01/10/19 at 9:45am revealed: -He noticed recently, in the past few months the food was "cold as ice when it is served" and there was less staff to assist residents. -"One time I called several times and after almost an hour I went to the nurses' station and found her sleeping, I tried six times to wake her up before it worked and she gave me my medicine." Interview with a second Resident on 01/10/19 at 11:09am revealed: -It took staff on average twenty to twenty-five minutes when he called for assistance using the call bell. -He thought there were not enough staff and received help getting to meals often from other residents. Interview with a third Resident on 01/16/19 at 11:35am revealed: - It took staff up to thirty minutes to respond to his call bell when he had requested assistance changing his clothing, after an incontient episode. -Staff often argued with him when they did come to assist him after an episode of incontience his soiled bed pad. Interview with the Administrator on 01/11/19 at 1:15pm revealed: - A resident missed an appointment the day before because she was unable to find a facility staff who could take the resident to the appointment. -The driver had a conflict with another resident. -The floor staff were already short staffed from a staff member calling out of work.	D 188		

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The facility used a red dot system indicating a staff member from the current shift had to stay and work the next shift if needed, due to the next shift being short.
"Staff have decided I can not enforce the red dot by firing them all, so on some shifts all staff that are supposed to stay over on the next shift leave."

Observation on 01/10/19 at 9:48am revealed call bells ringing with no staff at the nurses' station to respond to resident needs.

Observation on 01/15/19 at 12:41am revealed no staff in nurses' station for two minutes as call bells were alarming and lights outside the doors connected to the call bell system, were not illuminatting.

Interview with the Physician Assistant on 01/10/19 at 12:10pm revealed:
-"My folder of things for me to review and sign has been quite thin the last 6 months."
-He had a feeling things were being missed and brought it to the previous Care Directors attention.
-"There seems to be a lot of chaos and no direct leadership lately."

Interview with a personal care aide (PCA) on 01/14/19 at 11:41am revealed:
-There was only one PCA working with the residents on the Assited Living side of the facility; the needs of the residents showed they needed more than one PCA.

Interview with a resident on 01/11/19 at 10:51am revealed:
-The entire facility was short staffed.
-The laundry was always behind because the

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laundry worker was also a PCA and was always being pulled to help with resident care.
-The residents were not supposed to help other residents.
-The residents had to help get residents to and from the dining room because the staff were busy.

Interview on 01/16/19 at 5:51pm with the Administrator revealed:
-They were short staffed a lot; staff called out every day, every shift.
-They had a red dot system in place for call outs; a red dot was placed beside staff names indicating the expectation for them to stay after their shift and work the next shift.
-If there was not enough staff on a shift, the Care Manager and/or the medication aide/supervisor would work the shift.
-Staff were supposed to give notice if they were not going to be able to work their scheduled shift; a 24-hour notice was expected prior to their shift during the week and 8-hours during the weekend.
-Staff called out at the last minute all the time.
-She has had staff say "what are they going to do fire us all" as they left the building at the end of their shift.
-She had some staff members that were very reliable and always stayed over.

Review of the Resident Bed List Report dated 12/05/18 revealed there was a census of forty-six residents residing on the assisted living (AL) unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/05/18 revealed there were 11.96 aide hours provided on third shift leaving the AL unit

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D 188	Continued From page 32 4.04 aide hours short. Review of the Resident Bed List Report dated 12/06/18 revealed there was a census of forty-five residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift. Review of the Individual Employee Time Cards dated 12/06/18 revealed there were 13.31 aide hours provided on third shift leaving the AL unit 2.69 aide hours short. Review of the Resident Bed List Report dated 12/07/18 revealed there was a census of forty-five residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift. Review of the Individual Employee Time Cards dated 12/07/18 revealed there were fifteen aide hours provided on third shift leaving the AL unit one aide hour short. Review of the Resident Bed List Report dated 12/08/18 revealed thee was a census of forty-five residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift. Review of the Individual Employee Time Cards dated 12/08/18 revealed: -There were 15.60 aide hours provided on second shift leaving the AL unit 4.40 aide hours short. -There were no aide hours provided on third shift leaving the AL unit sixteen aide hours short.	D 188		

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Review of the Resident Bed List Report dated 12/09/18 revealed there was a census of forty-four residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/09/18 revealed:
-There were 16.71 aide hours provided on first shift leaving the AL unit 3.29 aide hours short.
-There were 10.58 aide hours provided on third shift leaving the AL unit 5.42 aide hours short.

Review of the Resident Bed List Report dated 12/11/18 revealed there was a census of forty-five residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/11/18 revealed there were 10.73 aide hours provided on third shift leaving the AL unit 5.27 aide hours short.

Review of the Resident Bed List Report dated 12/12/18 revealed there was a census of forty-five residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/12/18 revealed there were 11.02 aide hours provided on third shift leaving the AL unit 4.98 aide hours short.

Review of the Resident Bed List Report dated 12/13/18 revealed there was a census of forty-five residents residing on the AL unit, which

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required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/13/18 revealed there were 7.05 aide hours provided on third shift leaving the AL unit 8.95 aide hours short.

Review of the Resident Bed List Report dated 12/14/18 revealed there was a census of forty-three residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/14/18 revealed:
-There were 15.06 aide hours provided on second shift leaving the AL unit 4.94 aide hours short.
-There were 7.14 aide hours provided on third shift leaving the AL unit 8.86 aide hours short.

Review of the Resident Bed List Report dated 12/27/18 revealed there was a census of forty-three residents residing on the AL unit, which required twenty hours of aide duty for first and second shift, and sixteen hours of aide duty on third shift.

Review of the Individual Employee Time Cards dated 12/27/18 revealed there were 11.11 aide hours provided on third shift leaving the AL unit 4.89 aide hours short.

Review of the Resident Bed List Report dated 01/02/19 revealed there was a census of forty-four residents residing on the AL unit, which required twenty hours of aide duty for first and

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D 188	Continued From page 35 second shift, and sixteen hours of aide duty on third shift. Review of the Individual Employee Time Cards dated 01/02/19 revealed there were 11.07 aide hours provided on third shift leaving the AL unit 4.93 aide hours short. The facility failed to assure there was adequate staff present at all times on all 3 shifts to respond to daily personal care needs and supervision of the residents residing in the AL for 14 of 39 shifts for 13 days from December 2018 through January 2019. The facility's failure to provide sufficient staffing to meet the needs of the residents in the AL unit was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 01/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2019.	D 188		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting	D 234		

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the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (Resident #3) was tested upon admission for tuberculosis (TB) disease.

The findings are:

Review of Resident #3's current FL2 dated 11/29/18 revealed diagnoses included cognitive disorder, psychosis, hearing loss, and vision loss both eyes.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/26/18.

Review of Resident #3's record revealed:
-There was no documentation of a TB skin test in the record.
-There was a chest x-ray obtained on 10/24/18 with documentation "no active TB."

Interview with the Care Manager (CM) on 01/16/19 at 2:34pm revealed:
-The CM was responsible for making sure all residents had a TB skin test upon admission.
-She was not the CM when Resident #3 was admitted to the facility.
-She had noticed resident records were missing a lot of required documentation.
-She had told the Administrator that some residents "charts" were incomplete.

Interview with the Administrator on 01/16/19 at

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D 234	Continued From page 37 5:52pm revealed: -She knew Resident #3 did not have a TB skin test upon admission to the facility. -To her knowledge Resident #3 did not have a history of positive TB test. -The hospital wanted to quickly discharge Resident #3 so she told the hospital to do a chest x-ray instead of a TB skin test. -After admitting Resident #3 to the facility she did not complete a TB skin test on the resident. Based on record review, observation, and attempt interview on 01/09/19 it was determined Resident #3 was not interviewable.	D 234		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or	D 254		

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substance abuse services or community resource.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to complete assessments and care plans for 4 of 7 residents sampled (#3, #4, #5, and #20) to determine levels of assistance required for the residents.

The findings are:

1. Review of Resident #5's current FL-2 dated 11/29/18 revealed:
-Diagnoses included chronic respiratory failure with hypoxia, hypertension, muscle weakness, difficulty walking, heart failure and schizophrenia.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing and dressing.

Review of Resident #5's Resident Register revealed an admission date of 09/21/18.

Review of Resident #5's record revealed there was no documentation of an assessment and care plan for activities of daily living within thirty days of admission.

Interview with Resident #5 on 01/09/19 at 11:12am revealed:
-She was not ambulatory due to weakness.
-She was dependent on a wheelchair and required assistance with transfers at times.
-She needed assistance with bathing and dressing.

Interview with a personal care aide (PCA) on 01/11/19 at 1:00pm revealed:

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D 254	Continued From page 39 -Resident #5 was dependent on a wheelchair for ambulation; there were times Resident #5 would ask for assistance with transfers. -Resident #5 would allow staff to do everything for her, but was able to do things for herself, so they encouraged her to be more independent. -Resident #5 needed assistance with washing her feet and back. -Resident #5 would tell you when she needed assistance. Interview with a medication aide (MA) on 01/15/19 at 5:00pm revealed: -Resident #5 would ask for assistance when she needed it. -She was not sure what assistance Resident #5 needed because she had not looked at her record; she usually reviewed new residents records, but she had been busy and had not had time. Interview with a second MA on 01/16/19 at 11:27am revealed: -Resident #5 needed assistance with washing her back and her feet. -Resident #5 sometimes needed assistance with transfers; she liked for others to do things for her that she could do herself. Interview with the Care Manager on 01/16/19 at 2:34pm revealed she did not know Resident #5 did not have a care plan completed. Interview with the Administrator on 01/16/19 at 5:51pm revealed she did not know Resident #5 did not have a care plan completed. Refer to interview with Business Office Manager on 01/16/19 at 10:23am.	D 254		

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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 254	Continued From page 40 Refer to interview with the Care Manager on 01/16/19 at 2:34pm. Refer to interview with the Administrator on 01/16/19 at 5:50pm. 2. Review of Resident #3's current FL2 dated 11/29/18 revealed: -Diagnoses included cognitive disorder, psychosis, hearing loss, and vision loss both eyes. -There was no disorientation status marked. -Ambulatory status was ambulatory. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/26/18. Review of Resident #3's record revealed there was no documentation of an assessment and care plan for activities of daily living within thirty days of admission to the facility. Interview with the Care Manager (CM) on 01/16/19 at 2:34pm revealed: -The facility staff provided activities of daily living assistance to Resident #3 with bathing/showering and dressing. -The other staff were verbally made aware of residents needs and they talked with the residents and/or their family. -She knew some residents, especially the new residents did not have a care plan. -A few weeks ago she told the Administrator (by text message) that some residents "charts" were incomplete and missing documents like Care Plans. -The Administrator did not respond back to her. -She had been working to get the records completed with the required paperwork, but it was	D 254		

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D 254	Continued From page 41	D 254		

still a work in progress because the facility admitted nine new residents within the past two-three months.
-She did not know specifically that Resident #3 did not have a care plan, but it did not surprise her.

Interview with the Administrator on 01/16/19 at 5:52pm revealed:
-She did not do audits of the residents records.
-She did not know Resident #3 did not have a care plan.

Based on record review, observation and attempt interview on 01/09/19, it was determined that Resident #3 was not interviewable.

Refer to interview with Business Office Manager on 01/16/19 at 10:23am.

Refer to interview with the Care Manager on 01/16/19 at 2:34pm.

Refer to interview with the Administrator on 01/16/19 at 5:50pm.

3. Review of Resident #20's current FL2 dated 09/28/18 revealed:
-Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia.
-The resident was ambulatory with a rolling walker.
-The resident had a colostomy.

Review of Resident #20's Resident Register revealed the resident was admitted to the facility on 10/28/18.

Review of Resident #20's record revealed there

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D 254	Continued From page 42 was no documentation of an assessment and care plan for activities of daily living within thirty days of admission to the facility. Interview with Resident #20 on 01/16/19 at 3:57pm revealed: -He had resided at the facility since September 2018. -He did not have a guardian or power of attorney, he was his own decision maker. -The facility had not met with him and discussed a service plan or services they would offer to him. -When he was admitted to the facility they showed him a room, told him where to go eat meals and ask staff for help with the colostomy. Interview with the Care Manager (CM) on 01/16/19 at 2:34pm revealed: -The facility staff provided activities of daily living assistance to Resident #20 with transfers, ambulation, dressing and caring for his colostomy. -She knew some residents did not have a care plan. -She did not know specifically Resident #20 did not have a care plan, but was not surprised. Interview with the Administrator on 01/16/19 at 5:52pm revealed she did not do audits of the residents records and she did not know Resident #20 did not have a care plan. Refer to interview with Business Office Manager on 01/16/19 at 10:23am. Refer to interview with the Care Manager on 01/16/19 at 2:34pm. Refer to interview with the Administrator on 01/16/19 at 5:50pm.	D 254		

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D 254	Continued From page 43 4. Review of Resident #4's current FL2 dated 01/03/19 revealed diagnoses included bipolar affective disorder, depressed severe with psychotic behavior, diabetes mellitus, heart disease, hypertension, asthma, hypothyroidism, lumbar radiculopathy, and esophageal reflux. -Resident #4 required personal care assistance with bathing and dressing. -Resident #4 was in a semi-ambulatory with a wheelchair. -Resident #4 was a diabetic who received insulin. Review of Resident #4's Resident Register revealed an admission on 01/10/18. Review of Resident #4's care plan records revealed there was no documentation a Care Plan or assessment had been completed. Interview with a Medication Aide (MA) on 01/15/19 at 5:08pm revealed the Care Manager was responsible for all Care Plans for residents on the Assisted Living and Memory Care Units. Interview with Administrator on 01/16/19 at 5:50pm revealed: -She was not aware that Resident #4 did not have a Care Plan. -The Care Manger was responsible for Care Plans. Refer to interview with Business Office Manager on 01/16/19 at 10:23am. Refer to interview with the Care Manager on 01/16/19 at 2:34pm. Refer to interview with the Administrator on 01/16/19 at 5:50pm.	D 254		

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D 254	Continued From page 44 Interview with Business Office Manager on 01/16/19 at 10:23am revealed: -Record audits were done by the Care Manager , but ultimately the Administrator was responsible for ensuring Care Plans were completed on all residents. -The Care Manager, Administrator and the Resident Care Coordinator (RCC) were to work together to ensure everything was completed, however, the RCC position had been open since early 2018 which had created more hardships. -The Care Manager was having to complete record audits for both the Assisted Living and Memory Care Units. Interview with Care Manager on 01/16/19 at 2:34pm revealed: -She started her current position 12/19/18. -Previously she was a MA and she still worked shifts about every other day, and had trouble getting everything done. -She had told the Administrator there were missing Care Plans on residents. -She was working on the record audits for the newly admitted residents and then would start with the residents that had been in the facility when she took the position. Interview with the Administrator on 01/16/19 at 5:50pm revealed: -The Care Manager was responsible for Care Plans. -She did not know how to do Care Plan documentation in the computer system. -She had not done record audits, she expected the Care Manager to have done record audits.	D 254		

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D 269	Continued From page 45	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure staff provided personal care assistance for 4 of 7 sampled resident's (Residents #7, #9, #10 and #20) regarding a resident not receiving colostomy care (#20), two residents being blind and not receiving timely assistance with incontinence care (#7 and #9), and a resident who had incontinence episodes while waiting for toileting assistance (#10). The findings are: Interviews with six residents during the initial tour of the facility on 01/10/19 between 10:15am and 11:45am revealed: -He thought the facility did not have enough staff and he had often received help getting to meals from other residents. -Two residents said they had soiled their clothes waiting for staff assistance with toileting. -Four residents said they had heard residents yelling for staff assistance to come and help. -One resident said he had seen a male resident that was blind in the hallway without clothes on	D 269		

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D 269	Continued From page 46 yelling for staff to help him. 1. Review of Resident #20's current FL2 dated 09/28/18 revealed: -Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia. -The resident had a colostomy. Review of Resident #20's Resident Register revealed the resident was admitted to the facility on 10/05/18. Review of Resident #20's record revealed there was no documentation of an assessment and care plan for activities of daily living within thirty days of admission to the facility. Observation of Resident #20 in his room on 01/16/18 at 3:58pm revealed: -Resident #20 was sitting in a wheelchair. -The resident had both his arms folded across the lower part of his stomach as if he was holding something. Interview with Resident #20 on 01/16/19 at 11:35am revealed: -He had a colostomy. -He was out of colostomy bags and the facility used "chuck pads" to cover the stoma. -The pad was soaked and leaking. -He had been waiting for staff for a long time to come and help him. -He also needed staff assistance to get of the wheelchair into bed and he needed assistance getting out of bed into the wheelchair. -It sometimes took staff up to thirty minutes for staff to respond when he pulled the call bell. -When in the bed he could not reach the call bell cord so he yelled for staff to come and help him.	D 269		

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D 269	Continued From page 47 -Sometimes it took a long time for staff to come and help him get in or out of bed he tried to transfer himself. -Sometimes he was successful, sometimes he fell to the floor. Interview with a personal care aide (PCA) on 01/10/19 at 10:51am revealed: -Resident #20 required assistance with changing the "chuck pad" that was used to cover his colostomy. -The assistance was provided by the medication aides (MA). -Resident #20 did not have bags for the colostomy and chuck pads were used to cover the colostomy. -The colostomy leaked and the "chuck pad" often got soaked. -It took a long time to clean the resident and the room. Interview with a second shift medication aide (MA) on 01/15/19 at 5:16pm revealed: -Resident #20 had a colostomy. -The MAs assisted Resident #20 with incontinence personal care by changing the colostomy after a bowel movement. -Resident #20 was out of colostomy bags, she used "chuck pads" to cover the opening. -Because Resident #20 had no bags for the colostomy he frequently soiled the "chuck pads" that were used to cover the colostomy. Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am. Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am. 2. Review of Resident #7's current FL2 dated	D 269		

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D 269	Continued From page 48 01/03/19 revealed: -Diagnoses included depression, glaucoma, degenerative joint disease, fracture of humerus, macular degenerative. -The resident was semi-ambulatory with the use of an electric wheel-chair. Review of Resident #7's Care Plan dated 06/07/18 revealed: -Resident #7 vision was "very limited (blind)." -Resident #7 was sometimes disoriented, but had adequate memory. -Resident #7 required extensive assistance with bathing/showering. -Resident #7 required limited assistance with ambulation, transfers to the toilet, dressing and cutting food. -The resident required supervision with transfers. Observation of Resident #7 in her room on 01/09/19 at 11:28am revealed: -Resident #7 was blind. -The resident was observed sitting in a lounge chair in her room. -The resident's pants were pulled down middle ways on her thighs. -The resident's white incontinence brief was showing and visible when opening the door to the room. Interview with Resident #7 on 01/09/19 at 11:29am revealed: -She was blind. -She was waiting to go to the bathroom. -She had on a incontinence brief, and without the brief she would have soiled herself. -"I have been waiting for over thirty minutes to go to the bathroom. -She knew how long it took staff because she checked her watch, which verbally told her the	D 269		

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time, date, month and year.
-She could not take herself to the bathroom because she had been feeling weak in her legs.
-She was afraid to stand without staff assistance for fear she might fall.
-Staff complained that she should have called them earlier, but it did not matter what time she pulled her call bell cord, they still took a long time to come and assist her.

Interview with Resident #7's guardian on 01/15/19 at 1:30am revealed:
-Resident #7 was blind and needed staff to help her with toileting, dressing, showering/bathing, transferring to meals and helping with cutting up food.
-When Resident #7 had to use the bathroom she had to get into the wheelchair.
-She needed staff assistance because she might fall.
-If the resident did not have on the brief she would soil for chair.

Interview with another resident's family member on 01/10/19 at 9:25am revealed:
-She visited her family member every other day.
-She knew that Resident #7 was blind.
-Sometimes when she came to see her family member she heard Resident #7 yelling from her room.
-The Resident's door was usually closed, "but you could still hear her yelling I need help."
-On several occasions she observed staff casually walking down the hallway saying "Oh' it's [named resident]."

Interview with the Physician Assistant (PA) at Resident #7's primary care physician's office on 01/11/19 at 10:50am revealed Resident #7 was blind and needed staff assistance with most of

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the activities of daily living, like dressing, showering, toileting, assistance to the dining room.

Interview with a personal care aide (PCA) on 01/11/19 at 10:18am revealed:
-Resident #7 was blind and dependent on facility staff to assist her with toileting, taking her to meals, dressing, showering/bathing.
-She checked Resident #7 every two hours and provided incontinence care and other care needs the resident required.
-It was the facility's policy to check residents every two hours.

Interview with a second shift medication aide (MA) on 01/15/19 at 5:43pm revealed:
-Resident #7 needed help getting dressed, bathing and going to the bathroom.
-Resident #7 was blind, but did go to the bathroom without staff assistance.
-Resident #7 also had an incontinence brief on in case she did not make it to the bathroom.
-The facility policy was to check on residents every two hours and provide incontinence care.

Interviews with four residents on 01/16/19 from 9:40am to 11:10am revealed:
-One resident heard Resident #7 yell for help at least two times per week.
-When she heard Resident #7 yell for help, she went to get staff to help the resident.
-A second resident heard Resident #7 yell for help.
-Resident #7 hollered loudly through her closed door.
-She heard Resident #7 yell and holler for help sometimes twice per day, on all shifts.
-A third resident heard Resident #7 yell for help, but did not know what was going on with the

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resident.
-A fourth resident heard somebody yell for staff to help, but could not identify the resident because he was blind.

Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am.

Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am.

3. Review of Resident #9's current FL2 dated 07/16/18 revealed:
-Diagnosis included legally blind.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory.

Review of Resident #9's Care Plan dated 11/29/17 revealed:
-The resident was blind, ambulatory with assistive device, had limited range of motion.
-Resident #9 required extensive assistance with bathing/showering and oral care.
-Resident #9 required limited assistance with dressing, ambulation and transferring.

Interview with Resident #9 on 01/15/19 at 10:03am revealed:
-He was blind and needed staff assistance with getting in and out of bed, going to the bathroom, getting dressed and going to meals.
-When he needed to get out bed to use the bathroom he had to wait a long time for staff to come.
-He had on a disposable brief, if he did not have the brief on he would soiled his clothes.

Interview with a personal care aide (PCA) on 01/11/19 at 10:18am revealed:
-Resident #9 was blind and needed staff

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assistance with bathing, toileting, and assistance to the dining room.
-Resident #9 had on an incontinence brief, and was checked every two hours for incontinence.
-If resident #9 waited too long he always yelled for help.

Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am.

Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am.

4. Review of Resident #10's current FL-2 dated 01/25/18 revealed:
-Diagnoses included schizophrenia, hypertension, hypothyroidism, irritable bowel, personality disorder, diabetes mellitus and bipolar mood disorder.
-Resident #10 was incontinent of bowel and bladder.
-Resident #10 required assistance with bathing and dressing.

Review of Resident #10's assessment and care plan dated 04/30/18 revealed:
-Resident #10 required extensive assistance with toileting including removing incontinent brief, fastening garments and hygiene after toileting.
-Resident #10 required extensive assistance with bathing, dressing, and grooming.

Interview with Resident #10 on 01/14/19 at 10:42am revealed:
-She required assistance with bathing, dressing, and toileting.
-If she needed assistance, she would pull her cord by the bed or commode.
-She always had to wait for someone to help her.
-She had soiled herself with both bowel and

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D 269	Continued From page 53 bladder on several occasions while waiting for someone to respond to her call bell. Interview with a medication aide (MA) on 01/15/19 at 5:00pm revealed: -Resident #10 required assistance with "everything"; she needed help with dressing and toileting. -Resident #10 wears incontinent briefs; "we ask her every two hours if she needed to toilet". -There could have been times they were so busy that Resident #10 may have not been able to wait and soiled herself. Interview with a personal care aide (PCA) on 01/16/19 at 9:53am revealed Resident #10 required assistance with showers, toileting and transfers. Interview with a MA on 01/16/19 at 11:27am revealed Resident #10 required assistance with dressing, showers and transfers. Refer to interview with a personal care aide (PCA) on 01/10/19 at 10:51am. Refer to interviews with two family members on 01/11/19 at 11:00am and 11:15 am. _____ Interviews with two family members on 01/11/19 at 11:00am and 11:15 am revealed they visited family members almost daily, "This place needs management, and staff needed training." Interview with a personal care aide (PCA) on 01/10/19 at 10:51am revealed it was the facility's policy to check residents every two hours with personal care need like toileting.	D 269		

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D 270	Continued From page 54	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 3 of 6 sampled residents (Residents #2, #6, and #20) with diagnoses of dementia, a history of repeated falls resulting in fractures. 1. Review of Resident #6's current FL2 dated 09/07/18 revealed: -Diagnoses included myocardial infarction, epilepsy, muscle weakness, hypertension and hypokalemia. -The resident was intermittently disoriented. -The resident was semi-ambulatory. -There was a physician's order physical therapy for five weeks. Review of Resident #6's Resident Register revealed there was no admission date documented (Other documents in the record revealed an admission date of 09/10/18).	D 270		

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D 270	Continued From page 55 Review of Resident #6's record revealed: -A hospital discharge summary dated 09/07/18, documented Resident #6's cognitive communication status fluctuated due to delusions. -The resident had a history of falls due to "poor safety awareness." Review of Resident #6's record revealed a summary visit note from the Physician Assistant (PA) dated 10/03/18 that documented Resident #6 was a "falls precaution." Review of Resident #6's record revealed a physical therapy document dated 12/05/18, stating Resident #6 "remains a high fall risk due to advanced dementia." Review of Resident #6's accident/incident reports and the hospital discharge summary reports from 09/10/18 through 01/16/19 revealed: -The resident had 13 falls from 09/10/18 through 01/02/19. -Two of falls resulted in fractures. -There was no documentation the facility put systems in place to supervise or monitor Resident #6 more frequently. -Review of the records revealed there was no documentation the facility had put any interventions and/or systems in place that routinely supervised or monitored Resident #6 with attempts to prevent or reduce the frequency of resident's falls. Review of Resident #6's accident/injury report and fall risk worksheets from September 2018 through January 2019 revealed: -On 09/10/18 at 8:15pm, Resident #6 was found sitting on the floor in her bedroom. Was not sent to the hospital and was put on the "72 hour	D 270		

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follow-up resident fall" watch.
-On 09/13/18 at 11:15am, Resident #6 was found in her bedroom, on the floor on her back. Was not sent to the hospital.
-On 09/24/18 at 2:45pm, Resident #6 was found siting on the floor in her bedroom. Was not sent to the hospital.
-On 10/15/18 at 9:50am, Resident #6 was found sitting on the floor. Was not sent to the hospital and put on "72 hour follow-up fall watch".
-On 10/16/18 at 1:00pm, Resident #6 was found sitting on the floor in her bedroom.
-On 11/02/18 11:30am, Resident #6 was found sitting on the floor. Resident #6 was sent to the hospital and was put on the "72 hour fall watch".
-On 11/14/18 at 1:50pm, Resident #6 was found lying in the floor in the lobby of the facility. Resident was to hospital.
-On 11/18/18 at 6:30pm, Resident #6 was found siting on the floor in her bedroom. Was not sent to the hospital.
-On 12/06/18 at 3:25pm, Resident #6 was found sitting on the floor at the end of her bed. Was not sent to the hospital, put on a "72 hour follow-up on resident fall" watch.
-On 12/09/18 at 7:45am, Resident #6 was found on the floor. Was not sent to the hospital.
-On 12/27/18 at 3:55pm, Resident #6 was observed on the floor in her room. There was documentation the resident had a "T" (thoracic) fracture.

