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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on July 31-August 2, 2019. | D 000 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 3 sampled residents' (#1) who had falls.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 03/13/19 revealed:<br>-Diagnoses included dementia with behaviors, type 2 diabetes mellitus, hypertension, hypothyroid, anxiety, history of cerebrovascular accident.<br>-Resident #1 required personal care assistance with bathing and dressing.<br>-Resident #1 was ambulatory and continent.<br><br>Review of Resident #1's care plan dated 05/15/19 | D 270 | | |

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revealed:
-Resident #1 ambulated with an assistive device.
-Resident #1 was disoriented sometimes.
-Resident #1 needed limited assistance with bathing and grooming/personal hygiene.

Observation of Resident #1 ambulating in the hallway on 08/01/19 at 12:20 pm revealed:
-Resident #1 used a walker as she ambulated towards the A/B dining room.
-Resident #1 was escorted to the A/B dining room by a personal care aide (PCA).

Interview with the PCA on 08/01/19 at 12:20 pm revealed she was walking with Resident #1 to ensure she did not fall and made it to the dining room safely.

Observation of Resident #1 in resident room on 08/02/19 at 2:15 pm revealed:
-Resident #1 was sitting on the side of her bed with the rollator in front of her.
-There was a PCA sitting with her in the room.

Interview with the PCA sitting with Resident #1 on 08/02/19 at 2:16 pm revealed:
-She was assigned as the sitter for Resident #1.
-She had to escort her everywhere she went during the shift.
-She was unsure of when sitting with Resident #1 began.
-She was sitting with Resident #1 because the resident fell recently.

Review of the facility's Occurrence Report (incident report) dated 07/06/19 for Resident #1 revealed:
-Resident #1 was found on the floor on her right side next to her bed.
-The Resident Care Coordinator (RCC)

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instructions of "advised to follow up with" physician's office.
-No injuries were noted on the report.

Attempted telephone interview with the medication aide (MA) who completed the Occurrence Report dated 07/06/19 on 08/02/19 at 11:07 am was unsuccessful.

Review of the facility's post fall assessment tool dated 07/06/19 for Resident #1 revealed:
-The fall was unwitnessed.
-Resident #1 was wearing socks and looking for something in her room.
-Resident #1 was disoriented.
-Resident #1's call bell was within reach and the light was on at the time of the fall.

Review of facility's progress notes dated 07/06/19 for Resident #1 revealed Resident #1 was found on the floor on her right side and transferred to the local emergency room.

Review of Resident #1's local hospital discharge summary dated 07/06/19 revealed:
-Resident #1 had an abrasion on the right elbow, hematoma of the forehead and a chronic wound to the right calf.
-Resident #1 did not complain of any pain and the computed tomography (CT) scan of the head revealed a right frontal scalp hematoma.
-The CT scan of the cervical spine was negative for fractures and the x-ray of the pelvis was also negative.
-Diagnoses at discharge was minor head injury and multiple contusions.
-Resident #1 was to follow-up with her physician and no time parameters was given for the follow-up.

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Based on record reviews and interviews, there were no new interventions placed for Resident #1 to prevent falls.

Review of the facility's Occurrence Report (incident report) dated 07/07/19 for Resident #1 revealed:
-Resident #1 was found on the floor in her room and Resident #1 complained of back pain.
-Resident #1 was transferred to the local hospital.
-The RCC instructions included "send out, advised to follow up with physician and contact family".

Attempted telephone interview with the MA who completed the Occurrence report dated 07/07/19 on 08/02/19 at 2:00 pm was unsuccessful.

Review of the facility's post fall assessment tool dated 07/07/19 for Resident #1 revealed:
-The fall was unwitnessed.
-Resident #1 was wearing socks, attempted to get out of bed and the call bell was within reach.
-Resident #1 was found on her right side, alert, awake, disoriented/confused, weak and reported pain.
-Resident #1 used a walker for an assistive device.

Review of facility's progress notes dated 07/07/19 for Resident #1 revealed:
-There was a note documented at 12:00 pm that revealed Resident #1 was very weak and unsteady and she was lying down.
-There was a note documented at 2:00 pm that revealed Resident #1 fell and was transferred to the local hospital due to complaints of right arm, back and rib pain.
-There was a note documented at 7:00 pm that revealed Resident #1 returned from the local

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hospital.

Review of Resident #1's local hospital discharge summary dated 07/07/19 revealed:
-Resident #1 fell and was seen the day before on 07/06/19 and had a contusion and hematoma from the 07/06/19 fall.
-Resident #1 denied any pain.
-Resident #1's CT scan revealed a frontal scalp hematoma and no fractures.
-Resident #1's pelvic x-ray revealed no fractures.
-Resident #1's diagnoses were fall and multiple contusions.
-The hospital discharge instructions were to follow up with Resident #1's physician.

Review of the facility's [Resident Observation every 15 minutes check] form dated 07/08/19 revealed:
-The form had a space for the resident name, room and date at the top and below the resident name were columns with the following headings: 1,2, and 3.
-Column 1 was for the time, column 2 was for staff initials, and column 3 was for resident location.
-The time was divided into 15 minutes intervals.
-There was documentation Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Review of Resident #1's physician's order dated 07/08/19 revealed there was an order for home health referral.

Based on record reviews and interviews, there were no new interventions placed for Resident #1 to prevent falls.

Review of the facility's Occurrence Report (incident report) dated 07/09/19 for Resident #1

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revealed:
-Resident #1 was found on the floor in her room and had a skin tear on the right wrist.
-The RCC instructed to send the resident to the hospital.

Interview with the MA who completed the Occurrence Report dated 07/09/19 on 08/02/19 at 11:09 am revealed:
-She found Resident #1 on the floor while doing blood glucose checks prior to lunch.
-She was unsure of how the resident came to be on the floor.
-When she came closer to Resident #1, she saw her wrist had a skin tear.
-The RCC told staff to not do anything such as move Resident #1 because she was agitated.
-An ambulance was called and Resident #1 was transported to the local hospital.
-Resident #1 did not return from the hospital during her shift.
-When Resident #1 returned from the hospital, the RCC placed her on frequent checks, either every 15 minutes or every 30 minutes.
-The RCC made the decision on how frequently a resident was checked when the resident had frequent falls.
-She did not know the frequency of Resident #1's checks prior to the 07/09/19 fall.
-Residents were checked every 2 hours normally.
-She did not know of any other interventions put into place to prevent Resident #1 from future falls.
-She recalled staff completed a few extra forms when a resident falls but could not recall any other things put into place for falls.
-She did not know if there was a policy related to resident falls.

