STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	R 04/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Warren County Department of Social Services conducted an annual and follow-up survey on April 24-26, 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 and interviews, the facility failed to assure walls, ceilings and floors in 3 resident bathrooms, resident rooms(#2, #4 # 11, #12, #26), the dining room on the Assisted Living (AL) main hallway, and Special Care Unit (SCU) resident rooms (#3, #4, #5, #6) were kept clean and in good repair. The findings are: Observation on 04/24/19 at 10:20 am of resident room #12 revealed: -There were black and tan stains and a build-up of black dust on the door frame, corners and baseboard at the entry to the bathroom. -There brown and yellow stains on the walls and the linoleum flooring. -There was a build-up of black grim and dust on the top edges and bottom edge of the baseboard.	D 074		

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D 074	Continued From page 1 -There were sections of missing popcorn coating on the walls and ceiling. -There was a missing 2 foot long section of baseboard at the back wall. -There was a 1-1/2 inch nail protruding from the top section of the closet door and on the wall next to the closet. Observation on 04/24/19 at 10:22 am of the bathroom for resident room #12 revealed: -There was a build-up of black grime and gray dust on the top edges and bottom edge of the marble baseboard. -There was a sprinkling of a white powdery substance on the floor tiles at the base of the baseboard. -There was a coating of gray and yellow dust on the thermostat control at the base of the side wall. -The shower water fixture was loose from the wall creating a hole in the wall behind the faceplate. -The light fixture above the sink had a coating of yellowed dust. -There were black stains on the wall beside the sink. Observation on 04/24/19 at 10:33 am of resident room #26 revealed: -The threshold flooring at the doorway was cracked and was coated with a black sticky substance. -There were black and tan stains and a build-up of black dust on the door frame, corners, threshold and baseboard. -There was a crack in the flooring across the length of the room. -There were yellow stains on the walls in the room. -There were dried tan drip stains on the door frame at the entrance to the bathroom.	D 074		

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D 074	Continued From page 2 Observation on 04/24/19 at 10:43 am of the bathroom for resident room #26 revealed: -There were brown and tan smears and stains on the walls of the bathroom. -There was a build-up of brown dust and grime on the floor around the toilet and on the wall behind the toilet. -There were black and tan stains and a build-up of black dust on the door frame, corners, threshold and baseboard in the room. -There was a coating of yellow and brown dust partcles on the air vent on the ceiling. Observation on 04/24/19 at 10:56 am of resident room #11 revealed: -The threshold flooring at the doorway was cracked and was coated with a black sticky substance. -There were black and tan stains and a build-up of black dust on the door frame, in the corners, threshold and baseboard in the room. -There was a crack in the flooring across the length of the room. -There were yellow stains on the walls in the room. -There was a build-up of dark brown dust particles and black spotted stains on the windowsill. -There was a coating of brown dust particles on the top of the 6 foot long heat register at the wall beside the resident's bed. -There was a large splattering of a dried brown substance at the left side of the windowsill and blinds. Observation on 04/24/19 at 10:54 am of the bathroom for resident room #11 revealed: -There were black and tan stains and a build-up of black dust on the door frame, in the corners,	D 074		

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D 074	Continued From page 3	D 074		

threshold and baseboard at the entry to the bathroom.
-The threshold flooring at the doorway was cracked and was coated with a black sticky substance.
-There was a sprinkling of a white powdery substance on the floor tiles at the base of the baseboard in the room.
-There was a build-up of a large dark brown granular substance in the front corner of the room.
-There were yellow-orange stains on the flooring tiles next to the toilet.
-The tile walls were coated with a dried white substance.

Interview on 4/25/19 at 4:15 pm with a resident on the AL main hall revealed:
-She was admitted to the facility about 3 years ago.
-There were stains on the walls and floors; no one had come to paint since she had been residing at the facility.
-Housekeeping staff mopped the bedroom floors every other day but did not clean the walls.
-The bathrooms were cleaned every other day, but still looked like it needed scrubbing and painting.
-She did not like to use a dirty bathroom.

Interview on 04/26/19 at 8:55 am with a Housekeeping staff revealed:
-Housekeepers cleaned the window sills and swept the floors in resident rooms and bathrooms every other day.
-There was no list of tasks for cleaning resident areas.

Interview on 04/26/19 at 5:36 pm with Maintenance staff revealed:

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D 074	Continued From page 4 -He observed Housekeeping staff sweeping and mopping the floors in resident rooms. -Maintenance dids touch-up painting on the doors that had been scraped by residents' wheelchairs. -The vents in the bathroom had just been cleaned (was not specific as to when). -He planned to meet with Housekeeping staff about doing more thorough cleaning. Observation on 05/25/19 at 4:28 pm of the dining room revealed: -There was a heavy build-up of brown dust particles and grime on the threshold, the bottom of the door frame, the baseboard and corners in the room. -There were brown and yellow stains on the linoleum flooring in the room. -There were scrapes along the bottom 2 feet of the wall paneling in the room. -There was a heavy coating of dust particles on the electrical boxes. -There was a heavy coating of dust particles on the large air vent in the wall. -There were yellow spots and smears on the wall in the dining room. -There was a 3 foot wide circle of brown dust on the ceiling air vent. Observations of resident room #2 on the AL hall on 04/24/19 at 10:15 am revealed: -There was a four inch long brown hand mark and smear on the wall in the bed room. -The door to the bathroom had six large chipped sections of wood along the side and bottom of the door; one chip was approximately three and a half inches long by one inch wide. -The sink in the bathroom was partially separated from the wall. Interview with the resident who resided in room	D 074		

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D 074	Continued From page 5 #2 on 04/24/19 at 10:15 am revealed he would be moved to another room because he had used the sink to pull up on instead of the pull bar after using the toilet and he had pulled the sink off the wall; the sink had been separated from the wall for a week. Observations of resident room #4 on the AL hall on 04/24/19 at 10:35 am revealed: -The door for room #4 did not stay shut when pulled closed because the wooden door jamb was cracked and missing the plate for the door knob button to snap into; there was a large hole where the plate should have been. Interview with the resident who resided in room #4 on 04/24/19 at 10:35 am revealed: -The door to the room had been "that way for a long time". Observation of the shower room on the main hall on 04/24/19 at 10:40 am revealed a large patch of untilled concrete and an approximate four inch by four inch section of dry rotted baseboard next to the shower stall. Observations of resident room # 8 on the Special Care Unit (SCU) on 04/24/19 at 10:24 am revealed: -There was a layer of dust on the smoke detector and it was discolored; it appeared orange in color. -There was a bent curtain rod used to hang the curtains. Based on observations and interviews it was determined the residents who resided in resident room #8 were not interviewable. Observation of resident room # 6 on the SCU on 04/24/19 at 10:30 am revealed there was debris inside the ceiling light fixture.	D 074		