Review of Resident #6's records revealed the following hospital discharge reports related to falls:
-On 09/27/18 Resident #6's roommate found her on the floor with a laceration. The resident sustained a two centimeter (cm) subcutaneous laceration to the left side of the head.
-On 11/02/18 Resident #6 fell and sustained an

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D 270	Continued From page 57 injury to the head. -On 11/14/18 Resident #6 fell and sustained a hematoma to the forehead and scalp contusion. -On 12/27/19 Resident #6 fell and sustained an "acute compression fracture T3" (thoracic spinal vertebrae located down the spinal column near the skull.) and pulmonary contusion. The documented Resident #6's "pelvis showed an age indeterminate L3 (located in the middle of the lumbar spine) compression fracture." -On 01/02/19 Resident #6 fell and sustained fall pulmonary contusion compression fracture and sustained a "1 x 5 cm superficial abrasion on the forehead." -All the hospital reports documented Resident #6 had dementia and cognitively was unable to provide creditable information. Review of Resident #6's record revealed the facility did not have accident/incident reports related to the falls that occurred on 09/27/18 and 01/02/19. Observation of Resident #6 from 01/09/19 through 01/16/19 revealed: -Resident #6 was sitting in her wheelchair in the main hallway from 8:30am through 5:00pm. -Resident #6 was unable to ambulate or walk without staff assistance. -At various times from 8:30am through 5:00pm there were no staff observed in the hallway with the resident. -There were periods up to forty minutes that no staff were present in the hallway with the resident. Interview with a personal care aide (PCA) on 01/10/19 at 10:48am revealed: -When staff documented a resident was found on the floor that meant the resident had a fall and no one was present to witness the fall.	D 270		

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D 270	Continued From page 58 -All staff knew Resident #6 had a lot of falls and was a fall risk. -Resident #6 fell because the resident tried to get up and walk. -When he saw Resident #6 trying to get up he told the resident not to get up. -When Resident #6 had a fall, she was put on fifteen minute checks for seventy-two hours. -After the seventy-two hours were completed, he checked on the resident every two hours, which was the facility's policy. -A couple of months ago the MAs told staff to "keep a good eye" on Resident #6, and to put Resident #6 in the main hallway to be viewed by all staff. Interview with the Administrator on 01/10/19 at 2:52pm revealed: -Resident #6 had physical therapy but it was not working due the resident's Dementia. -She thought the staff were doing a better job keeping the resident from falling. -She thought about having Resident #6 do activities to keep her busy. -She had not talked with the Activity Director about spending more time with Resident #6. -When Resident #6 had a fall the facility's policy was to put the resident on a "72 hour fall watch." -The seventy-two hour fall watch required staff to document every 15 minutes their observation of Resident #6. -After the seventy-two hours were completed staff had to check the resident every two hours, which was the facility's policy for all residents. -She had not considered other alternatives to keep Resident #6 from falling. -The facility's falls policy also required, when a resident fell and hit their head or was unconscious the resident was immediately sent to the hospital.	D 270		

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-The person that finds the resident was to contact the MA supervisor on duty.
-The MA supervisor assessed the resident and contact the PA and the guardian.
-If no injuries were observed the fall was considered "non-reportable" and no incident report was completed for the fall.

Interview with the first shift MA on 01/11/19 at 9:00am revealed:
-Resident #6 had about "forty" falls.
-She did not know if the resident had fractures or broken bones.
-Five or six of the falls were because the resident was trying to walk and lost her balance and the resident was found sitting on the floor.
-Most of Resident #6's falls were in the resident's room.
-Resident #6 was considered a "high risk."
-A couple of months ago staff started keeping Resident #6 in the hallway, so the resident was in sight of staff.
-She noticed the resident fell less on her shift.
-There were no other interventions or systems put in place to decrease or prevent Resident #6 falls.
-The facility's protocol for falls was if a resident fell and hit their head, they were automatically sent to the hospital.
-The incident report was faxed to the PA and if there was a guardian the MA called the guardian.
-If the resident did not complain about pain and there were no visible injuries, that was considered a non-reportable incident, therefore no incident report was done and the PA and guardian were not notified.

Interview with a personal care aide (PCA) on 01/11/19 at 10:18am revealed:
-She checked the residents every two hours for incontinence and to assess their well-being.

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-The only time she checked Resident #6 more often was after a fall, the resident was checked every fifteen minutes for seventy-two hours.
-Once the seventy-two hours were up, the resident was back on two hour checks.
-Resident #6 was always left in the hallway to be observed by staff, but the resident still had falls.
-Resident #6 was forgetful and always tried to get up out of her chair and walk.
-The resident was unable to walk and she fell to the floor.
-Other than leaving the resident in the hallway during the daytime hours no others interventions were put in place to reduce or prevent Resident #6 falls.
-The facility's falls policy required, when a resident fell and hit their head or was unconscious the resident was immediately sent to the hospital.
-The person that finds the resident was to contact the MA supervisor on duty.
-The MA supervisor assessed the resident.
-If the resident stated they were in pain or they were bleeding, the MA called the PA or on-call services.
-The PA decided if the resident went out to the hospital.
-Resident #6 had a PA, but in October 2018, the PA stopped coming to the facility.
-She still sent Resident #6's accident/incident reports to the PA, but never got a response back.
-On 01/10/19 Resident #6 got a new PA, but that PA did know the resident had falls.

Interview with a medication aide (MA) on 01/15/19 at 5:34pm revealed:
-Since she started working at the facility in July 2018, she witnessed Resident #6 had at least three falls.
-The last fall the resident sustained resulted in a

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fracture to a bone in her back.
-Resident #6 was considered a "fall risk," but no instructions had been given to watch the resident or monitor her more frequently.
-She tried to keep an eye on the resident, but that was not easy because she could not be in one place.

Based on record review, observation and attempted interview on 01/09/19 it was determined Resident #6 was not interviewable.

Attempted interview on 01/15/19 at 11:13am with Resident #6's guardian was not successful.

Refer to interview with the Care Manager (MA) on 01/10/19 at 2:08pm.

Refer to interview with the first shift personal care aide (PCA) on 01/11/19 at 10:18am.

2. Review of Resident #2's current FL2 dated 10/01/18 revealed:
-Diagnoses included vascular dementia, chronic obstructive pulmonary disease, and acute respiratory failure.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory.

Review of Resident #2's Care Plan dated 03/12/18 revealed:
-The resident was ambulatory with "aide or device."
-Resident #2 required limited assistance with bathing and dressing.
-The resident was independent with ambulation, transfers, toileting and eating.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and

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D 270	Continued From page 62 quarterly review dated 06/19/18 revealed: -The task of physical therapy was documented and evaluated by the nurse. -The nurse documented the resident ambulates with a walker. -The nurse documented on 05/30/18 staff observed Resident #2 sitting on the floor. Review of Resident #2's accident/incident reports, hospital discharge summary reports and other documents revealed: -Resident #2 had seven falls from 01/24/18 through 01/16/19. -One fall resulted in a hip fracture and another fall resulted in sprain of the spine and head injury. -Review of the records revealed there was no documentation the facility had put any interventions and/or systems in place that routinely supervised and/or monitored Resident #2 with attempts to prevent or reduce the frequency of resident's falls Review of Resident #2's accident/incident reports and 72 hour follow-up resident fall worksheet revealed: -On 01/24/18 (no time documented) Resident #2 fell on the first shift, no injury documented. -On 04/12/18 (no time documented) Resident #2 fell on the third shift, no injuries documented. -On 06/19/18 (no time documented) Resident #2 fell on the first shift, no injuries documented. -On 08/20/18 at 8:55pm, Resident #2 was observed lying on the floor on her left side. The resident was sent to the hospital. -On 10/01/18 at 9:45am, Resident #2 was found sitting on the floor against the bed. -On 12/14/18 at 9:10pm, Resident #2 was found sitting in the floor with red fluid coming from her eye.	D 270		

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Review of Resident #2's record revealed hospital discharge summary reports related to falls:
-On 08/20/18 Resident #2 fell and received a hip fracture and head injury (sent to rehabilitation).
-On 12/14/18 Resident #2 fell and received superficial injury of the head, contusion of right knew, sprain of ligaments of cervical spine.

Observation of Resident #2 at various times from 01/09/18 through 01/15/19 revealed:
-From 8:30 am to 3:00pm Resident #2 was observed sitting in her wheelchair in the main hallway.
-The resident sometimes wheeled herself from the front of the building to the back of the building.
-No attempts were observed of the resident trying to get up or falling.

Interview with Resident #2's guardian on 01/10/19 at 9:25am revealed:
-She visited Resident #2 every other day and had never seen the Administrator.
-She had left several notes, putting them under the Administrator door regarding Resident #2's declining mental status.
-She had also left several phone messages for the Administrator regarding the same issue.
-As of today's date (01/10/19), the Administrator had not returned her phone call or tried to communicate with her.
-Resident #2 fell in August 2018, and sustained a hip fracture.
-The resident was in rehab until October 2018.
-The same night that Resident #2 returned back to the facility she fell again.
-Resident #2 had another fall three weeks ago.
-That was one of the reasons why she needed to talk with the Administrator.
-The facility had made her aware that Resident

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D 270	Continued From page 64 #2 had at least three falls. -If the resident had more falls she did not know. -In 08/2018 (unable to recall exact date), Resident #2 fell and broke her hip. -The resident returned back to the facility on 10/01/18 and fell again the same day. -Resident #2 had another fall before Christmas, but she was told the resident had no injuries. Interview with a personal care aide (PCA) on 01/11/19 at 10:18am revealed: -Resident #2 was considered a "fall risk." -Resident #2 frequently moved around and tried to get out of her chair. -Resident #2 was kept in the main hallway during the first shift for staff to keep an eye on the resident. -The facility's fall policy required, if a resident was found on the floor, that was an "unwitnessed fall." -The staff that finds the resident should contact the MA supervisor on duty. -The MA supervisor will asses the resident for injuries and if injuries or pain the MA contacted the PA. -If the resident does not go to the hospital the "72 hour follow-up fall worksheet" system will start immediately. -If the resident goes out to the hospital, when the resident returned staff completed the"72 hour fall follow-up worksheet." Interview with a medication aide (MA) on 01/15/19 at 5:34pm revealed: -Resident #2 had falls, but she did not think the resident had a lot of falls. -Resident #2 was kept in the main hallway during the first shift for staff to keep an eye on the resident. -The facility's fall policy required after a fall staff implemented the "72 hours follow-up fall	D 270		

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worksheet."
-If Resident #2 fell and hit their head, she would automatically be sent to the hospital.
-If no injuries were observed and the resident did not complain of pain, the that was considered a "non-reportable incident and no documentation was completed.
-Other than the "72 hour follow-up fall worksheet," and keeping Resident #2 in the main hallway during the first shift, no other interventions had been put in place regarding Resident #2's falls.

Interview with the Care Manager (CM) on 01/16/19 at 2:52pm revealed:
-Resident #2 was a fall risk.
-The staff were to keep Resident #2 in the hallway during the first shift for staff to observe the resident.
-The facility's falls policy consisted of monitoring Resident #2 after a fall "72 hours.
-The "72 hours follow-up fall worksheet required staff to observe Resident #2 every 15 minutes for "72 hours."
-After the "72 hours were completed" Resident #2 was back on checks every two hours.
-No other documented interventions or systems were put in place for Resident #2 falls outside of staff keeping the resident in the main hallway.

Based on record review, observation, and attempt interview on 01/09/19 at 12:10pm it was determined Resident #2 was not interviewable.

Refer to interview with the Care Manager (MA) on 01/10/19 at 2:08pm.

Refer to interview with the first shift personal care aide (PCA) on 01/11/19 at 10:18am.

3. Review of Resident #20's current FL2 dated

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09/28/18 revealed:
-Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia.
-Ambulatory status was "ambulatory" with a rolling walker.

Review of Resident #20's Resident Register revealed the resident was admitted to the facility on 10/05/18.

Review of Resident #20's record revealed there was no Care Plan.

Review of Resident #20's record revealed on 12/03/18 Resident #20's Physician Assistant (PA) noted the resident had a history of "repeated falls and muscle weakness."

Review of Resident #20's accident/incident report and hospital discharge summary report revealed:
-Resident #20 had four documented falls from October 2018 to January 2019.
-One fall resulted in a fracture of the coccyx.
-Review of the records revealed there was no documentation the facility had put any interventions and/or systems in place to supervise or monitor Resident #20 in an attempt to prevent the resident from falling.

Review of the Resident #20's accident/incident reports and "72 hour follow-up resident fall worksheet" revealed:
-On 10/20/18 at 9:30am Resident #20 fell, a"72 hour follow-up fall worksheet" was completed, no injuries noted.
-On 12/21/18 (no specific time) fell getting out of the wheelchair, a "72 hour follow-up fall worksheet" was completed.
-On 12/30/18 at 10:09pm, Resident #20 fell trying

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to transfer from his chair to his bed.
-On 01/05/19 at 2:45pm, Resident #20 was observed laying on the floor in his bedroom with injury to the right hip (did not go to the hospital).

Review of Resident #20's records revealed the following hospital discharge summary reports related to falls:
-On 12/21/18, Resident #20 was sent the emergency department as the result of a fall.
-Documentation in the report noted Resident #20 fell while getting out of the wheelchair.
-There were no fractures noted, instructions were to follow-up with the physician in one - two days.
-On 12/30/18, Resident #20 was sent the emergency department as the result of a fall.
-Documentation in the report noted Resident #20 fell on this "buttock" getting in his wheelchair.
-Resident #20 received a fracture of the coccyx.
-Discharge instructions were to follow-up with the physician in one - two days.
-There was documentation Resident #20 was unable to independently transfer, bathe, toilet, and dress himself.

Interview with Resident #20 on 01/16/19 at 3:57pm revealed:
-He resided at the facility since September 2018.
-He had fallen several times since he moved into the facility.
-He sustained a fracture from one of his falls.
-All falls occurred because he was trying to transfer himself from the wheelchair to the bed or from the bed to the wheelchair.
-He needed staff assistance with the transfers getting out of the wheelchair to the bed and out of the bed to the wheelchair.
-He pulled the call bell for staff, but it took staff a long time to come to this room.
-He sometimes had to holler for staff to come to

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the room.
-He usually got tired of waiting and tried to transfer himself.
-Sometimes he waited three to four hours for staff to come and assist him.
-When transferring himself sometimes he did not make the transfer and he fell.
-When he fell his roommate yelled in the hallway for staff to come and assist him.
-He fell because his legs sometimes "locked up."
-He was sure facility staff knew about his falls because they had to help him up off the floor.
-Also, he did not have shoes to balance himself when he stood.
-He returned from the hospital last week wearing shoes, but now he could not find his shoes.
-He asked facility staff about his shoes and they told him that they could not find his shoes.
-Staff did not check on him every two hours, if they checked on him it was when they walked passed his room.

Interview with Resident #20's roommate on 01/16/19 at 4:11pm revealed:
-Resident #20 was always falling.
-The resident fell more than six times since he came to the facility.
-Last week Resident #20 fell three times.
-It took staff a long time to come and help Resident #20 get in or out of his bed and wheelchair.
-Resident #20 got tired of waiting so tried to transfer himself.
-Resident #20 did not fall every time he transferred himself, but there were times when he fell to the floor.
-He was sure the staff knew about Resident #20's falls because they had to help the resident off the floor.

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D 270	Continued From page 69 Attempted interview with the PA of Resident #20's primary care physician's office on 01/16/19 at 4:52pm was unsuccessful. Refer to interview with the Care Manager (MA) on 01/10/19 at 2:08pm. Refer to interview with the first shift personal care aide (PCA) on 01/11/19 at 10:18am. _____ Interview with the CM on 01/10/19 at 2:08pm revealed: -The facility's falls policy consisted of the "72 follow-up falls worksheet" and sending the resident to the emergency room if the resident hit their head. -The MA supervisor on duty was to do an assessment of the resident, then notify the PA if the resident complained of pain and there was blood. -If the resident fell and hit their head, they were immediately sent to the emergency. -The staff who found the resident was to take the resident's vital signs. -The MA was to notify the responsible person/guardian to tell what happened. -A fall incident report should be done on all falls when the resident was sent out of the facility. -If the resident fell, but had no injuries or pain, that was considered a "non-reportable incident" and no report of the incident was done. -However, staff should document any incident on the shift notes to give the oncoming staff updates on the residents. -The staff coming on the next shift should read the shift notes, but management did not check shift notes. -When the resident returned to the facility the resident was put on a "72 hour follow-up falls worksheet", for three days.	D 270		

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D 270	Continued From page 70 -During the "72 hours" staff documented that they check on the resident every fifteen minutes. -After the "72 hours" were completed the resident was back on the standard facility policy of checking residents every two hours. -The hospital report was put in the folder for the PA to review. -The PA visited the facility every Thursday. Interview with the first shift PCA on 01/11/19 at 10:18am revealed: -She worked at the facility as a MA, PCA and as the laundry person. -The falls policy consisted of "72 hour follow-up falls worksheet," and sending the resident immediately to the hospital if they hit their head. -She checked on residents every two hours, that was the facility's practice and how she was trained. -When she checked the residents, she checked for incontinence and to assess their well-being. -When she worked as a PCA she had to assist the residents and answer the call bells. -The MAs would come to find her and told her which resident was calling for help. -It sometimes took a while to help residents, especially when she did not know they needed help. _____ The facility failed to provide supervision for Resident #6, who had dementia and a history of frequent falls and sustained two fractures; Resident #2 who also had dementia and received a broken hip and multiple contusions and Resident #20 who frequently fell because staff did not provide timely response to calls for assistance. The facility's failure resulted in physical injuries to the residents, and placed the residents at substantial risk for further physical harm and neglect which constitutes a Type A2	D 270		

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D 270	Continued From page 71 Violation _____ The facility provided a plan of protection on 01/10/19 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure physician notification and referrals for 5 of 6 sampled residents (Residents #2, #4, #12, #13, and #14) related to transportation to medical appointments and medication refusals (#4); failed to schedule dermatology follow-up appointments for residents in the Special Care Unit with a rash (#12, #13, #14) and failed to contact the oxygen medical supplier for oxygen tank refills for a resident ordered continuous oxygen (#2). The findings are:	D 273		

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D 273	Continued From page 72 Review of Resident #4's current FL2 dated 01/03/19 revealed diagnoses included bipolar affective disorder, depressed severe with psychotic behavior, diabetes mellitus, heart disease, hypertension, asthma, hypothyroidism, lumbar radiculopathy, and esophageal reflux. A. Review of Resident #4's Accident/Injury Reports revealed: -On 12/03/18 at 5:45am the resident had chest pain and wanted to be sent to hospital. -On 12/10/18 at 7:01pm the resident had chest pain and wanted to be sent to the hospital. Review of a Hospital Discharge Summary report for Resident #4 dated 12/03/18 revealed: -Resident #4 was seen in the Emergency Department for chest wall pain and was to follow up with her Physician Assistant (PA) in two to three days. -There was a scheduled appointment reminder for Resident #4's pulmonary appointment on 01/08/19. -There was a scheduled appointment reminder for Resident #4's neurology appointment on 01/10/19. Review of Gastroenterologist visit summary report for Resident #4 dated 12/13/18 a scheduled cardiology appointment for 12/20/18. Interview with Resident #4 on 01/09/19 at 11:53am revealed: -She had two medical appointments she had made "months ago" that had to be rescheduled due to not having transportation. -She had made the appointments during her visit and brought the paperwork back to the facility, so they could be put on the transportation schedule.	D 273		

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D 273	Continued From page 73 -She missed her appointment for 01/08/19 and the next available appointment was not until 02/22/19. -She missed an appointment for 12/11/18 and the next available appointment was not until April 2019. -She was concerned she had missed her appointments because they were for ongoing medical problems. Interview with Resident #4 on 01/15/19 at 4:48pm revealed: -She got the available dates from staff in advance before she scheduled her appointments. -She was very concerned she missed so many appointments. -She missed her cardiology follow up appointment one time because she told the transporter and he forgot to put it on the calendar and then another resident was scheduled for an appointment at that time. -She was concerned the staff decided what resident went to their appointments and which appointments last minute had to be canceled. -She missed an appointment the other day because another resident had an emergency. -She felt her appointments were important and if another resident had an emergency she should not have to miss her appointment and someone else should have taken her to the appointment. Interview with the primary care PA of Resident #4's on 01/10/19 at 1:14pm revealed: -He was not aware Resident #4 had missed multiple cardiology, neurology and pulmonary appointments recently. -He was very concerned that Resident #4 had missed appointments, because she needed to be followed closely by specialists to monitor, assess, and evaluate her medical needs.	D 273		

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D 273	Continued From page 74 -He was also concerned about the impact all the missed appointments had on Resident #4's mindset. Telephone interview with a nurse from Resident #4's cardiologist's office on 01/11/19 at 9:30am revealed: -Resident #4 had canceled appointments on 12/20/18, 01/28/19, and 01/31/19 due to no transportation and was currently now scheduled for 02/01/19. -She was concerned Resident #4 did not have an appointment after her chest wall pain first started on 12/03/18 and she was taken to the hospital. -Resident #4 was already being seen by cardiology for edema (swelling) of her legs and tachycardia (increased heart rate). -There was concern that the lack of follow-up care could worsen Resident #4's condition and that she could have more chest pain, an abnormal heart rhythm, or even a heart attack. Telephone interview with a nurse from pulmonologist's office Resident #4's on 01/11/19 at 9:46am revealed Resident #4 had an appointments for 01/08/19 and 02/22/19 that were canceled she was supposed to be seen for a follow up and medication management of her asthma. Telephone interview with a nurse from Resident #4's neurologist's office on 01/11/19 at 9:58am revealed -Resident #4 had an appointment on 01/10/19 that was canceled and rescheduled for 04/11/19 for her 6 month follow-up appointment. -Resident #4 was last seen 07/09/18 and was to be followed every 6 months for her tremors and medication management. -Resident #4 was to have her medication possibly	D 273		

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adjusted based upon this appointment, without her coming to the appointment the medication could not be adjusted by her physician.

Telephone interview with a nurse from Resident #4's cardiologist office on 01/11/19 at 12:34pm revealed the cardiologist was also concerned about medication management with all of the missed appointments recently.

Interview with the Facility Transporter on 01/11/19 at 10:15am revealed:
-He worked 8am-5pm weekdays and was on call on weekends for emergencies.
-He drove the residents in a facility van.
-He and the MA's were in charge of maintaining the appointment schedule
-When a resident came back with paperwork he gave it to their MA and the MA looked at the appointments and wrote them in the calendar.
-If there were conflicting appointments he rescheduled a resident appointment.
-When a resident had an emergency and another resident was schedule for an appointment he asked the Administrator, or Memory Care Director who he should take and whose appointment had to be rescheduled.
-In an emergency the Activity Director took residents to appointments.

Interview with the Activity Director on 01/11/19 at 12:58pm revealed:
-She had driven residents to appointments before when she was asked and the transporter was not working.
-She had never been asked to take one resident to appointment while the transporter was busy taking another resident to an appointment.

Interview with a MA on 01/11/19 at 10:38am

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revealed:
-When a resident returned from a physician's appointment or was discharged from the hospital the paperwork listed upcoming appointments and the MA's were responsible for informing the transporter.
-When the MAs told the transporter the dates of the upcoming resident appointments the transporter was responsible for putting them on the transportation schedule.
-If there were conflicting appointments the transporter rescheduled the appointments.
-The transporter asked the Administrator when there were conflicting appointments which one to delay.
-Resident #4 made her own appointments.
-Staff sometimes had been pulled from the floor to help transport a resident on occasion, when one resident had an emergency and another had an already scheduled appointment.