Review of the facility's post fall assessment tool

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dated 07/09/19 for Resident #1 revealed Resident #1 was found on her left side wearing shoes and she was alert and oriented.

Review of facility's progress notes dated 07/09/19 for Resident #1 revealed there was a note written at 4:55 pm indicating Resident #1 returned from the hospital and received a new order for naproxen (used to treat pain and inflammation).

Review of Resident #1's local hospital discharge summary dated 07/09/19 revealed:
-Resident #1's discharge diagnoses were fall, closed head injury, contusion of face, contusion of scalp, cervical strain, and right wrist sprain.
-Resident #1 fell face forward; her forehead was swollen, bilateral periorbital ecchymotic areas, abrasions and swelling to right wrist and hand.
-Resident #1's computerized axial tomography (CAT) scan of the head and spine, CT scan of the maxillofacial, and x-ray of the right wrist were negative.
-The discharge instructions were to follow-up with Resident #1's primary care physician.

Review of the facility's Resident Observation every 15 minutes check form dated 07/09/19 revealed there was documentation that Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Based on record reviews and interviews, there were no new interventions placed for Resident #1 to prevent falls.

Review of the facility's Occurrence Report (incident report) dated 07/10/19 for Resident #1 revealed:
-Resident #1 was found on the left side of the bed on the floor with pillows.

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-Resident #1 refused help and was combative.
-No injuries were noted for Resident #1.

Attempted telephone interview with the MA who completed the Occurrence Report dated 07/10/19 on 08/02/19 at 11:34 am was unsuccessful..

Review of the facility's progress notes dated 07/10/19 for Resident #1 revealed:
-There was a note written at 2:50 pm that Resident #1 was found on the floor by her roommate lying on her left side.
-The RCC and home health nurse assessed Resident #1 who was described as combative.
-Resident #1 was transferred to the local hospital.
-There was a note written at 3:20 pm that revealed the MA would contact Resident #1's family concerning the 07/10/19 incident.
-There was a noted written with the time documented as "7-3 shift", that revealed Resident #1's physician was notified via fax.
-There was a noted written at 4:45 pm that revealed Resident #1's family member returned the phone call to the facility and spoke with staff concerning a mental decline with Resident #1.

Review of Resident #1's local hospital discharge summary dated 07/16/19 revealed:
-Resident #1 was admitted to the inpatient unit at the local hospital due to altered mental status.
-Resident #1 was oriented to self only upon arrival to the emergency room.
-A cerebrovascular accident was ruled out and Resident #1 was diagnosed with elevated thyroid stimulating hormone, microcytic hyperchromic anemia due to iron deficiency and history of falls with multiple bruises with healing cellulitis on leg.
-The physician noted Resident #1 needed physical therapy/occupational therapy(PT/OT).
-Resident #1 was seen by PT/OT on 07/16/19

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and evaluated.
-Resident #1 was discharged on 07/16/19.

Review of the facility's Resident Observation every 15 minutes check form dated 07/16/19 revealed:
-There was documentation that Resident #1 was checked hourly.
-Resident #1's checks began at 4:00 pm and ended at 11:00 pm on 07/16/19.

Based on record reviews and interviews, there were no new interventions placed for Resident #1 to prevent falls.

Review of the facility's Occurrence Report (incident report) dated 07/17/19 for Resident #1 revealed:
-Resident #1 slipped off of her bed and did not have any injuries.
-She was sent to the hospital.
-The RCC instructions were to send resident to hospital.

Interview with the MA who completed the Occurrence Report dated 07/17/19 on 08/02/19 at 11:40 am revealed:
-She had sent Resident #1 out to the local hospital on one or two dates and only for a fall.
-When residents returned from the hospital the MA reviewed the hospital report and faxed it to the pharmacy.
-Resident #1 was placed on frequent checks after returning from the hospital.
-Resident #1 had just returned from the hospital on 07/16/19 and was on frequent checks prior to the 07/17/19 fall.
-Resident #1 had a sitter now and she first saw Resident #1 with a sitter on 08/01/19.
-Resident #1 did not have anything else put into

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place for the falls except for frequent checks.
-The PCAs completed the frequent checks on the residents.
-The RCC did the assignments for staff.
-No one had shared any new interventions for Resident #1 with her.

Review of the facility's post fall assessment tool dated 07/17/19 for Resident #1 revealed:
-Resident #1 had an unwitnessed fall in her room and was found sitting on her buttocks.
-Resident #1 was wearing socks and was alert and oriented.
-Resident #1's room light was on and the call bell was within reach.

Review of the facility's progress notes dated 07/17/19 for Resident #1 revealed:
-There was a note written at 3:20 pm that revealed Resident #1 had an unwitnessed fall and was sent to the hospital with no injuries based on the instructions from the RCC.
-There was a note written at 10:00 pm that revealed Resident #1 returned from the hospital without any new orders.

Review of Resident #1's local hospital discharge summary dated 07/17/19 revealed:
-Resident #1's discharge diagnoses were fall in elderly patient and chronic wound of extremity.
-The discharge instructions were for Resident #1 to follow up with her physician.
-The hospital noted Resident #1 was at the hospital twice the week before due to falls at the facility.

Review of the facility's Resident Observation every 15 minutes check form dated 07/17/19 revealed:
-Resident #1 was checked hourly from 12:00 am

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to 3:00 pm and then 9:00 pm to 11:00 pm.
-Resident #1 was at the hospital from 3:00 pm to 9:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/18/19 revealed there was documentation that Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/19/19 revealed:
-There was documentation that Resident #1 was checked hourly from 12:00 am to 1:00 pm and 7:00 pm to 11:00 pm.
-There was documentation that Resident #1 was at the hospital from 1:00 pm to 7:00 pm.