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D 074	Continued From page 6 Observation of resident room # 5 on the SCU on 04/24/19 at 10:31 am revealed there was debris inside the ceiling light fixture. Observation of resident room # 3 on the SCU on 04/24/19 at 10:44 am revealed there was debris inside the ceiling light fixture. Observation of resident room #4 on the SCU on 04/24/19 at 11:59 am revealed there was debris inside the ceiling light fixture. Interview with a SCU housekeeper on 04/25/19 at 12:45 pm revealed: -She did not clean the inside of the light fixtures and was only responsible for dusting the outside of the light fixtures. -The maintenance staff cleaned the inside of the light fixtures. Interview with the maintenance staff on 04/26/19 at 8:56 am revealed: -He cleaned the inside of the light fixtures and the housekeepers helped him when he requested. -He cleaned the light fixtures every three to four months and last cleaned them in January 2019. -He used a warm cloth and window cleaner when cleaning the light fixtures. Interview on 04/26/19 at 6:30 pm with the Administrator revealed: -She made rounds of resident rooms 2 to 3 times a week to observe the cleanliness of the resident's rooms and the effectiveness of the housekeeping staff. -There was not a list of housekeeping duties with a schedule posted for housekeeping staff to refer to. -She was responsible for ensuring resident areas	D 074		

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D 074	Continued From page 7 were clean and in good repair; there was some work to be done. -The maintenance staff was responsible for repairs. -She would be meeting with housekeeping staff to develop a plan to ensure resident areas were clean and in good repair.	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: Based on observations and interviews, the facility failed to assure a hand bell or other signaling device was available for all residents in the facility with a current census of 48. The findings are: Observation on 04/24/19 at 9:15 am of the initial tour of eight rooms on the Assisted Living (AL) main hall revealed there were no call bells, no hand bells or any other devices for signaling staff when a resident needed assistance. Interview with a main hall resident on 04/24/19 at 10:35 am revealed: -He did not have a call bell or staff notification system in his room. -He would call out if he needed help from staff, but he did not need staff to help him do anything.	D 119		

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D 119	Continued From page 8 Interview with a second main hall resident on 04/24/19 at 10:50 am revealed: -He did not have a call bell system in his room or anyway to alert staff when he needed help. -He "just calls out" when he needed help; staff always came when he called for help. Observation on the initial tour of the Special Care Unit (SCU) on at revealed no call bells, no hand bells, or any other devices for signaling staff when a resident needed assistance. Observation of SCU resident room #14 on 04/24/19 at 10:15 am revealed: -The resident was not in the room. -There was no hand bell or other signaling device observed. Based on observations and interviews it was determined the resident who resided in resident room #14 was not interviewable. Observation of SCU resident room #8 on 04/24/19 at 10:22 am revealed: -The resident was not in the room. -There was no hand bell or other signaling device observed. Based on observations and interviews it was determined the resident who resided in resident room #8 was not interviewable. Observation of SCU resident room #6 on 04/24/19 at 10:25 am revealed: -There was one resident lying on the bed who sat up without assistance and used a walker to ambulate. -There was another resident sitting on the side of her bed. -Both residents walked out into the hallway to	D 119		

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D 119	Continued From page 9 speak with staff. -There were no hand bells or other signaling devices observed. Interview with a SCU resident who resided in room #6 on 04/24/19 at 10:26 am revealed she called the staff if she needed anything. Observation of SCU resident room #5 on 04/24/19 at 10:27 am revealed: -There was a resident lying in a hospital bed with a full bed rail elevated on one side. -There was a high back wheelchair in the room. -There was an empty bed on the opposite side of the room. -There were no hand bells or other signaling devices observed. Based on observations and interviews it was determined the resident who resided in resident room #5 was not interviewable. Observation of SCU resident room #1 on 04/24/19 at revealed: -There was a resident lying across the bed with her legs dangling over the side with a walker within reach. -There was a resident who was a double amputee lying in a hospital bed with a full bed rail elevated on one side. -There was a third bed that was empty. -There were no hand bells or other signaling device observed. Based on observations and interviews it was determined one of the residents who resided in resident room #1 was not interviewable. Interview with a resident who resided in room #1 on 04/24/19 at 10:30 am revealed:	D 119		

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D 119	Continued From page 10 -She called out to get the attention of staff when she needed help. -The SCU staff did come when she called. Observation of SCU resident room #3 on 04/24/19 at 10:44 am revealed: -There was an empty bed near the doorway. -There was a resident lying in a hospital bed asleep. -There was a geri-chair near the hospital bed. -There were no hand bells or other signaling devices observed. Based on observations and interviews it was determined the resident who resided in resident room #3 was not interviewable. Observation of SCU resident room #4 on 04/24/19 at 10:46 am revealed: -The residents were not in the room. -There were no hand bells or other signaling devices observed. Observation of SCU resident room #2 on 04/24/19 at 11:00 am revealed: -The residents were not in the room. -There were no hand bells or other signaling devices observed. Observation of SCU resident room #7 on 04/24/19 at 11:15 am revealed: -There was a resident lying in bed asleep. -There was a second bed that was empty. -There were no hand bells or other signaling devices observed. Based on observations and interviews it was determined the resident who resided in resident room #7 was not interviewable.	D 119		

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D 119	Continued From page 11 Interview with SCU personal care aide (PCA) on 04/24/19 at 10:40 am revealed: -When the residents needed something they yelled out to the staff. -This was the way she was told the residents request help from staff since she started working at the facility in January 2019. Interview with medication aide (MA) on 04/25/19 at 12:30 am revealed: -The residents who were able to speak called out to the staff when they needed them. -The SCU staff were supposed to make every thirty minute rounds and someone had to be on the hallway or in the dayroom or dining room at all times. -A SCU staff person was supposed to be wherever the majority of the SCU residents were at any given time on the unit. Interview with the Resident Care Coordinator (RCC) on 04/26/19 at 3:55 pm revealed: -The residents on the Assisted Living (AL) unit were able to ask for help when needed or the roommate would come to get staff. -All staff were supposed to make every thirty minute rounds. -There was no documentation maintained of the thirty minute rounds. -The Administrator had "a couple of hand bells in her office but they had not handed out hand bells to any resident". -She and the Administrator were responsible for assessing if a hand bell was given to a resident. -No one had been given a hand bell on the AL or SCU. -She had seen two or three hand bells in the Administrator's office. -She did not know if the facility had a policy related to hand bells or other signaling devices.	D 119		