Interview with another MA on 01/11/19 at 10:50am revealed:
- The MAs told the transporter about resident appointments then he ensured the appointments were on the schedule.
-Third shift MAs completed record audits and should have seen missed appointments.

Interview with the Memory Care Director on 1/11/19 at 11:08 revealed:
-She knew Resident #4 had missed appointments.
-She was concerned that Resident #4 missed appointments.
-She expected the transporter to have rescheduled appointments when needed.
-The Administrator decided when there were two residents who needed to be seen by their physicians who should go and whose

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D 273	Continued From page 77 appointment had to be rescheduled. Interview with the Administrator on 01/11/19 at 1:15pm revealed: -Resident #4 missed an already rescheduled neurology appointment because she was unable to find a facility staff member who could take her to the appointment. -The transporter had to take another resident to dialysis that was an emergency conflict, therefore, he was unable to drive Resident #4. -She knew Resident #4 had missed appointments and expected staff to know scheduling conflicts ahead of time. -She made the decisions when there were multiple residents who needed to be transported at the same time. -She expected the transporter to reschedule appointments for residents in a timely manner. -She had talked to Resident #4 several months ago about facility staff making all of her appointments. -The Activity Director took one resident once and had since refused to drive. -She or the Business Office Manger took residents to appointments on occasion. -Residents rarely missed appointments. b. Review of Resident #4's physician orders revealed an order on 09/04/18 for Polyethylene Glycol, used for constipation, 17gm packet with 8 ounces of water daily. Review of Resident #4's November Electronic Medication Administration Record (eMAR) revealed: -Polyethylene Glycol 17gm was documented as refused 21 of 30 times. -Resident #4 was documented as refusing Polyethylene Glycol 17gm on: 11/02/18, 11/03/18,	D 273		

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D 273	Continued From page 78 11/05/18-11/10/18, 11/12/18-11/18/18, 11/24-11/28/18, and 11/30/18 at 8:00am. Review of Resident #4's physician orders revealed an order on 10/23/18 for Ipratrop-Bromide 0.03% 21 mcg spray for allergies to be sprayed 1-2 times into each nostril three times a day before meals. Review of Resident #4's November Electronic Medication Administration Record (eMAR) revealed Ipratrop-Bromide 0.03% 21mcg spray was refused 9 of 90 times on 11/26/18 at 11:30am; 11/18/18-11/20/18, 11/23/18-11/26/18, and 11/28/18-11/29/18 at 4:30pm. Review of Resident #4's physician orders revealed an order on 10/23/18 for Ipratropium-Albuterol, used to treat asthma, to be inhaled via her nebulizer 4 times a day. Review of Resident #4's November Electronic Medication Administration Record (eMAR) revealed: -Ipratropium-Albuterol nebulizer was documented as refused 25 of 42 times on: 11/01/18-11/07/18 at 8:00am; 11/01/18-11/11/18 at 12:00pm; and 11/03/18, 11/06/18, 11/08/18-11/10/18 at 4:00pm. - Ipratropium-Albuterol nebulizer order was discontinued by the PA on 11/11/18. Review of Resident #4's December eMAR revealed: - Ipratrop-Bromide 0.03% 21mcg spray was documented as refused 15 out of 90 times on: 12/08/18, 12/09/18 at 7:30am; 12/04/18, 12/08/18, 12/09/18 and 12/13/18 at 11:30am 12/01/18, 12/04/18, 12/06/18-12/09/18, 12/14/18-12/16/18 at 4:30pm.	D 273		

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D 273	Continued From page 79 Interview with Resident #4 on 01/15/19 at 10:15am revealed she had refused medications on occasion. Interview with a MA on 01/15/19 at 5:08pm revealed: -Resident #4 refused nose spray, she had told the Memory Care Director about her refusals at least once in the past month. -She could not recall any other medications Resident #4 refused. -She had told the PA about other residents' medication refusals in the past either verbally or she left the PA a note. Interview with another MA on 01/15/19 at 11:42am revealed: -Resident #4 refused medications such as her nasal spray. -She had never notified the PA or anyone else about Resident #4's refusals of medications. Interview with the Memory Care Director/MA on 01/15/19 at 12:46pm revealed: -She expected the PA would see the holes and documentation in the MAR and know a resident was refusing medication. -She expected the MA's to verbally tell her if a resident was refusing medications a few times and she would verbally tell the PA. -She did not document her conversation telling the PA of resident medication refusals. Interview with Resident #4's PA on 01/16/19 revealed: - He could not recall being told Resident #4 had refused any medication besides her Bio-freeze. -He expected to have been notified of medication refusals and was concerned he had not been	D 273		

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D 273	Continued From page 80 notified. Interview with the Administrator on 01/16/19 at 5:50pm revealed: -She did not know before this morning when she was told by an MA that Resident #4 refused medications. -She was told this morning by the MA Resident #4 refused her medications because she was upset. -She expected the MA to notify the PA when a resident refused a medication three days and to document contacting the PA in the resident's chart. Review of Resident #16's current FL2 dated 01/02/19 revealed: -Diagnoses included dysphagia, transient ischemic attack (TIA), diabetes, hypertension, and hyperlipidemia -There was an order for a mechanical soft diet with chopped meats. Observation of Resident #16 on 01/09/19 at 5:37 revealed he was served a regular diet dinner. Observation of Resident #16 on 01/09/19 at 5:38 revealed the Dietary Aide was told by the MA to take his plate back, she wanted him to have one yogurt and one sorbet for dinner. Observation of Resident #16 on 01/09/19 at 5:40-5:45pm revealed he was given one sorbet and one yogurt and ate both then asked for a Popsicle. Observation of assisted living dining room from 5:45-6:06 revealed Resident #16 did not get a Popsicle but another Resident was given two Popsicles by the Dietary Aide.	D 273		

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D 273	Continued From page 81 Observation of Resident #16 on 01/09/19 at 6:09pm revealed the cook came and gave him a Popsicle. Interview with the Cook on 01/09/19 at 3:48pm revealed: -He only had a notebook with resident diet orders. -He knew by memory what resident to give what diet to. -He did not know what happened when he was not hear in regards to how staff knew what diet to give each resident. -"I'll remember what diet to give what resident until the day I get dementia." Interview with Resident #16 on 01/09/19 revealed "I'm having trouble keeping things down, I have been struggling with chewing." Interview with the Dietary Aide on 01/09/19 at 6:07 revealed she thought she gave Resident #16 a Popsicle but had confused his name with a Resident across the room. Interview with a Medication Aide (MA) on 01/09/19 at 6:15pm revealed: -Resident #16 came to the facility two days ago and he had been vomiting several times, so she thought yogurt and sorbet would be easier for him to eat. -She did not know if the nurse had seen him, and she had not called his PA, and did not know if any of the other MA's called the PA "the PA will see him in the morning." -She was not able to give Resident #16's diet order. Interview with a MA on 01/09/19 at 6:17pm revealed: -She was aware Resident #16 had been vomiting.	D 273		

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D 273	Continued From page 82 -She was not sure what was causing Resident #16 to vomit and did not call the PA. Interview with Resident #4's PA on 01/10/19 at 12:10pm revealed: -He was not aware Resident #16 had been vomiting, he was not called by the facility staff. -He was not told about the multiple vomiting episodes Resident #16 had over the last three days by the facility staff today either. -If Resident #16 was thought to have had a gastrointestinal problem staff should have been feeding him clear liquids or better yet called. -He expected the staff to call when a resident had vomiting of unknown origin even if it was just one time. -He talked to Resident #16 and he self-reported vomiting three-four times in the past three days. -He believed the vomiting was related to a stroke or difficulty swallowing and being given a regular instead of a mechanical diet. Interview with Administrator on 01/09/19 at 6:20pm revealed: -She was not aware that Resident #16 was given a regular diet initially for dinner instead of a mechanically soft dinner. -She expected all residents to be given the correct meal based upon their diet orders. -She expected staff to know what residents received what food or to ask more experienced MA's. -She expected the MA to call the PA when Resident #16 continued to vomit multiple times over the last few days without being seen by a PA. -She believed Resident #16 came from the hospital a few days ago and was not in the computer system yet. -She did not know if Resident #16 was vomiting	D 273		

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D 273	Continued From page 83 prior to his admission to the facility. 4. Observation on 01/11/19 at 12:26 pm of a Special Care Unit (SCU) resident revealed: -A resident's family was sitting with the resident in the dining room waiting for the meal. -The resident was scratching her arm. -The family member verbally told the medication aide (MA) the resident had a rash and was itching. -The family member said to the staff she was concerned the rash would spread. -The MA took a picture of the rash with her cell phone. -The MA texted the picture to someone. -The MA verbally told the family member that she had sent the picture of the rash to the Administrator to make an appointment with the physician. Interview with a family member on 01/11/19 at 12:30 pm revealed: -Her family member resided in the SCU and cognitively could not verbalize she had rash and was itching. -The resident could not tell when she got a rash or how the rash made her feel. -She was at the facility at least once a week visiting her family member. -She visited last Thursday and her family member did not have a rash and was not scratching or itching. -Today, she observed her family member had a rash and was scratching. -She was concerned the rash might be scabies, but was not certain. -A staff member at the facility had informed her that several residents at the facility had rashes all over their bodies.	D 273		

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D 273	Continued From page 84 -The staff told her the rashes were getting worse and spreading to other residents. Interview with a SCU medication aide (MA) on 01/11/19 at 12:40 pm revealed: -Three residents in the facility were itching and had "horrible" rashes. -One resident (#12) had it worse. -The rash and itching had been going on for several months. -The Primary Care Physician (PCP) had prescribed a cream for the itching, but the rash continued to get worse. -She had concerns about the residents because it was a SCU and most residents could not verbally say they were itching, staff had to observe them scratching. a. Review of Resident #12's FL-2 dated 01/19/18 revealed diagnoses of Alzheimer's dementia, vascular dementia, dysphagia, hypertension, asthma, and chronic renal disease. Interview on 01/16/19 at 9:05 am with a SCU Personal Care Aide (PCA) revealed: -Resident #12 had a rash on her whole body, she itched all of the time. -The resident had the rash several months (did not know the date). Interview on 01/16/19 at 9:35 am with the second SCU (PCA) revealed: -Resident #12 had a rash all over her body since September 2018; she constantly itched and scratched herself. -The PCA applied a cream all over her body after giving the resident a shower. -The cream did not appear to work. -The physician's assistant (PA) told the Administrator (did not remember the date)	D 273		

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D 273	Continued From page 85 Resident #12 had a rash all over her body and the cream was not working. Interview on 01/16/19 at 8:10 am with the SCU Medication Aide (MA) revealed: -Resident #12 had a rash all over her body for at least 30 days. -The resident was prescribed a cream to put on the rash, but the rash did not go away; there were no changes in the rash. -The PA wanted Resident #12 to see a dermatologist to get a skin test to diagnose the rash and to receive a treatment that would get rid of the rash. Observation on 01/16/19 at 8:22 am of Resident #12 revealed: -The resident was seated in the dining room eating breakfast. -There were three small raised red bumps in a line on the right side of her neck; there were four small raised red bumps on the palm of her left hand. Observation on 01/06/19 at 9:55 am of Resident #12 revealed: -There was a rash of red bumps over her entire back; many were in a line pattern and were beginning to crust on the top of the rash. -There was a rash of raised red bumps on her left arm from her shoulder to her wrist; there were multiple bumps in a line pattern and had scabs on the top of the rash from scratching. -There was a continuous rash of raised red bumps on her buttocks, down her legs to her ankles; there were multiple bumps in a line pattern that had scabs on the top of the rash from scratching. Interview on 01/16/19 at 9:57 am with Resident	D 273		

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D 273	Continued From page 86 #12 revealed "I am a mess; I scratch all of the time." Interview 01/17/19 at 3:33 pm with Resident #12's Power of Attorney (POA) revealed: -Resident #12 had a rash on her body for several months; she did not remember when the rash started. -The POA wanted the resident to be seen by a dermatologist for treatment. -She received a phone call in December 2018, (did not remember the date) from a female staff at the facility. -The POA expected a call back regarding a scheduled dermatology appointment for Resident #12. -The POA did not receive a call from staff at the facility about scheduling a dermatology appointment for Resident #12 since the call to her in December 2018. -Resident #12 was not seen by a dermatologist for the rash on her body; the facility did not send Resident #12 to a dermatologist for examination and skin testing of her rash. Interview on 1/16/19 at 10:45 am with the Care Manager (CM) revealed: -Resident #12 "currently had a rash on her body, it comes and goes." -A cream had been applied to the areas of her body that had the rash; the rash would go away and come back a month later. -The Administrator told the previous CM (left in December) to set up a dermatology appointment for Resident #12 three to four months ago (did not remember the dates). -No appointment was made with a dermatologist for Resident #12 by the previous CM. -The Administrator was responsible for making the dermatologist appointment for Resident #12.	D 273		

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D 273	Continued From page 87 Refer to interview on 01/16/19 at 12:02 pm with the physician's assistant (PA). Refer to interview on 01/16/19 at 6:00 pm with the Administrator. b. Review of Resident #13's current FL-2 dated 07/05/18 revealed diagnoses of Alzheimer's disease, atherosclerotic heart disease, hypertension and gastroesophageal reflux disease. Interview on 01/16/19 at 9:10 am with a Special Care Unit (SCU) PCA revealed: -Resident #13 started having a rash more than a month ago (did not remember the date). -Resident #13 had the rash on his arms, legs, and back. -He itched and scratched his skin all of the time. Interview on 1/16/19 at 9:35 am with the second SCU PCA revealed: -Resident #13 was covered with a rash all over his body; he scratched his skin all of the time and had blood on his skin from scratching. -Resident #13 was given a medication for the rash , but it was not working to clear the rash. -Resident #13 became frustrated with the itching and scratching. Interview on 01/16/19 at 8:00 am with the SCU MA revealed: -Resident #13 had a rash on his arms, legs, feet and back; he itched and scratched frequently. -Resident #13's medication, Predisone, was not working to clear the rash. -Resident #13's PA was trying to get a dermatology assessment appointment for the resident.	D 273		

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D 273	Continued From page 88 Attempted observation on 01/16/19 at 10:15 am of Resident #13 was unsuccessful; the resident was out of the facility. Attempted interview on 01/16/19 at 4:00 pm with Resident #13's POA was unsuccessful. Interview on 01/16/19 at 10:45 am with the Care Manager (CM) revealed: -Resident #13 had a rash on his body; a dermatologist was called yesterday (01/15/19) and she and was waiting for a return call for an appointment date for the resident. -The Administrator told the previous CM (left in December) to set up a dermatology appointment for Resident #13 three to four months ago (did not remember the dates). -No appointment was made with a dermatologist for Resident #13. -The Administrator was responsible for making the dermatologist appointment for Resident #13. c. Review of Resident #14's current FL-2 dated 11/15/18 revealed diagnoses of dementia, anxiety, insomnia and hemiplegia. Interview on 01/16/19 at 9:00 am with a SCU PCA revealed: -She noticed a small rash on Resident #14's back a couple of months ago, in November 2018. -"The rash comes and goes" on Resident #14. Interview on 01/16/19 at 8:09 am with a SCU MA revealed: -Resident #14 had a "spot" on her right arm; she would not call it a rash. -The facility's PA was scheduled to see Resident #14 on Thursday (01/17/19).	D 273		

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Observation on 01/16/19 at 10:05 am of Resident #14 revealed:
-There were two raised red spots with five smaller raised red spots, two on the inside of her right elbow.
-There was a red rash with three areas of raised red spots, in a line, on her lower back; there were scabs on the center section of the rash.

Interview on 01/16/19 at 10:06 am with Resident #14 revealed:
-She had been itching and scratching for about 2 weeks.
-"Right now her back was itching!"

Interview on 01/18/19 at 10:50 am with the Care Manager revealed:
-Resident #14 just broke out in a rash about three days ago (01/13/19).
-Resident #14 would be seen by the PA on Thursday (01/17/19) for the rash.

Attempted interview on 01/16/19 at 3:45 pm with Resident #14's POA was unsuccessful.

Interview on 01/16/19 at 12:02 pm with the PA revealed::
-Every year, for the past four years, there had been an outbreak of rashes in the SCU.
-There was an agreement for treatment for all SCU residents using Stromectol (Ivermectin, an anti-parasite used to treat scabies) (scabies is an itchy skin condition caused by a tiny burrowing mite leading to intense itching in the areas of its burrows.)
-After the treatments, the rashes disappeared.
-In late August to early September (did not remember exact dates), he requested permission to treat the SCU residents and was not given approval; he needed a dermatology report (with

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diagnoses) to be allowed to treat the residents.
-There were several residents in the SCU that had rashes; he had been monitoring the rash patterns (indicates possible scabies).
-He had been trying to keep the affected residents' symptoms under control.
-There had been no scheduling of dermatology appointments for the SCU residents; the Administrator had not gotten back with him.
-The rash appeared to be scabies, but he could not make a definitive diagnosis without a dermatology follow-up for the residents.
-The prediction was the scabies would spread while waiting on residents' dermatology referrals and treatment.

Interview on 01/16/19 at 6:00 pm with the Administrator revealed:
-The PA informed her in December, 2018, the rash in the SCU was scabies and he wanted to treat the residents.
-Management wanted dermatology appointments to obtain skin scrapings for a diagnosis.
-The PA told the previous Care Manager dermatology appointments needed to be scheduled for the SCU residents in December (did not know the date).
-The previous Care Manager was to have made the dermatology appointments
-She had been very busy, she had not made the appointments, she had slipped in her responsibility, it was her fault the appointments were not made.

5. Review of Resident #2's current FL2 dated 10/01/18 revealed:
-Diagnoses included vascular dementia, chronic obstructive pulmonary disease, and acute respiratory failure.
-The resident was intermittently disoriented

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D 273	Continued From page 91 -The resident was semi-ambulatory. -An order for oxygen was not listed on the FL2. Review of Resident #2's record revealed: -A signed physician's order dated 10/04/18 for oxygen 2 liters per minute (2 2L/MIN) continuous via concentrator and nasal cannula tubing. -A signed physician's order dated 11/15/18 for 02 2L/MIN continuous by 02 concentrator and nasal cannula, tubing. Review of Resident #2's Care Plan dated 03/12/18 revealed: -The resident was ambulatory with the aide of assistive device. -Resident #2 required limited assistance with bathing and dressing. -The resident was independent with ambulation, transfers, toileting and eating. -Oxygen was not a service documented on the Care Plan. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 06/19/18 revealed: -The task of oxygen was not documented on the form. -There were no more LHPS evaluations and quarterly reviews for Resident #2. Review of Resident #2's electronic Medication Administration Record (eMAR) revealed: -An entry for oxygen 2L/MIN continuous to check every shift 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am. -There was documentation oxygen was administered daily every shift at 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am.	D 273		

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D 273	Continued From page 92 Observation of Resident #2 on 01/09/19 from 10:20am to 1:07pm revealed: -At 10:30am Resident #2 was sitting in a wheelchair in the main hallway. -The back of Resident #2's wheelchair was against the wall. -Resident #2 was observed without her oxygen on from 10:30am through 12:15pm. -At 11:30am a medication Aide (MA) was observed at the medication cart in the main hallway, but left it periodically. -A second MA was in the back of the building on the 500 and 600 hallway passing medications. -The MAs moved the carts around the building and were not stationary in the main hallway. -At 12:15pm Resident #2 was still in the main hallway without oxygen on. -The medication aide (MA) on duty was informed that Resident #2 was without oxygen. -The MA asked Resident #2 where her oxygen "hose" was located. -Resident #2 "said I don't know and mumbled unidentifiable words. -Resident #2 started to move around and found the cannula tubing tucked behind the resident and could not be seen. -The MA turned Resident #2's wheelchair around and pulled the portable tank up from the pouch. -The MA announced to Resident #2 that she was going to take the resident to her room because her oxygen (02) container was empty. -Resident #2 did not appear to be struggling for air or having a difficult time breathing. -In Resident #2's room was a stationary 02 concentrator. -The concentrator was set at 2.5 L/MIN (liters per minute). -At 1:07pm Resident #2 was observed in the hallway without her nasal cannula tubing on her face.	D 273		

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D 273	Continued From page 93 -The resident had the nasal cannula tubing rolled up in a round circle in one hand as wheeled herself down the hallway. -There was no staff in the hallway near Resident #2. -The resident was unable to respond why the tubing was not on. Observation of Resident #2 on 01/10/19 at various times throughout the morning from 8:45am to 9:15am revealed: -Resident #2 was sitting in the main hallway, near the dining room. -Resident #2's nasal cannula was on the resident's face. -At 9:15am the MA checked the 02 container and found it was empty. -The MA informed Resident #2 that she was taking the resident to her room to get another 02 container. Observation of Resident #2 on 01/11/18 from 8:45 am to 12:00pm revealed: -At 11:25am Resident #2 was in the main hallway near the dining room. -Resident #2 was not wearing the 02 nasal cannula. -At 11:25am the Activity Director tried to assist the resident putting the nasal cannula back on. -The MA came to help the Activity Director with putting Resident #2's nasal cannula back on. -The MA checked Resident #2's oxygen container and it was empty. -Resident #2 had been sitting in the hallway since 8:45am, it could not be determined how long the oxygen container had been empty. Observation of Resident #2 on 01/14/19 at 11:45am revealed: -Resident #2 was sitting in the main hallway near	D 273		

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D 273	Continued From page 94 the dining room. -Resident #2 did not have her 02 nasal cannula on. -The MA was informed Resident #2 was not wearing her oxygen. -The oxygen container was observed empty. Interview with the MA regarding Resident #2's oxygen on 01/15/19 at 11:55am revealed: -The MA stated "There is no more." -Resident #2 was out of portable 02 containers. -The resident ran out of the portable containers yesterday (01/14/ 19). -She called the supplier yesterday and ordered more 02 containers. -Today (01/15/19), she borrowed another resident's portable 02 container for Resident #2. -Resident #2's portable 02 containers did not last long. -The containers were 7.5 pounds and Resident #2 used three to four containers per day. -Yesterday, when she placed the order for Resident #2's 02 containers she ordered almost double what the resident usually got because the resident used two to three oxygen containers per day. -Resident #2's portable 02 containers ran out fast, sometimes she did not know the container was empty. -The PCAs or MA were supposed to check the 02 container when they got Resident #2 out of bed. -Staff were also supposed to check the portable 02 container every two hours when they toileted Resident #2, if the oxygen containers were down to three or four the staff should tell the MAs so they can order more containers. Interview with Resident #2's guardian on 01/10/19 at 9:25am revealed: -She visited Resident #2 every other day.	D 273		

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D 273	Continued From page 95 -She knew Resident #2 continually took her 02 cannula off, because of her declining mental status the resident did not know the importance of continuously wearing the 02. -She visited Resident #2 every other day and what mainly concerned her was every time she visited Resident #2's portable 02 container was empty. -She did not know how long Resident #2 was not breathing 02. -She visited Resident #2 on Sunday, 01/06/19, and she had to tell staff the 02 container was empty. -She visited Resident #2 on Wednesday, 01/09/18 at 8:00pm and the 02 container was empty, she had to tell staff again to replace the container. Interview with the Care Manager (CM) on 01/16/19 at 2:52pm revealed: -Resident #2 had a regular oxygen concentrator in her room. -The resident used the concentrator at night only when going to bed. -During the daytime Resident #2 was always kept in the hallway for staff to keep an eye on the resident. -When in the hallway the resident used her portable oxygen tank. -The MAs and PCAs should check Resident #2's oxygen tanks throughout the day, but there was no way to ensure that was being done. -The MAs were responsible for reordering the portable oxygen tanks for Resident #2. -The oxygen distributor had told the facility when Resident #2 got down to three portable tanks they should call and request replacements because it may take more than 24 hours to deliver more tanks of oxygen. -The Administrator told staff, if Resident #2 ran	D 273		

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out of oxygen, staff had to borrow a portable tank from another resident.
-Resident #2's portable oxygen tank only had 7.5 liters of oxygen and it did not last long because when staff put the resident in the bed they left the tanks on.
-All Resident #2's portable oxygen tanks in the storage should not be empty, the resident should not be in the hallway with an empty tank.

Interview with the Physician Assistant (PA) from Resident #2's Primary Care Physician's office on 01/11/19 at 11:00am revealed:
-He saw Resident #2 at least once a month.
-He ordered Resident #2 oxygen two liters continuously due to the resident's diagnoses of chronic obstructive pulmonary disease.
-There were no set limits to the amount of oxygen containers for the resident to use.
-There should always be oxygen available for Resident #2 to use.
-The facility staff should re-order oxygen containers in a timely manner so the resident did not run out of oxygen
-It was the facility's responsibility to make sure Resident #2's oxygen containers were always full and available for use.

Based on record review, and observation, and attempt interview on 01/09/19 at 12:10pm it was determined Resident #2 was not interviewable.