Review of the facility's Resident Review Observation every 15 minutes check form dated 07/20/19 revealed there was documentation that Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Review of the facility's Resident Review Observation every 15 minutes check form dated 07/21/19 revealed there was documentation that Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Review of the facility's Occurrence Report (incident report) dated 07/22/19 at 2:55 pm for Resident #1 revealed:
-Resident #1 was found on the floor beside her bed without injury.
-No new intervention was noted for Resident #1.

Interview with the personal care aide (PCA) listed on the Occurrence Report dated 07/22/19 on

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| D 270 | Continued From page 11<br><br>08/02/19 at 12:00 noon revealed:<br>-Resident #1 had a habit of sitting on the edge of the bed and was resistant to repositioning.<br>-She thought Resident #1 had slid off of her bed on 07/22/19 and that it was not a fall.<br>-Resident #1 had good and bad days and on a bad day she leaned forward when sitting down.<br>-Resident #1 was also combative sometimes; for instance on 07/28/19, Resident #1 had a good day and was up walking in the hallway and then on 07/30/19 she was slumped over in the chair.<br>-Resident #1 had a sitter with her now.<br>-She saw a sitter with her for the first time on 08/01/19 but not prior to that date.<br>-Resident #1 had frequent checks every 15 minutes.<br>-She was not on duty from 07/01/19 to 07/13/19 and was told by staff when she returned that Resident #1 had fallen frequently.<br>-On 07/28/19, Resident #1 was on every 15 minutes checks.<br>-The forms for the frequent checks were placed in a book and kept by the RCC.<br><br>Review of the facility's post fall assessment tool dated 07/22/19 at 2:55 pm for Resident #1 revealed:<br>-Resident #1 was getting out of bed and was found on her buttocks wearing slippers.<br>-Resident #1 used a walker for an assistive device.<br><br>Review of the facility's Occurrence Report (incident report) dated 07/22/19 at 4:30 pm for Resident #1 revealed:<br>-Resident #1 was sitting on the side of her bed and slid off the edge of the bed without injury.<br>-No new intervention was noted for Resident #1.<br>-Resident #1 was not sent to the local hospital. | D 270 | | |

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Attempted telephone interview with the MA who completed the Occurrence report dated 07/22/19 at 4:30 pm on 08/02/19 at 11:37 am was unsuccessful.

Review of the facility's post fall assessment tool dated 07/22/19 at 4:30 pm for Resident #1 revealed:
-Resident #1 was getting out of bed and found sitting on her buttocks wearing shoes.
-Resident #1 was alert and oriented with the call bell within reach.

Review of the facility's progress notes dated 07/22/19 for Resident #1 revealed:
-There was a note for 2:00 pm that revealed Resident #1 was resting in her room.
-There was a note written below the 2:00 pm note without a time documented, revealing Resident #1 was sitting on the side of her bed and slide off without injury.

Review of the facility's Resident Observation every 15 minutes check form dated 07/22/19 revealed Resident #1 was checked hourly from 12:00 am to 11:00 pm.

Review of Resident #1's record revealed there was a home health and hospice service referral form with documentation that a verbal order was received from Resident #1's physician for PT/OT and Speech therapy (ST) on 07/22/19.

Review of the facility's Occurrence Report (incident report) dated 07/23/19 for Resident #1 revealed:
-Resident #1 rolled out of bed and had complaints of head pain.
-The RCC instructions were to send Resident #1 to the local hospital.

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| D 270 | Continued From page 13<br>-No new intervention was noted for Resident #1.<br><br>Attempted telephone interview with the MA who completed the Occurrence Report dated 07/23/19 at 4:30 pm on 08/02/19 at 11:39 am was unsuccessful.<br><br>Review of the facility's post fall assessment tool dated 07/23/19 for Resident #1 revealed:<br>-Resident #1 had an unwitnessed fall getting out of the bed and was found on her lying on her left side.<br>-Resident #1's call bell was within reach and bed locked.<br><br>Review of facility's progress notes dated 07/23/19 for Resident #1 revealed:<br>-There was a note written at 1:00 pm that revealed Resident #1 returned from the local hospital at 10:00 am after having a fall during the night shift.<br>-Resident #1 was weak and unsteady to walk and a lunch tray was brought to her room.<br>-There was a note written at 10:00 pm that revealed Resident #1 eating all of her dinner and resting without any complaint of pain.<br>-There was no documentation of new orders or new interventions for Resident #1.<br><br>Review of Resident #1's local hospital discharge summary dated 07/23/19 revealed:<br>-Resident #1 was heard falling out of bed by her roommate.<br>-Resident #1 has advanced dementia and did not talk only responded to painful stimuli.<br>-CT scan of cervical spine and x-ray of pelvis were negative.<br>-Resident #1's discharge diagnoses were acute fall and dementia.<br>-Discharge instructions for Resident #1 were to | D 270 | | |

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| D 270 | Continued From page 14<br>make an appointment with her physician and fall prevention.<br><br>Review of the facility's Resident Observation every 15 minutes check form dated 07/23/19 revealed Resident #1 was checked hourly from 12:00 am to 6:00 am and from 1:00 pm to 11:00 pm.<br><br>Review of the facility's Resident Observation every 15 minutes check form dated 07/24/19 revealed Resident #1 was checked hourly from 12:00 am to 11:00 pm.<br><br>Review of the facility's Resident Observation every 15 minutes check form dated 07/25/19 revealed Resident #1 was checked hourly from 12:00 am to 11:00 pm.<br><br>Review of the facility's Occurrence Report (incident report) dated 07/26/19 for Resident #1 revealed:<br>-Resident #1 fell in her room and had a skin tear to the right elbow.<br>-Resident #1 was sent to the local hospital.<br><br>Attempted telephone interview with the MA who completed the Occurrence report dated 07/26/19 at 4:30 pm on 08/02/19 at 11:36 am was unsuccessful.<br><br>Interview with the PCA who reported the Occurrence dated 07/26/19 on 08/02/19 at 2:43 pm revealed:<br>-Resident #1 was sitting on the edge of the bed on 07/26/19 when she first saw her and when she came back up the hallway Resident #1 was face down on the floor.<br>-Resident #1 was assessed by the MA and she sat with Resident #1 until the ambulance arrived. | D 270 | | |

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-Resident #1 was placed on every 15 minutes checks on 07/31/19 and had a sitter with her when she came back from the hospital.
-When she first started working at the facility, 7 to 8 months ago, Resident #1 was doing well.
-Resident #1 used to walk up and down the hallways and sit in the television room.
-Resident #1 was on hourly frequent checks in the middle of July 2019, she did not know the specific date.
-At the beginning of July 2019, Resident #1 was not on every 15-minute checks, and she did not recall the frequency of the checks.
-The PCAs completed the checks and documented the checks on a form.
-She was not told of any other interventions to do for Resident #1 to prevent her from falling.