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D 119	Continued From page 12 -She and the Administrator were responsible for ensuring residents had a way to notify staff if they needed assistance. -The staff were told to make every thirty minute rounds when they were hired. Interview with the Administrator on 04/26/19 at 5:47 pm revealed: -She was told by the previous owners that a call system was not necessary for the facility. -She did not know she needed to provide hand bells or other signaling devices for the residents. -She did have hand bells available for use in storage and would provide them to residents.	D 119		
D 166	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (b) Training shall be provided by a registered nurse and shall include the following: (1) alternatives to physical restraints; (2) types of physical restraints; (3) medical symptoms that warrant physical restraint; (4) negative outcomes from using physical restraints; (5) correct application of physical restraints; (6) monitoring and caring for residents who are restrained; and (7) the process of reducing restraint time by using alternatives. This Rule is not met as evidenced by: Based on record review and interview, the facility faied to provide training on physical restraints for 3 of 3 sampled staff (Staff D, Staff E, and Staff F)	D 166		

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D 166	Continued From page 13 in the Special Care Unit (SCU). The findings are: Observation on 04/24/19 at 10:45 am of the resident revealed: -The resident was lying in bed, on her right side, and looking towards the room's open door. -Full length bed rails were attached to both sides of the bed; one bed rail was in the upward position. -The hospital bed was positioned against a wall. Observation on 04/25/19 at 1:40 pm of the resident revealed: -The resident was lying in bed, on her right side. -One full length bed rail was in the upward position -The hospital bed was positioned against the wall. Observation on 04/26/19 at 4:00 pm of the resident revealed: -The resident was lying in bed, on her right side. -One full length bed rail was in the upward position. -The hospital bed was positioned against the wall. Interview with a Special Care Unit (SCU) personal care aide (PCA) on 04/24/19 at 10:40 am revealed: -The resident had the full bed rail up because she would roll out of the bed. -The bed rails had been in place since she started working at the facility in January 2019. -She would not leave the resident's bed rail down because the resident may swing her legs and roll out of the bed. -She had observed the reesident move from side to side by swinging her leg and because the resident's s disease process she may not know	D 166		

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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
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when she was on the edge of the bed.
-No one told her to use the bed rail for the resident, she kept the residents's bed rail up because she was rolls around the bed often.
-She had not seen other things used to prevent the resident from rolling out of the bed.

Interview with a day shift SCU Medication Aide (MA) on 04/25/19 at 10:12 am revealed:
-Using the bed rail kept the resident from rolling out of bed and the bed rail was an enabler which was used to help the resident turn and move in the bed.
-The SCU staff made every thirty minute checks to ensure all residents were safe.
-The resident was on hospice and the bed was ordered by hospice.
-The bed rails came with the bed and the bed rails were sent when the resident was admitted to hospice services in the fall of 2018.
-She would not leave the resident's bed rail down because she was afraid she would swing her leg and continue to roll out of bed.
-The MA was not sure the resident would not roll out of bed unless the bed rail was in the upward position.
-The resident was able to move from side to side by swinging her leg but she did not ambulate.
-All staff used the bed rails when the resident was in the bed.

1. Review of Staff D's personnel record revealed:
-Staff D was hired on 02/18/16 as a medication aide (MA) for the SCU.
-There was no documentation of restraint training in her personnel record.
-The restraint portion of the LHPS competency validation was not completed for Staff D.

Attempted telephone interview with Staff D on

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D 166	Continued From page 15 04/26/19 at 4:16 pm was unsuccessful. Refer to interview with the Administrator on 04/26/19 at 4:20 pm. 2. Review of Staff E's personnel recordrevealed: -Staff E was hired on 10/12/18 as a personal care aide (PCA) for the SCU. -There was no documentation of restraint training in her personnel record. -The restraint portion of the LHPS competency validation was not completed for Staff E. Attempted telephone interview with Staff E on 04/26/19 at 4: 18 pm was unsuccessful. Refer to interview with the Administrator on 04/26/19 at 4:20 pm. 3. Review of Staff F's personnel record revealed: -Staff F was hired on 01/25/19 as a PCA for the SCU. -There was no documentation of restraint training in her personnel record. -The restraint portion of the LHPS competency validation was not completed for Staff F. Attempted telephone interview with Staff F on 04/26/19 at 4:19 pm was unsuccessful. Refer to interview with the Administrator on 04/26/19 at 4:20 pm. _____ Interview with the Administrator on 04/26/19 at 4:20 pm and 6:59 pm revealed: -She knew there was a resident in the SCU that had a physician's order for a restraint. -She did not know there was no documentation of training on the use of physical restraints in the	D 166		

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D 166	Continued From page 16 personnel records for Staff D, Staff E, and Staff F. -She thought staff completed restraint training using the online program. -She did not know the restraint portion of the LHPS competency validation was not completed for staff. -She had not requested an LHPS nurse do staff training on the use of restraints. -She was responsible for ensuring staff had training on physical restraints prior to using and applying restraints. -She was responsible for ensuring Staff D, Staff, E, and Staff F had physical restraint documentation in their personnel records.	D 166		
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, record reviews, and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to rodent droppings in the kitchen and in the pantry, food particle buildup in the dish washer, debris and ice buildup in the freezers and a brownish colored film on the screens to the hood filter system. The findings are: Review of the most current NC Division	D 282		

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D 282	Continued From page 17 Environment Health sanitation report dated 12/13/18 revealed: -The food service area had been inspected on 12/13/18 and received a score of 99. -The inspection report indicated observation of rodent droppings on the bottom shelf of one of the cabinets and the top of the dish washer needed cleaning. Observation of the kitchen on 04/25/19 at 8:00 am revealed: -There were rodent droppings on the floor in the dishwashing area, in a corner near a reach in refrigerator and on the floor in the dry storage pantry. -There was debris on the top of the dish washer and on the inside there was food particle build up that included interior walls and the spray nozzles. -There was debris and a red substance on the bottom of the two reach in freezers and a sticky build up on the handles. -There was a thick buildup of ice on the inside of the ice cream freezer and a crack on the outside that had condensation and black spots around the crack; the handle and glass had a sticky brown residue. -There was a dark brown sticky buildup, dust and discoloration on the hood filters. -There were no visible cleaning schedules or cleaning list posted in the kitchen. Interview with the cook on 04/25/19 at 8:15 am revealed: -She did not sweep or mop the kitchen floors because the floors were swept and mopped in the evening by the second shift kitchen staff; she had not noticed the mouse droppings on the floor. -The dish washer was cleaned once a month by the evening cook; she did not know how the dish washer was cleaned.	D 282		

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D 282	Continued From page 18 -The second shift kitchen staff were responsible for wipping off the doors to the freezers every night. -All kitchen staff were responsible for deep cleaning the inside of the freezers once a month; the freezers were deep cleaned about a month ago. -The kitchen staff did not use a cleaning schedule or cleaning assignments and nothing was documented; the kitchen staff would tell each other when they cleaned equipment and then staff knew what was due to be cleaned next. -The kitchen staff shared the deep cleaning and daily cleaning responsibilities with each other; the Administrator was in charge of the kitchen. Interview with a second cook on 04/25/19 at 4:15 pm revealed: -He cleaned the filters in the hood about two months ago; he took them outside and sprayed them with degreaser and then sprayed the filters clean with water. -He swept and mopped the floors every day in the evenings at the end of his shift. -He had not noticed the rodent droppings on the floor and had not seen rodents in the kitchen. -The reach in freezers and ice cream freezer were deep cleaned once a month; the freezers had been deep cleaned a month ago. -Every two weeks the bottom shelf on the inside of the reach in freezer was wiped out; the outside of the freezers were wiped off every evening. -The dish washer was deep cleaned every two weeks; the inside was washed and rinsed with a bucket of soap and a clean towel. -The outside of the dish washer was wiped off every night and the trap was cleaned after every meal. -There were cleaning schedules to follow at one time, but no one had given him a blank schedule	D 282		

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to document on in three months and he did not ask for a new schedule; the Administrator was in charge of the kitchen.
-He looked at an old cleaning schedule for reference and cleaned other equipment as he noticed it needed to be cleaned, but he did not document what was cleaned.

