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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 28, 2019 through August 30, 2019.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure referral and follow up to meet the acute healthcare needs of 2 of 2 sampled diabetic residents (#4, #6) regarding notifying the physician of fingerstick blood sugar (FSBS) readings outside of parameters. The findings are: 1. Review of Resident #6's current FL2 dated 03/29/19 revealed: -Diagnoses included diabetes, Alzheimer's Disease, hypertension, and hypothyroidism. -There was a physician's order to notify physician if FSBS was <50 or >400. Review of Resident #6's August 2019 electronic Medication Administration Record (eMAR) revealed:	D 273		

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-There was a computer-generated entry to monitor FSBS; notify MD for FSBS <50 or >400.
-FSBS reading was documented as 561 at 8:30pm on 8/22/19 and 403 at 8:30pm on 8/23/19.
-There was no documentation on eMAR related to contact with the physician.

Review of Resident #6's record revealed no documentation that the primary care provider was notified regarding the elevated FSBS's on 8/22/19 and 8/23/19.

Interview with Resident #6 on 08/29/19 at 8:35am revealed she did not know what her FSBS readings were, but the facility checked her FSBS daily.

Interview with a medication aide (MA) on 08/30/19 at 10:32am revealed:
-She worked first and second shift.
-She did not remember contacting Resident #6's physician regarding elevated fingerstick blood sugar during August.
-If she had contacted the physician, it was documented in Resident #6's record.
-She did not remember Resident #6 having an elevated FSBS recently.

Telephone interview with a nurse from Resident #6's primary care provider's office on 08/29/19 at 4:58pm revealed:
-There was no documentation since 7/31/19 regarding Resident #6 having any FSBS outside of the parameters ordered by the physician.
-The facility should have contacted the office if the resident had a FSBS outside of the parameters so the physician could adjust her insulin dose.
-Hyperglycemia could lead to many complications

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but she would "need to ask the doctor" how that would relate to this resident because of the other health issues.

Interview with the Administrator on 08/29/19 at 4:50pm revealed she did not know the MAs did not contact Resident #6's primary care provider regarding elevated FSBS readings in August.

Refer to the interview with a medication aide (MA) on 8/29/19 at 7:45am.

Refer to the interview with the Resident Care Coordinator (RCC) on 08/29/19 at 10:28am.

Refer to the interview with the Administrator on 8/29/19 at 4:50pm.

2. Review of Resident #4's current FL2 dated 06/11/19 revealed diagnoses included diabetes, hypothyroidism, and constipation.

Review of Resident #4's physician's orders dated 07/10/19 and 8/8/19 revealed a physician's order to notify the physician if fingerstick blood sugar (FSBS) was <70 or >300.

Review of Resident #4's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry to call Endocrinologist for FSBS <70 or >300 every shift.
-There was a computer-generated entry to check FSBS before each meal, at bedtime and at 3:00am in the morning.
-The FSBS blood sugar was recorded daily at 7:30am, 11:30am, 4:30pm, 9:00pm, and 3:00am.
-FSBS were recorded outside of the parameters for 56 out of 140 opportunities from 08/01/19 to 08/28/19.

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D 273	Continued From page 3 -The FSBS ranged from 63 to 584 from 08/01/19 to 08/28/19. -There was no documentation that the physician had been contacted regarding the elevated FSBS. Interview with a medication aide (MA) on 08/29/19 at 7:45am revealed: -The MAs were responsible for contacting a resident's physician for a FSBS reading outside the parameters set by the physician's order. -She was responsible for contacting the physician and documenting the information in the resident's record. -If the physician was contacted regarding a resident, the documentation was in the resident's record. -She did not know why the MA's were not contacting the physician every time Resident #4's FSBS was outside of the parameters. Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 10:48am revealed: -Resident #4's FSBS fluctuated from low to high throughout the day. -She knew Resident #4 had multiple elevated FSBS readings. -She did not remember the MAs notifying her regarding a specific FSBS reading outside of the parameters set by Resident #4's physician. -The MA's were responsible for contacting the physician every time the FSBS were outside of the parameters based on the physician's order. -She would not know a resident's FSBS was outside of parameters unless the MAs told her. Telephone interview with Resident #4's Endocrinologist on 08/30/19 at 8:50am revealed: -Resident #4 was a "very brittle diabetic" and has extreme high and low FSBS readings.	D 273		