Review of the facility's post fall assessment tool dated 07/26/19 for Resident #1 revealed:
-Resident #1 had a unwitnessed fall, wearing slippers and was found lying face down.
-Resident #1 had a walker for an assistive device and was oriented.

Review of the facility's progress notes dated 07/26/19 for Resident #1 revealed:
-There was a note written at 7:00 pm that revealed Resident #1 returned from the hospital without any new orders and was seen for a fall.
-There was a note written at 10:00 pm that revealed Resident #1 was combative and agitated while getting medication and incontinent brief change.
-Resident #1 would continue to be monitored.
-There was a note written with the time noted as "11-7", and the documentation was Resident #1 was awake a portion of the night shift.

Review of Resident #1's local hospital discharge

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summary dated 07/26/19 revealed:
-Resident #1's discharge diagnosis was fall.
-Resident #1's discharge instructions were to contact her physician for a follow-up appointment.
-Resident #1 had six visits to the hospital in the past three weeks status post fall.

Review of the facility's Resident Observation every 15 minutes check form dated 07/26/19 revealed:
-Resident #1 was checked every 30 minutes from 12:00 am to 2:00 pm and from 7:00 pm to 11:00 pm.
-Resident #1 was at the local hospital from 2:00 pm to 7:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/27/19 revealed:
-Resident #1 was checked every thirty minutes from 12:00 am to 11:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/28/19 revealed Resident #1 was checked every thirty minutes from 12:00 am to 11:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/29/19 revealed
-Resident #1 was checked every thirty minutes from 12:00 am to 11:00 pm.

Review of the facility's Resident Observation every 15 minutes check form dated 07/30/19 revealed Resident #1 was checked every thirty minutes from 12:00 am to 11:00 pm.

Review of Resident #1's physician orders dated 07/30/19 revealed:

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-There was an order to hold lorazepam (used to treat anxiety), and hold losartan (used to treat hypertension).
-Refer to PT for gait training and muscle strengthening, refer to "HAN for port care", and blood pressure check daily.

Review of facility's progress notes dated 07/31/19 for Resident #1 revealed:
-There was a note written at 7:38 am that Resident #1 had an unwitnessed fall in her room and Resident #1 was found face down on the floor.
-There was a note written below the note for 7:38 am but the time was illegible.
-The note revealed Resident #1 was returned from the local hospital without any new orders and a follow up appointment and evaluation was made with Resident #1's physician to evaluation her for a higher level of care.
-There was a note written at 2:00 pm that Resident #1 was sent to the hospital and Resident #1's family member, physician, and hospice services were notified.
-There was a note written at 2:22 pm that staff spoke with the hospice nurse who was on site to discuss a different level of care for Resident #1.

Review of Resident #1's local hospital discharge summary dated 07/31/19 revealed:
-Resident #1 fell that morning, she was not able to provide a history, no indication of pain was noted.
-Resident #1's pelvis x-ray was negative.
-Resident #1's discharge diagnosis was acute fall.
-Resident #1's discharge instructions were fall prevention and make an appointment with her physician.
-No other new instruction or interventions were

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| D 270 | Continued From page 18<br>provided.<br><br>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable.<br><br>Interview with a Resident Care Coordinator (RCC) on 08/02/19 at 3:12 pm revealed:<br>-The RCCs assessed residents after falls to decide the frequency of checks.<br>-The term used by the facility was "hot box" when a resident was on increased supervision after a fall.<br>-Residents who were in the "hot box" were placed there for 72 hours.<br>-Residents were checked every 30 minutes to one hour depending on the number of falls.<br>-The RCCs communicated to the MAs and PCAs in conversation, at shift change and at stand up meetings with staff if there were any changes with a residents' care.<br>-She thought Resident #1 was already on frequent checks prior to the 07/06/19 fall, but she would have to check her records.<br>-She did not know what specifically was put into place after Resident #1's 07/06/19 fall by looking at the Occurrence Report dated 07/06/19.<br>-Resident #1 was sent to the hospital on 07/06/19 and if anything was put into place it would be in Resident #1's progress notes.<br>-Resident #1 was placed in the hot box after her 07/07/19 fall and she was checked on frequently but, did not know the frequency of checks.<br>-Resident #1 was already in the hot box for the 07/09/19 fall and there was nothing done differently for Resident #1's supervision after the 07/09/19 fall.<br>-Resident #1 remained on hourly checks after the 07/09/19 fall.<br>-Resident #1 did not fall on 07/10/19 and was | D 270 | | |

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sitting on the floor, propped up by pillows and refused to get up.
-Resident #1 was sent to the hospital on 07/10/19 because she was agitated, and staff did not know the cause of Resident #1's behavior.
-No new interventions were received from Resident #1's physician after the falls from 07/06/19 to 07/16/19..
-Resident #1 had vitamin B12, and ferrous sulfate ordered by the emergency room physician on 07/16/19 when she returned from the hospital.
-Staff placed a chair in Resident #1's room on 07/17/19 to try to encourage her not to sit on the edge of the bed.
-She told staff to send Resident #1 out to the local hospital for any future falls and she continued on the increased supervision at the same level she already had.
-Resident #1 received home health services for the wound on her leg and physical therapy/occupational therapy (PT/OT) was ordered on 07/21/19 because of the frequent falls.
-Resident #1 began receiving PT/OT services on 07/24/19.
-The facility had difficulty getting orders from Resident #1's physician.
-She began working on Resident #1's admission to hospice services but had to wait for her responsible person to sign the paperwork for hospice services.
-When Resident #1 slipped off the bed on 07/22/19 at 2:55 pm there was no change in her level of supervision.
-Resident #1 fell again on 07/22/19 at 4:30 pm and she was transported to the hospital.
-Resident #1 refused physician office visits on 07/09/19 and 07/18/19.
-She did not know a lot of information about Resident #1's fall on 07/23/19 but there was no

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change in her supervision after this fall.
-There was documentation of increased supervision on 07/25/19 when Resident #1 was placed on every 30 minutes checks.
-Resident #1 went to the physician's office last week, she thought on 07/26/19 and they held her losartan.
-Resident #1 fell on 07/26/19 and her checks were increased to every 15 minutes.
-The hospice nurse completed an intake assessment on Resident #1 on 07/28/19.
-Resident #1 was sent to the hospital on 07/31/19 due to behaviors and when she returned, she was placed on one to one supervision.
-Staff really tried their best to take care of Resident #1.
-She had not attempted to speak directly with Resident #1's physician to explain the sequence of events and the frequent falls.
-She did not recognize she needed to be more insistent with Resident #1's physician to obtain interventions to assist with monitoring Resident #1.