Observation in the kitchen on 04/25/19 at 4:20 pm revealed:
-There was a three ring binder that had completed daily and weekly cleaning schedules; the most recent schedule was on 10/01/18.
-The kitchen floors were assigned to be swept after each meal and scrubbed nightly.
-The freezers were assigned to be wiped down daily and cleaned out on Tuesdays.
-The oven hood was to be cleaned "inside and out" on Wednesdays.
-The dish washer was not listed on the daily or weekly cleaning schedule.

Interview with the Administrator on 04/25/19 at 4:50 pm revealed:
-She did not know there were rodent droppings in the kitchen; no one had told her about any rodents or droppings in the kitchen.
-The staff was supposed to sweep the floor after each meal and sweep and mop every evening.
-She did not know if the pest control company treated the kitchen for rodents; she would call the pest control company to schedule a treatment in the kitchen for rodents.

Attempted telephone interview with the facility's contracted pest control company on 04/26/19 at 11:10 am were unsuccessful.

Interview with the Administrator on 04/26/19 at 5:45 pm revealed:

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D 282	Continued From page 20 -She monitored and was responsible for the kitchen; she went into the kitchen daily and did a walk through once a week to monitor sanitation. -She did a walk through on 04/26/19 and noticed the rodent droppings on the floors and noticed the floors needed a deep cleaning in the corners and along the baseboards. -She expected the floors, the dish washer and the freezers to be cleaned daily. -She had not contacted the pest control company to schedule a treatment for rodents, but she would contact them on the "next day". -The kitchen staff had a duty list for cleaning but did not have an actual cleaning schedule to document completed task. -She did not know the last time the hood was deep cleaned; the hood would be cleaned by one of the cooks on the weekend.	D 282		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents in the Special Care Unit (SCU) had a non-disposable place setting	D 287		

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D 287	Continued From page 21 including al utensils at each meal. The findings are: Observation of the dinner meal service on 04/24/19 at 5:01 pm revealed: -The residents were served chicken casserole, coleslaw, corn, and a tropical fruit dessert. -There were fourteen residents in the SCU dining room. -The residents received and used a spoon as the eating utensil. -The residents did not receive a fork or knife to use to eat their meal. Observation of the lunch meal service on the SCU on 04/25/19 at 12:04 pm revealed: -The residents were served chopped pork tenderloin, macaroni and cheese, mixed vegetables, a roll, and sherbet. -The pork tenderloin was not shredded it was served as chunks. -There was sixteen residents in the SCU dining room. -The residents received and used a spoon as the eating utensil. -The residents did not receive a fork or knife to use to eat their meal. Interview with a resident on the SCU on at 12:40 pm revealed she always ate her meal with a spoon. Interview with a SCU medication aide (MA) on 04/25/19 at 12:30 pm revealed: -She had worked at the facility for twenty three years. -She served the meals to the residents along with the PCA. -The SCU was made about fifteen years ago and	D 287		

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had always given the SCU residents spoons to use for eating their meals.
-She was told by the previous Resident Care Coordinator not to give the SCU residents forks and knives for safety reasons.
-Some of the SCU residents have attacked other residents in the past with forks several years ago.
-There were four residents on the unit who may exhibited behaviors when they were assisted with incontinent care and one exhibited behaviors of fighting when he was fed by staff.
-The dietary staff cut the meats before the meal was delivered to the SCU.

Interview with the SCU housekeeper on 04/25/19 at 12:45 pm revealed:
-She assisted staff with serving plates to the SCU residents at meal times.
-The SCU residents only received spoons to use to eat their meals.
-The meats were already cut up when served to the SCU residents.

Interview with a cook on 04/25/19 at 4:21 pm revealed:
-The SCU residents were sent spoons to use for eating their meals.
-He had worked at the facility for two and a half years and was taught by the previous dietary manager to only give the SCU residents spoons.
-He was told the SCU residents may attack one another with forks or knives.
-All SCU residents were on a chopped diet and meats were cut prior to serving them to the SCU residents.

Interview with the Administrator on 04/26/19 at 5:47 pm revealed:
-She was told by the previous owners to only give spoons to the SCU residents to use for eating

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D 287	Continued From page 23 meals and snacks. -She thought the use of spoons only for eating meals in the SCU was in the disclosure or a SCU policy but she was not sure. -She knew residents were supposed to receive a non-disposable place setting consisting of a plate, knife, fork and spoon with each meal. -The staff were taught the eating utensils to provide to SCU residents in their orientation. -She did not know if any of the care plans for the SCU residents indicated the use of only spoons for meals.	D 287		
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 eight ounces of milk was served twice daily to residents in the special Care Unit (SCU) and the Assisted Living (AL). The findings are: 1. Observation of the Assisted Living (AL) main	D 299		

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dining room dinner meal on 04/24/19 at 5:00 pm revealed:
-There were twenty-nine residents seated in the main dining room for dinner.
-The residents were served a glass of water and a glass of tea with their meal.
- Milk was not served or offered to the residents at dinner.

Review of the lunch meal menu for 04/25/19, Thursday, revealed there was milk listed as an item to be served to the residents.

Observation of the AL main dining room lunch meal on 04/25/19 at 12:10 pm revealed:
-There were twenty-nine residents seated in the dining room for lunch.
-The residents were served a glass of water and a glass of tea with their meal.
-Two residents were served a glass of milk; milk was not offered to any other residents.

Review of the facility's menu for 04/24/19 revealed eight ounces of milk was to be served to the residents at the breakfast, lunch and dinner meals.

Observation on 04/24/19 at 5:00 pm of the kitchen's refrigerator revealed:
-There were two full gallons of skim milk on the shelf.
-The facility census was forty-eight; six gallons of milk would be required to serve all residents two, eight ounce glasses of milk per day.