_____

The facility failed to provide a resident (#4) transportation resulting in missed cardiology, neurology, and pulmonary appointments and to notify the physician of the resident's medication refusal; scheduling dermatology appointments for residents itching and scratching from having a rash (#12, #13, #14), and failed to ensure oxygen tanks were refilled for a resident with an order for

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D 273	Continued From page 97 continuous oxygen (#2) which resulted in substantial risk of physical harm and neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 01/14/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 2, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review, observation and interviews the facility failed to implement physician's orders for 2 of 7 sampled residents (#2 and #20) related to a resident being out of his colostomy bags (#20) and a resident's portable oxygen tanks continually being empty (#2).	D 276		

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D 276	Continued From page 98 The findings are: 1. Review of Resident #2's current FL2 dated 10/01/18 revealed: -Diagnoses included vascular dementia, chronic obstructive pulmonary disease, and acute respiratory failure. -The resident was intermittently disoriented -The resident was semi-ambulatory. -An order for oxygen was not listed on the FL2. Review of Resident #2's Care Plan dated 03/12/18 revealed: -The resident was ambulatory with the aide of assistive device. -Resident #2 required limited assistance with bathing and dressing. -The resident was independent with ambulation, transfers, toileting and eating. -Oxygen was not a service documented on the Care Plan. Review of Resident #2's record revealed: -A signed physician's order dated 10/04/18 for oxygen 2 liters per minute (2L/MIN) continuous via concentrator and nasal cannula tubing. -A signed physician's order dated 11/15/18 for oxygen 2L/MIN continuous by 02 concentrator and nasal cannula, tubing. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 06/19/18 revealed: -The task of oxygen was not documented on the form. -There were no more LHPS evaluations and quarterly reviews for Resident #2. Review of Resident #2's electronic Medication Administration Record (eMAR) revealed:	D 276		

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-An entry for oxygen 2L/MIN continuous to check every shift 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am.
-There was documentation oxygen was administered daily every shift at 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am.

Observation of Resident #2 on 01/09/19 from 10:20am to 1:07pm revealed:
-At 10:30am Resident #2 was sitting in a wheelchair in the main hallway.
-The back of Resident #2's wheelchair was against the wall.
-Resident #2 was observed without her oxygen on from 10:30am through 12:15pm.
-At 11:30am a medication Aide (MA) was observed at the medication cart in the main hallway, but left it periodically.
-A second MA was in the back of the building on the 500 and 600 hallway passing medications.
-The MAs moved the carts around the building and were not stationary in the main hallway.
-At 12:15pm Resident #2 was still in the main hallway without oxygen on.
-The medication aide (MA) on duty was informed that Resident #2 was without oxygen.
-The MA asked Resident #2 where her oxygen "hose" was located.
-Resident #2 "said I don't know and mumbled unidentifiable words.
-Resident #2 started to move around and found the cannula tubing tucked behind the resident and could not be seen.
-The MA turned Resident #2's wheelchair around and pulled the portable tank up from the pouch.
-The MA announced to Resident #2 that she was going to take the resident to her room because her oxygen (02) container was empty.
-Resident #2 did not appear to be struggling for

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air or having a difficult time breathing.
-In Resident #2's room was a stationary 02 concentrator.
-The concentrator was set at 2.5L/MIN (liters per minute).
-At 1:07pm Resident #2 was observed in the hallway without her nasal cannula tubing on her face.
-The resident had the nasal cannula tubing rolled up in a round circle in one hand as wheeled herself down the hallway.
-There was no staff in the hallway near Resident #2.
-The resident was unable to respond why the tubing was not on.

Observation of Resident #2 on 01/10/19 at various times throughout the morning from 8:45am to 9:15am revealed:
-Resident #2 was sitting in the main hallway, near the dining room.
-Resident #2's nasal cannula was on the resident's face.
-At 9:15am the MA checked the 02 container and found it was empty.
-The MA informed Resident #2 that she was taking the resident to her room to get another 02 container.

Observation of Resident #2 on 01/11/18 from 8:45 am to 12:00pm revealed:
-At 11:25am Resident #2 was in the main hallway near the dining room.
-Resident #2 was not wearing the 02 nasal cannula.
-At 11:25am the Activity Director tried to assist the resident putting the nasal cannula back on.
-The MA came to help the Activity Director with putting Resident #2's nasal cannula back on.
-The MA checked Resident #2's oxygen container

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and it was empty.
-Resident #2 had been sitting in the hallway since 8:45am, it could not be determined how long the oxygen container had been empty.

Observation of Resident #2 on 01/14/19 at 11:45am revealed:
-Resident #2 was sitting in the main hallway near the dining room.
-Resident #2 did not have her 02 nasal cannula on.
-The MA was informed Resident #2 was not wearing her oxygen.
-The oxygen container was observed empty.

Interview with the MA regarding Resident #2's oxygen on 01/15/19 at 11:55am revealed:
-Resident #2's oxygen containers were 7.5 pounds and the resident used three to four containers per day.
-She thought when the PCAs put Resident #2 to bed they did not turn off the portable 02 containers and that caused the oxygen tanks to run out.
-The PCAs or the MAs were supposed to check the 02 container when they got Resident #2 out of bed.
-Staff were also supposed to check the portable 02 container every two hours when they toileted Resident #2.
-Resident #2's portable 02 containers ran out fast, sometimes she did not know the container was empty.

Interview with Resident #2's guardian on 01/10/19 at 9:25am revealed:
-She visited Resident #2 every other day.
-She knew Resident #2 continually took her 02 cannula off, because of her declining mental status the resident did not know the importance

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of continuously wearing the 02.
-She visited Resident #2 every other day and what mainly concerned her was every time she visited Resident #2's portable 02 container was empty.
-She did not know how long Resident #2 was not breathing 02.
-She visited Resident #2 on Sunday, 01/06/19, and she had to tell staff the 02 container was empty.
-She visited Resident #2 on Wednesday, 01/09/18 at 8:00pm and the 02 container was empty, she had to tell staff again to replace the container.

Interview with the Care Manager (CM) on 01/16/19 at 2:52pm revealed:
-Resident #2 had a regular oxygen concentrator in her room.
-The resident used the concentrator at night only when going to bed.
-During the daytime Resident #2 was always kept in the hallway for staff to keep an eye on the resident.
-When in the hallway the resident used her portable oxygen tank.
-The MAs and PCAs should check Resident #2's oxygen tanks throughout the day, but there was no way to ensure that was being done.
-The MAs were responsible for reordering the portable oxygen tanks for Resident #2.
-The oxygen distributor had told the facility when Resident #2 got down to three portable tanks they should call and request replacements because it may take more than 24 hours to deliver more tanks of oxygen.
-The Administrator told staff, if Resident #2 ran out of oxygen, staff had to borrow a portable tank from another resident.
-Resident #2's portable oxygen tank only had 7.5

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liters of oxygen and it did not last long because when staff put the resident in the bed they left the tanks on.
-All Resident #2's portable oxygen tanks in the storage should not be empty, the resident should not be in the hallway with an empty tank.

Interview with the Physician Assistant (PA) from Resident #2's Primary Care Physician's office on 01/11/19 at 11:00am revealed:
-He ordered oxygen two liters continuously for Resident #2 due to the resident's diagnoses of chronic obstructive pulmonary disease.
-He knew Resident #2 frequently took off her nasal cannula.
-He did not know the resident oxygen containers were frequently empty.
-The facility staff should make sure the resident's oxygen containers were filled with oxygen at all times.

Based on record review, and observation, and attempt interview on 01/09/19 at 12:10pm it was determined Resident #2 was not interviewable.

2. Review of Resident #20's current FL2 dated 09/28/18 revealed:
-Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia.
-The resident was was ambulatory with a rolling walker.
-The resident had a colostomy.

Review of Resident #20's record revealed there was no Care Plan.

Review of Resident #20's record revealed a physician's order dated 10/11/18 for colostomy supplies.

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D 276	Continued From page 104 Review of Resident #20's hospital discharge summary report dated 12/25/18 revealed: -Resident #20 was at the hospital for abdomen pain. -There was documentation Resident #20 was out of "bags" for the ileostomy (The bowel is rerouted through an artificially created hole (stoma) in the abdomen so that feces can exit the body). Review of the home care agency notes in Resident #20's record revealed: -The agency provided services to Resident #20 from 10/26/18 through 12/11/18, caring for the colostomy and a rash caused by a yeast infection. -Five of the visits specifically addressed care for the colostomy. -There was documentation noted each visit the "colostomy bag was intact with no leakage." -On 10/30/18, the nurse documented she provided training with return demonstration to three medication aides (MAs) how to apply Resident #20's colostomy bags. -On 11/01/18, the nurse documented training was provided for two MAs on how to apply Resident #20's colostomy bags. Review of Resident #20's record revealed: -There was no documentation the physician had been notified regarding Resident #20 not having bags for this colostomy. -There was no documentation the distributor had been contacted regarding reordering Resident #20's bags. -There was no documentation the distributor had refused to allow the reordering of Resident #20's bags. -There was no documentation the facility had attempted to purchase bags.	D 276		

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D 276	Continued From page 105 Review of the fax sent to the distributor of Resident #20's colostomy bags by the MA supervisor revealed the order and request to supply Resident #20's colostomy bags was faxed today, 01/16/19 at 2:47pm. Observation of Resident #20 on 01/16/18 at 3:59pm revealed: -The resident was sitting in a wheelchair in his room. -The resident had his hand holding a pad that was covering the lower middle section of his stomach. -The pad was a "chuck pad" that was normally used as incontinent protective bed pad for the mattresses. -The pad was soaked and wet with liquid bowel. Interview with Resident #20 on 01/16/19 at 3:57pm revealed: -He resided at the facility since September 2018. -He had a "colostomy" (ileostomy) that had to be covered with plastic bags for his bowels to drain. -Changing the bags was a process and he needed staff assistance with changing the bags. -Currently, he did not have any plastic bags to cover the hole where his bowel drained. -He ran out of the colostomy bags two to three weeks ago. -The facility knew he did not have the bags and told him there was something going on with his insurance. -His skin around the stoma and the lower part of his stomach were irritated from the leaking bowel. -The reason he was out of bags, was facility staff placed the bags over the colostomy and they often did not seal the bags good, so they leaked. -The leaking loosened the seal between the bag and his skin. -He used a new bag each time to see if he could	D 276		

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stop the leaking.
-He had the colostomy for 50 years.
-He previously had skin irritation, but it was getting worse.
-He also did not run out of bags.
-When he first moved into the facility a nurse visited him two times per week.
-When the nurse placed the colostomy bags they did not leak.
-Because he did not have colostomy bags facility staff took plastic "chuck pads" and rolled them up to cover the opening of the colostomy.
-The process was disgusting, because the pad quickly got soaked, it drained, smelled bad and the bowel was irritating his skin further down his stomach.
-He could not remember the last time he had seen the PA, and did not know if the PA knew he was out of bags for his colostomy.

Interview the personal care aide (PCA) on 01/16/19 at 12:53pm revealed:
-Resident #20 had been without bags for his "colostomy" for two weeks.
-The facility used "chuck pads" to cover the opening of the colostomy.
-The pads soaked quickly and the resident usually had a big mess that took a long time to clean up.
-He thought the resident not getting bags for the colostomy had something to do with his insurance, but he was not sure.

Interview with the Care Manager (CM) on 01/16/19 at 3:00pm revealed:
-The home care agency was initially responsible for getting Resident #20's colostomy bags to cover the opening in his stomach.
-They had called to order the colostomy bags, but the resident was using the colostomy bags and

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was running out.
-The insurance company had a set quota.
-She did not have a letter or documentation from the insurance company stating Resident #20 had reached his quota.
-She did not know the number of colostomy bags that were considered the quota.
-She knew the resident got 20 colostomy bags on 12/12/18, but the resident used two - three colostomy bags per week.
-Facility staff changed the colostomy bags for the resident, because the resident claimed the colostomy bags were leaking.
-The MAs used incontinent pads over the opening for Resident #20's bowel and changed the resident more frequently.
-The MA supervisor ordered Resident #20's colostomy bags yesterday.
-She did not know when the colostomy bags would be delivered.
-The facility had not considered purchasing the colostomy bags by other means to obtain the colostomy bags for Resident #20.

Interview with a medication aide (MA) on 01/16/19 at 4:01pm revealed:
-Resident #20 had a colostomy.
-The MAs had been trained by the home care agency how to apply the bag over Resident #20's colostomy.
-Resident #20 had been without bags to cover his colostomy for about one week.
-Resident #20 was out of bags because he often changed the bags.
-Staff used "chucks pads" to cover the colostomy opening.
-He was not sure why Resident #20 did not have plastic bags, but thought it had something to do with his insurance.

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D 276	Continued From page 108 Interview with a nurse at the home care agency on 01/16/19 at 4:04pm revealed: -Resident #20 was a patient of the agency, but he was discharged from their services in December 2018. -When they provided services for Resident #20 they ordered supplies for the resident's ileostomy. -Now the resident was discharged from their services the facility staff were responsible for ordering the supplies. -The facility staff had told the home care agency they were going to seek a different method of getting Resident #20's supplies. -If Resident #20 was out of bags the facility should have placed an order for the bags. Interview with the distributor of Resident #20's ileostomy bags on 01/16/19 at 4:39pm revealed: -Resident "Pouches" were ordered and dispensed on 11/16/18 and 12/12/18. -Both requests for the pouches were made by an outside home care agency. -A request for the pouches must be accompanied by an order. -The pouches were dispensed for a quantity of 20 and two paste sealants were dispensed with pouches. -The quantity was anticipated by each individual (patient) usage. -There was no documentation in their records regarding the facility's request to reorder Resident #20's pouches. Attempted interview with PA at Resident #20's primary care physician's office on 01/16/19 at 4:52pm was unsuccessful. _____ The facility failed to implement orders from the primary care provider for oxygen continuously for Resident #2 who had a history of chronic	D 276		

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D 276	Continued From page 109 obstructive pulmonary disease and respiratory failure; for colostomy bags for Resident #20 who had a colostomy and there were no colostomy bags available at the facility. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 01/11/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2019.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical	D 280		

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D 280	Continued From page 110 assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility failed to assure that Licensed Health Professional Support evaluations were completed by a Registered Nurse (RN) for 4 of 10 sampled residents (Residents #2, #5,#9 and #20) with LHPS tasks of care of a colostomy and fingerstick blood sugars (#20), oxygen and physical therapy (#2), collecting fingerstick blood sugars (#9) and transferring semi-ambulatory residents (#5). The findings are: 1. Review of Resident #2's current FL2 dated 10/01/18 revealed: -Diagnoses included vascular dementia, chronic obstructive pulmonary disease, and acute respiratory failure. -Disorientation status was constantly. -Ambulatory status was ambulatory. -Oxygen was not documented on the FL2. Review of Resident #2's Care Plan dated 03/12/18 revealed: -The resident was ambulatory with the aide of assistive device. -Oxygen administration was not a service documented on the Care Plan. Review of Resident #2's physician's revealed: -There was a signed physician's order dated	D 280		

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D 280	Continued From page 111 10/04/18 for oxygen 2 liters per minute (2L/min) continuous via concentrator and nasal cannula tubing. -There was a subsequent physician's order dated 11/15/18 for 02 2L/MIN continuous by 02 concentrator and nasal cannula, tubing. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 06/19/18 revealed: -The task physical therapy was documented and evaluated by the nurse. -There was no documented physical assessment that related to the resident's condition and need for oxygen. -No evaluation was completed within thirty days of the ordered task. -There were no more LHPS evaluations for Resident #2. Review of Resident #2's electronic Medication Administration Record (eMAR) revealed: -An entry for oxygen 2L/MIN continuous was documented on the eMAR to check every shift. -There was documentation oxygen administration was was documented daily every shift. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation and quarterly review dated 06/19/18 revealed: -The task oxygen administration was not documented on the LHPS evaluation form. -There were no more quarterly LHPS evaluations for Resident #2 related to oxygen usage. Observations of Resident #2 on 01/09/19, 01/10/19, 01/11/19, 01/15/19 and 01/16/19 at various times from 8:30am to 5:00pm the resident's oxygen being administered with nasal cannula tubing.	D 280		

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D 280	Continued From page 112 Interview with the LHPS nurse on 01/15/19 at 9:00am revealed: -She had not seen Resident #2 since June 2018 and did not know the resident had a new task. -The facility sometimes called her back to complete LHPS evaluations. -The facility did not tell her Resident #2 needed an LHPS evaluation. -She depended on the facility to make her aware when resident's had a new task. -When she visited the facility on 01/09/18, staff did not give her specific names of residents that needed LHPS evaluations. -The Administrator told her to do 5 or 6 resident records, so she completed LHPS evaluations on five diabetic residents. Refer to interview on 01/15/19 at 9:08 am with the LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM) Refer to interview on 01/16/19 at 5:58 pm with the Administrator. 2. Review of Resident #20's current FL2 dated 09/28/18 revealed: -Diagnoses included major depression disorder, type 2 diabetes, hypertension, muscle weakness, and hyperlipidemia. a. Review of Resident #20's current FL2 dated 09/28/18 revealed bowel status was "colostomy." Review of the home care agency notes for Resident #20's revealed: -The agency provided services to Resident #20 from 10/26/18 through 12/11/18, caring for this	D 280		

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colostomy and a rash caused by yeast infection.
-Five of the twelve visits specifically addressed care for the colostomy.

Review for Resident #20's record revealed there was no documented quarterly LHPS evaluation in Resident #20's record.

Observation of Resident #20 on 01/16/18 at 3:59pm revealed:
-The resident was sitting in a wheelchair in his room.
-The resident had his hand holding a pad that was covering the lower middle section of his stomach.
-The pad was a chuck pads that was normally used as protective pads for mattresses.

Interview the personal care aide (PCA) on 01/16/19 at 12:53pm revealed:
-Resident #20 had lived at the facility since early fall 2018.
-The resident had a "colostomy."
-Staff at the facility cared for Resident #20's colostomy by replacing the bags when needed.

Interview with Resident #20 on 01/16/19 at 3:57pm revealed:
-He lived at the facility since September 2018.
-He had a "colostomy" (ileostomy) that had to be covered with plastic bags for his bowels to drain.
-Facility staff assisted him with changing the bags.
-He was seen by a nurse from the home care agency but she no longer visited.
-It had been over a month since he had seen the home care nurse.
-He had not been seen by a nurse other than the home care agency nurse.

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D 280	Continued From page 114 Interview with the medication aide (MA) on 01/16/19 at 4:01pm revealed: -Resident #20 had a colostomy. -The MAs had been trained by the home care agency how to apply the bag over Resident #20's colostomy. -The facility did not have a regular nurse to complete LHPS evaluations. -A nurse that previously worked at the facility and retired sometimes came to the facility to complete the LHPS evaluations. -She could not remember the last time that nurse came to the facility. Refer to interview on 01/15/19 at 9:08 am with the LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM) Refer to interview on 01/16/19 at 5:58 pm with the Administrator. b. Review of Resident #20's current FL2 dated 09/28/18 revealed a physician's order for fingerstick blood sugars (FSBS) three times daily. Review of Resident #20's September, October, November and December 2018 electronic Medication Administration Record (eMAR) revealed: -An entry for FSBS three times daily at 7:30am, 11:00am, and 4:30am. -There was documentation Resident #20's FSBS were checked three times daily at 7:30am, 11:00am, and 4:30am. Review of Resident #20's record revealed there was no documentation of an LHPS review had been completed for the task FSBS.	D 280		

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D 280	Continued From page 115 Interview with Resident #20 on 01/16/19 at 3:57pm revealed: -He lived at the facility since September 2018. -He was a diabetic and facility staff checked his FSBS three times daily. -Since he moved into the facility no nurse had assessed or visited him regarding his diabetes. Interview with the medication aide (MA) on 01/16/19 at 4:01pm revealed: -Resident #20 was a diabetic. -Resident #20's FSBS were scheduled to be checked three times. -The Care Manager (CM) was responsible for making the nurse aware of LHPS tasks. - The nurse was in the building last week, but she was not sure the nurse looked at Resident #20. Interview with the LHPS nurse on 01/15/19 at 9:01am revealed: -She did not know Resident #20, and thought he must be a new resident. -The facility staff had not told her Resident #20 had LHPS tasks. -She retired in June 2018, but had visited the facility a couple of times to help them out with LHPS evaluations. Refer to interview on 01/15/19 at 9:08 am with the LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM) Refer to interview on 01/16/19 at 5:58 pm with the Administrator. 3. Review of Resident #9's current FL2 dated 07/16/18 revealed:	D 280		

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D 280	Continued From page 116 -Diagnose included legal blindness. -Disorientation status was intermittently. -Ambulatory status was semi-ambulatory. -Fingerstick blood sugars (FSBS) were not documented on the FL2. Review of Resident #9's record revealed a physician's order dated 11/15/18 for FSBS Monday, Wednesday, and Friday at 6:30am, and for FSBS Tuesday, Thursday, Saturday and Sunday at 2:00pm. Review of the LHPS evaluation in Resident #9's record revealed: -On 06/26/18 the nurse evaluated Resident #9 for the task of fingerstick blood sugars. -The nurse documented the resident was a diabetic and his blood sugar was checked once daily. -There were no recommendations suggested by the nurse. -There were no documented quarterly LHPS evaluations after the 06/26/18 date. Review of Resident #9's October, November and December 2018 and January 2019 electronic Medication Administration Record (eMARs) revealed: -An entry for blood sugar checks on Monday, Wednesday and Friday at 6:30am. -There was documentation the resident's blood sugar was checked on Monday, Wednesday and Friday at 6:30am from 10/01/18 through 01/16/19. -An entry for blood sugar checks on Tuesday, Thursday, Saturday and Sunday at 2:00pm. -There as documentation Resident #9's blood sugars were checked on Tuesday, Thursday, Saturday and Sunday at 2:00pm. -Resident #9's blood sugars ranged from 105 to 411.	D 280		

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D 280	Continued From page 117 Interview with Resident #9 on 01/15/19 at 10:03am revealed: -He was blind. -Facility staff checked his blood sugars once daily. -He did not know the exact time because he could not see a clock. -He did not recall a nurse visiting him or discussing his blood sugars. Interview with the LHPS nurse on 01/15/19 at 9:02am revealed: -She had not completed an LHPS evaluation on Resident #9 since June, 2018. -She worked as needed to help the facility out and had only worked a couple of times since she retired. Interview with a second shift medication aide (MA) on 01/15/19 at 5:40pm revealed: -Resident #9 was a diabetic and staff checked his blood sugars daily. Refer to interview on 01/15/19 at 9:08 am with the LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM) Refer to interview on 01/16/19 at 5:58 pm with the Administrator. 5. Review of Resident #5's current FL-2 dated 11/29/18 revealed diagnoses included chronic respiratory failure with hypoxia, hypertension, muscle weakness, difficulty walking, heart failure and schizophrenia. Review of Resident #5's Resident Register	D 280		

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D 280	Continued From page 118 revealed an admission date of 09/21/18. There was no documentation of a Licensed Health Professional Support (LHPS) review in Resident #5's record. Interview with Resident #5 on 01/09/19 at 11:12am revealed: -She was not ambulatory due to weakness. -She required assistance with transfers at times. Interview with a Personal Care Aide (PCA) on 01/11/19 at 1:00pm revealed there were times Resident #5 would ask for assisstance with transfers. Interview with a Medication Aide (MA) on 01/16/19 at 11:27am revealed Resident #5 sometimes needed assistance with transfers. Interview with the Care Manager (CM) on 01/16/19 at 2:34pm revealed she was not aware Resident #5 did not have an LHPS review completed. Interview with the Administrator on 01/16/19 at 5:51pm revealed she was not aware Resident #5 a LHPS evaluation was not completed. Refer to interview on 01/15/19 at 9:08 am with the LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM) Refer to interview on 01/16/19 at 5:58 pm with the Administrator. Refer to interview on 01/15/19 at 9:08 am with the	D 280		

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D 280	Continued From page 119 LHPS RN. Refer to interview on 01/16/19 at 10:35 am with the Care Manager (CM). Refer to interview on 01/16/19 at 5:58 pm with the Administrator. _____ Interview on 01/15/19 at 9:08 am with the LHPS RN revealed: -She did the LHPS quarterly reviews for the facility until December, 2018 (did not remember the date). -The Administrator called her last week (not sure of the day or time) and asked her to come in to do 5 LHPS resident reviews; she was to choose which ones, just do 5 reviews. -She did 5 reviews on residents with diabetes and left the facility; she was not aware of anyone else doing the quarterly LHPS reviews. Interview on 01/16/19 at 10:42 am with the Care Manager (CM) revealed: -The CM was not aware there were missing LHPS reviews for residents having LHPS tasks; she had not audited residents' records to see who needed reviews. -She started her position of CM in December, notifying an RN to come and make the reviews was her responsibility. -The previous LHPS RN retired in December. -There was no current RN to do resident LHPS reviews. -The Administrator was aware the previous RN retired and currently there was no RN to do quarterly LHPS reviews, -She was not aware if the Administrator was trying to get another RN to do the LHPS reviews.	D 280		

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D 280	Continued From page 120 Interview on 01/16/19 at 5:58 pm with the Administrator revealed: -There was currently no RN doing the LHPS quarterly reviews. -The Care Manager was responsible for having someone come and assess the residents for LHPS tasks. -The previous Care Manager left the job in December; another staff started the position when it became vacant. -She called the previous RN last week to come in and do 5 resident LHPS reviews.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the kitchen area was clean and free of contamination including dirty walk-in refrigerator, dirty stove, expired food, improperly stored food, and unlabeled food. The findings are: Observation of the facility kitchen on 01/09/19 at 1:12pm-1:37pm revealed: -The stove hood was dirty with light brown to medium brown areas. -All six of the stove burners had black baked on material with some white areas. -The area behind the burners which was a silver	D 282		

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D 282	Continued From page 121	D 282		

metal had medium and light brown colored baked on areas.
-The walk-in refrigerator had a French fry under the shelves, dust, and a coin.
-The walk-in refrigerator also had rusty spots around the edges and another rusty spot about a foot in eight inches in length.
-The shelves in the walk-in refrigerator had rust on the bottom.
-The opened grape jelly was left out on the counter, the bottle stated "refrigerate when opened."

Observation of the facility kitchen on 01/10/19 at 11:54am revealed the grape jelly was sitting in the same spot on the counter.