Interview with the Executive Director on 08/02/19 at 5:19 pm revealed:
-Staff completed incident reports based on injury to the resident, notified the resident's physician and family member.
-Resident #1 fell on 07/06/19 and she was placed on increased supervision.
-She defined increased supervision as staff, a PCA, checking on the resident more frequently such as hourly checks.
-When PCAs went on breaks they were to communicate with the MAs so that the increased supervision continued.
-The RCCs made the decision of when and who was placed on increased supervision.
-Staff were told if a resident was on increased

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supervision during stand-up, which was held at 10:00 am each weekday.
-Resident #1 fell on 07/07/19 and she was sent to the hospital.
-When Resident #1 returned they tried to make a follow up appointment and the increased supervision continued.
-At some point and time, Resident #1 was placed on every 30 minutes checks.
-The documentation on the incident reports for Resident#1 varied depending on who completed the form.
-The RCC instructions were not always documented on the incident report.
-Resident #1 fell on 07/09/19 and the facility notified Resident #1's physician and if she was not on every 30-minute checks, it may have started at this point.
-She was unsure if there were any interventions suggested by the physician after the 07/09/19 fall for Resident #1.
-When Resident #1 fell on 07/10/19 she was already on increased supervision, but she was unsure of the frequency of the checks.
-Resident #1 remained in the hospital after the 07/10/19 fall until 07/16/19.
-During Resident #1's 07/10/19 through 07/16/19 hospital stay, she was assessed by PT/OT and outpatient PT was not recommended.
-There were no other interventions started after Resident #1's 07/10/19 fall.
-Resident #1 fell on 07/17/19 and she was sure that Resident #1 was on every 15-minute checks.
-Resident #1 had a follow up appointment with her physician on 07/26/19.
-Resident #1's physician did not make any recommendations and stated Resident #1 did not meet the qualifications for skilled nursing care.
-Resident #1 slid from the bed on 07/22/19, the physician was notified, and she was on increased

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supervision.
-Resident #1 was given a chair and the thought was that Resident #1 would sit in the chair and not on the edge of her bed.
-Staff thought even though Resident #1 had the diagnosis of dementia she would understand to use the chair.
-Using the chair, and increased supervision did not work because Resident #1 fell again on 07/23/19.
-Resident #1 went to the hospital on 07/23/19 for mental status changes not due to falling.
-Resident #1's mental health provider did not provide any interventions to assist with decreasing Resident #1 fall risk.
-Resident #1 fell on 07/26/19 and this was the same day she saw her physician.
-Resident #1's physician ordered PT for gait training and she was seen by PT on 07/24/19.
-Resident #1 was sent out on 07/31/19 due to anemia and when Resident #1 returned from the hospital, she had a sitter 24 hours a day.
-Staff should have been more insistent with Resident #1's physician to gain his input concerning increased supervision interventions for Resident #1.
-She was accountable for the overall supervision of the residents and held the RCCs accountable for ensuring residents were receiving the adequate level of supervision based on the resident's needs.
-The RCCs held the MAs and PCAs accountable for supervising the residents as instructed.

Attempted telephone interview with Resident #1's family member on 08/02/19 at 9:27 am was unsuccessful.

Attempted telephone interview with Resident #1's physician on 08/02/19 at 9:04 am was

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| D 270 | Continued From page 23<br>unsuccessful.<br>_____<br>The facility failed to supervise a resident who was intermittently oriented, had a diagnosis of dementia with behaviors, and used a walker to assist with ambulation; the resident had multiple falls resulting in contusions and multiple bruises. The facility's failure resulted in substantial risk of serious injury of the resident and constitutes a Type A2 Violation.The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/19.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2019 | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure the physician was notified when the blood glucose reading was less than 60 or greater than 400 for 1 of 2 sampled residents (#1).<br><br>The findings are: | D 273 | | |

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| D 273 | Continued From page 24<br><br>Review of Resident #1's current FL-2 dated 03/13/19 revealed:<br>-Diagnoses included: dementia with behaviors, type 2 diabetes mellitus, hypertension, hypothyroid, anxiety, and history of cerebrovascular accident.<br>-There was an order for blood glucose checks three times a day.<br>-There was a medication order for Humalog insulin 100 mg/1 ml (used to treat diabetes mellitus) sliding scale: BS < 150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251- 300 = 6 units, 301 - 350 = 8 units, 351 - 400 = 10 units, > 400 give 10 units and notify the physician. Give orange juice if blood glucose is less than 65 and recheck in 15 minutes.<br><br>Review of Resident #1's six-month physician orders dated 03/26/19 revealed there was an order for blood glucose checks four times a day.<br><br>Review of Resident #1's subsequent physician order revealed there was an order dated 06/11/19 if blood glucose less than 60 give 8 ounces of orange juice and recheck blood glucose in 15 minutes. If blood glucose still less than 60 repeat and notify provider. Notify physician if blood glucose greater than 500.<br><br>Review of Resident #1's June 2019 blood glucose flow sheet:<br>-There was documentation of the Humalog sliding scale and check blood glucose four times a day handwritten at the lower half of the blood glucose flow sheet.<br>-The Humalog sliding scale was hand written as follows: Give sliding scale: <150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 251- 300 = 4 units, 301 - 350 = 6 units, 351- 400 = 8 units, >400 give 10 | D 273 | | |