Interview with three AL residents on 04/25/19 at 10:20 am and 10:35 am revealed:
-They were not offered milk to drink with their meals.
-They liked milk and would drink it if it was

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D 299	Continued From page 25 offered. -One resident bought his own half pints of milk to drink when he went to the store. Review of delivery invoices from the contracted food supply company revealed four gallons of skim milk were delivered on 03/14/19, 03/28/19, 04/04/19, 04/11/19, 04/18/19 and 04/25/19; no other milk was listed on the delivery invoices. Interview with a AL Medication Aide (MA) on 04/26/19 at 11:25 am revealed; -She served breakfast and lunch meals to the residents in the main dining room. -She did not ask residents if they wanted milk at the lunch meal. -She did ask residents if they wanted milk at breakfast, but she did not ask every day because "not too many residents want milk". -She knew two residents got milk every day at breakfast. Interview with a AL personal care aide (PCA) on 04/26/19 at 3:00 pm revealed: -She helped serve the residents in the main dining room at breakfast and lunch. -She did not ask residents if they wanted milk to drink with their meal. -She knew two residents got milk at breakfast and lunch and she always gave them milk. Refer to interview with the morning cook on 04/25/19 at 12:45 pm. Refer to interview with the Administrator on 04/26/19 at 5:15 pm. Review of the dinner meal menu for 04/24/19, Wednesday, revealed there was milk listed as an item to be served to the residents.	D 299		

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D 299	Continued From page 26 Observation of the dinner meal service on the Special Care Unit (SCU) on 04/24/19 at 5:01 pm revealed there were fourteen residents who were not served milk. Review of the lunch meal menu for 04/25/19, Thursday, revealed there was milk listed as an item to be served to the residents. Observation of the lunch meal service on the SCU on 04/25/19 at 12:04 pm revealed there were sixteen resident who were not served milk. Interview with a SCU resident on 04/25/19 at 12:40 pm revealed: -She liked milk and she did get milk on the unit sometimes. -She would drink milk if it was given to her at meals. Refer to interview with the morning cook on 04/25/19 at 12:45 pm. Refer to interview with the Administrator on 04/26/19 at 5:15 pm. _____ Interview with the morning cook on 04/25/19 at 12:45 pm revealed: -Eight gallons of skim milk were purchased each week for cooking and for residents to drink. -Milk was given to residents that got dry cereal at breakfast; she did not know how many residents got dry cereal because it changed from day to day. -She knew two residents always got milk to drink at breakfast and about three residents a day asked for milk at other meals. -Residents were given milk when they asked for a cup to drink; residents could always ask for milk to drink with their meals.	D 299		

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D 299	Continued From page 27 Interview with the Administrator on 04/26/19 at 5:15 pm revealed: -She knew certain residents got milk with their meals, but she did not know how many. -She did not know if the staff offered milk to the residents at meals, but she knew it was available at every meal if a resident asked for milk. -She ordered milk to be used in recipes and for residents to drink; some weeks she ordered four gallons and some weeks she ordered eight gallons. -She did not know how many times a day milk was on the resident menu and she did not know residents were supposed to be offered milk to drink at two meals a day. -She did not know how much milk she needed to order to provide residents with milk if it was offered twice a day, but she could calculate it; she knew four gallons a week was not enough milk if residents were offered milk to drink at meals.	D 299		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure an accurate listing of residents with physician-ordered	D 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(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 309	Continued From page 28 therapeutic diets was available for guidance of food service staff for 1 of 6 sampled residents (#6). The findings are: Observation of the facility's therapeutic diet list on 04/25/19 at 8:50 am revealed: -The diet list was posted in the kitchen and listed diets for forty-eight out of forty-eight residents; the diet list was not dated. -Resident #6 was listed as a no added salt and pureed diet; Resident #6 was not listed as a nectar thickened liquid. Review of Resident #6's current FL-2 dated 04/03/18 revealed: -Diagnosis included Alzheimer's disease, dementia, hypertension, hyperthyroidism, osteoarthritis, bradycardia, seasonal allergies and gastro esophageal reflux disease. -There was a diet order for puree consistency and nectar thickened liquids. Review of Resident #6's signed physician's diet order dated 02/27/19 revealed an order for a no added salt, pureed consistancy and nectar thickened liquid diet. Interview with the cook on 04/25/19 at 9:15 am revealed: -She knew there were three residents on thickened liquids because she referenced the diet list posted in the kitchen. -The medication aide (MA) prepared and served all thickened beverages needed for the residents. Observation of the lunch meal service in the main dining room on 04/25/19 at 12:10 revealed four residents were served thickened beverages;	D 309		

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D 309	Continued From page 29 Resident #6 was served nectar thick tea and water that had been prepared by the medication aide. Interview with the MA on 04/25/19 at 12:30 pm revealed: -She "just knew who was supposed to get thickened liquids"; but there was a list posted in the kitchen if staff needed to know who got thickened liquids. -Resident #6 was served nectar thickened liquids. Interview with the same MA on 04/26/19 at 11:20 am revealed: -She knew which residents got thickened beverages because thickened liquids were listed on the medication administration record (MAR). -She knew Resident #6 got nectar thickened liquids because the MAR listed Resident #6 as nectar thickened liquids. -The personal care aides (PCAs) served all the residents that got regular thin liquids; she told the PCAs which residents got thickened beverages and the PCAs knew not to serve those residents regular beverages. -The PCAs can also look at the diet list in the kitchen if they are not sure who to serve the correct beverages too. Interview with a PCA on 04/26/19 at 3:00 pm revealed: -She served all of the residents that were not on thickened beverages; she knew which residents were served thickened beverages because the MA told her. Interview with the Administrator on 04/26/19 at 5:50 pm revealed: -She was responsible for updating the diet list for the kitchen; the Resident Care Coordinator also	D 309		

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D 309	Continued From page 30 helped to keep it up to date. -The diet list included every resident, their diet and their food consistency; residents on thickened liquids and supplements were also included on the list. -The diet list was updated when new residents were admitted to the building and when there was a change in a diet order; the diet list was last updated on 04/24/19. -She did not know Resident #6 was not included on the list for nectar thick liquids	D 309		
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: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 1 sampled Special Care Unit (SCU) resident (#1) and 2 of 3 sampled Assisted Living (AL) residents (#3, and #5), with orders for no concentrated sweets (NCS) was served as ordered. The findings are:	D 310		

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D 310	Continued From page 31 Observation of the ice cream freezer on 04/25/19 at 12:43 pm revealed: -There was a three gallon container of sherbet that was not sugar free or low sugar and there was a three gallon container of no sugar added vanilla ice cream in the freezer; both containers had equal amounts of ice cream remaining in them. 1. Review of Resident #1's in the Special Care Unit (SCU) current FL-2 dated 03/27/19 revealed: -Diagnoses included dementia with delirium, diabetes, hypertension, hyperlipidemia. -There was a diet order for no concentrated sweets(NCS)/chopped. Review of the lunch meal menu for 04/25/19 revealed the menu for the NCS diet indicated no added sugar vanilla ice cream for the dessert. Observation of the lunch meal service on the SCU on 04/25/19 at 12:04 pm revealed Resident #1 was served sherbet and ate 100% of the sherbet. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable. Refer to interview with a dietary aide (DA) on 04/25/19 at 12:35 pm. Refer to interview with the cook on 04/25/19 at 12:45 pm. Refer to interview with two cooks on 04/26/19 at 12:15 pm. Refer to interview with the Administrator on 04/26/19 at 5:45 pm.	D 310		