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D 273	Continued From page 4 -He expected the facility to notify the office if Resident #4's FSBS was outside of the parameters. -The facility would send an individual FSBS reading "occasionally" to the office but it was helpful to have multiple readings throughout the day to determine any trends that were developing. -He would request the facility to send multiple FSBS's readings over several days so he could have more information to adjust Resident #4's insulin dose. -It is important for him to know Resident #4's FSBS readings so he can adjust the insulin dose appropriately. Interview with the Administrator on 08/29/19 at 4:50pm revealed she did not know the MAs did not contact Resident #4's Endocrinologist regarding multiple elevated FSBS during the month of August. Refer to the interview with a medication aide (MA) on 8/29/19 at 7:45am. Refer to the interview with the Resident Care Coordinator (RCC) on 08/29/19 at 10:28am. Refer to the interview with the Administrator on 8/29/19 at 4:50pm. ______________________ Interview with a medication aide (MA) on 8/29/19 at 7:45am revealed: -The MAs were responsible for notifying the physician if residents had a blood pressure or fingerstick blood sugar (FSBS) outside of the parameters ordered by the physician. -The MAs were responsible for calling the physician then faxing if they could not reach the	D 273		

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D 273	Continued From page 5 physician by phone. -The MAs were responsible for documenting the information in the resident's record. Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 10:28am revealed: -The MAs were responsible for calling the physician for a FSBS <70 or >300 based on the facility policy. -She or the Resident Care Director (RCD) was responsible for auditing the medication carts weekly. -The facility did not have a set procedure in place to audit the electronic Medication Administration Records (eMAR) to make sure the MAs were contacting a resident's physicians for FSBS readings outside of the parameters. Interview with the Administrator on 8/29/19 at 4:50pm revealed: -The MAs were responsible for contacting the physician for residents with FSBS outside of parameters ordered by their physician. -The MAs were responsible for documenting the call or fax and putting the information in a "pending box" to continue to monitor until they get a response from the physician. -If the physician did not respond in 24 hours then the MAs were responsible for calling or faxing the physician again to follow up.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage,	D 286		

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preparation and service.

This Rule is not met as evidenced by:
Based on observation and interview the facility failed to assure the food processor was sufficient to prepare therapeutic diets in accordance with physician orders.

The findings are:

Observation on 08/29/19 at 7:25am revealed:
-There was a food processor in the kitchen which was used to process food to different consistencies.
-The food processor's lid was broken.
-Food service staff used a screwdriver to turn on the food processor since the lid was broken and would not lock properly.

Interview with a cook on 08/28/19 at 12:40pm revealed:
-She was responsible for processing puree food for residents.
-The Food Service Director (FSD) taught her how to puree food and process any foods that needed to be changed in consistency.
-The food processor in the kitchen was the only processor the facility utilized.
-She thought the food processor did not puree food very well and staff "do the best we can with the equipment we have".
-The FSD knew about the broken equipment as they had been promising kitchen staff a new one for approximately 3 months.

Interview with another cook on 08/29/19 at 7:25am revealed:
-She was responsible for processing puree food for residents.
-The food processor in the main kitchen was the

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D 286	Continued From page 7 only processor the facility utilized. -The food processor did not puree food very well. -The food processor has been broken since she started working there in June 2019. -She had to use a screwdriver to make the machine turn on becasue the lid was broken and it would not lock properly. Interview with the Administrator on 08/29/19 at 4:40pm revealed: -She was told about the broken food processor in June 2019. -She was unaware that the food processor needed a screwdriver to operate. -She had been trying to purchase a new food processor since June 2019. -She had requested a new food processor but was awaiting authorization from the corporate office. -She would try to expedite the purchase of a new food processor. -She expected kitchen staff to process food according to physician written diet orders. -She was ultimately responsible for dietary services and was currently the acting FSD.	D 286		
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.	D 309		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to maintain an accurate and current listing of residents with physician order therapeutic diets for the guidance of food service staff for 2 of 5 sampled residents (#2 and #5)