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| D 273 | Continued From page 25<br>units and notify physician, give within 15 minutes of food.<br>-There was documentation on 06/13/19 at 8:00 pm of a blood glucose reading of 411.<br>-There was documentation on 06/14/19 at 11:45 am of a blood glucose reading of 428.<br>-There was documentation on 06/17/19 at 11:45 am of a blood glucose reading of 417.<br>-There was documentation on 06/20/19 at 8:00 pm of a blood glucose reading of 445.<br>-There was documentation on 06/22/19 at 11:45 am of a blood glucose reading of 492.<br>-There was documentation on 06/24/19 at 11:45 am of a blood glucose reading of 401.<br>-There was documentation on 06/29/19 at 7:45 am of a blood glucose reading of 57.<br><br>Review of Resident #1's June 2019 medication administration records (MARS) revealed:<br>-There was an entry for Humalog 100 units/ml "kwik blood sugar" four times a day sliding scale: <150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 -400 = 10 units, >400 give 10 units and notify the physician. Give within 15 minutes of food, scheduled for 7:45 am, 11:45 am, 4:45 pm, and 8:00 pm.<br>-There was documentation on 06/13/19 at 8:00 pm of "see sheet".<br>-There was documentation on 06/14/19 at 11:45 am of a blood glucose reading of 428, with staff initials and 10 units of insulin documented as administered.<br>-There was documentation on 06/17/19 at 11:45 am of a blood glucose reading of 417, with staff initials, and 10 units of insulin documented as administered.<br>-There was documentation on 06/20/19 at 8:00 pm of "see sheet".<br>-There was documentation on 06/22/19 at 11:45 | D 273 | | |

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am of a check mark, with staff initials and 10 units of insulin documented as administered.
-There was documentation on 06/24/19 at 11:45 am of a "check mark", with staff initials and 10 units of insulin documented as administered.
-There was documentation on 06/29/19 at 7:45 am of a blood glucose reading of 57, with staff initials and 10 units of insulin documented as administered.
-There was documentation on the back of the MAR on 06/04/19 of a blood glucose reading of 59 upon recheck, the blood glucose reading was 82.
-There was documentation on the back of the MAR on 06/15/19 of physician notification for a blood glucose of 585.
-There was documentation on the back of the MAR on 06/21/19 of physician notification for a blood glucose of 462.

Review of Resident #1's July 2019 blood glucose flow sheet revealed:
-There was documentation of the Humalog sliding scale and check blood glucose four times a day handwritten at the lower half of the blood glucose flow sheet.
-The Humalog sliding scale was hand written as follows: Give sliding scale: <150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 251- 300 = 4 units, 301 - 350 = 6 units, 351- 400 = 8 units, >400 give 10 units and notify physician, give within 15 minutes of food.
-There was documentation on 07/02/19 at 11:45 am of a blood glucose reading of 461.

Review of Resident #1's July 2019 MARS revealed:
-There was an entry for Humalog 100 units/ml "kwik" inject 10 units subcutaneously three times daily before meals hold if blood sugar less than

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100, scheduled for 7:45 am, 11:45 am , and 4:45 pm.
-There was no documentation on 07/02/19 at 11:45 am of a blood glucose reading, staff initials, amount of insulin or location administered.
-There was an entry for Humalog 100 units/ml "kwik blood sugar" four times a day sliding scale: <150 = 0 units, 151 - 200 = 2 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 -400 = 10 units, >400 give 10 units and notify the physician. Give within 15 minutes of food, scheduled for 7:45 am, 11:45 am, 4:45 pm, and 8:00 pm.
-There was documentation on 07/02/19 at 11:45 am of "see sheet".
-There was documentation on the back of the MAR on 07/09/19 of a blood glucose recheck for a blood glucose of 55 and the humalog 10 units was held because the blood glucose less than 100.
-There was documentation on the back of the MAR on 07/29/19 of physician notification for a blood glucose of 564.

Review of Resident #1's progress notes revealed:
-There was no documentation of physician notification for the blood glucose readings over 400 on 06/13/19, 06/14/19, 06/17/19, 06/20/19, 06/22/19, 06/24/19, and 07/02/19.
-There was no documentation of physician notification for the blood glucose reading less than 60 on 06/29/19 and 07/09/19.
-There was documentation of physician notification for other blood glucose readings over 400 on 06/07/19, 06/16/19, 06/21/19, and 07/23/19.

Based on record reviews, and interviews there were nine blood glucose readings that were below 60 or above 400 that staff did not notify the

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| D 273 | Continued From page 28<br>physician as ordered.<br><br>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable.<br><br>Telephone interviews with a medication aide (MA) who worked on 06/14/19, and 06/29/19 on 08/02/19 at 11:09 am revealed:<br>-She told the Resident Care Coordinator (RCC) about any blood glucose readings that were below 60 or above 400 for Resident #1.<br>-She thought she had called on 06/29/19 about the blood glucose reading of 57, but she did not document the notification.<br>-She did not document the physician notification for blood glucose readings below 60 or greater than 400 when she reported the blood glucose reading to the RCC.<br><br>Telephone interview with another MA who worked on 06/13/19 on 08/02/19 at 11:40 am revealed she was not able to remember the specific day, but she did document in the care notes or communication log whenever she notified the physician.<br><br>Interview with a third MA who worked on 06/17/19 and 07/02/19 on 08/02/19 at revealed:<br>-She thought she had called the physician on 06/17/19 and spoke with the nurse and documented in the progress notes, but she could not locate the documentation.<br>-She knew she was supposed to call the physician for a blood glucose reading of 461 but she was not able to locate any documentation of the notification.<br><br>Interview with a RCC on 08/02/19 at 4:55 pm revealed: | D 273 | | |