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D 310	Continued From page 32 2. Review of the label on a can of lemon pudding in the dry storage pantry on 04/26/19 at 12:15 pm revealed the second ingredient listed on the label for the canned lemon pudding was sugar. a. Review of Resident #3's current FL2 dated 04/03/19 revealed: -Diagnoses included diabetes type II, dysphagia, hypertension, history of alcohol abuse, history of seizure disorder, and hypercholesterolemia. -There was a diet order for no concentrated sweets (NCS) and chopped consistency. Review of the lunch meal menu for 04/25/19, Thursday, revealed the menu for the NCS diet indicated no added sugar vanilla ice cream for the dessert. Observation of the lunch meal service in the AL dining room on 04/25/19 at 12:10 pm revealed Resident #3 was served rainbow sherbet ice cream; Resident #3 ate 100% of the served sherbet ice cream. Review of the lunch meal menu for 04/26/19, Friday, revealed the therapeutic diet menu for the NCS diet indicated diet lemon pudding for the dessert. Observation of the lunch meal service in the AL dining room on 04/26/19 at 12:10 revealed Resident #3 was served lemon pudding. Interview with Resident #3 on 04/25/19 at 12:30 pm revealed: -He knew he was a diabetic, but he did not know if he was on a special diet. -He ate his dessert because it was good. -He did not know if it was sugar free ice cream.	D 310		

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D 310	Continued From page 33 Refer to interview with a dietary aide on 04/25/19 at 12:35 pm Refer to interview with the cook on 04/25/19 at 12:45 pm. Refer to interview with two cooks on 04/26/19 at 12:15 pm. Refer to interview with the Administrator on 04/26/19 at 5:45 pm. b. Review of Resident #5's current FL-2 dated 03/27/19 revealed: -Diagnoses included diabetes type II, acute coronary syndrome, hypertension, cerebral palsy and anxiety. -There was a diet order for a no concentrated sweets (NCS) diet. Review of the dietitian's therapeutic diet menu for 04/25/19 for the lunch meal revealed no added sugar vanilla ice cream was to be served to residents having a NCS diet. Observation on 04/25/19 at 12:05 pm to 12:30 pm of the lunch meal service revealed: -Resident #5 was served sherbet for dessert. -Resident #5 ate all of the sherbet. Review of the lunch meal menu for 04/26/19, Friday, revealed the therapeutic diet menu for the no concentrated sweets diet indicated diet lemon pudding for the dessert. Observation of the lunch meal service on 04/26/19 at 12:10 revealed Resident #5 was served lemon pudding in the Assisted Living (AL) dining room.	D 310		

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D 310	Continued From page 34 Interview on 04/25/19 at 12:30 pm with Resident #5 revealed: -She was on a NCS diet and thought she was supposed to be served a sugar free dessert. -The rest of the residents had the same dessert; the sherbet looked good, so she ate it. Refer to interview with a dietary aide on 04/25/19 at 12:35 pm Refer to interview with the cook on 04/25/19 at 12:45 pm. Refer to interview with two cooks on 04/26/19 at 12:15 pm. Refer to interview with the Administrator on 04/26/19 at 5:45 pm. Interview on 04/25/19 at 12:35 pm with a dietary aide revealed: -Residents ordered a no concentrated sweets (NCS) diet were supposed to have a sugar free dessert. -There was no sugar free sherbet in the freezer, all of the residents were served regular sherbet. -An alternative sugar free dessert was not offered to residents having a NCS diet for lunch that day, 04/25/19. Interview with the cook on 04/25/19 at 12:45 pm revealed she served all the residents the sherbet because she thought the sherbet was sugar free; she did not serve any of the residents the no sugar added vanilla ice cream. Interview with two cooks on 04/26/19 at 12:15 pm revealed:	D 310		

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D 310	Continued From page 35 -They served the canned lemon pudding to all of the residents for dessert at the lunch meal; they thought the lemon pudding was sugar free and okay to serve to all the residents. -They did not check the label for the lemon pudding prior to serving the pudding; they thought all of the canned pudding was sugar free. -They thought all residents were served the same food; they knew there were residents who were ordered no concentrated sweets diets but still served everyone the same diet. -They did not follow the diet spread sheets when preparing meals; no one ever showed them how to reference the diet spread sheets when preparing and serving meals. Interview with the Administrator on 04/26/19 at 5:45 pm revealed: -She monitored the kitchen and ordered all of the food needed for meals. -She ordered sugar free items and mixes for the cooks to prepare and serve to the residents on the no concentrated sweets diet; some sugar free items, like sugar free cake mixes, were served to all of the residents. -She thought the sherbet was sugar free; the cooks should have known to serve the no sugar added vanilla ice cream to the residents on the no concentrated sweets diet. -She expected the cooks for follow the therapeutic diet spread sheet for each meal and each therapeutic diet. -She expected all staff to refer to and follow the diet list posted in the kitchen when serving residents their meals. -Every residents' diet was listed on the diet list, including residents on thickened liquids. -All of the cooks had been trained on how to reference the therapeutic diet spread sheet and prepare the correct food for each diet.	D 310		

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D 310	Continued From page 36 -Current kitchen staff were responsible for training new kitchen staff.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 5 sampled residents (#4) with orders to discontinue three medications and continued administration for twenty days after the physician's order. The findings are: Review of Resident #4's current FL-2 dated 03/22/19 revealed: -Diagnoses included invasive cancer of the right	D 358		

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D 358	Continued From page 37	D 358		

breast, squamous cell cancer of the left palate/tonsil, and weight loss.
-There was a medication order for magnesium oxide 400 mg (used to treat indigestion and as a supplement) twice daily.
-There was a medication order for potassium chloride extended release 20 meq (used to treat potassium deficiency) daily.
-There was a medication order for aspirin 325 mg (used to treat inflammation and as a blood thinner) daily.

Review of Resident #4's pharmacist recommendations dated 03/07/19 revealed:
-He noted Resident #4 received hospice services.
-The non-comfort medications and checks were recommended to be discontinued.

Review of the contracted pharmacist note to attending physician/prescriber dated 03/07/19 revealed:
-There were recommendations to discontinue aspirin 325 mg, potassium chloride extended release 20 meq daily, and magnesium oxide 400 mg.
-The signature of the contracted pharmacist was at the end of the list of recommendations.
-The bottom portion of the document was for the physician response and had choices of agree, disagree, or other.
-There was an X beside the box for agree and below the choice was the signature of the physician with the date 03/27/19.