The findings are:

1. Review of Resident #2's current FL2 dated 03/11/19 revealed:
-Diagnoses included Alzheimer's disease, intestinal obstruction, irritable bowel syndrome and hypertension.
-Resident #2 had an order for a puree diet.

Observation of the kitchen's therapeutic diet list on 08/28/19 at 10:02am revealed:
-The therapeutic diet order list was kept on an erasable white board in the kitchen.
-Resident #2 was not listed on the therapeutic diet list.

Interview with a cook on 08/28/19 at 10:05am revealed:
-The list of therapeutic diets was kept in the kitchen.
-There was only one puree diet order, so she kept that list "in her head".

Interview with the lead cook on 08/30/19 at 12:00pm revealed:
-He was the lead cook and oversaw the kitchen operations.
-Medication aides (MA) informed dietary staff of any diet order changes.
-Diet order changes were filed by dietary staff in a book for future reference.
-The therapeutic diet list was updated by dietary

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staff when they received a new diet order.
-The dining room seating chart that showed therapeutic diets was "usually" updated by the Food Service Director (FSD).
-The dining room seating chart, which showed the therapeutic diets, was not current since they did not have a FSD to update it.

Interview with the Resident Care Coordinator (RCC) on 08/30/19 at 11:46am revealed:
-MAs informed dietary staff of any diet changes.
-MAs gave copies of diet orders to the dietary staff.
-Dietary staff filed the orders in a notebook they kept in the kitchen.
-The therapeutic diet list was updated by dietary staff when they received a new diet order from the MA.
-The dining room seating chart that showed therapeutic diets was updated by the facility's program coordinator not the FSD.

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-She was the acting FSD since that position was vacant.
-Kitchen staff were informed of diet changes by the clinical staff and kept a current list to reference.
-She expected dietary staff to maintain a current list of resident diet orders by following established procedures.

2. Review of Resident #5's FL2 dated 04/04/19 revealed:
-Diagnoses included dementia, lung cancer and chronic obstructive pulmonary disease.
-Resident #5 had an order for a No Added Salt diet (NAS).

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Rreview of the kitchen's therapeutic diet list on 08/28/19 at 10:02am revealed:
-The therapeutic diet order list was kept on an erasable white board in the kitchen.
-Resident #5 was not listed on the therapeutic diet list that was kept in the kitchen.

Review of the dining room seating chart on 08/28/19 at 10:03am revealed:
-The chart had a date of 08/28/19 on the bottom.
-Resident #5's diet was listed as regular.

Interview with the lead cook on 08/30/19 at 12:00pm revealed:
-He was the lead cook and oversaw the kitchen operations.
-Medication aides (MAs) informed dietary staff of any diet changes.
-Diet order changes were filed by dietary staff in a book for future reference.
-The therapeutic diet list was updated by dietary staff when they received a new diet order.
-The dining room seating chart that showed therapeutic diets was updated, when a change occured, by the FSD.
-The dining room seating chart which showed the therapeutic diets, was not current since they did not have a FDS to update it.

Interview with the Resident Care Coordinator (RCC) on 08/30/19 at 11:46am revealed:
-MAs informed dietary staff of any diet changes.
-MAs gave copies of diet orders to the dietary staff.
-Dietary staff filed the orders in a notebook they kept in the kitchen.
-The therapeutic diet list was updated by dietary staff when they received a new diet order from the MA.
-The dining room seating chart that showed

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therapeutic diets was updated by the facility's program coordinator.

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-She was the acting FSD since that position was vacant.
-Kitchen staff were informed of diet changes by the clinical staff and kept a current list to reference.
-She expected dietary staff to maintain a current list of resident diet orders.