Observation of the facility kitchen on 01/10/19 at 1:29pm revealed:
-There was milk with an expiration date of 01/09/19 did not have an open date, and was past the manufactory date.
-There was a cheese sandwich in the front right corner of the refrigerator, which was not labeled.

Observation of the facility kitchen on 01/10/19 at 4:58pm revealed the undated sandwich was in the same spot.

Interview with the Dietary Manager on 01/14/19 at 3:20pm revealed:
-She did not receive any training in her current role.
-She did not have anyone to ask questions to when she did not know something.
-She had been short staffed in the kitchen since November 2018 and was "doing the best she could."
-She often had to work as a cook, or dietary aide

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D 282	Continued From page 122 in the kitchen and that did not give her enough time to clean. -She use to have Mondays to check dates on the food, without enough staff she no longer was able to complete the task of checking the dates on the food. -She was not aware she had expired food in the kitchen or that the opened jelly on the counter needed to be in the fridge. Interview with the Administrator on 01/10/19 at 1:56pm revealed: -She expected there to be a cleaning schedule in the kitchen and had already given a list of what needed to be done. -She expected all food to be dated when it was opened. -She was not aware that there were sandwiches in the refrigerator that were not dated, she expected them to be dated. -She was not aware there was expired food in refrigerator. -She made rounds every two weeks around the facility including the kitchen.	D 282		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve appropriately	D 292		

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D 292	Continued From page 123 substituted meal items and maintain documentation to indicate the foods actually served to residents. The findings are: Review of the dinner menu for 01/09/19 revealed spaghetti with meatballs, garden salad, crusty garlic bread, and grapes were to be served. Observation of the dinner meal service on 01/09/19 revealed the residents were served a popsicle instead of grapes. Interview with the cook on 01/09/19 at 6:00pm revealed: -He did not know he was supposed to serve grapes; he looked at the wrong menu. -He did not document he had made a substitution; he did not know where the substitution logs were. Interview with the dietary aide (DA) on 01/09/19 at 6:06pm revealed she served popsicles for dessert because the cook told her to. Review of the lunch menu for 01/10/19 revealed the residents were to be served Hawaiian pizza, apple spinach salad, and pears. Observation of the lunch meal service on 01/10/19 revealed: -The residents were served Hawaain pizza and a garden salad. -The residents were not served an apple spinach salad or pears. -A resident asked for pears; the dietary aide (DA) told the resident she could have dessert at dinner. -No one was served dessert.	D 292		

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D 292	Continued From page 124 Interview with the cook on 01/10/19 at 1:40pm revealed: -He did not have an apple spinach salad to serve; he thought a garden salad was an equal substitution. -He did not document the substitution of a garden salad in the substitution log. -He did not have pears to serve; the dietary aide should have served cookies. Interview with the DA on 01/10/19 at 1:44pm revealed: -She gave the residents the food the cook had prepared. -Pears were not given to her to serve to the residents; there are times when they do not have dessert to serve at every meal. Review of the lunch menu for 01/11/19 revealed the residents were to be served breadcrumb tilapia fillet, buttery carrots, fresh asparagus, biscuits and chocolate pudding. Observation of the lunch meal service on 01/11/19 revealed residents were not served asparagus or a substitution. Review of the menu substitution notebook provided on 01/11/19 revealed there were no substitutions documented since August 2018. Interview with a resident on 01/11/19 at 10:30am revealed there were a lot of times they did not get what was posted on the menu; sometimes they received different food and sometimes there was no replacement provided. Interview with a second resident on 01/14/19 at 4:07pm revealed:	D 292		

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D 292	Continued From page 125 -The menu did not match what was served and if you ask for something else you cannot have a substitute because you asked "too late." -There were times there was not enough food provided because they did not have what was on the menu. Interview with the Dietary Manager (DM) on 01/14/19 at 2:25pm and 3:20pm revealed: -She expected the staff to serve what was on the menu. -She did not know why grapes were not served for the dinner meal on 01/09/19; there were grapes available to be served. -She based substitutions on what was available to be served; she did not have a lot of substitutions because she ordered her food according to the menu. -There were foods on the menu the residents did not like, so she ordered an appropriate substitution. -They had substitution logs in the kitchen; she should have shown the staff where the logs were kept. -She expected the cook to be able to make appropriate substitutions, if needed. -She expected the staff to let her know when they made a substitution and to document the substitution in the log. -She had not been able to train the new Dietary Aide that started just over a week ago, so she expected she would not understand how to do substitutions. -She had not been trained as a DM, she had worked in restaurant before. Observation of the walk-in cooler on 01/14/19 at 3:30pm revealed grapes were available to be served.	D 292		

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D 292	Continued From page 126 Interview with the Administrator on 01/10/19 at 1:56pm revealed: -She was did not know residents were not served dessert. -She expected meals to be served according to the menu; substitutions should be of equal value. -She expected substitutions to be documented in the log book.	D 292		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there were matching therapeutic diet menus for 2 of 6 residents sampled (#15, #16) with an order for a mechanical soft diet. The findings are: 1. Review of Resident #16's current FL2 dated 01/02/19 revealed: -Diagnoses included dysphagia, transient ischemic attack (TIA), diabetes, hypertension, and hyperlipidemia -There was an order for a mechanical soft diet with chopped meats. Review of Resident #16's physician's order dated 01/10/19 revealed an order for a mechanically	D 296		

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D 296	Continued From page 127 soft diet with chopped meats. Observation of the kitchen on 01/09/19 revealed there was no therapeutic diet menus available to be used for staff guidance when preparing meals. Observation of the dinner meal service on 01/09/19 between 5:35pm and 5:55pm revealed Resident #16 was served spaghetti with meatballs, a garden salad and a piece of French bread; Resident #16 gave the plated food back to the server and said he could not eat the meal. It could not be determined if Resident #16 was served the appropriate meal due to no mechanical soft menu available in the facility. Interview with the cook on 01/09/19 at 6:00pm revealed: -There was no therapeutic diet menu available for review. -He looked the menu up on his phone to know what to cook; the menu he used as a guide to cook was for a regular diet. -He did not have a menu for mechanical soft diet but knew what the residents could eat and not eat and made changes as needed. Refer to interview with the cook on 01/09/19 at 5:55pm. Refer to interview with the Dietary Manager on 01/14/19 at 2:25pm. Refer to interview with the Administrator on 01/10/19 at 1:56pm. 2. Review of Resident #15's current FL-2 dated 04/17/18 revealed a diagnosis of acute pancreatitis; intellectual disabilities, sepsis, and	D 296		

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D 296	Continued From page 128 weakness. Review of Resident #15's diet order revealed an order for a mechanical soft diet on 06/28/18. Observation of the kitchen on 01/09/19 revealed there was no therapeutic diet menus available to be used for staff guidance when preparing meals. Observation of the dinner meal service on 01/09/19 between 5:35pm and 5:55pm revealed Resident #15 was served spaghetti with meatballs, a garden salad and a piece of French bread. It could not be determined if Resident #15 was served the appropriate meal due to no mechanical soft menu available in the facility. Refer to interview with the cook on 01/09/19 at 5:55pm. Refer to interview with the Dietary Manager on 01/14/19 at 2:25pm. Refer to interview with the Administrator on 01/10/19 at 1:56pm. Interview with the cook on 01/09/19 at 5:55pm revealed he did not have a mechanical soft diet menu; he used the regular menu and made adjustments. Interview with the Dietary Manager (DM) on 01/14/19 at 2:25pm revealed she had not seen a therapeutic diet menu for mechanical soft diets but knew what should be substituted. Interview with the Administrator on 01/10/19 at 1:56pm revealed:	D 296		

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D 296	Continued From page 129 -The DM was responsible for having therapeutic menus available for review. -She expected the mechanical soft diet menu to be posted for the cooks to refer to when preparing meals. -She expected the cooks to be taught what to cook for modified meals. -She was concerned the cooks had not used the mechanical soft diet menu for guidance and not been taught how to prepare mechanical soft diets.	D 296		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents on the Special Care Unit (SCU). Observation on 01/09/19 at 6:02 pm of the kitchen's refrigerator and walk in cooler revealed: -There were 3 full gallons and 1- 2/3 full gallon of milk in the refrigerator. -There were 24 full gallons of milk in the walk-in	D 299		

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cooler.
-The facility census was 78; 10 gallons would be required to serve all residents two, 8 oz. glasses of milk per day

Review of the facility's Weekly Menu for 01/09/19 revealed 8 ounces of milk was to be served to the residents at the breakfast and dinner meals.

Observation of the dinner meal on 01/09/19 between 5:15 pm and 6:00 pm revealed there were two dining rooms in the SCU, one on the women's side and one on the men's side.

Observation on 01/09/19 at 5:15 pm to 5:30 pm of the SCU women's dining room revealed:
-There were 17 residents seated in the women's dining room for dinner.
-Two food carts were brought into the women's dining room; one cart contained plated meals and the other cart contained pitchers of water, tea, glassware, and a 3/4 full gallon of milk .
-Residents were served water, tea, and their plated meals.
-Milk was not served to the residents to drink with their meal.
-After the residents had been eating for 15 minutes, a Personal CAre Aide (PCA) came to the side of the dining room and called out "does anyone want milk!"; no resident answered the PCA.
-Staff did not offer each resident milk to drink; the milk delivered on the dinner food cart was not served to the residents.

Interview on 01/09/19 at 5:35 pm with 4 residents seated a table at the back of the women's dining room revealed:
-The residents had not been served milk with their meal; they had not been asked if they

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wanted milk to drink.
-One resident nodded her head when asked if she would like milk to drink with her meal.
-One resident said " I would love to have a glass of milk to drink."

Interview on 01/09/19 at 5:45 pm with a PCA revealed:
-Milk was brought to the dining room, on the beverage cart, for the breakfast and dinner meals.
-Milk was available to residents if they asked for it; residents usually did not ask for milk to drink with their meals in the SCU.
-The PCA did not read the menus, she was not aware milk was to be served to residents twice a day.
-The PCA was not told to serve milk to the residents at meals.

Observation on 01/09/19 at 5:35 pm to 6:00 pm of the men's dining room revealed:
-There were 18 residents seated in the SCU men's dining room for dinner.
-Two food carts were brought into the men's dining room; one cart contained plated meals and the other cart contained pitchers of water, tea, glassware, and a 2/3 full gallon of milk .
-Residents were served water, tea, and their plated meals.
-Four residents were served milk to drink with their meal; no other residents were served or asked if they wanted milk with their dinner.

Interview on 01/09/19 at 5:45 pm with a second PCA revealed:
-She assisted with the dinner meal service in the SCU men's dining room.
-She served milk to 4 residents who liked to drink milk with meals; other residents did not ask for

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milk.
-She did not ask other residents if they wanted milk with their meal.
-A dinner menu was not posted in the men's dining room for her to read.
-She was not sure if milk was to be served to all residents at the dinner meal.
-The milk sent on the cart ran out after serving the 4 residents.

Interview on 01/09/19 at 5:55 pm with the SCU MA/Supervisor revealed:
- Eight ounces of milk was to be served to each resident at the breakfast and dinner meals.
-She was not aware all of the residents were not served milk to drink with their meals.
-If milk ran out, staff should have requested more.

Interview on 01/09/19 at 6:05 pm with the cook in charge revealed:
-Milk and glasses were sent on the beverage carts to both SCU dining rooms for dinner.
-Staff were to serve the milk to the residents with their dinner meal according to the dietitian's menu.
-He did not know staff did not serve milk to all of the residents.
-He did not know the milk ran out during the meal service on the SCU men's dining room; staff should have requested more milk.

Interview on 01/16/19 at 3:15 pm with the Dietary Manager revealed:
-Staff should offer milk to the residents with the breakfast and dinner meals as per the dietitian's menu.
-Milk sent on the beverage carts to the SCU dining rooms usually come back to the kitchen.
-The residents were not getting milk with dinner.
-Staff needed more dietary training on the

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D 299	Continued From page 133 dietitians menu and serving milk to residents. Attempted interview on 01/09/19 at 6:15 pm with the Dietary Manager was unsuccessful.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 6 residents sampled (#3, #15, #16, #17, and #18) with physician's orders for a mechanical soft (MS) diet with chopped meats (#15, #16), and residents with food allergies (#3, #17, and #18) were served as ordered. The findings are: 1. Review of Resident #16's current FL2 dated 01/02/19 revealed: -Diagnoses included dysphagia, transient ischemic attack (TIA), diabetes, hypertension,	D 310		

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and hyperlipidemia
-There was an order for a mechanical soft diet with chopped meats.

Review of Resident #16's physician's order dated 01/10/19 revealed Resident #16 was to be served a mechanical soft diet with chopped meats.

There was no therapeutic diet list or therapeutic menu available for review on 01/09/19.

Observation of Resident #16 on 01/09/19 at 5:37 revealed:
-Resident #16 was served spaghetti with meatballs, a garden salad and a piece of French bread; Resident #16 gave the plated food back to the server and said he could not eat the meal.
-Without a therapeutic diet menu, it could not be determined if Resident #16 was served a mechanical soft diet as ordered by the physician.

Observation of Resident #16 on 01/09/19 at 5:38pm revealed the Dietary Aide was told by the Medication Aide (MA) to take his plate back, she wanted him to have one yogurt and one sorbet for dinner.

Observation of Resident #16 on 01/09/19 at 5:40pm-5:45pm revealed he was given one sorbet and one yogurt and ate both then asked for a Popsicle.

Interview with Resident #16 on 01/09/19 at 6:07pm revealed:
-They had given him this to eat (he showed his container of sorbet and yogurt) because they thought he was going to throw up.
-He was given a turkey sandwich and a bowl of soup for lunch on 01/09/19; he ate his sandwich and when he started eating his soup he started

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D 310	Continued From page 135 gagging and threw it up in his bowl. Observation of assisted living dining room from 5:45pm-6:06pm revealed Resident #16 did not get a Popsicle. Observation of Resident #16 on 01/09/19 at 6:09pm revealed the cook came and gave him a Popsicle. Interview with the Cook on 01/09/19 at 3:48pm revealed: -He only had a notebook with resident diet orders. -He knew by memory what resident to give what diet to. -He did not know what happened when he was not here with regard to how staff knew what diet to give each resident. Interview with Resident #16 on 01/09/19 at 5:38pm revealed "I'm having trouble keeping things down, I have been struggling with chewing." Interview with a MA on 01/09/19 at 6:15pm revealed: -Resident #16 came to the facility two days ago, and he had been vomiting several times, so she thought yogurt and sorbet would be easier for him to eat. -She did not know Resident #16's diet order. Interview with Resident #16's Primary Care Provider (PCP) on 01/10/19 at 12:10pm revealed he believed the vomiting was related to a stroke or difficulty swallowing and being given a regular instead of a mechanical diet. Interview with Administrator on 01/09/19 at 6:20pm revealed:	D 310		

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D 310	Continued From page 136 -She did not know Resident #16 was given a regular diet initially for dinner instead of a mechanical soft dinner. -She expected all residents to be given the correct meal based upon their diet orders. -She expected staff to know what residents received what food or to ask more experienced MAs. -She did not know if Resident #16 was vomiting prior to his admission to the facility. Observation of Resident #16 during the lunch meal service on 01/10/19 between 1:04pm and 1:20 pm revealed: -Resident #16 was served a slice of pizza and a small garden salad. -None of the food had been cut up by the staff. -At 1:04pm Resident #16 requested a different meal service "I cannot eat this." -At 1:11pm Resident #16 told a personal care aide (PCA) that he could not eat the pizza because it was not chopped and that he could not eat the salad. -At 1:20pm Resident #16 was served an 8-ounce container of yogurt. Review of the mechanical soft menu provided on 01/10/19 revealed Hawaiian pizza, cooked spinach, pears, and beverage choice were to be served for the lunch meal service. Interview with Resident #16 on 01/10/19 at 1:20pm revealed: -"I could not chew my salad or eat that pizza." -They gave me yogurt because they thought I was going to throw up. -I threw up because the food they were giving me; I could not chew the food up and it got "hung up in my throat" and made him gag and he threw it back up.	D 310		

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D 310	Continued From page 137 -He reported that he ate breakfast without throwing up because it was soft and easy to eat. Review of the MS menu for the lunch meal on 01/10/19 revealed Hawaiian Pizza (MS), cooked spinach and pears (MS). Interview with the cook on 01/10/19 at 1:40pm revealed: -He served the residents plates according to their diet order. -He did not have a list but knew the residents and what they were supposed to be served. -The plates were plated correctly but were not served correctly because of the lack of communication. -Residents on a mechanical soft diet should have been given green beans instead of a garden salad. -His job was to cook the food and plate it; the aides were responsible for serving the plates. -The aides were responsible for knowing who received mechanical soft plated food. -A mechanical soft diet was usually for people who had ill-fitting dentures or no teeth; they cannot chew up their food. -For Hawaiian pizza, a mechanical soft diet got the same thing as everyone else because it was on the steam table and was soft. Telephone interview with Resident #16's family member on 01/14/19 at 4:29pm revealed: -If Resident #16 did not eat the right food he would throw it back up. -Resident #16's food needed to be cut up. -When Resident #16 lived at home she cooked a lot of vegetables and ground the meat up for Resident #16. -He could not eat some meats like chicken	D 310		

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because it was too dry and even ground up Resident #16 would get choked and throw up.
-Resident #16 did well with creamed potatoes, ice cream, and other soft foods.

Interview with a dietary aide on 01/10/19 at 1:44pm revealed:
-She had not seen a diet list, but she "just about knew who was on a mechanical soft diet."
-She was responsible for beverages and preparing alternate menu items like sandwiches.
-The PCAs and MAs were responsible for serving plated food.
-The cook should tell the PCAs and MAs who to give the plated food to.
-She had not seen a diet list, but she "just about knew who was on a mechanically soft diet."

Interview with a MA on 01/10/19 at 1:47pm revealed:
-Usually, the dietary staff told her who had a mechanical soft diet.
-Sandwiches were given a lot for mechanical soft diets; she thought a sandwich was fine for a mechanical soft diet.
-If the Dietary Manager (DM) was working, she always gave the servers the mechanical soft plated food first to serve before any other plates were served.
-The DM told her who was to be served the mechanical soft plates, but she already knew who they were for.

Interview with the Dietary Manager on 01/14/18 at 2:25pm revealed:
-She had been working at the facility since May 2018.
-Her role was the Dietary Manager, but there were often times she was the cook and dietary aide as they had been short-handed since

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November 2018.
-The Care Manager (CM) would bring any new diet orders to her, and she would file in the dietary book.
-They would use a whiteboard to write any new diet orders.
-She had a laminated list of residents with special diets, but it was lost last fall (2018) and she had not replaced it.
-The kitchen staff should have known what residents had therapeutic diets.
-They usually always served special diets together; the first plates that were plated and served.
-The cook should have known to do it that way as it was the way it was always done.
-If a resident was served the wrong plate she expected the staff to throw that plate away and serve the correct plate.

Interview with a MA on 01/15/19 at 5:00pm revealed:
-She had helped serve meals in the dining room.
-The dietary staff would give the plated food to her and tell her who the plate was for.
-There have been times she was given a plate to serve that was not chopped, so she would give it back to them or chop it herself.

Interview with the Administrator on 01/10/19 at 1:56pm revealed:
-Her role was to oversee the DM.
-She did not know there was not a therapeutic diet list posted; she expected the DM to keep an updated diet list in the kitchen.
-She did not know a therapeutic spreadsheet was not available for the cook to use for guidance.
-She had not seen residents who were on mechanical soft diets be served the wrong meal; she would have referred the dietary staff to the

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mechanical soft menu to prepare the meal.
-Mechanical soft diets should have the meats ground up like ground beef.
-She expected the cooks to be taught what to cook for modified meals.
-She was concerned the cooks had not been taught how to prepare mechanical soft diets.
-She made rounds in the dining room every 2 weeks.
-She expected all staff to know what the resident's diets were as everyone helped serve meals.
-She expected staff to not give residents food they were not supposed to have.
-It was mandatory all care staff were in the dining room at meals.
-She expected the cook to tell the dietary aides who would then tell the PCAs and MAs who the plates were to be served to.

Telephone interview with the PCP on 01/16/19 at 9:11am revealed:
-He was concerned about the safety of residents who had an ordered mechanical soft diet getting food that was not chopped up.
-For Residents who needed a mechanical soft diet and were given a regular diet "there is a risk for them to choke to death in the dining room or get aspiration pneumonia."

2. Review of Resident #15's current FL-2 dated 04/17/18 revealed a diagnosis of acute pancreatitis; intellectual disabilities, sepsis and weakness.

Review of documentation from a skilled nursing and rehabilitation facility dated 04/17/18 revealed:
-Resident #15 was admitted on 03/12/18 with diagnoses of sepsis, pneumonia, and pancreatitis.

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D 310	Continued From page 141 -Resident #15 also had diagnoses of dysphagia and severe calorie malnutrition. -Resident #15 was on a pureed diet. Review of Resident #15's subsequent diet order revealed an order for a pureed diet on 05/03/18 and a mechanical soft diet on 06/28/18. There was no therapeutic diet list or therapeutic menu available for review on 01/09/19. Observation of the assisted living dining room on 01/09/19 at 5:28pm revealed: -Residents were all being served spaghetti with meatballs, a garden salad and a piece of French bread from a cart that began in the kitchen and went from table to table. -There were no variations of plates noted on the cart. Observation of the dinner meal service on 01/09/19 between 5:35pm and 5:55pm revealed: -Resident #15 was served spaghetti with meatballs, a garden salad and a piece of French bread. -No food had been cut up by the staff. -Resident #15 used her fork to cut-up her spaghetti and meatballs; she did not eat her salad or bread. -Without a therapeutic diet menu, it could not be determined if Resident #15 was served a mechanical soft diet as ordered by the physician. Interview with the cook on 01/09/19 at 5:55pm revealed: -He did not have a mechanical soft diet menu; he used the regular menu and made adjustments. -The residents on mechanical soft diets could have spaghetti and meatballs; the meatballs should have been chopped, but he ran out of	D 310		

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time.
-The meatballs were soft.
-The residents should not have been served a garden salad; he ran out of time.

Observation of the lunch meal service on 01/10/19 between 1:04pm and 1:14pm revealed:
-Resident #15 was served a turkey sandwich with tomato slices and green beans.
-No food had been cut up by the staff.
-Resident #15 picked her sandwich up and took bites from it; she ate all of her sandwich.
-She ate half of her green beans.

Review of the mechanical soft lunch menu for 01/10/19 revealed Hawaiian pizza, cooked spinach, pears, and beverage choice were to be served.

Interview with Resident #15's Primary Care Provider on 01/10/19 at 12:11pm revealed:
-Resident #15 should have been served meals as ordered.
-Resident #15 had been on a pureed diet but had been upgraded to a mechanical soft diet; he did not recall why Resident #15's diet had been upgraded.
-If Resident #15 ate food that was not mechanically softened the food could get lodged in her throat.
-If Resident #15 ate a regular meal she was at risk for aspiration and pneumonia.

Interview with the cook on 01/10/19 at 1:40pm revealed:
-He served the residents plates according to their diet order.
-He did not have a list but knew the residents and what they were supposed to be served.
-The plates were plated correctly but were not

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served correctly because of the lack of communication.
-His job was to cook the food and plate it; the aides were responsible for serving the plates.
-The aides were responsible for knowing who to give mechanical soft plates too.
-A mechanical soft diet was usually for people who had ill-fitting dentures or no teeth; they could not chew their food up.

Interview with a dietary aide on 01/10/19 at 1:44pm revealed:
-She had not seen a diet list, but she "just about knew who was on a mechanical soft diet."
-She was responsible for beverages and preparing alternate menu items like sandwiches.
-The PCAs and MAs were responsible for serving plated food.
-The cook should tell the PCAs and MAs who to give the plated food to.
-She had not seen a diet list, but she "just about knew who was on a mechanically soft diet."

Interview with a MA on 01/10/19 at 1:47pm revealed:
-Usually, the dietary staff told her who had a mechanical soft diet.
-Sandwiches were given a lot for mechanical soft diets; she thought a sandwich was fine for a mechanical soft diet.
-If the Dietary Manager (DM) was working, she always gave the servers the mechanical soft plated food first to serve before any other plates were served.
-The DM told her who was to be served the mechanical soft plates, but she already knew who they were for.

Interview with Resident #15 on 01/11/19 at 9:23am revealed:

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D 310	Continued From page 144 -Her food was supposed to be chopped. -She did not know why she was on a chopped diet but knew it was easier to eat when her food was soft; she did not have bottom teeth. -She was served meals that were not chopped; her meals had not been chopped lately; she wished her food was chopped. -She did not ask for assistance with cutting her food up and did it herself the best she could. Telephone interview with Resident #15's family member on 01/15/19 at 11:42am revealed: -Resident #15 had acid reflux and needed to have her food cut-up to eat. -He had seen Resident #15 get choked and cough when her food was not cut-up; he could not recall the last time he saw her get choked. -Resident #15 had her throat stretched but would still get choked if her food was not cut-up. Interview with the Dietary Manager on 01/14/18 at 2:25pm revealed: -She had been working at the facility since May 2018. -Her role was the Dietary Manager, but there were often times she was the cook and dietary aide as they had been short-handed since November 2018. -The Care Manager (CM) would bring any new diet orders to her, and she would file in the dietary book. -They would use a whiteboard to write any new diet orders. -She had a laminated list of residents with special diets, but it was lost last fall (2018) and she had not replaced it. -The kitchen staff should have known what residents had therapeutic diets. -They usually always served special diets together; the first plates that were plated and	D 310		

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served.
-The cook should have known to do it that way as it was the way it was always done.
-If a resident was served the wrong plate she expected the staff to throw that plate away and serve the correct plate.