Review of Resident #4's March 2019 eMARs revealed:
-There was an entry for aspirin 325 mg daily, scheduled at 8:00 am.
-There was documentation of administration of aspirin 325 mg from 03/01/19 to 03/31/19 at 8:00

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D 358	Continued From page 38	D 358		

am.
-There was an entry for potassium chloride extended release 20 meq daily, scheduled at 8:00 am.
-There was documentation of administration of potassium chloride extended release 20 meq from 03/01/19 to 03/31/19 at 8:00 am.
-There was an entry for magnesium oxide 400 mg twice daily, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration from 03/01/19 to 03/31/19 at 8:00 am and 8:00 pm.

Review of Resident #4's April 2019 eMARs revealed:
-There was an entry for aspirin 325 mg daily, scheduled at 8:00 am.
-There was documentation of administration of aspirin 325 mg from 04/01/19 to 04/16/19 at 8:00 am.
-There was documentation that the aspirin 325 mg was discontinued on 04/17/19.
-There was an entry for potassium chloride extended release 20 meq daily, scheduled at 8:00 am.
-There was documentation of administration of potassium chloride extended release 20 meq from 04/01/19 to 04/16/19 at 8:00 am.
-There was documentation that the potassium chloride was discontinued on 04/17/19.
-There was an entry for magnesium oxide 400 mg twice daily, scheduled at 8:00 am and 8:00 pm.
-There was documentation of administration of magnesium oxide 400 mg from 04/01/19 to 04/16/19 at 8:00 am and 8:00 pm.
-There was documentation that magnesium oxide 400 mg was discontinued on 04/17/19.

Observation of Resident #4's medication on hand

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D 358	Continued From page 39 on 04/25/19 at 5:08 pm revealed there was no aspirin, magnesium oxide, and potassium chloride available. Interview with Resident #4 on 04/25/19 at 4:23 pm revealed she was not able to remember which medications were discontinued by her physician. Telephone interview with the facility contracted pharmacy on 04/25/19 at 4:10 pm revealed: -Medication orders were faxed and electronically sent to the pharmacy from the facility and/or Resident #4's physician. -The medication order to discontinue Resident #4's order for aspirin, potassium chloride, and magnesium oxide was received via fax on 04/16/19. Telephone interview with facility contracted Pharmacist on 04/26/19 at 11:30 am revealed he recommended discontinuing the medications because they were not necessary for the comfort of Resident #4. Telephone interview with Resident #4's physician's office representative on 04/26/19 at 12:19 pm revealed Resident #4's pharmacist's recommendations were faxed to the physician's office, signed by a physician and then faxed back to the facility. Telephone interview with Resident #4's physician on 04/26/19 at 5:34 pm revealed: -He did sign and agree with the pharmacist's recommendations to discontinue aspirin, potassium chloride, and magnesium oxide on 03/27/19. -He normally gave the pharmacist's recommendations documentation to the Resident	D 358		

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D 358	Continued From page 40 Care Coordinator (RCC) after he reviewed and signed the document. -He did not know if he gave Resident #4's document back to the RCC or if his staff faxed it back to the facility. Interview with Medication Aide (MA) on 04/25/19 at 5:08 pm revealed: -The facility's process for processing medication orders was the physician usually gave orders to the Administrator and she faxed them. -Once the pharmacy received the order, the MAs were able to see the change on the eMAR. Interview with the RCC on 04/26/19 at 3:40 pm revealed: -She and the Administrator were responsible for faxing over the physician signed pharmacist's recommendations to the pharmacy. -The physician reviewed and signed with his decision, and then she faxed any medication order changes to the pharmacy. -This was the first time she and the Administrator had utilized the process they put into place. -She did not lose Resident #4's document, but she did not know why the pharmacy did not receive the document with the medication changes until 04/16/19. Interview with the Administrator on 04/26/19 at 6:00 pm revealed: -The pharmacist emailed his recommendations to her directly and she printed the document and gave it to the RCC. -The RCC was supposed to obtain the physician's signature and then send the document to pharmacy. -She and the RCC have only done this process once. -She did not know what happened to after the	D 358		

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D 358	Continued From page 41 physician signed the orders and why it took so long to stop administering the medications. -She did not know Resident #4 continued to receive the medication for twenty additional days after the physician signed to discontinue the aspirin, potassium chloride, and magnesium oxide. -The RCC was responsible for ensuring the medications were administered as ordered by the physician.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours	D 468		

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of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to assure 1 of 3 sampled staff (Staff F) assigned to perform duties in a Special Care Unit (SCU), received 6 hours of orientation training within the first week of hire.

The findings are:

Review of Staff F's personnel record revealed:
-Staff F was hired on 01/25/19 as a personal care aide for 3rd shift on the SCU.
-There were 3 hours of documented training within the first week of training for Staff F.
-There was no documentation Staff F received 6 hours of (SCU) training within the first week of employment.

Attempted telephone interview on 04/26/19 at 4:20 pm with Staff F was unsuccessful.

Interview on 04/26/19 at 4:30 pm and 6:59 pm with the Administrator revealed:
-Staff F worked on third shift in the SCU assisting residents with personal care and meals.
-She did not know Staff F did not have documentation for 6 hours of orientation training within the first week of employment.
-She was responsible for ensuring staff working in the SCU received the six hours of training during their first week of employment.
-She thought the online training program included

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D 468	Continued From page 43 the required six hours of special care training. -She had not completed an audit of staff folders for required training.	D 468		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as	D 482		

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D 482	Continued From page 44 opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure physical restraints were used only after an assessment, care and team planning, use of alternatives were tried and documented and written physician orders for 1 of 2 sampled residents on the Special Care Unit (SCU) (#1) with full bed rails. The findings are: Review of Resident #1's current FL-2 dated 03/27/19 revealed: -Diagnoses included dementia with delirium, diabetes, hypertension, and chronic joint pain. -There was documentation of the resident as semi-ambulatory. -There was documentation of assistive devices as a wheelchair. -There was documentation of the need for total care.	D 482		

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D 482	Continued From page 45 Review of Resident #1's current assessment and care plan dated 05/08/18 revealed: -The resident was sometimes disoriented and needed to be directed. -The resident needed supervision with ambulation. -The resident needed extensive assistance with toileting, bathing, dressing and grooming. -There was no documentation for the use of bed rails for Resident #1. Review of Resident #1's Licensed Health Professional (LHPS) review dated 04/15/19 revealed: -The Registered Nurse (RN) made an initial assessment of the resident. -There were no LHPS tasks ordered; there was no documentation for the use of bed rails for Resident #1. Review of a signed physician's hospice orders for Resident #1 dated 08/30/18 revealed: -There was an order for a hospital bed and gel mattress overlay. -There was no order for bed rails or instructions regarding the use of bed rails. Observation on 04/24/19 at 10:45 am of Resident #1 revealed: -The resident was lying in bed, on her right side, and looking towards the room's open door. -One side of the bed was against the wall and the full length bed rail was up on the side of the bed facing the door. Observation on 04/25/19 at 1:40 pm of Resident #1 revealed: -The resident was lying in bed, on her right side. -One side of the bed was against the wall and the	D 482		