D 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service D 310

10A NCAC 13F .0904 Nutrition and Food Service
(e) Therapeutic Diets in Adult Care Homes:
(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews the facility failed to assure therapeutic diets were served as ordered for 4 of 5 sampled residents (#1, #2, #4 and #5) who had physician orders for a carbohydrate controlled diet (#1 and #4), a puree diet (#2) and a no added salt diet (#5).

The findings are:

1. Review of Resident #2's current FL2 dated 03/11/19 revealed:
-Diagnoses included Alzheimer's disease,

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intestinal obstruction, irritable bowel syndrome and hypertension.
-A physician's order for a puree diet.

Review of Resident #2's diet order dated 06/01/17 revealed:
-Resident #2 was to receive a puree diet.
-The puree diet was defined as "pureed, homogenous and cohesive foods".
-The puree diet excluded foods that required "mastication (chewing), controlled manipulation or bolus formation".

Review of the lunch menu for 08/28/19 revealed:
-The menu consisted of cucumber salad, herb-roasted chicken, boiled red-skinned potatoes, buttered corn, biscuit and chocolate cake.
-There was a list of substitutions for a pureed diet.
-Tomato juice was substituted for the cucumber salad.
-The pureed meat was to be pureed and served with gravy.
-The potatoes, corn and biscuit were all specified to be pureed.

Observation of Resident #2's lunch meal on 08/28/19 at 12:30pm revealed:
-All foods served were of a ground consistency.
-The foods served to Resident #2 consisted of chicken, potatoes, corn and chocolate cake.
-The chicken was ground and did not contain gravy.
-Red potato skins were visible on the ground potatoes.
-The corn was ground and had an appearance of creamed style corn.
-The chocolate cake was ground rather than pureed and was runny.

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-The pureed biscuit was not visible in any of the food containers.
-The tomato juice was not visible in any of the food containers.

Interview with a personal care aide (PCA) on 08/28/19 at 12:23pm revealed:
-The food that Resident #2 received at lunch looked "the same as it had every other day" since she started working there.
-She was regularly in the dining room while Resident #2 ate meals.
-She had not observed Resident #2 coughing or choking at meals.
-Resident #2 ate well if it was a food she enjoyed.
-She did not know why Resident #2 was on a puree diet.
-Resident #2 needed frequent reminders to swallow during her meals.

Interview with a cook on 08/28/19 at 12:40pm revealed:
-Resident #2 was admitted to the facility on a pureed diet.
-She did not know why Resident #2 was on a pureed diet.
-Her FSD taught her how to puree food.
-She pureed Resident #2's food in the kitchen using a food processor.
-The food processor she used did not puree food very well and "I do the best I can with it".
-Her director knew that the processor was broken.
-The kitchen staff had been promised a new food processor "for a long time".
-She tried to get the pureed food to a baby-food like consistency so Resident #2 only had to minimally chew.
-She was able to mash some soft foods with a fork.

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-Resident #2 would let staff know if the food had too much texture and she was unable to chew it.

Review of the facility's lunch menu for 08/29/19 revealed:
-The facility was having a "special picnic meal" which replaced the pre-printed menu for that day.
-The menu consisted of cheeseburgers with lettuce, tomato and pickles, slaw, potato chips and popsicles.
-The special meal menu did not account for any changes necessary for therapeutic diets.

Observation of Resident #2's lunch meal on 08/29/19 at 12:15pm revealed:
-Resident #2 received ground hamburger meat and yogurt.
-She forcibly coughed while eating the ground meat.
-The ground meat was expelled from her mouth and went onto the table.

Interview with a second cook on 08/29/19 at 7:25am revealed:
-She did not know why Resident #2 was on a puree diet.
-The lead cook taught her how to puree food.
-She was responsible for processing puree food for residents.
-The food processor was broken and did not puree food very well so kitchen staff did the best they could with the equipment they had.
-She did not plan to serve the oatmeal that was on the puree menu because it was too thick to puree.