Interview with a MA on 01/15/19 at 5:00pm revealed:
-She had helped serve meals in the dining room.
-The dietary staff would give the plated food to her and tell her who the plate was for.
-There have been times she was given a plate to serve that was not chopped, so she would give it back to them or chop it herself.

Interview with the Administrator on 01/10/19 at 1:56pm revealed:
-Her role was to oversee the DM.
-She did not know there was not a therapeutic diet list posted; she expected the DM to keep an updated diet list in the kitchen.
-She did not know a therapeutic spreadsheet was not available for the cook to use for guidance.
-She had not seen residents who were on mechanical soft diets be served the wrong meal; she would have referred the dietary staff to the mechanical soft menu to prepare the meal.
-Mechanical soft diets should have the meats ground up like ground beef.
-She expected the cooks to be taught what to cook for modified meals.
-She was concerned the cooks had not been taught how to prepare mechanical soft diets.
-She made rounds in the dining room every 2 weeks.
-She expected all staff to know what the resident's diets were as everyone helped serve meals.
-She expected staff to not give residents food

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they were not supposed to have.
-It was mandatory all care staff were in the dining room at meals.
-She expected the cook to tell the dietary aides who would then tell the PCAs and MAs who the plates were to be served to.
4. Review of Resident #16's current FL2 dated 01/02/19 revealed:
-Diagnoses included dysphagia, transient ischemic attack (TIA), diabetes, hypertension, and hyperlipidemia
-There was an order for a mechanical soft diet with chopped meats.

Observation of Resident #16 on 01/09/19 at 5:37 pm revealed he was served a regular diet dinner of spaghetti with meatballs, a garden salad and a piece of French bread.

Observation of Resident #16 on 01/09/19 at 5:38 pm revealed the Dietary Aide was told by the medication aide to take his plate back, she wanted him to have one yogurt and one sorbet for dinner.

Observation of Resident #16 on 01/09/19 at 5:40-5:45pm revealed he was given one sorbet and one yogurt and ate both then asked for a Popsicle.

Observation of Resident #16 on 01/09/19 at 6:09pm revealed the cook came and gave him a Popsicle.

Interview with the Cook on 01/09/19 at 3:48pm revealed:
-He only had a notebook with resident diet orders.
-He knew by memory what resident to give what diet to.
-He did not know what happened when he was

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not here in regards to how staff knew what diet to give each resident.

Interview with Resident #16 on 01/09/19 at 5:38pm revealed "I'm having trouble keeping things down, I have been struggling with chewing."

Interview with a medication aide (MA) on 01/09/19 at 6:15pm revealed:
-Resident #16 came to the facility two days ago and he had been vomiting several times, so she thought yogurt and sorbet would be easier for him to eat.
-She did not know if the nurse had seen him, and she had not called his Physician Assistant, and did not know if any of the other MAs called the PA.
-She did not know Resident #16's diet order.

Interview with Administrator on 01/09/19 at 6:20pm revealed:
-She did not know that Resident #16 was given a regular diet initially for dinner instead of a mechanical soft dinner.
-She expected all residents to be given the correct meal based upon their diet orders.
-She expected staff to know what residents received what food or to ask more experienced MA's.
-She expected the MA to call the PA when Resident #16 continued to vomit multiple times over the last few days without being seen by a PA..
-She did not know if Resident #16 was vomiting prior to his admission to the facility.

3. Review of Resident #3's current FL2 11/28/18 and diagnoses included major neurocognitive

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D 310	Continued From page 148 disorder with behaviors, psychosis, mild dehydration, hearing loss, partial vision loss both eyes. Review of Resident #3's physician assistant order dated 11/29/18 revealed Resident #3 was to be served a regular diet and was allergic to eggs and was lactose intolerant. Observation on 01/09/19 from 5:35-5:55pm revealed Resident #3 ate all her dinner including drinking a cup of regular, non-lactose free milk, which was poured directly from the container. Based on records, interviews, and observations Resident #3 was not interviewable. Interview with Dietary Manager on 01/11/19 at 12:55pm revealed: -She was not aware that the residents that were lactose intolerant should have had a substitution. - There was lactose free milk in the resident refrigerator and she was not sure why residents that were lactose intolerant were not being given lactose free milk. Interview with the Physician Assistant (PA) on 01/10/19 at 12:50pm revealed a lactose intolerant resident would experience diarrhea, gas, abdominal discomfort and possible vomiting from eating lactose. Interview with Administrator on 01/10/19 at 1:56pm revealed: -She did not know there were any lactose intolerant residents. -She expected that the dietary staff would have an updated spreadsheet created by the Dietary Manager of all the food allergies and special diets.	D 310		

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-She expected the dietary staff to know the residents who had special diets and food allergies.
-She expected the residents who were lactose intolerant to not have been served pizza with cheese for lunch today.

There was no therapeutic diet list posted in the kitchen on 01/09/19.

4. Review of Resident #17's physician assistant's orders dated 06/27/18 revealed Resident #17 was to be served a mechanical soft and lactose free diet.

Observation of Resident #17 in the MCU on 01/11/19 at 12:22pm revealed Resident given milk poured from milk container with an expiration date of 01/09/19.

Observation of personal care aide (PCA) in MCU on 01/11/19 at 12:23pm revealed:
-She took away Resident #17's milk and lactose free milk was not offered.
-Resident #17 had not drank any milk, but yelled "hey!"

Observation on 01/11/19 at 12:33pm revealed the plate put in front of Resident #17 was a regular diet with a tilapia fillet, buttery carrots, and a biscuit.

Observation of Medication Aide (MA) in MCU on 01/11/19 at 12:34pm revealed she told the PCA to take Resident #17's plate she could not eat that food.

Interview with PCA in memory care on 01/11/19 at 12:23pm revealed when she was asked about Resident #17 getting milk she said "o yeah, she's

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D 310	Continued From page 150 not supposed to have it." Interview with MA in MCUon 01/11/19 at 12:33pm revealed she did not know Resident #17 needed a mechanically soft diet and was lactose intolerant. Based on records, interviews, and observations Resident #17 was not interviewable. Telephone interview with Resident #17's Power of Attorney on 01/15/19 at 9:34am revealed: -She had been lactose intolerant for a long time and she was missing most of her teeth. -Food had to be chopped up for her, she did not know to chop her own food before she ate. Interview with PCA in MCU on 01/11/19 at 12:40pm revealed: -Residents with food allergies usually had name tags with their full name and food allergy and were served special food. -The food came from the kitchen about "60% of the time correctly." -She usually knew by memory what residents had food allergies, the MAs told the PCAs the diet orders and food allergies. Interview with Dietary Manager on 01/11/19 at 12:55pm revealed: -She was not aware that the residents that were lactose intolerant should have had a substitution. -She did have lactose free milk in the resident refrigerator and was not sure why residents that were lactose intolerant were not being given lactose free milk. Interview with the Physician Assistant (PA) on 01/10/19 at 12:50pm revealed a lactose intolerant resident would experience diarrhea, gas,	D 310		

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abdominal discomfit and possible vomiting from being fed lactose.

Telephone interview with the PA on 01/16/19 at 9:11am revealed:
-He was concerned about the safety of residents who had an ordered mechanically soft diet getting food that was not chopped up.
-Residents who needed a mechanically soft diet and were given a regular diet "there is a risk for them to choke to death in the dining room or get aspiration pneumonia."

Interview with Administrator on 01/10/19 at 1:56pm revealed:
-She did not know there were any lactose intolerant residents.
-She expected that the dietary staff would have an updated spreadsheet created by the Dietary Manager of all the food allergies and special diets.
-She expected the dietary staff to know the residents who had special diets and food allergies.

There was no therapeutic diet list posted in the kitchen on 01/09/19.

5. Review of Resident #18's physician assistant's orders dated 08/20/18 revealed: Resident #18 was to be served a regular diet and she was allergic to seafood and sausage.

Observation of Resident #18 on 01/11/19 at 12:31pm revealed she was in the MCU and the plate put in front of Resident #18 was a regular diet with a tilapia fillet, buttery carrots, and a biscuit.

Interview with Medication Aide (MA) on 01/11/19

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D 310	Continued From page 152 at 12:33pm in Memory Care Unit (MCU) revealed she needed to get Resident #18 a plate that did not have seafood on it. Observation of a MA in MCU 01/11/19 at 12:36pm revealed she sent a PCA to the kitchen for food for those with food allergies. Based on records, interviews, and observations Resident #18 was not interviewable. Telephone interview with Resident #18's guardian on 01/15/19 at 12:13pm revealed: -She was allergic to seafood, and in the past got itchy and had hives when she ate seafood. -Her guardian was not sure if she was allergic to sausage, or if she just would not eat it. Interview with Personal Care Aide (PCA) in memory care on 01/11/19 at 12:40pm revealed: -Residents with food allergies usually had name tags with their full name and food allergy and were served special food. -The food came from the kitchen about "60% of the time correctly." -She usually knew by memory what residents had food allergies, the MA's told the PCA's the diet orders and food allergies. Telephone interview with the PA on 01/16/19 at 9:11am revealed: -He did know that Resident #18 was allergic to seafood. -He expected residents that had seafood allergies and other food allergies to not get the food. -He said, "repeated exposures can make the symptoms worse." Interview with Administrator on 01/10/19 at 1:56pm revealed:	D 310		

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D 310	Continued From page 153 -She expected that the dietary staff would have an updated spreadsheet created by the Dietary Manager of all the food allergies and special diets. -She expected the dietary staff to know the residents who had special diets and food allergies. There was no therapeutic diet list posted in the kitchen on 01/09/19. _____ The facility's failure of not serving diets as ordered resulted in Resident #16 gagging on his food and subsequently vomiting during multiple meals that were not served as mechanical soft, increased risk for Resident (#15) to choke on food who had a diagnosis of dysphagia and an increased risk of residents (#3, #17, and #18) having an allergic reaction to food that was served when they had physicians orders indicating an allergy, which was detrimental to the safety and health of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S, 131D-34 on January 14, 2019 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 2, 2019.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained	D 338		

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D 338	Continued From page 154 and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents recieved a resonable response from staff for 5 residents who requested to go outside to smoke, at the designated times, and had to wait; a resident requesting to have ice in their beverage and did not receive ice, residents who waited 15-20 minutes for meals to be served and received cold meals, and residents not receiving salad dressing with their salads at mealtime. The findings are: a. Interview with 5 residents who smoke on 01/14/19 at 11:35am revealed: -Smoking was allowed at 8:30am, 11:00am, 1:00pm, 4:00pm and 7:00pm. -They always had to wait to go outside to smoke; they had been waiting since 11:00am to go out today (35 minutes). -They waited 45 minutes to an hour a lot of times. Interview with 3 residents who smoke on 01/14/19 at 12:00pm revealed they were frustrated because no one ever took them smoking at the 11:00am smoking break, so they would have to wait until after lunch for their next	D 338		

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smoke break.

Interview with a resident on 01/14/19 at 4:10pm revealed:
-They never went outside to smoke at the times they were told they could smoke; 9:00am, 11:00am, 1:00pm, 4:00pm and 7:00pm.
-The staff always told them they were busy.
-Their cigarettes were kept in a box by staff and were often missing or broke.

Interview with a personal care aide (PCA) on 01/15/19 at 8:58 am revealed:
-Residents have complained about waiting so long to go out to smoke.
-The residents went into the lounge area and had to wait to go outside.
-If the staff were really busy the residents would look for them to remind them they wanted to smoke.
-The PCAs were supposed to take the residents out to smoke; if they were busy the medication aides (MA) were supposed to take the residents out to smoke.
-It was really busy taking care of resident needs and the smokers had to wait; they usually only had to wait 15-20 minutes.

Interview with the Care Manager on 01/15/19 at 10:22am revealed:
-Residents were allowed to smoke at 8:00am, 11:00am, 1:00pm, 4:00pm and 7:00pm.
-The PCAs or MAs could take residents out to smoke.
-The residents may have to wait but it was usually no more than 10-15 minutes.
-If both MAs were in the middle of a medication pass and the PCA was in the middle of a shower, smoking would have to wait.
-The residents had complained about having to

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D 338	Continued From page 156 wait; the Administrator knew the residents complaints. Interview with a MA on 01/15/19 at 10:36am revealed: -The PCAs were responsible for taking residents out to smoke. -The residents complained about having to wait; they may have to wait 15-20 minutes. Interview with the Business Office Manager on 01/16/19 at 8:59am revealed: -Residents were given the smoking policy at the time of admission. -Residents were allowed to smoke five times a day; they should expect an hour before or an hour after the assigned times. -The care staff was responsible for taking residents outside to smoke; smoking came after resident care needs were addressed. Interview with the Administrator on 01/16/19 at 5:51pm revealed: -Residents were able to go outside to smoke after meals and at bedtime. -The Supervisor was responsible for assigning a staff person to take the residents outside to smoke. -She knew the residents had to wait a long time; sometimes she had taken them out to smoke herself. -She expected staff to assign a PCA to take the residents out and to remind them if they were busy. -It concerned her the residents had to wait but it was often because the staff were busy with resident care. b. Observation of several Residents on 01/09/19 at 5:35pm revealed three residents asked	D 338		

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D 338	Continued From page 157 between one and three times for salad dressing for their dinner salad. Observation of the dining room on 01/10/19 between 11:57am and 1:01pm revealed: -A cup of ice tea and water had been placed at all the tables by 11:57am. -At 12:01pm the residents were seated in the dining room. -At 12:38pm a resident asked for ice for their tea glass. -At 1:01 pm the meals were being served. -The resident was not given ice for their tea glass until all the meals were served at 1:14pm. Interview with the Administrator on 01/10/19 at 1:56pm revealed: -She expected drinks be prepared no more than 15-20 minutes before the meal was served. -She expected the first plate to be served at the beginning of the meal time; if lunch was at 12:00pm then she expected the first plate to be served at 12:00pm. -She expected staff to walk around and ask residents if they need anything throughout the meal. -She expected appropriate condiments be served with meals; salad dressing should be provided with garden salads. Interview with a resident on 01/11/19 at 9:15am revealed: -They had to wait a long time for meals and the meals were usually cold. -They did not always get condiments with their meals; he would have liked to have salad dressing for his salad. Interview with a second resident on 01/14/19 at 4:07pm revealed:	D 338		

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-They always had to wait on meals; usually at least 15-20 minutes.
-Sometimes they had to sit in the hall so long all the ice had melted in their tea.
-Residents had to ask for ice for watered down tea; sometimes the residents got it and sometimes they did not.
-He could not eat a garden salad without dressing; he asked for dressing several times on 01/09/19 and 01/10/19 and was eventually given a pack of mayonnaise.

Interview with a third resident on 01/15/19 at 10:14am revealed they had to wait a long time for meals and the food was usually cold; even the soup was served cold.

Interview with a fourth resident on 01/15/19 at 10:30am revealed:
-They had to wait a long time for meals; sometimes they may have to wait an hour.
-They did not always get salad dressing in their salads; she would have liked to have had salad dressing.
-She did not eat her salad because she did not have salad dressing.

Observation on 01/09/19 at 1:04pm revealed Italian and Ranch salad dressing in the resident kitchen fridge.

Interview with two Residents on 01/09/19 at 5:39pm revealed both residents expected the staff to at the very least to have responded to their request verbally so they knew why they could not get salad dressing for their salads. "I cannot eat a salad without dressing and it's nothing but iceberg lettuce."

Interview with the Dietary Aide on 01/09/19 at

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D 338	Continued From page 159 6:02 pm revealed: -She was not sure if they had salad dressing to serve the residents. -The menu said "green salad" so she thought it was a plain salad only on the menu for dinner. Interview with the cook on 01/09/19 at 6:00pm revealed: -He served the dinner meal exactly by the menu; the menu did not indicate they ere to serve salad dressing. -He did not know anyone had asked for salad dressing. Interview with the Dietary Manager on 01/14/19 at 3:20pm revealed: -She expected salad dressing to be served to the residents when salad was on the menu. -She expected the cook to have taken care of serving salad dressing with salad. Interview with the Administrator on 01/09/19 at 6:20pm revealed: -She expected salad dressing to be served to the resident with options of dressing when salad was on the menu. She expected not only salad dressing but other condiments also.	D 338		
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	D 358		

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D 358	Continued From page 160 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure long acting insulin was administered as ordered by a licensed prescribing practitioner for 1 of 8 sampled residents (Resident #4). The finding are: 1. Review of Resident #4's current FL2 01/03/19 revealed diagnoses included diabetes mellitus. Review of Resident #4's physician orders revealed an order for Lantus, a long acting insulin, 30 units to be injected subcutaneously at bedtime every day for diabetes mellitus. Review of Resident #4's November 2018 electronic Medication Administration Record (eMAR) revealed her Lantus was documented as not administered "per doctors' orders" 7 out of 30 times. Review of Resident #4's December 2018 eMAR revealed: -Resident #4's Lantus was documented as not	D 358		

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D 358	Continued From page 161 administered "per doctors' orders" 3 out of 29 times. -Her blood sugar was documented as 108 on 12/02/18 at 8:00pm and Lantus was documented as "withheld per doctor orders." -Her blood sugar was documented as 78 on 12/07/18 at 8:00pm and Lantus was documented as "withheld per doctor orders." -Her blood sugar was documented as 121 12/14/18 at 8:00pm and Lantus was documented as "withheld per doctor orders." Review of Resident #4's January 2019 eMAR revealed Lantus insulin was documtned as adminstered at 8:00pm on 01/01/19 through 01/09/19. Interview with Resident #4 on 01/15/19 at 10:15am revealed that the MAs hold her Lantus when her blood glucose was less than 149. Interview with a MA on 01/15/19 at 5:08pm revealed if Resident #4's blood sugar was less than 149 she always held both her insulins per her medication orders. Interview with another MA on 01/16/19 at 11:42am revealed: -She had read Resident #4's eMAR as hold all insulin for blood sugars less than 149. -On the computer Resident #4's eMAR indicated "hold insulin it did not specifically indicate which one" to hold insulin for the blood sugar less than 149. -"I had a hunch that maybe there was something more to that and I should have questioned it before." -She knew that Resident #4 took both a fast and a slower acting insulin and she knew Lantus was the slower acting insulin.	D 358		

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D 358	Continued From page 162 Interview with PA on 01/16/19 at 9:16am revealed: -He had not intended for Resident #4's Lantus to ever be held based upon her blood sugar because it was a long acting insulin. -He expected if there was confusion about an order he wrote that he would be contacted. Interview with the Administrator on 01/16/19 at 5:50pm revealed: -She did not know that Resident #4 had missed Lantus insulin because the MAs were confused about a medication order. -She had expected the MA who received the medication order to have gotten clarification if they did not understand the order. -The MA should have seen that Resident #4's insulin orders needed clarification. -She expected the MAs to know the difference between slow and long acting insulin.	D 358		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the	D 454		

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resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the responsible party for one resident (Resident #11) who was transported to the emergency department for a behavioral health evaluation.

Review of Resident #11's current FL-2 dated 01/03/19 revealed diagnoses included depression, anxiety, alcohol abuse, and insomnia.

Review of the facility's Incident/Accident reports revealed there was no incident report available for Resident #11 for the date (01/01/19) that Resident #11 was transported by Emergency Medical Services (EMS) from the facility to a medical center for evaluation.

Interview with the Primary Care Provider (PCP) on 01/10/19 at 12:11pm revealed he had not been notified Resident #11 had been transferred to a medical center for evaluation on 01/01/19.

Telephone interview with Resident #11's Guardian on 01/11/19 at 10:00am revealed:
-Their agency had not received notification

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D 454	Continued From page 164 Resident #11 had been transferred to the emergency department (ED) on 01/01/19. -They received a call from an employee at the facility at 1:15pm on 01/08/19 notifying them Resident #11 was missing after he had been sent to the ED on 01/01/19. Telephone interview with a county representative on 01/11/19 at 11:08am revealed: -Their agency had not received notification Resident #11 had been transferred to the emergency department on 01/01/19. -She did not know Resident #11 had been sent to the emergency department on 01/01/19 until she had received an anonymous call on 01/08/19 from an employee at the facility at 1:08pm that a resident under guardianship had been transferred to the hospital on 01/01/19 and on 01/08/19 the Business Office Manager had discovered this resident (Resident #11) was discharged from the hospital on 01/02/19 and was missing. -The Administrator could not provide her with an incident report. -They were told by the Administrator an incident report had been completed when Resident #11 was sent out for an evaluation on 01/01/19; the incident report was not provided. -The facility reported they had called on 01/01/19 to notify the Guardian Resident #11 was being transferred to the ED for evaluation; there was no documentation provided to show the Guardian had been notified. -She contacted staff to inquire if a call had been received on 01/01/19 regarding Resident #11 being sent to the hospital and there was no record of any calls from the facility to their agency. Review of Emergency Medical Services (EMS) logs dated 01/01/19 revealed:	D 454		

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D 454	Continued From page 165 -The EMS call was received at 3:31pm. -Resident #11 wanted to go to the ED for mental health services. -Resident #11 had anxiety and was being stressed all the time. -Resident #11 reported that he "wanted to hurt himself." -Resident #11 was transported to the ED with an arrival time of 4:40pm. Interview with the Care Manager on 01/14/18 at 10:20am revealed the Medication Aide (MA) who contacted EMS for a resident was responsible for calling the PCP, the responsible party and completing an incident report. Interview with a MA on 01/14/19 at 9:44am revealed: -When a resident needed to be sent out of the facility for evaluation the procedure was to contact the PCP to let them know what was going on and get direction on what to do. -She would then do what the PCP directed them to do; if the resident was sent out they would notify the responsible party, either family or the Guardian. Interview with the Business Office Manager on 01/14/19 at 11:13am revealed: -Resident #11 had come to her on 01/01/19 and said he was feeling overwhelmed and wanted to go to the hospital. -She talked to the MA who coordinated sending Resident #11 to the hospital. -The MA was responsible for notifying Resident #11's Guardian. Interview with a second MA on 01/14/19 at 12:01pm revealed: -She was coming on duty when Resident #11 was	D 454		

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being sent out on 01/01/19.
-She knew Resident #11 was going out, but she did not have anything to do with it.
-She was asked by the Administrator on 01/08/19 if she had completed any paperwork on Resident #11 being sent out, and she reported she did not because she "did not have anything to do with it."
-She did a late entry on 01/08/19 to show she did not have anything to do with the transfer.

Review of a progress note dated 01/08/19 at 5:18pm for Resident #11 revealed:
-This progress note was documented as a late entry.
-The MA documented that when she arrived to work (no date) Resident #11 was being sent out by the first shift MA.
-The MA documented the first shift MA reported to the second shift MA that the Business Office Manager had told her to send Resident #11 to the ED at the local behavioral health unit.
-The MA documented the PCP was called at 2:59pm, Emergency Medical Services (EMS) was called at 3:17pm and the Guardian was called at 4:46pm.

Interview with the same MA on 01/15/19 at 11:34am revealed:
-She entered the late entry progress note after it was discovered Resident #11 was missing, and she was asked questions about what had occurred the day Resident #11 was sent out.
-She got the times she documented because that was the time she remembered the first shift MA had made the calls.
-She did not know whom the calls were made to, but she knew the first shift MA made calls related to Resident #11 being sent out.

Interview with the MA who sent Resident #11 to

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the ED on 01/16/19 at 7:22pm revealed:
-The Business Office Manager told her to send Resident #11 to the ED.
-She called the on-call provider who questioned why Resident #11 needed to go to the ED.
-She explained to the on-call provider Resident #11 was requesting to go to the ED, and he gave her permission to call EMS.
-Resident #11 was sent out, and she was doing her work when she remembered she had not call Resident #11's Guardian.
-She called the number for the Guardian in Resident #11's record and left a voicemail for the Guardian.
-Resident #11 told her the ED usually kept him for 2-3 days; she would ask when she was working, and she was told Resident #11 was still out.
-She usually worked 11:00pm-7:00am or 7:00pm-7:00am.
-She did not call the ED to check on Resident #11.

Third interview with the same MA on 01/16/19 at 7:28pm revealed:
-She knew what time the calls were made related to Resident #11 because she had looked at the telephone history.
-She had not reported looking at the telephone history previously because "there was just so much going on."

Review of the telephone history on 01/16/19 revealed the telephone history did not have anything stored in the call log memory for the date of 01/01/19.

Interview with the Administrator on 01/16/19 at 5:51pm and 7:32pm revealed:
-She expected staff to contact the PCP and responsible party; she expected documentation of

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D 454	Continued From page 168 times they were contacted. -On 01/08/19, she was made aware of the incident with Resident #11 being discharged from the ED on 01/02/19, and she called the Guardian and the PCP. -When she asked the MA that sent the resident to the hospital if she did an incident report she reported did not do an incident report because the Business Office Manager told her she did not need to do one since it was not an incident. -When she talked to the Business Office Manager the Business Office Manager reported she told the MA to do an incident report. An incident report was not available to review before exiting the facility on 01/16/19.	D 454		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of	D 463		

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this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to assure 3 of 4 sampled residents (#1, #13, #14) admitted to the Special Care Unit (SCU) had a pre-admission screening documented in the residents' record.

The findings are:

1. Review of Resident #1's current FL-2 dated 09/19/18 revealed diagnoses of dementia without behavioral disturbances, late onset Alzheimer's disease, restlessness, agitation, muscle weakness, and insomnia.

Review of Resident #1's Resident Register revealed the resident was admitted the SCU on 09/22/18.

Review of Resident #1's record revealed there was no pre-admission screening documentation completed for admission to the SCU.