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D 482	Continued From page 46 full length bed rail was up on the side of the bed facing the door. Observation on 04/26/19 at 4:00 pm of Resident #1 revealed: -The resident was lying in bed, on her right side. -One side of the bed was against the wall and the full length bed rail was up on the side of the bed facing the door. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable. Interview with a Special Care Unit (SCU) personal care aide (PCA) on 04/24/19 at 10:40 am revealed: -Resident #1 had the full bed rail up because she would roll out of the bed. -The bed rails had been in place since she started working at the facility in January 2019. -She would not leave Resident #1's bed rail down because Resident #1 may swing her legs and roll out of the bed. -She had observed Resident #1 move from side to side by swinging her leg and because of Resident #1's disease process she may not know when she was on the edge of the bed. -No one told her to use the bed rail for Resident #1, she kept Resident #1's bed rail up because she was rolls around the bed often. -She had not seen other things used to prevent Resident #1 from rolling out of the bed. Interview with a day shift SCU Medication Aide (MA) on 04/25/19 at 10:12 am revealed: -Using the bed rail kept Resident #1 from rolling out of bed and the bed rail was an enabler which was used to help the resident turn and move in the bed.	D 482		

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-The SCU staff made every thirty minute checks to ensure all residents were safe.
-Resident #1 was on hospice and the bed was ordered by hospice.
-The bed rails came with the bed and the bed rails were sent when Resident #1 was admitted to hospice services in the fall of 2018.
-She would not leave Resident #1's bed rail down because she was afraid she would swing her leg and continue to roll out of bed.
-The MA was not sure Resident #1 would not roll out of bed unless the bed rail was in the upward position.
-Resident #1 was able to move from side to side by swinging her leg but she did not ambulate.
-All staff used the bed rails when Resident #1 was in the bed.

Review of Resident #1's record revealed:
-There was no documentation of an assessment or care planning for the use of restraints for the resident.
-There was no documentation of medical symptoms for the use of restraints for the resident.
-There was no documentation of the use of alternatives to restraints for the resident.
-There was no documentation of a signed consent for restraints for the resident.

Interview with Resident #1's hospice Registered Nurse (RN) on 04/25/19 at 4:30 pm revealed:
-Resident #1 was assessed by another RN to need a hospital bed and gel mattress.
-The hospital bed was used to assist with changing Resident #1's incontinent brief, positioning of her edematous legs and repositioning.
-The durable medical equipment (DME) company should have delivered the bed without rails.

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D 482	Continued From page 48 -She last saw Resident #1 on 04/23/19 and Resident #1 was sitting in a high back wheel chair. -When she visited Resident #1, she remembered Resident #1 always sitting in the wheel chair. -Resident #1 was able to move around in the bed from side to side and move around in the wheelchair but she was not able to ambulate. -Resident #1 had days when she moved more than others. -Bed rails were not ordered for Resident #1 and should not be used for Resident #1. -If she had noticed bed rails on Resident #1's bed she would have arranged the bed rails to be picked up and returned to the DME. -She would have removed the bed rails if she had noticed them on the bed. -She had not discussed the equipment with Resident #1's family member. -She did not recall Resident #1 rolling out of the bed since admission to hospice. Interview with a representative of DME company on 04/25/19 at 4:55 pm revealed: -A semi-electric bed with full rails was delivered for Resident #1. -Resident #1's bed was exchanged twice because the bed was not operating properly. -Bed rails were sent with each hospital bed unless indicated by hospice. -There was no documentation in their computer system indicating bed rails were not needed with the bed. Interview with another SCU MA on 04/26/19 at 10:51 am revealed: -Resident #1 had full bed rails and they were in the upward position because she would fall out of the bed. -The bed rails were used as an enabler, which	D 482		

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meant the rails were used for a resident to turn and get out of bed.
-Resident #1 was not able to get out of bed independently and she was assisted by staff to get into her wheelchair.
-Resident #1 had a mattress placed beside her bed in the past as an intervention for falls but she did not recall any other interventions used.
-Resident #1 could move from side to side by swinging her leg while lying in bed.
-She did not know if Resident #1 had a physician's order for bed rails to be used as a physical restraint.
-SCU had staff present on the unit at all times to listen for residents' and check on the residents.
-The SCU staff made every thirty minute rounds.

Interview with Resident #1's physician on 04/26/19 at 1:43 pm revealed:
-No one had discussed the use of bed rails or the need to use bed rails for Resident #1.
-He had not completed an assessment for Resident #1 for the need to use bed rails.
-He had not discussed with the resident's Power Of Attorney (POA) about the use of bed rails or alternatives.

Interview with Resident #1's POA on 04/26/19 at 9:37 am revealed:
-Resident #1's condition had progressed over the five years since admission to the facility and she was receiving hospice services.
-Resident #1 needed the high back wheelchair and hospital bed for comfort.
-She just wanted her to be as comfortable as possible.
-Resident #1 had a history of falls but had not fallen since being placed on hospice services, over six months ago.
-Prior to hospice services, Resident #1 had a bed

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and chair alarm used to assist preventing her from falling.
-When she visited Resident #1 several weeks ago and Resident #1 was sitting in her wheelchair.
-She did not recall any discussions with hospice concerning the bed rails on the bed and she did not sign anything regarding Resident #1's durable medical equipment.

Interview with the Resident Care Coordinator (RCC) on 04/26/19 at 4:29 pm revealed:
-The staff were only supposed to use the full rails on SCU residents hospital beds when the resident received a bed bath, received incontinent care or to assist with positioning.
-All staff knew this was the only times the full rails should be in an upward position.
-She was not aware the staff were using Resident #1's full bed rails by placing them in the upward position when she was lying in the bed.
-Resident #1 did not have an assessment and order, or discussion with her POA about the use of bed rails.
-The staff had annual training and restraints were reviewed on 03/11/19 from an instructor who was a Registered Nurse (RN).

Interview with the Administrator on 04/26/19 at 5:47 pm revealed:
-She and the RCC were responsible for ensuring residents received the medical equipment ordered by their physicians.
-The staff were aware that they could not keep bed rails in an upward position without a restraint order.
-The staff had been told that they could not use bed rails as restraints before by previous management and during orientation when hired.
-She made rounds on the SCU but she observed

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D 482	Continued From page 51 if the residents were receiving care and if there were any repairs needed on the unit. -She was not aware Resident #1's bed rails were kept in an upward position while the resident was in the bed. -She did not recall an order, assessment or consent for using Resident #1's full bed rails as restraints.	D 482		