Interview with Medication Aide (MA) on 08/28/19 at 1:00pm revealed Resident #2 was on a puree diet due to problems swallowing.

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Interview with Resident #2's physician on 08/29/19 at 3:07pm revealed:
-She was not the physician that wrote the order for Resident #2's puree diet.
-She did not know why Resident #2 was on a puree diet.
-She was not aware of any aspiration, choking or pneumonia.
-She would expect the facility to contact her if Resident #2 had any choking or coughing.
-She was unaware that the facility's puree food did not match the description of a puree diet.
-Resident #2 would benefit from a "speech referral" to evaluate the necessity of a puree diet.
-She did not know if eating a ground diet would be detrimental to Resident #2 until a speech evaluation was completed.

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-She was ultimately responsible for dietary services.
-She was told about the broken food processor in June 2019.
-It was difficult to puree foods in the food processor they had.
-She had requested to purchase a new food processor in June 2019 when she was told it was broken, but she was awaiting authorization from the corporate office.
-She would try to expedite the purchase of a new food processor.
-She expected kitchen staff to process food according to physician written diet orders.
-The kitchen had a variety of food groups to substitute for a puree diet, but they apparently had not used what was available.
-All food groups should be given to a person on a puree diet.
-She was not aware that Resident #2 had ever

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D 310	Continued From page 16 coughed or choked at a meal. 2. Review of Resident #1's current FL2 dated 07/22/19 revealed: -Diagnoses included Alzheimer's, anxiety disorder, Atrial Fibrillation, diabetes, gastro-esophageal reflux disorder, hyperlipidemia, hypothyroidism and renal insufficiency. -There was a physician's order for a carbohydrate controlled diet. Review of Resident #1's diet order dated 07/22/19 revealed she was to receive a carbohydrate controlled diet. Review of the lunch menu for 08/28/19 revealed: -The menu consisted of cucumber salad, herb-roasted chicken, boiled red-skinned potatoes, buttered corn, biscuit and chocolate cake. -The carbohydrate control menu specified a reduced-sugar, frosted chocolate cake rather than regular chocolate cake. Observation of Resident #1's lunch meal on 08/28/19 at 12:30pm revealed frosted, chocolate cake was served for her dessert. Interview with a cook on 08/29/19 at 7:25am revealed: -She made the cake that was served for lunch on 08/28/19. -She used the same cake mix for all residents. -She was taught when she was trained that the carbohydrate controlled cake was the same as the regular cake but without frosting. -They did not use sugar-free cake mix when cake was on the menu because that is how she was trained.	D 310		

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Review of the facility's lunch menu for 08/29/19 revealed:
-The facility was not serving the regularly scheduled menu but instead was having a special picnic meal.
-The menu consisted of cheeseburgers with lettuce, tomato and pickles, slaw, potato chips and popsicles.
-The special meal menu did not account for any changes necessary for therapeutic diets.

Interview with the Medication Aide on 08/29/19 at 12:00pm revealed that the residents on a carbohydrate-controlled diet would not get a hamburger bun or chips with their lunch "that day".

Observation of Resident #1's lunch meal on 08/29/19 at 12:15pm revealed:
-The meal consisted of a hamburger pattie with cheese, lettuce and tomato, a serving of slaw and a popsicle.
-Resident #1 did not receive any carbohydrate appropriate substitutions for the hamburger bun or potato chips.

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-She was ultimately responsible for the food service department.
-She expected the food service staff to follow diet orders and menus.

3. Review of Resident #4's current FL2 dated 05/21/19 revealed:
-Diagnoses included dementia, diabetes, hypothyroidism and constipation.
-A physician's order for a carbohydrate control diet.

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Review of Resident #4's diet order dated 06/12/19 revealed she was to receive a carbohydrate controlled diet.

Review of the facility's lunch menu for 08/28/19 revealed:
-The menu consisted of cucumber salad, herb-roasted chicken, boiled red-skinned potatoes, buttered corn, biscuit and chocolate cake.
-The carbohydrate controlled menu specified a reduced sugar chocolate cake rather than regular chocolate cake.