Refer to interview on 01/16/19 at 11:10 am with the Care Manager.

Refer to interview on 01/16/19 at 6:00 pm with the Administrator.

2. Review of Resident #13's current FL-2 dated 07/05/18 revealed diagnoses of Alzheimer's disease, atherosclerotic heart disease, polyosteoarthritis, hypertension, and gastroesophageal reflux disease.

Review of Resident #13's Resident Register

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D 463	Continued From page 170 revealed the resident was admitted to the SCU on 11/10/16. Review of Resident #13's record revealed there was no pre-admission screening documentation completed for admission to the SCU. Refer to interview on 01/16/19 at 11:10 am with the Care Manager. Refer to interview on 01/16/19 at 6:00 pm with the Administrator. 3. Review of Resident #14's current FL-2 dated 11/15/18 revealed diagnoses of dementia, anxiety, insomnia, and hemiplegia. Review of Resident #14's Resident Register revealed the resident was admitted to the SCU on 10/06/17. Review of Resident #13's record revealed there was no pre-admission screening documentation completed for admission to the SCU. Refer to interview on 01/16/19 at 11:10 am with the Care Manager. Refer to interview on 01/16/19 at 6:00 pm with the Administrator. _____ Interview on 01/16/19 at 11:10 am with the Care Manager (CM) revealed: -The pre-admission screening for SCU residents was done by the Administrator at admission. -She knew the pre-admission screening documentation was not in residents' records after making audits of the records last week. -She informed the Administrator the screening documents were missing from the residents'	D 463		

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D 463	Continued From page 171 records. Interview on 01/16/19 at 5:58 pm with the Administrator revealed: -She did admission screenings of residents in the facility. -The previous Care Manager was responsible for assuring the SCU pre-admission screening documentation was in the residents' record. -She did not know the pre-admission screening documents were missing in the residents' records. -She was concerned about documents missing in the residents' records; she had not done audits of the residents' records.	D 463		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost	D 464		

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D 464	Continued From page 172 abilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 4 sampled residents (#1, #12,) admitted to the Special Care Unit (SCU) had a resident profile completed within 30 days of admission and quarterly thereafter, and 3 of 4 sampled residents (#1, #12, #14) admitted to the SCU had a care plan developed and completed within 30 days of admission and yearly thereafter. 1. Review of Resident #1's current FL-2 dated 09/19/18 revealed diagnoses of dementia without behavioral disturbances, late onset Alzheimer's disease, restlessness, agitation, muscle weakness, and insomnia. Review of Resident #1's Resident Register revealed the resident was admitted to the SCU on 09/22/18. Review of Resident #1's record revealed there was no resident profile completed within thirty days of admission to the SCU and no quarterly resident profile completed for the resident since admission to the SCU on 09/22/18. Review of Resident #1's record revealed there was no care plan developed and completed for the resident since admission to the SCU on 09/22/18. Interview on 01/16/19 at 3:05 pm with the Care Manager revealed she did not know SCU Resident #1was missing or had an incomplete care plan and profile.	D 464		

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D 464	Continued From page 173 Refer to interview on 01/16/19 at 3:10 pm with the Care Manager. Refer to interview on 01/16/19 at 6:05 pm with the Administrator. 2. Review of Resident #12's FL-2 dated 01/19/18 revealed diagnoses of Alzheimer's dementia, vascular dementia, dysphagia, hypertension, asthma, and chronic renal disease. Review of Resident #12's Resident Register revealed the resident was admitted to the SCU on 01/29/15. Review of Resident #12's record revealed: -There was a resident profile completed on 06/15/18. -There were no quarterly resident profiles documented after 06/15/18. Review of Resident #12's record revealed: -There was a care plan dated 03/12/18; there was no signature indicating the resident's physician reviewed and approved the care plan. -There was no care plan documented in the record for Resident #12 after 03/12/18. Interview on 01/16/19 at 3:07 pm with the Care Manager revealed she did not know SCU Resident #12 was missing or had an incomplete care plan and profile. Refer to interview on 01/16/19 at 3:10 pm with the Care Manager. Refer to interview on 01/16/19 at 6:05 pm with the Administrator. 3. Review of Resident #14's current FL-2 dated	D 464		

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D 464	Continued From page 174 11/15/18 revealed diagnoses of dementia, anxiety, insomnia, and hemiplegia. Review of Resident #14's Resident Register revealed the resident was admitted to the SCU on 10/06/17. Review of Resident #14's record revealed: -There was an assessment and care plan completed on 12/06/17 and signed by the resident's physician on 12/21/17. -There was no yearly care plan documented after 12/21/17. Interview on 01/16/19 at 3:09 pm with the Care Manager revealed she did not know SCU Resident #14 was missing or had an incomplete care plan and profile. Refer to interview on 01/16/19 at 3:10 pm with the Care Manager. Refer to interview on 01/16/19 at 6:05 pm with the Administrator. _____ Interview on 01/16/19 at 3:10 pm with the Care Manager (CM) revealed: -She did not know some of the SCU residents were missing or had incomplete care plans and profiles. -She knew the care plans were to be completed within thirty days of admission and yearly thereafter, and the profiles were to be completed in thirty days and quarterly. -The profiles and care plans were prepared by the Administrator and the previous CM and filed in the residents' records by the previous CM. -The residents' care plans were completed using a computer program; the Administrator had not started her training on how to use the program.	D 464		

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	HAL017054	A. BUILDING: _____ B. WING _____	R 01/16/2019

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D 464	Continued From page 175 Interview on 01/16/19 at 5:58 pm with the Administrator revealed: -The previous CM assisted her with processing residents' documents, filing care plans and profiles filed in the residents' records. -The current CM took over the job in December. -She did not do record audits, that was the CM's job. -She never taught the current CM how to use the computer programs. -She was concerned about the missing documents.	D 464		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 17 of 39 shifts sampled for 13 days from December 2018 through January 2019.	D 465		

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D 465	Continued From page 176 The findings are: Review of the facility's 2018 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of forty-two beds. Review of the Resident Bed List Report dated 12/05/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/05/18 revealed 29.8 staff hours were provided on second shift leaving the shift short 1.2 staff hours. Review of the Resident Bed List Report dated 12/06/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/06/18 revealed 20.08 staff hours were provided on first shift leaving the shift short 10.92 staff hours. Review of the Resident Bed List Report dated 12/07/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/07/18 revealed 14.11 staff hours were provided on second shift leaving the shift short 16.89 staff hours.	D 465		

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D 465	Continued From page 177 Review of the Resident Bed List Report dated 12/08/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/08/18 revealed 22.6 staff hours were provided on first shift leaving the shift short 8.4 staff hours. Review of the Resident Bed List Report dated 12/10/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/10/18 revealed: -There were 24.24 staff hours provided on first shift leaving the shift short 6.76 staff hours. -There were 28.56 staff hours provided on second shift leaving the shift short 2.44 staff hours. Review of the Resident Bed List Report dated 12/11/18 revealed there was a SCU census of thirty-one residents, which required thirty-one staff hours on first and second shift, and 24.8 hours on third shift. Review of the Individual Employee Time Cards dated 12/11/18 revealed 15.2 staff hours were provided on first shift leaving the shift short 15.8 staff hours. Review of the Resident Bed List Report dated 12/12/18 revealed there was a SCU census of thirty-one residents, which required thirty staff	D 465		

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D 465	Continued From page 178	D 465		

hours on first and second shift, and 24.8 hours on third shift.

Review of the Individual Employee Time Cards dated 12/12/18 revealed:
-There were 20.54 staff hours provided on first shift leaving the shift short 10.46 staff hours.
-There were 26.08 staff hours provided on second shift leaving the shift short 4.92 staff hours.

Review of the Resident Bed List Report dated 12/13/18 revealed there was a SCU census of thirty-two residents, which required thirty-two staff hours on first and second shift, and 25.6 hours on third shift.

Review of the Individual Employee Time Cards dated 12/13/18 revealed:
-There were 26.78 staff hours provided on first shift leaving the shift short 5.22 staff hours.
-There were 26.84 staff hours provided on second shift leaving the shift short 5.16 staff hours.

Review of the Resident Bed List Report dated 12/27/18 revealed there was a SCU census of thirty-three residents, which required thirty-three staff hours on first and second shift, and 26.4 hours on third shift.

Review of the Individual Employee Time Cards dated 12/27/18 revealed:
-There were 30.68 staff hours provided on first shift leaving the shift short 2.32 staff hours.
-There were 27.23 staff hours provided on second shift leaving the shift short 5.77 staff hours.

Review of the Resident Bed List Report dated

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D 465	Continued From page 179 12/31/18 revealed there was a SCU census of thirty-three residents, which required thirty-three staff hours on first and second shift, and 26.4 hours on third shift. Review of the Individual Employee Time Cards dated 12/31/18 revealed: -There were 15.95 staff hours provided on first shift leaving the shift short 17.05 staff hours. -There were 22.18 staff hours provided on second shift leaving the shift short 10.82 staff hours. Review of the Resident Bed List Report dated 01/02/19 revealed there was a SCU census of thirty-three residents, which required thirty-three staff hours on first and second shift, and 26.4 hours on third shift. Review of the Individual Employee Time Cards dated 01/02/19 revealed: -There were 26.86 staff hours provided on first shift leaving the shift short 6.14 staff hours. -There were 32.16 staff hours provided on second shift leaving the shift short 0.84 staff hours. Interview on 01/16/19 at 8:50 am with a SCU Personal Care Aide (PCA) revealed: -She worked at the facility since September 18, 2018; the SCU had been short of staff since she started working. -Sometimes there were call outs; sometimes there were not enough staff scheduled to work (the shift). -When the SCU was short of staff, other staff from the assisted living (AL) side would be pulled to work in the SCU. -Staff was short especially on the weekends, there would be 1 medication aide (MA) and 1	D 465		

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D 465	Continued From page 180 PCA. -Sometimes staff needed to work 12 hour shifts; yesterday (01/15/19) the SCU was short 1 staff and she worked from 7:00 am to 7:00 pm. -The Administrator was responsible for making the staffing schedule. -She did not know if the Administrator tried to get more staff. -The Administrator was in the building 1 to 2 days a week. -When the Administrator was not there, the Business Office Manager (BOM) tried to get staff to come in and work. Interview on 01/16/19 at 9:10 am with a second SCU PCA revealed: -There were times when the SCU was short staffed; this past weekend, on Saturday (01/12/19), she needed to work a 12 hour shift, from 7:00 am to 7:00 pm. -There were not enough staff scheduled and sometimes scheduled staff did not come in to work. -Staff worked long shifts and became frustrated. -If staff were short, the priority was to keep the residents safe. -Staff helped each other to get the work done. -The Administrator was responsible for making the schedule, she was "hardly in her office; she was at the facility maybe 3 days a week". -The BOM would take the responsibility of locating a staff to come in when the Administrator was not at the facility. -To keep our jobs, staff needed to work over; if there were red dots beside a staff's name on the schedule, that indicated the staff had to work past their shift. Interview on 01/16/19 at 10:12 am with the SCU Medication Aide/Supervisor (MA) revealed:	D 465		

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D 465	Continued From page 181 -She started working at the facility on 04/03/17; the SCU had been short staffed at times since then, they were not short staffed today. -The SCU was short staffed mostly on 2nd shift, 1st shift staff needed to do 12 hour shifts to cover and get the work done. -She was required to work 12 hour shifts almost every day she came to work. -The Administrator was responsible for making the schedule. -The Administrator was normally at the facility 1 to 2 days a week; if a shift was short of staff, she and other MAs would try to find a replacement. -Today was the end of the last staffing schedule, she did not know what tomorrow's schedule was to be. -"Staff worked hard to meet the needs of all of the residents; staff often worked over, past their shifts, and were burned out." Interview with a Medication Aide (MA) on 01/11/19 at 10:38 am revealed sometimes staff were removed from their assignments to help transport a resident to an appointment. Interview on 01/16/19 at 10:35 am and 2:34 pm with the Care Manager (CM) revealed: -The SCU had been short staffed since she became the CM in December, 2018; there needed to be 4 more SCU staff to make the minimum number per shift for the current census. -She worked as a MA about every other day, on the assisted living (AL) and SCU, because there was a lack of staff. -The Administrator was responsible for making the schedule every 2 weeks; the Administrator was in her office maybe 1 to 2 days a week. -The Administrator was supposed to be notified if a staff would be out; if she was not available, the CM or MAs would try to locate staff to fill in.	D 465		

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D 465	Continued From page 182 -Staff in the SCU did their best to assist the residents, no resident went without care. Interview on 01/16/19 at 6:20 pm with the Administrator revealed: -She was responsible for making the SCU schedule every 2 weeks. -There were call outs for almost every shift. -When she made the schedule, a red dot was placed beside staff names indicating the expectation for them to stay after their shift and work the next shift. -If there was not enough staff on a shift, the CM and/or the MA/Supervisor would work the shift. -Her normal office hours were from 9:00 am or 9:30 am to 5:00 pm, 5 days a week; she would do her 8 hrs. and leave. -She was on call 24 hours a day, 7 days a week. -She tried to hire more staff; she was currently interviewing for more staff. The facility failed to assure the minimum number of staff were present at all times on all 3 shifts to meet the needs of residents residing in the Special Care Unit (SCU) for 17 of 39 shifts sampled for 13 days from December 2018 through January 2019. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G. S. 131D-34 on 01/16/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 2, 2019.	D 465		

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D912	Continued From page 183	D912		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other requirements, personal care and staffing, personal care and supervision, health care, nutrition and food service, special care unit staffing, implementation and Declaration of Resident Rights. The findings are: 1. Based on observations and interviews the facility failed to assure all the components of the call light system were operating as designed to assure residents' calls were received by staff and responded to in a timely manner in the Assisted Living unit (ALU) for 4 of 4 sampled residents (#7, #8, #9, and #20) with special care needs that included blindness (#7 and #9), a resident that had a cerebrovascular accident and left side paralysis (#8), and a resident with a colostomy that needed frequent changes (#20). [Refer to Tag 119 10A NCAC 13F .0311(j) Other	D912		

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D912	Continued From page 184 Requirements (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 39 shifts sampled for 13 days from December 2018 - January 2019. [Refer to Tag 188 10A NCAC 13F .0604(e) Personal Care and Staffing (Type B Violation)] 3. Based on observations, interviews, and record reviews the facility failed to provide supervision for 3 of 6 sampled residents (Residents #2, #6, and #20) with diagnoses of dementia, a history of repeated falls resulting in fractures [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure physician notification and referrals for 5 of 6 sampled residents (Residents #2, #4, #12, #13, and #14) related to transportation to medical appointments and medication refusals (#4); failed to schedule dermatology follow-up appointments for residents in the Special Care Unit with a rash (#12, #13, #14) and failed to contact the durable medical supplier for oxygen tank refills (#2). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 5. Based on record review, observation and interviews the facility failed to implement physician's orders for 2 of 7 sampled residents (#2 and #20) related to a resident being out of his colostomy bags (#20) and a resident's portable oxygen tanks continually being empty (#2). [Refer to Tag 276 10A NCAC 13F .0902 (c)(3)(4) Health Care (Type B Violation)].	D912		

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D912	Continued From page 185 6. Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 6 residents sampled (#3, #15, #16, #17, and #18) with physician's orders for a mechanical soft (MS) diet with chopped meats (#15, #16), and residents with food allergies (#3, #17, and #18) were served as ordered. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 7. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 17 of 39 shifts sampled for 13 days from December 2018 through January 2019. [Refer to Tag D465, 10A NCAC 13F.1308(a) Special Care Unit Staffing (Type B Violation)]. 8. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, call bells, staff qualifications, assisted living staffing, resident tuberculosis tests, resident assessments, personal care and supervision, health care, licensed health professional support, nutrition and food service, resident rights, medication administration, reporting of accidents and incidents, special care unit admissions, profiles, care plans and staffing. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation)]. 9. Based on observations, interviews, and record reviews, the facility failed to implement their follow-up process when a resident had been transferred to a medical center for a mental health evaluation for 1 of 1 sampled resident	D912		

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D912	Continued From page 186 (#11), the facility staff did not contact the medical center for 7 days which resulted in the resident being found staying under an overpass without his medications, shelter or food. [Refer to Tag 914 G.S. 131D-21(4) Declaration of Residents' Rights (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement their follow-up process when a resident had been transferred to a medical center for a mental health evaluation for 1 of 1 sampled resident (#11), the facility staff did not contact the medical center for 7 days which resulted in the resident being found staying under an overpass without his medications, shelter or food. The findings are: Review of Resident #11's current FL-2 dated 01/03/19 revealed diagnoses included depression, anxiety, alcohol abuse, and insomnia. Review of the facility's Incident/Accident reports revealed there was no incident report available for Resident #11 for the date (01/01/19) that resident was transported by Emergency Medical Services (EMS) from the facility to a medical center for	D914		

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D914	Continued From page 187 evaluation. Telephone interview with a local country representative on 01/10/19 at 11:54am revealed: -Their agency had been notified by the Administrator on 01/08/19 at approximately 4:30pm that Resident #11 was missing. -The Administrator reported they had been too busy to follow up on Resident #11 after he had been transferred out of the facility on 01/01/19 until today (01/08/19). Interview with the Primary Care Provider (PCP) on 01/10/19 at 12:11pm revealed: -He had not been notified Resident #11 had been transferred to a medical center for evaluation, -He had not been notified Resident #11 was missing until 01/08/19. -He was very concerned Resident #11 was missing because of his history of alcoholism. -Resident #11 could get himself intoxicated to a dangerous capacity which could result in alcohol poisoning and other issues associated with excessive drinking including choking on his own vomit, which could lead to death. Interview with a Medication Aide (MA) on 01/10/19 at 12:32pm revealed Resident #11 had been brought into the facility today (01/10/19); she did not know who brought Resident #11 back to the facility. Interview with the Care Manager (CM) on 01/10/19 at 12:34pm revealed she did not know what occurred with Resident #11. Interview with the Administrator on 01/10/19 at 12:40pm revealed: -She was working as the MA in the special care unit on 01/01/19 when Resident #11 requested to	D914		

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go to the hospital.
-The Assisted Living first shift MA and the Business Office Manager were the staff involved in Resident #11's transfer to the medical center for evaluation.
-On 01/08/19, the Business Office Manager reported to her she had called the medical center to check on Resident #11 and was told he had been discharged on 01/02/19.
-On 01/08/19, local law enforcement was notified, Resident #11's Guardian, the local county representative, and a silver alert were initiated; she did not recall the times of these calls "right off."
-On 01/09/19, she was notified by Resident #11's guardian that he had been located, was heavily intoxicated and had not eaten in several days, so he was being taken to the emergency department (ED) for evaluation.
-An incident report had been completed but was not able to locate it to provide at this time.

Telephone interview with Resident #11's Guardian on 01/11/19 at 10:00am revealed:
-Their agency had received a call from an employee at the facility at 1:15pm on 01/08/19 that Resident #11 was missing.
-They were told by the Administrator an incident report had been completed when Resident #11 was sent out for an evaluation on 01/01/19; the incident report was not provided.
-The facility reported they had called the Guardian on 01/01/19 to notify Resident #11 was being transferred to the ED for evaluation; there was no documentation provided to show the Guardian had been notified.
-On 01/09/11, their agency had called the Administrator for an update.
-On 01/09/19, the Administrator reported that she had a number for Resident #11 but had not called

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it because she "did not want to spook (Resident #11)."
-The Guardian obtained the telephone number and called it and Resident #11 answered the telephone and told her his location.
-She went to the location and picked Resident #11 up and took him to the ED to be evaluated as he had not has medication since 01/01/18 and had not eaten in days.

Interview with Resident #11 on 01/11/19 at 10:14am revealed:
-He had talked to the Business Office Manager on 01/01/19 about being "keyed up" and felt he needed to go to the ED; the last time he felt this way the ED helped him.
-He was transferred by EMS to the ED on 01/01/19, and they evaluated him and felt he was better and there was no reason to keep him; they pushed him in a wheelchair into the hospital lobby.
-He thought the hospital staff had called the facility to pick him up.
-After he had been waiting "a long time," he called the resident facility telephone number and talked to a resident (he did not know whom he talked to) and told them to tell someone to come to get him; he called the same number three times and talked to different residents each time.
-He did not have any other telephone number for the facility.
-He waited about 4 hours and still no one had come to pick him up.
-He waited another 2 hours and asked a nurse in the ED if he could stay the night, and they told him no (he did not recall whom he talked to).
-He decided if he was going to get home he needed to start walking home.
-He walked about fourteen miles before his feet hurt too bad to go any further; he was wet and

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cold because it had been raining.
-He went into a local store and asked if they would donate him a blanket which they did, and they also coordinated with a local restaurant to provide him with dinner.
-After he ate, it was getting late, so he found an underpass to sleep under.
-When he got up the next morning, he went to a local restaurant to get warm.
-He did not try to walk home again because he was tired and weak from not eating.
-He went to a local shelter and someone there told him his picture was on the television; he did not know anyone was looking for him.
-He talked to his Guardian, and she picked him up and took him to the hospital.
-He had not taken a drink of alcohol until the day he was picked up, 01/09/18.
-He was "just so down" because he was tired and hungry and had not had his medicine, and he "just gave in" when another homeless man offered alcohol to him.

Review of a discharge summary provided by Resident #11 dated 01/02/19 revealed:
-Resident #11 was seen in the ED on 01/01/19 and after the evaluation was transferred to the behavioral health unit for further evaluation.
-Resident #11 was discharged on 01/02/19 with a recommendation that he follow-up with outpatient mental health services in 1-2 days.

Telephone interview with the county representative's supervisor on 01/11/19 at 11:08am revealed:
-Their agency was the responsible party for Resident #11.
-She had received an anonymous call from an employee at the facility at 1:08pm that a resident under guardianship had been transferred to the

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hospital on 01/01/19 and on 01/08/19 the Business Office Manager had discovered this resident (Resident #11) was discharged from the hospital on 01/02/19 and was missing.
-The anonymous reporter reported the facility had not notified local law enforcement Resident #11 was missing because they were going to do their own investigation.
-She called the Administrator and left her a voicemail.
-The Administrator returned her call at 1:23pm and reported Resident #11 was missing.
-She started her own investigation; they checked the library, shelters in all surrounding counties and no one reported they had seen Resident #11.
-She reported they called anyone they could think of that had previously known Resident #11 and located someone that said Resident #11 showed up at their house, soaking wet, dirty and smelled like alcohol; she provided him with a cup of coffee, and he showed her his hospital discharge papers. He told this individual he did not want to go back to the facility.
-She called the telephone number for Resident #11, and he answered. He was at a local hotel, but he was not there. They then rode around looking for him and found him under an overpass. He was light-headed, reported he had consumed 2-forty ounce beers and had not had food or medications.
-She transported him to the local emergency department to be evaluated.
-The Guardian transported Resident #11 back to the facility upon discharge from the hospital on 01/09/19.
-The Administrator reported at 4:08pm on 01/08/19 they had completed a missing person report for Resident #11 with local law enforcement.

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D914	Continued From page 192 Review of EMS logs on 01/11/19 dated 01/01/19 revealed: -The EMS call was received at 3:31pm. -Resident #11 wanted to go to the ED for mental health services. -Resident #11 had anxiety and was being stressed all the time. -Resident #11 reported he "wanted to hurt himself." -Resident #11 was transported to the ED with an arrival time of 4:40pm. Telephone interview with an officer of local law enforcement on 01/14/19 at 9:30am revealed their department was notified by the facility's Business Office Manager on 01/08/19 at 4:05pm that Resident #11 had been discharged from a local medical center and his whereabouts were not known. Interview with the Care Manager on 01/14/18 at 10:20am revealed: -The MA who contacted EMS for a resident was responsible for calling the PCP, the responsible party and completing an incident report. -If a resident left the building for any reason by EMS, an incident report would be to be completed. -There was no incident report on the computer system; the computer system was new and if the MA did not know how to complete an incident report on the computer they would use the paper form. -She had seen a paper copy of the incident report; she did not know where a copy of the incident report was. -MAs were responsible for contacting the medical facility where the resident was transported to for follow-up. -She did not know if anyone had contacted the	D914		

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hospital for follow-up on Resident #11; there was no documentation in his medical record related to his status.
-There was documentation on the 24-hour report Resident #11 was in the hospital.

Interview with a MA on 01/14/19 at 9:44am revealed:
-When a resident needed to be sent out of the facility for evaluation they would contact the PCP to let them know what was going on and get direction on what to do.
-She would then do what the PCP directed them to do; if the resident was sent out they would notify the responsible party, either family or DSS Guardian.
-She would document the incident on the 24-hour report and in the residents care notes.
-Sometimes she would call the hospital a couple of hours later after giving them time to evaluate the resident, for an update.
-She would call the hospital before her shift was over, or if it was at the end of the shift the next shift's MA would call to check on the resident.
-If the resident was gone for more than 3-days they would have to be reassessed to come back to the facility.
-If she had sent Resident #11 to the hospital she would call "ongoing" to check on the resident.
-She did not call to check on Resident #11.

Interview with a second MA on 01/14/19 at 9:51am revealed:
-If a resident needed to go to the hospital to be evaluated she would do an assessment and call the PCP to discuss.
-If the resident was being sent out she would call EMS.
-She would give the hospital time to assess the resident and then call to check on the resident.