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| D 273 | Continued From page 29<br>-She expected the MAs to notify the physician by calling during business hours and after business hours the physician's office had a physician on call who the MAs spoke with about blood glucose levels.<br>-Resident #1's physician sometimes called back or sent an order via the fax machine.<br>-She expected the MAs to document on the progress notes when the physician was notified because they were the staff who administered insulin according to the sliding scale range.<br>-She did not know there was no documentation the physician was notified for the blood glucose readings on 06/13/19, 06/14/19, 06/17/19, 06/20/19, 06/22/19, 06/24/19, 06/29/19, and 07/02/19.<br>-She audited the blood glucose flow sheets against the glucometers, and she may check the amount of insulin documented.<br>-She had not done an audit in a while and she could not recall the last time.<br><br>Interview with the Executive Director on 08/02/19 at 5:19 pm revealed:<br>-She expected the MAs to follow the order as written by the physician.<br>-If the order was written to contact the physician, she expected the physician to be contacted and the notification documented on the back of the MAR or in the progress notes.<br>-The RCCs had daily tasks to complete and she expected the RCCs to check to ensure the physician was contacted based on the blood glucose reading documented.<br>-She expected the RCCs to note discrepancies and address the discrepancy with the staff who made the discrepancy.<br>-She did note the dates when Resident #1's blood glucose reading was below 60 or greater than 400 and documentation of physician notification | D 273 | | |

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| D 273 | Continued From page 30<br>could not be located on the back of the MAR or the progress notes but she was not able to locate documentation either.<br><br>Attempted telephone interview with Resident #1's family member on 08/02/19 at 8:27 am was unsuccessful.<br><br>Attempted telephone interview with Resident #1's physician on 08/02/19 at 9:04 am was unsuccessful. | D 273 | | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to the floor and walls, food storage carts, beverage area, coffer maker, dishwasher area, stove top and hood vent, deep fryer, griddle, metal rack in the walk-in refrigerator, floor of the walk-in freezer, air curtain, ceiling vent cover, and small and large work stations.<br><br>The findings are:<br><br>Review of the current county Food Establishment Inspection Report revealed: | D 282 | | |

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| D 282 | Continued From page 31<br>-The food service area received an inspection score of 94.5 on 02/28/19.<br>-There was chipping coating or rusting of the shelving in the walk-in refrigerator.<br><br>Observation on 08/01/19 at 10:13 am of the kitchen entrance doorway revealed:<br>-There were black splatter marks on the kitchen side of the entry door, door frame, and threshold.<br>-There was a build-up of dark brown dust and greasy dirt at the base of the door frame and along the top and bottom edges of the baseboard tiles.<br><br>Observation on 08/01/19 at 10:14 am of the 2 left side metal storage carts revealed:<br>-There was a build-up of sticky dust and rust on the shelves and legs.<br>-The wheels were coated with a build-up of a black greasy dirt.<br>-The metal wheel covers were rusted.<br><br>Observation on 08/01/19 at 10:15 am of the beverage table and cart revealed:<br>-There were 3 cartons containing thickened water, orange juice, and cranberry juice stacked on the metal cart under the beverage table.<br>-There were brown drip marks on the top of the thickened liquid carton.<br>-There were dispensing connectors attached to the bags of orange and cranberry juice.<br>-The push button devices for the orange and cranberry juices were hanging down, over the bottom edge of the cart, 2 inches above the floor.<br>-The storage crates for cleaned glasses were speckled with an unknown white substance.<br>-The wheels on the cart were coated with a build-up of a black greasy dirt.<br>-The metal wheel covers were rusted.<br>-There were black specks on the top edge of the | D 282 | | |

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cart and a build-up of a black greasy substance around the bases of the burners of the industrial sized coffee maker.
-There was no covering over the 3 empty carafes and one half-full carafe of coffee was on the coffee maker.
-There was a build-up of white and black greasy substances on the front panel and control buttons of the coffee maker.
-There was a heavy build-up of dust on the wall electrical outlet, water lines, controls, and wide window sill behind and above the uncovered coffee carafes on the coffee maker.

Observation on 08/01/19 at 10:21 am of the dishwasher area revealed:
-There were brown and yellow stains on the wall behind the dish washing sinks.
-There was a build-up of greasy dust and white specks on the hand sanitizer box on the wall above the end sink.
-There was an unknown yellow liquid with dried black edges, in the bottom of a plastic bucket, under the sink.
-The wall, the floor, and drain pipes at the dish washing sink and the dishwasher were coated with black and brown greasy dust.
-There were small crumbs and flecks of white paint on the floor under the sinks.
-There was peeling paint on the wall behind the sinks and dishwasher.
-There were brown and black stains on the flooring tiles under the sinks and dishwasher.
-There was a coating of rust on the top one-third of the electric water heater under the draining table of the dishwasher.
-There were drops of water on the rusted top of the water heater.

Observation on 08/01/19 at 10:26 am of the

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| D 282 | Continued From page 33<br>double sink food preparation area revealed:<br>-There were black stain marks and splatters on the wall behind the double sinks.<br>-There were dark brown stains on the flooring and baseboard tiles around the preparation area.<br>-There were brown splatter marks on the side panel of the right sink.<br>-There was a build-up of greasy dust on the legs of the sinks and on the water pipe below the sinks.<br>-There was peeling paint on the ceiling above the window at the sinks.<br>-There were yellow stains and a heavy coating of dust on the windowsill and frame of the window above the sinks.<br><br>Observation on 08/01/19 at 4:08 pm of the cook top, hood, griddle and deep fryer area revealed:<br>-There was a yellowed brown coating on the slats of the stove hood.<br>-There was a dark brown build-up between and behind the slats of the cook top hood.<br>-There were brown stains, food crumbs and flecks of a white substance on the stove top and around the burners of the stove.<br>-There was a coating of black and brown stains on the back splash of the cook top.<br>-There was a coating of black and brown stains on the surface of the griddle.<br>-There was a heavy coating of dark brown grease on the right side panel of the griddle.<br>-There were yellow and brown stains on the flooring tiles in front of the deep fryer and griddle.<br>-There was a yellow coating of dried grease and a white powder substance on the control knob and front panel of the deep fryer and oven.<br>-There was a thick build-up of dark brown and black grease on the side panel and floor at the deep fryer.<br>-There was a coating of a white powder | D 282 | | |

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substance on the bottom shelf of the cabinet and floor around the deep fryer.
-The front wheels of the deep fryer cabinet were coated with rust.

Observation of the walk-in freezer floor on 08/01/19 at 10:14 am revealed:
-There were small pieces of debris and a piece of plastic under the metal racks on the left side of the floor.
-There were small pieces of debris and reddish stains on the floor under the metal racks on the right side of the floor.