Observation of Resident #4's lunch plate on 08/28/19 at 12:30pm revealed frosted chocolate cake was served for her dessert.

Interview with a cook on 08/29/19 at 7:25am revealed:
-She made the cake that was served for lunch on 08/28/19.
-She used the same cake mix for all residents.
-She was taught when she was trained that the carbohydrate controlled cake was the same as the regular cake but without frosting.
-They did not use sugar-free cake mix when cake was on the menu because that is how she was trained.

Review of the lunch menu for 08/29/19 revealed:
-The facility was not serving the regularly scheduled menu but instead was having a "special picnic meal" .
-The menu consisted of cheeseburgers with lettuce, tomato and pickles, slaw, potato chips and popsicles.
-The menu for the special meal did not account for any changes necessary for therapeutic diets.

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Observation of Resident #4's lunch meal on 08/29/19 at 12:30pm revealed:
-The meal consisted of a hamburger pattie with cheese, lettuce and tomato, a serving of slaw and a popsicle.
-Resident #4 did not receive any carbohydrate appropriate substitutions for the hamburger bun or potato chips.

Interview with the Medication Aide on 08/29/19 at 12:00pm revealed that the residents on a carbohydrate-controlled diet would not get a hamburger bun or chips with their lunch "that day".

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-She was ultimately responsible for the food service department.
-She expected the food service staff to follow diet orders and menus.

4. Review of Resident #5's current FL2 dated 04/04/19 revealed:
-Diagnoses included dementia, lung cancer and chronic obstructive pulmonary disease.
-Resident #5 had an order for a No Added Salt diet.

Review of Resident #5's diet order dated 04/09/18 revealed:
-He was to receive a No Added Salt diet.
-The No Added Salt diet was defined as the regular house diet without the use of salt at the table.

Observation of Resident #5's lunch meal on 08/28/19 at 12:15pm revealed:
-A salt shaker was in the middle of his table.

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-He used the salt shaker to salt his food after his meal was given to him.

Observation of Resident #5's lunch meal on 08/29/19 at 12:15pm revealed:
-A salt shaker was in the middle of his table.
-The dining room staff who served his meal handed him the salt shaker at the same time she placed his meal in front of him.

Interview with the cook on 08/29/19 at 7:25am revealed that the facility did not use table salt in any food preparation.

Interview with Resident Care Coordinator (RCC) on 08/29/19 at 8:18am revealed:
-Salt and pepper were usually on every table at every meal.
-She was not aware that Resident #5 was on a No Added Salt diet.

Interview with a Personal Care Aide (PCA) on 08/30/19 at 12:15pm revealed she did not know that Resident #5 was on a No Added Salt diet.

Interview with Resident #5's Hospice provider on 08/29/19 at 10:30am revealed she did not know why Resident #5 was on a No Added Salt diet.

Interview with the Administrator on 08/29/19 at 4:40pm revealed:
-Clinical staff would communicate to the dining room staff about any resident who should not use the salt shaker.
-It was her expectation that kitchen staff and dining room staff would follow all diet orders.

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The facility failed to serve therapeutic diets as ordered to 4 of 5 sampled residents, which included an ordered puree diet for Resident #2,

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D 310	Continued From page 21 who was served a ground diet, which caused her to forcibly cough causing food to be expelled on to the table. These failures were detrimental to the health and safety of these residents, which constitutes a Type B Violation. ______________________________ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/29/19 for this violation.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Review of Resident #3's current FL2 dated 03/19/19 revealed diagnoses included Alzheimer's, hypercholesterolemia, hypertension and Vitamin B12 deficiency.	D 344		

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Review of Resident #3's record revealed:
-There was an order from the Hospice nurse dated 06/05/19 for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-There was a prescription written by the Hospice physician dated 06/05/19 for lorazepam 0.5mg, one tablet to be taken every 6 hours for anxiety or agitation.