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D914	Continued From page 194 -If it was close to the end of the shift she would pass it on to the next shift, so they could follow up on the resident. -She would call the hospital the next day to check on the resident. -The MAs, Administrator and CM were responsible for following up with the hospital on resident's status. -She had not followed up on Resident #11 because she did not work again until 01/03/19. -There were no shift notes available to be reviewed for 01/01/19 on the 24-hour report. -She had heard people say Resident #11 was still in the hospital. Interview with the Business Office Manager on 01/14/19 at 11:13am revealed: -Resident #11 had come to her on 01/01/19 and said he was feeling overwhelmed and wanted to go to the hospital. -She talked to the MA who coordinated sending Resident #11 to the hospital. -Residents who were being evaluated by mental health were usually out of the facility for a few days. -On 01/08/19 she called the hospital to check on Resident #11 around noon, and they told her Resident #11 had been discharged on 01/02/19. -She told a staff member to call Resident #11's Guardian. -She went to various hotels looking for him; no one had seen Resident #11 when she showed them his picture. -She called Resident #11's girlfriend's facility and the staff reported Resident #11 had called the facility to speak to his girlfriend a few days before; they provided her with a name and telephone number. -Resident #11 was found the next day, 01/09/18.	D914		

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D914	Continued From page 195 Interview with a MA on 01/14/19 at 12:01pm revealed: -She was coming on duty when Resident #11 was being sent out on 01/01/19. -She knew Resident #11 was going out, but she "did not have anything to do with it." -She was asked by the Administrator on 01/08/19 if she had completed any paperwork on Resident #11 being sent out, and she reported she did not send Resident #11 out. -She only did a late entry on 01/08/19 to cover herself to show she did not have anything to do with the transfer. Review of a progress note dated 01/08/19 at 5:18pm for Resident #11 revealed: -This progress note was documented as a late entry. -The MA documented that when she arrived to work (no date) Resident #11 was being sent out by the 1st shift MA. -The MA documented the 1st shift MA reported to the 2nd shift MA that the BOM had told her to send Resident #11 to the ED at the local behavioral health unit. -The MA documented the PCP was called at 2:59pm, Emergency Medical Services (EMS) were called at 3:17pm and the DSS Guardian was called at 4:46pm. Interview with the same MA on 01/15/19 at 11:34am revealed: -She entered the late entry progress note after it was discovered Resident #11 was missing to cover herself when she was asked questions about what had occurred the day Resident #11 was sent out. -She got the times she documented because that was the time she remembered the 1st shift MA had made the calls.	D914		

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D914	Continued From page 196 -She did not know whom the calls were made to, but she knew the 1st shift MA made calls related to Resident #11 being sent out. Third interview with the same MA on 01/16/19 at 7:22pm revealed: -She knew what time the calls were made related to Resident #11 because she had looked at the telephone call history. -During a previous interview she had not reported looking at the telephone call history because "there was just so much going on." Interview with the Admissions Director on 01/15/19 at 9:43am revealed: -She had been notified by the Business Office Manager Resident #11 was missing on 01/08/19 around mid-morning. -She was not aware Resident #11 had been sent to the ED on 01/01/19. -The Business Office Manager had asked her to notify the county representative about what had happened with Resident #11, including that he had been sent to the ED on 01/01/19, the ED had discharged him on 01/09/19 and his whereabouts were not known. Review of Resident #11's discharge summary from ED dated 01/09/19 revealed: -Resident #11 was seen for psychiatric evaluation. -Resident #11 was diagnosed with alcohol abuse and homelessness. -Resident #11's ethanol level was 262mg (normal range is less than 10mg). Telephone interview on 01/16/19 at 10:43am with a representative from the local hospital where Resident #11 was transferred on 01/01/19 revealed:	D914		

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D914	Continued From page 197 -Resident #11 had been seen at their facility on 01/01/19 and discharged on 01/02/19. -Resident #11 was transported to the hospital lobby; there was no documentation of any calls made for transport for Resident #11. Interview with the CM on 01/16/19 at 2:34pm revealed: -If a resident was transferred she expected the MA's to contact the PCP and responsible party; she expected the MA to report it to the next shift as well as a document on a progress note and on the 24-hour report. -She expected MAs to call the hospital to check on a residents' status within 1-2 days of the transfer. -She could not be sure if the MA made required calls when Resident #11 was transferred to the hospital; she thought the MA had made required calls. Interview with the Administrator on 01/16/19 at 5:51pm revealed: -She expected staff to complete an incident report on all transfers outside of the facility. -She expected staff to contact the PCP and responsible party; she expected documentation of times they were contacted. -She expected the MA to follow-up on a resident's status at the hospital and document their findings. -She had not worked again until 01/07/19 after the incident on 01/01/19 due to personal reasons and had not checked to see if anyone had followed up on Resident #11. -The BOM had told her on 01/08/19 she was going to call and check on Resident #11; the Care Manager should have checked on Resident #11 on 01/02/19. -As soon as she was made aware (01/08/10) of the incident with Resident #11 being discharged	D914		

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D914	Continued From page 198 from the ED on 01/02/19 she called the Guardian and the PCP. -An incident report was not completed on Resident #11 the day of the transfer because the MA reported to her the Business Office Manager said she did not need to do one because it was not an "incident"; the Business Office Manager reported to her she had instructed the MA to complete an incident report. -She was concerned that the CM and or MAs had not followed up on Resident #11 after he had been transferred out of the facility. _____ The facility failed to contact the hospital regarding Resident #11, who was transferred to the emergency room, resulting in the resident being discharged by the hospital and his whereabouts were unknown to staff for seven days. This failure lead to the resident being without his medication for 8 days including antidepressant medication and medication used to prevent relapse into alcohol abuse. He was exposed to cold and rainy weather, consuming alcohol for the first time in three years, and being found by county representative underneath a bridge. The failure of the facility resulted in serious neglect of the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/16/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 15, 2019.	D914		
D917	G.S. 131D-21(7) Declaration of Resident's Rights	D917		

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D917	Continued From page 199 G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to respond to a resident's request (#21) to be moved to another room due to odor of his roommate's colostomy. The findings are: Review of the facility's resident room assignment provided on 01/09/19 revealed Resident #21 and his roommate were assigned to resident room #103. Review of Resident #21's current FL2 dated for 09/16/18 revealed: -Diagnoses included stroke and left side weakness. -His disorientation status was intermittent. -His ambulation status was semi-ambulatory with assistive device. Review of Resident Register for Resident #21 revealed he was admitted to the facility on 01/03/16. Interview with Resident #21 on 01/16/19 at 4:11pm revealed: -He had roomed with his current roommate since October 2018. -His roommate had a colostomy. -The odor from the colostomy was "ridiculously horrible" and sometimes made him sick. -Sometimes staff came to the room at 3:00am to care for his roommate's colostomy. -They turned on the ceiling light, which usually	D917		

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D917	Continued From page 200	D917		

woke him up.
-It took a lone time to provide care for the colostomy so he could not go back to sleep.
-There were times when facility staff changed his roommate's colostomy and he was trying to eat a snack, and he had to quit eating due to the odor.
-At night he could not leave the room and during the day they never gave him the opportunity to leave, they just started changing the colostomy.
-"I should not be subject to that smell."
-When he was not in bed the staff did not ask him to leave the room and they did not give him a chance to volunteer to leave the room before they changed his roommate's colostomy bag.
-He had asked the Administrator to move him because he could not take the odor anymore.
-He understood that his roommate could not help his current situation with the colostomy.
-He felt the facility should give his roommate a single room due to the odor.
-He really wanted to move to another room.
Based on observations, interviews, and record reviews, the facility failed to respond to a resident's request (#21) to be moved to another room due to odor of his roommate colostomy.

Review of Resident #21's record revealed there was no documentation regarding Resident #2's request to move to another room.

Interview with Resident #21's roommate on 01/16/19 at 3:57pm revealed:
-He had a colostomy.
-Currently, he did not have any bags to cover the hole where the bowel drained.
-Because he did not have bags facility staff took "chuck" pads and rolled them up to cover the opening of the colostomy.
-The process was disgusting because the pads quickly got soaked, it drained, made a mess all

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D917	Continued From page 201 over the room and smelled bad. Interview with a personal care aide (PCA) on 01/16/19 at 12:53pm revealed: -Resident #21's roommate had a colostomy and currently did not have any bags to cover the colostomy. -They used chuck pads to cover the opening of the colostomy. -The pads soaked quickly and the resident usually had a big mess that took a long time to clean up and the odor was bad. -Resident #21 had mentioned that he wanted to move to another room, but he had not control over moving the residents. -He did not mention to anyone Resident #21 wanted to move, because the resident had told him that he talked with the Administrator. Interview with a medication aide (MA) on 01/16/19 at 4:01pm revealed: - Resident #21's roommate had a colostomy. -The resident was out of bags so facility staff started using plastic "chuck" pads to cover the colostomy opening. -It was a big mess to clean-up and had a pungent odor. -The process for changing the colostomy was in the resident's room with the resident lying down in the bed. -She was not surprised the odor bothered Resident #21 because it was a strong odor. -She had heard that Resident #21 wanted to move, and had talked with the Administrator. Interview with the Administrator on 01/16/19 at 5:34pm revealed: -Resident #21 had come to her and asked to move, she could not recall exactly when the resident requested to move.	D917		

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D917	Continued From page 202 -She was in the process of searching for a room, then Resident #21 changed his mind. -Resident #21 made another request to move, maybe a month or two ago. -She had not found another room for Resident #21, because she was waiting to see if he would change his mind again.	D917		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 5 Medication Aides (MA) sampled (Staff A and B), who had been	D934		

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D934	Continued From page 203	D934		

employed at least one year, completed the state-mandated infection control training annually.

The findings are:

1. Review of Staff A, medication aide's (MA) personnel record revealed:
-Staff A was hired on 05/13/08 .
-There was documentation Staff A completed the state infection control training course on 08/17/17.
-There was no additional documentation of infection control training for Staff A.

Review of a printed continuing education record provided by the Business Office Manager for Staff A on 01/16/19 revealed Staff A completed a corporate based infection control training on 02/27/18.

Interview with the Business Office Manager on 01/16/19 at 10:26am revealed this training was infection control training; Staff A had completed the corporate training but did not have a signed certificate.

Telephone interview with the computer training developer on 01/16/19 at 10:29am revealed:
-The corporate based training course was an infection control precursor training developed as an overview for new employees.
-Completion of this course did not meet the state required infection control training.
-To meet state requirements for infection control there were specific courses that must be completed with a passing score; the staff would then need to demonstrate their skills with an approved discipline who would sign the certificate of completion.

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D934	Continued From page 204 Interview with the Business Office Manager on 01/15/19 at 5:46pm revealed she thought Staff A had completed her annual infection control training. Interview with the Administrator on 01/16/19 at 5:51pm revealed she did not know Staff A had not completed her annual infection control training. Interview with Staff A on 01/16/18 at 10:34am revealed: -She thought she had completed infection control training in 2018. -The Business Office manager kept up with her training; the Business Office Manager told her what she needed to complete. Refer to interview with the Business Office Manager on 01/15/19 at 5:46pm. Refer to interview with the Administrator on 01/16/19 at 5:51pm. 2. Review of Staff B, medication aide's (MA) personnel record revealed: -Staff B was hired on 06/22/16 as a personal care aide (PCA), and MA. -There was documentation Staff B completed the state infection control training course on 08/16/17. -There was no additional documentation of infection control training for Staff B. Interview with the Business Office Manager on 01/15/19 at 5:46pm revealed she thought Staff B had completed her annual infection control training. Interview with the Administrator on 01/16/19 at 5:51pm revealed she did not know Staff B had	D934		

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D934	Continued From page 205 not completed her annual infection control training. Refer to interview with the Business Office Manager on 01/15/19 at 5:46pm. Refer to interview with the Administrator on 01/16/19 at 5:51pm. Attempted interview with Staff B on 01/16/19 at 5:32pm was unsuccessful. _____ Interview with the Business Office Manager on 01/15/19 at 5:46pm revealed: -She was responsible for personnel records. -The MAs were responsible for completing their annual infection control training. -She had a spreadsheet to keep track of staff CEUs. -She usually reviewed the spreadsheet at least monthly; she had not reviewed the spreadsheet since early December 2018. Interview with the Administrator on 01/16/19 at 5:51pm revealed: -The Business Office Manager was responsible for the personnel records. -The Business Office Manager was responsible for making sure the MAs had completed their annual infection control training. -The Business Office Manager assigned the training, scheduled training, sent reminders for training and audited the training records. -She did not audit personnel records; she expected the Business Office Manager to keep the personnel records in order. -She expected the MAs to complete their required training.	D934		

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D935	Continued From page 206	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 207 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interview and record reviews the facility failed to assure 1 of 5 sampled staff (Staff F) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration training courses and completed an Medication Clinical Skills Competency validation prior to administering medications. The findings are: 1. Review of Staff F, medication aide's (MA) personnel record revealed: -Staff F was hired on 07/23/18. -There was documentation Staff F passed the written medication examination on 08/22/14. -There was documentation Staff F completed the 5-hour MA training on 07/26/18. -There was no documentation Staff F completed the 10 hours of training. -There was no documentation of employment verification showing Staff F worked as a medication aide within the last 24 months. Review of a resident's November 2018 Medication Administration Record (MAR) revealed Staff F documented the administration of medication on 17 days.	D935		

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D935	Continued From page 208 Review of a resident's December 2018 MAR revealed Staff F documented administration of medication on 18 days. Review of a resident's January 2019 MAR revealed Staff F documented administration of medication on 3 days. Interview with the Business Office Manager on 01/15/19 at 5:46pm revealed: -She was responsible for personnel records. -She thought Staff F had completed her required MA training. -The MAs were responsible for completing their training on the computer. -She had a spreadsheet to keep track of staff training. -She usually reviewed the spreadsheet at least monthly; she had not reviewed the spreadsheet since early December 2018. Interviews with the Administrator on 01/16/19 at 5:51pm revealed: -The Business Office Manager was in charge of the personnel records. -The Business Office Manager was responsible for making sure the MA had the required training; she was not aware Staff F did not have the required 10-hour MA training. -The Business Office Manager assigned the training, scheduled training, sent reminders for training and audited the training records. -She did not audit personnel records; expected the Business Office Manager to keep the personnel records in order. -She expected the MAs to complete their required training. Attempted interview with Staff F on 01/16/19 at 5:29pm was unsuccessful.	D935		

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D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, call bells, staff qualifications, assisted living staffing, resident tuberculosis tests, resident assessments, personal care and supervision, health care, licensed health professional support, nutrition and food service, resident rights, medication administration, reporting of accidents and incidents, special care unit admissions, profiles, care plans and staffing. The findings are: Confidential staff interview on 01/14/19 at 11:30 am revealed the Administrator was in the facility one-two days per week; never before 10:00 am and sometimes left as early as 1:00 pm. Interviews with two family members on 01/11/19 at 11:00 am and 11:15 am revealed: -They visited family members almost daily, "This place needs management, and staff needed training because staff did not know how to help	D980		

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D980	Continued From page 210	D980		

the residents."
-One family member had a relative at the facility since July 2018 and had only seen the administrator once.
-His family member needed assistance and had to wait a long time for staff to help.
-The facility was always short staffed when he looked for staff he could never find them.

Interview with Resident #2's guardian on 01/10/19 at 9:25 am revealed:
-She visited Resident #2 every other day and had never seen the Administrator.
-She had left several notes, putting them under the Administrator door regarding Resident #2's declining mental status.
-She had also left several phone messages for the Administrator regarding the same issue.
-As of today's date (01/10/19), the Administrator had not returned her phone call or tried to communicate with her.

Interview on 01/16/19 from 5:58 pm to 6:30 pm with the Administrator revealed:
-She worked from 9:00 am or 9:30 am at the facility five days a week; she worked eight hours and then left.
-She was on call twenty-four/seven and stayed up until 4:00 am working on staff schedules.
-She made staff schedules every two weeks; staff may not show up for their shift, there were call -outs, she was currently interviewing for new staff.
-She was concerned about missing staff and resident documents, being in noncompliance.
-The PA talked to her in December (did not remember the date), about the SCU residents needing dermatology appointments, he wanted to treat the whole building for the rash; she was very busy, she had slipped in her responsibilities.

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D980	Continued From page 211 Interview with the Regional Director of Operations (RDO) on 01/16/19 at 5:30 pm revealed: -The Administrator's presence in the facility was required. -He had told the Administrator that she fluctuate her time, "just get the job done." -Parts of the job can be remote, but did not tell specific times to be in the facility. -He expected the Administrator in the facility by 8:00 or 9:00 am. -He had heard from staff that there were times when the Administrator came in late or left early. -The Administrator did have a sick family member that she needed to take care of. -He did not know the facility was short of staff. -He did not know the facility had transportation issues regarding residents keeping appointments. -Back in the fall of 2018, around August or September 2018, the Administrator had informed him the PA wanted all residents in the facility to be tested by a dermatologist. -He did not talk with the PA directly, and did not know why the PA wanted to test all the residents in the facility. -He did refuse to pay to have all the residents in the facility tested by the dermatologist because the Administrator told him that she talked with the PA and was told the residents had a rash. -He did not want to pay to have all the residents tested for rash. -After that, he heard no more about residents having a rash. Noncompliance identified at citation levels included: 1. Based on observations, interviews, and record reviews, the facility failed to implement their follow-up process when a resident had been transferred to a medical center for a mental	D980		

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D980	Continued From page 212 health evaluation for 1 of 1 sampled resident (#11), the facility staff did not contact the medical center for 7 days which resulted in the resident being found staying under an overpass without his medications, shelter or food. [Refer to Tag 914 G.S. 131D-21 (4) Declaration of Residents' Rights (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, call bells, staff qualifications, assisted living staffing, resident tuberculosis tests, resident assessments, personal care and supervision, health care, licensed health professional support, nutrition and food service, resident rights, medication administration, reporting of accidents and incidents, special care unit admissions, profiles, care plans and staffing. [Refer to Tag D980, G. S. 131D-25 Implementation (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure physician notification and referrals for 5 of 6 sampled residents (Residents #2, #4, #12, #13, and #14) related to transportation to medical appointments and medication refusals (#4); failed to schedule dermatology follow-up appointments for residents in the Special Care Unit with a rash (#12, #13, #14) and failed to contact the durable medical supplier for oxygen tank refills (#2) .Refer to Tag 273 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews the facility failed to provide supervision for 3 of 6 sampled residents (Residents #2, #6,	D980		

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D980	Continued From page 213 and #20) with diagnoses of dementia, a history of repeated falls resulting in fractures. [Refer to Tag 270 10A NCAC 13F .0901 Personal Care and Supervision (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure 5 of 6 residents sampled (#3, #15, #16, #17, and #18) with physician's orders for a mechanical soft (MS) diet with chopped meats (#15, #16), and residents with food allergies (#3, #17, and #18) were served as ordered. [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 6. Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 39 shifts sampled for 13 days from December 2018 - January 2019. [Refer to Tag 188 10A NCAC 13F .0604(e) Personal Care and Staffing (Type B Violation)] 7. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 17 of 39 shifts sampled for 13 days from December 2018 through January 2019. [Refer to Tag 465 10A NCAC 13F .1308 Special Care Unit Staff (Type B Violation)]. 8. Based on observations, interviews, and record reviews the facility failed to assure all the components of the call light system was operable for 40 of 40 residents in in the assisted living including 4 of 4 sampled residents with special needs that included blindness (#7 and #9), a resident that had a cerebrovascular accident and unable to use the left side of his body (#8), and a	D980		

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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
D980	Continued From page 214	D980		

resident with a colostomy that needed frequent changes because staff used chuck pads for disbursement of his bowel (#20). [Refer to Tag 119 10A NCAC 13F .0311(j) Other Requirements (Type B Violation).]

9. Based on record review, observation and interviews the facility failed to implement physician's orders for 2 of 7 sampled residents (#2 and #20) related to a resident being out of his colostomy bags (#20) and a resident's portable oxygen tanks continually being empty (#2). [Refer to Tag 276 10A NCAC 13F .0902 (c)(3)(4) Health Care (Type B Violation)].

10. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 medication aides sampled (B) completed six hours of continuing education annually related to medication administration. [Refer to Tag 127 10A NCAC 13F .0403(c)Qualifications Of Medication Staff].

11. Based on record reviews and interviews, the facility failed to assure 1 of 5 residents sampled (Resident #3) was tested upon admission for tuberculosis (TB) disease. [Refer to Tag 234 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization]

12. Based on observations, interviews, and record reviews, the facility failed to complete assessments and care plans for 4 of 7 residents sampled (#3, #4, #5, and #20) to determine levels of assistance required for the residents. [Refer to Tag 254 10A NCAC 13F .10A NCAC 13F .0801(b) Resident Assessment].

13. Based on observations, interviews, and record reviews, the facility failed to assure staff

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	HAL017054	A. BUILDING: _____ B. WING _____	R 01/16/2019

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D980	Continued From page 215 provided personal care assistance for 4 of 7 sampled resident's (Residents #7, #9, #10 and #20) regarding a resident not receiving colostomy care (#20), two residents being blind and not receiving timely assistance with incontinence care (#7 and #9), and a resident who had incontinence episodes while waiting for toileting assistance (#10). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision]. 14. Based on record reviews, observations and interviews the facility failed to assure that Licensed Health Professional Support evaluations were completed by a Registered Nurse (RN) for 4 of 10 sampled residents (Residents #2, #5,#9 and #20) with LHPS tasks of care of a colostomy and fingerstick blood sugars (#20), oxygen and physical therapy (#2), collecting fingerstick blood sugars (#9) and transferring semi-ambulatory residents (#5). [Refer to Tag 280 10A NCAC 13F .0903(c) Licensed Health Professional Support]. 15. Based on observations and interviews the facility failed to ensure the kitchen area was free of contamination including the dirty walk-in refrigerator, the dirty stove, expired food, improperly stored food, and unlabeled food. [Refer to Tag 282 10A NCAC 13F .0904 Nutrition and Food Service]. 16. Based on observations, interviews, and record reviews, the facility failed to serve appropriately substituted meal items and maintain documentation to indicate the foods actually served to residents. [Refer to Tag 292 10A NCAC 13F .0904(c) 3 Nutrition and Food Service]. 17. Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served twice daily to residents on the	D980		

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D980	Continued From page 216 Special Care Unit (SCU). [Refer to Tag 299 10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service]. 18. Based on observations, record reviews, and interviews, the facility failed to ensure there were matching therapeutic diet menus for 2 of 6 residents sampled (#15, #16) with an order for a mechanical soft diet. [Refer to Tag 296 10A NCAC 13F .0904(c)(7) Nutrition and Food Service]. 19. Based on observations, interviews, and record reviews, the facility failed to ensure residents recieved a resonable response from staff for 5 residents who requested to go outside to smoke, at the designated times, and had to wait; a resident requesting to have ice in their beverage and did not receive ice, residents who waited 15-20 minutes for meals to be served and received cold meals, and residents not receiving salad dressing with their salads at mealtime. [Refer to Tag 338 10A NCAC 13 F .0909 Residents Rights]. 20. Based on observations, interviews, and record reviews, the facility failed to assure long acting insulin was administered as ordered by a licensed prescribing practitioner for 1 of 8 residents (Resident #4). [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration]. 21. Based on record reviews and interviews, the facility failed to notify the responsible party for one resident (Resident #11) who was transported to the emergency department for a behavioral health evaluation. [Refer to Tag 454 10A NCAC 13F .1212 Reporting Of Accidents And Incidents]. 22. Based on observation, interviews, and record	D980		

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D980	Continued From page 217 reviews, the facility failed to assure 3 of 4 sampled residents (#1, #13, #14) admitted to the Special Care Unit (SCU) had a pre-admission screening documented in the residents' record. [Refer to Tag 463 10A NCAC 13F .1306 Admission To The Special Care Unit]. 23. Based on observations, interviews and record reviews, the facility failed to assure 2 of 4 sampled residents (#1, #12,) admitted to the Special Care Unit (SCU) had a resident profile completed within 30 days of admission and quarterly thereafter, and 3 of 4 sampled residents (#1, #12, #14) admitted to the SCU had a care plan developed and completed within 30 days of admission and yearly thereafter. [Refer to Tag 464 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan]. 24. Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to other requirements, personal care and staffing, personal care and supervision, health care, nutrition and food service, special care unit staffing, and implementation. [Refer to Tag 912 G.S. 131D-21 Declaration of Resident's Rights]. 25. Based on observations, interviews, and record reviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair in 11 resident rooms and bathrooms, 2 hallway ceilings and the Assisted Living (AL) dining room ceiling. [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping & Furnishings]. 26. Based on observations, interviews, and	D980		

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D980	Continued From page 218 record reviews, the facility failed to respond to a resident's request (#21) to be moved to another room due to odor of his roommate's colostomy. [Refer to Tag 917 G.S. 131D-21 (7) Declaration of Residents' Rights]. 27. Based on record reviews and interviews, the facility failed to assure 2 of 5 Medication Aides (MA) sampled (Staff A and B), who had been employed at least one year, completed the state-mandated infection control training annually. [Refer to Tag 934 G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements]. 28. Based on observations, interview and record reviews the facility failed to assure 1 of 5 sampled staff (Staff F) who administered medications, had employment verification or completed the 5, 10, or 15-hour medication administration training courses and completed an Medication Clinical Skills Competency validation prior to administering medications. [Refer to Tag 935 G.S. § 131D-4.5B(b) ACH Medication Aides; Training and Competency Evaluation Requirements]. _____ The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing call bells, assisted living staffing, special care unit staffing, personal care and supervision, health care, nutrition and food service, resident rights, and staffing. The Administrator's failure to implement rules and regulations placed the residents at substantial risk of physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 1/16/19 for	D980		

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D980	Continued From page 219 this violation. CORRECTION DATE FOR THE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 15, 2019.	D980		