Observation of the walk-in refrigerator on 08/01/19 at 10:17 am revealed:
-There were four metal racks in the walk-in refrigerator.
-There was one three shelf metal rack with areas of rusting throughout each shelf.

Observation of the ceiling vent cover in the A/B hallway dining room on 08/01/19 at 10:12 am revealed there was a dusty residue covering the entire area of the ceiling vent.

Observation of the air curtain above the kitchen door on 08/01/19 at 10:29 am revealed:
-There was a large air curtain above the back door of the kitchen that exited to the loading area and the rear parking lot.
-The machine was activated when the back door of the kitchen was opened.
-The machine was not activated by other inner doors of the kitchen being opened.
-There was a dusty residue covering on all three sides of the vents.

Observation of the C/D hallway dining room small stainless-steel work station on 08/01/19 at 10:42

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| D 282 | Continued From page 35<br>am revealed:<br>-There was a microwave, salt and pepper shakers, table cloths, and eating utensils wrapped in cloth napkins on the top of the work station.<br>-There were two compartments below the work station.<br>-The first compartment was storage for activities and had double doors.<br>-The second compartment was opened and had small pieces of debris on the bottom.<br><br>Observation of the C/D hallway dining room large stainless-steel work station on 08/01/19 at 10:45 am revealed:<br>-There was a coffee maker, drain system for liquids to flow into if spilled, a sink, a plastic storage container for eating utensils, disposable coffee filters, an empty glass storage container, disposable cups, and two dirty stainless-steel spoons on top of the work station.<br>-There were crumbs and small spots of coffee on the top of the work station near the coffee maker.<br>-There were brownish stains inside the walls of the sink with food debris in the drain area.<br>-There were two drawers at the bottom of the work station.<br>-There were white spots in the outer most drawer and small bits of debris in the inner drawer.<br><br>Interview on 08/01/19 at 3:30 pm with the Dietary Manager (DM) revealed:<br>-Most of the kitchen equipment and storage shelves were the same as when he started working at the facility in 2018.<br>-The DM was responsible for filling out the Daily Task Lists for the cook and the dietary aide.<br>-Currently there was one cook, besides himself, and one dietary aide.<br>-Daily cleaning tasks were cleaning and sanitizing | D 282 | | |

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|---|---|---|---|---|
| D 282 | Continued From page 36 | D 282 | | |

the carts and storage shelves, sweeping and mopping the floor.
-Deep cleaning was done once a month; the equipment was scrubbed with a professional cleaner.
-The stove top hood was taken down and sections were washed every week in the dishwasher.
-The stove top was scraped every week with steel wool and a brush.
-He assisted with cleaning the kitchen, dining room and cooking.
-The kitchen could use a thorough cleaning.
-The kitchen had never been steam cleaned.
-He could use more staff to help keep the kitchen clean and more effectively keeping the kitchen clean.

Review of the facility's daily dietary aide opening and closing task list revealed:
-A list of daily kitchen cleaning tasks was initialed as completed on 06/26/19 and 07/26/19.
-There was documentation of "Coffee table, ice machine, and juice dispenser" and an open box was beside the words with initials documented in the box.
-There was no documentation of cleaning the walk-in freezer floor, walk-in refrigerator metal racks, the ceiling vent in the dining room, or the air curtain.

Interview with the Dietary Manager (DM) on 08/01/19 at 10:10 am revealed:
-He supervised the dietary staff.
-The walk-in freezer was mopped once a week and he had not been able to mop it yet.
-He used a cleanser specifically developed for use in a cold temperature that he called deicer.
-He had ordered and received a new metal rack

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|---|---|---|---|
| | HAL043027 | A. BUILDING: _____ B. WING _____ | 08/02/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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for the walk-in refrigerator a few months ago.
-He would try to clean the three-shelf rack to remove the rust.
-He knew the three-shelf rack was rusty, but he did not have an opportunity to address it yet because there was not enough staff.
-The metals racks were cleaned monthly.
-The dietary staff cleaned the small and large work stations in the C/D hallway dining rooms at the end of their shift.
-He had difficulty keeping the work stations clean because they were located in the C/D hallway dining room where activities were sometimes held, and residents obtained coffee.

Interview with the Dietary Manager (DM) on 08/02/19 at 9:56 am revealed:
-He had a daily cleaning schedule for the kitchen staff initialed when an item was completed.
-He was not responsible for cleaning the vent cover in the A/B hallway dining room and he was not responsible for cleaning the air curtain in the kitchen.
-He thought housekeeping was responsible for the ceiling vent cover in the A/B hallway dining room and maintenance was responsible for the air curtain.
-He had not asked housekeeping to clean the ceiling vent cover in the A/B hallway dining room and he had not asked maintenance to clean the air curtain.
-He had so much to manage in the kitchen and he did not notice the air curtain and ceiling vent cover.
-He did not use the drawers on the large work station, and he did not know there was debris and stains in each.
-He knew the sink on the large work station was stained and had food debris in the drain.
-He told his staff to clean the sink and they did

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| D 282 | Continued From page 38<br>not always do as he requested.<br>-He did not know why the staff did not always clean the sink on the large workstation.<br>-He had have a scouring cleaner to clean the sink.<br><br>Interview with the Executive Director (ED) on 08/02/19 at 10:15 am revealed:<br>-She made daily rounds through the kitchen but did not note the cleanliness or any items that were out of place.<br>-Dietary services was responsible for cleaning the ceiling vent cover in the A/B dining room and the air curtain machine in the kitchen.<br>-She had not told the DM his department was responsible for cleaning these items.<br>-She had not reviewed the cleaning schedule with the DM but the DM was responsible for ensuring all items on the cleaning schedule were completed.<br>-She did not know about the stains on the walk-in freezer floor, the rusty three shelf rack in the walk in refrigerator, the debris on the small and large stainless-steel work station, the stains in the sink of the large work station, and the debris and stains in the drawers of the large work station.<br>-She knew dietary services had lost three staff in the past few weeks and they were in the process of hiring more dietary staff. | D 282 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. | D912 | | |

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| D912 | Continued From page 39<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision.<br><br>The findings are:<br><br>Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 3 sampled residents' (#1) who had falls. [10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A2 Violation)] | D912 | | |