FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 WEST STREET GOOD SHEPHERD HOME FOR THE AGED NEW BERN, NC 28560 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 000 Initial Comments D 000 The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on March 20 - 22, 2019. The complaint investigation was iniated by the Craven County Department of Social Services on February 5 and 13, 2019. D 269 10A NCAC 13F .0901(a) Personal Care and D 269 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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance with bathing and footcare for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 07/28/18 revealed:

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

-Diagnoses included acute kidney injury, essential

TITLE

(X6) DATE

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 WEST STREET GOOD SHEPHERD HOME FOR THE AGED NEW BERN, NC 28560 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 269 | Continued From page 1 D 269 hypertension, cellulitis of lower limb, dyslipidemia, schizophrenia, diabetes. -He required personal care assistance with his bathing. Observation of Resident #1 on 03/20/19 during the initial tour of facility at 11:00 a.m. revealed: -Resident #1 was standing in the facility's smoking area. -Resident #1 was dirty and unkempt. -There were stains on his shirt. -His hair was greasy and uncombed. -He had approximately 1/4 inch beard growth on his face. Review of Resident #1's Care Plans dated 01/11/19 revealed: -Resident #1 required limited assistance with bathing (shower three times per week), grooming and personal hygiene (nailcare and haircare). -He required supervision with dressing. Interview with a personal care aide (PCA) on 03/22/19 at 11:07 a.m. revealed: -Resident #1 was scheduled to take a shower every other day. -He sometimes refused his showers. -She supervised him during his showers but had to wash and lotion his feet for him. -Foot care was done once per day for Resident #1 and all residents who were diabetic. -She did not clip Resident #1's toe nails because he was diabetic. -Resident #1's clothes were changed daily and went in the regular clothes wash so they were washed every day. -His bed linens were changed every other day on the same schedule as his shower days.

Interview with the medication aide/assistant

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Interview with the Administrator in Training (AIT)

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **603 WEST STREET** GOOD SHEPHERD HOME FOR THE AGED NEW BERN, NC 28560 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 269 | Continued From page 3 D 269 on 03/22/19 at 7:58 p.m. revealed he expected staff to provide good personal care to all residents with daily rounds and address concerns with timely follow up. The Administrator was not available for a second interviewed. Documentation of Resident #1's personal care was requested on 03/21/19 at 9:30 a.m. but was not provided by the end of the survey. D 276 10A NCAC 13F .0902(c)(3-4) Health Care D 276 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 observations, interviews and record reviews, the facility failed to assure implementation of treatment orders for 1 of 3 sampled residents (#1) related to wound care.

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 603 WEST STREET GOOD SHEPHERD HOME FOR THE AGED NEW BERN, NC 28560 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 276 | Continued From page 4 D 276 The findings are: Review of Resident #1's current FL-2 dated 07/28/18 revealed diagnoses included acute kidney injury, essential hypertension, cellulitis of lower limb, dyslipidemia, schizophrenia, diabetes. Review of Resident #1's Physician Orders revealed: -There was an order dated 03/08/19 to wash foot with soap and water, pat dry, apply wet to dry sterile dressing to wound on bottom of left foot every day until healed. -There was an order dated 03/11/19 for an urgent podiatry consult, home health wound care and wet to dry dressing twice each day until podiatry -There was an order dated 03/11/19 for wound care to left foot with saline wet to dry dressing 4x4 wrap with kerlex/kling morning and evening until further orders from podiatry. -There was an order dated 03/18/19 for dressing changes twice a day with betadine and to schedule surgery on Monday, 03/25/19. Interview with the medication aide/assistant manager (MA/AM) on 03/22/19 at 12:11 p.m. and 8:00 p.m. revealed: -The latest order was to do dressing change to Resident #1's left foot twice per day. -Resident #1's dressing changes were ordered two times each day on 03/11/19. -The home health nurse (HHN) showed her how to complete the dressing change to Resident #1's left foot on 03/14/19. -When the home health nurse (HHN) came to the facility on Wednesday, 03/20/19 to do Resident #1's dressing change, she asked who did the

dressing change and if anyone did the dressing

change yesterday, Tuesday 03/19/19.

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SHEPHERD HOME FOR THE AGED **603 WEST STREET** NEW BERN, NC 28560 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 276 | Continued From page 5 D 276 -She told the HHN that she came out to the facility on Tuesday, 03/19/19 around 7:00 p.m. and did Resident #1's dressing change to his left -She did not know if the dressing change to the Resident #1's left foot was done on 03/19/19 prior to when she did it at 7:00 p.m. -She did not see any blood and the sore had a slight odor, until she washed it with Epsom Salt. -She acknowledged that the order did not say to wash with Epsom Salt and that no one told her to wash Resident #1's left foot with Epsom Salt. -She washed Resident #1's left foot with Epsom Salt because she thought it would help heal the wound on his left foot. -She did not recall if the order said to do anything to the foot such as washing before she did the wet to dry dressing. -Resident #1's dressing change to his left foot was not done on Thursday, 03/21/19. -She "forgot" to do the dressing changes to Resident #1's left foot yesterday, 03/21/19. -The dressing change to Resident #1's left foot was done on 03/22/19 by the manager. -She asked the manager to do Resident #1's left foot dressing change on 03/22/19 because she was busy. Interview with home health nurse (HHN) on 03/21/19 at 2:15 p.m. revealed: -She was told on 03/14/19 by the MA/AM that the facility would be able to provide wound care for Resident #1 on the days the HHN did not come to the facility. -The facility faxed a new order from the podiatrist visit on 03/18/19 that changed the cleansing of the wound to betadine instead of normal saline and to continue wet to dry dressing changes twice

each day.

-She arrived at the facility on 03/20/19 and started

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changes 2 times daily and agreed the HHN

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STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DAT	(X3) DATE SURVEY COMPLETED R-C 03/22/2019	
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D 276	Continued From page 7		D 276				
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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R-C HAL025023 B. WING 03/22/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SHEPHERD HOME FOR THE AGED 603 WEST STREET NEW BERN, NC 28560 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 276 | Continued From page 8 D 276 VIOLATION SHALL NOT EXCEED MAY 6, 2019 D912 G.S. 131D-21(2) Declaration of Residents' Rights D912 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 assure 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 health care. The findings are: Based on observations, interviews and record reviews, the facility failed to assure implementation of treatment orders for 1 of 3 sampled residents (#1) related to wound care. [Refer to Tag D276 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)].