Review of Resident #3's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-There were no doses of lorazepam documented as administered from 07/01/19 through 07/31/19.
-There was not an entry for lorazepam 0.5mg, one tablet to be taken every 6 hours for anxiety or agitation.

Review of Resident #3's August 2019 eMAR revealed:
-There was an entry for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-There were no doses of lorazepam documented as administered from 08/01/19 through 08/31/19.
-There was not an entry for lorazepam 0.5mg, one tablet to be taken every 6 hours for anxiety or agitation.

Observation of medications on hand for Resident #3 on 08/29/19 at 9:00am revealed:
-Lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation was not available for administration.
-Lorazepam 0.5mg, one tablet to be taken every

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6 hours for anxiety or agitation was not available for administration.

Interview with a medication aide (MA) on 08/29/19 at 9:00am revealed:
-She did not know why lorazepam was not available for administration.
-The lorazepam prescription written by the Hospice physician was required by the pharmacy to fill the prescription.
-When she received the written prescription, she did not recognize that it had been written as a scheduled medication instead of an as needed medication.
-When the facility received conflicting orders for the same medication, their policy was to call the physician for clarification of the order.
-She did not call the physician or the Hospice nurse to get clarification of the order.

Telephone interview with a representative from the facility's contracted pharmacy on 08/29/19 at 9:57am revealed:
-The pharmacy received the order written by the Hospice nurse on 06/05/19 for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-The pharmacy called the facility to get a written prescription from the Hospice physician in order to fill the prescription.
-The pharmacy never received a prescription for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-The pharmacy received a prescription from the Hospice physician on 06/05/19 for lorazepam 0.5mg, one tablet to be taken every 6 hours for anxiety or agitation.
-The pharmacy entered the prescription into Resident #3's pharmacy profile but never sent any lorazepam to the facility.

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-She did not know why the lorazepam was never sent to the facility and only placed in the resident profile.
-The facility would call the pharmacy if they realized a medication had not been delivered and they did not have a medication on hand.
-Pharmacy records did not show that any contact was made from the facility regarding the lorazepam prior to 08/29/19.
-Pharmacy records indicated the facility contacted them on 08/29/19 at 9:50am to see why lorazepam had never been sent to the facility.

Interview with Resident #3's Hospice nurse on 08/29/19 at 10:30am revealed:
-She wrote the order for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation on 06/05/19.
-She contacted the Hospice physician to get a written prescription for lorazepam 0.5mg, one tablet to be taken every 6 hours as needed for anxiety or agitation.
-She brought the prescription to the facility but did not realize that it had been written as a scheduled medication rather than an as needed medication.
-It was never her intention for Resident #3 to receive lorazepam 0.5mg, one tablet to be taken every 6 hours for anxiety or agitation on a scheduled basis.
-Her expectation was the facility would contact her if a medication order needed clarification.

Interview with a medication aide (MA) on 08/30/19 at 10:29am revealed:
-She and other MAs were responsible for processing new medication orders.
-She was responsible for entering the order on the electronic Medication Administration Record (eMAR) and attaching the order to a new order tracking form.

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-She audited to the medication carts every Wednesday that she worked to make sure all medications were available for each resident.
-She was not sure all the MAs audited the carts.

Interview with the Resident Care Coordinator (RCC) on 08/30/19 at 11:51am revealed:
-The MAs were responsible for letting her or Resident Care Director (RCD) know if a resident had a new physician's order.
-The facility did not have a set audit procedure to review new physician's orders.
-She and the RCD relied on the MA's to let them know about new physician's orders.
-She or the RCD was responsible for auditing the medication cart weekly.
-The third shift MA was responsible for making sure all medications that was ordered from the pharmacy was delivered.

Interview with the RCD on 08/29/19 at 3:30pm revealed:
-The MAs were responsible for processing new physician orders.
-The MAs were responsible for faxing the order to the pharmacy and entering the order into the eMAR.
-The MAs were responsible for copying the physician's order, attaching it to a new order tracking form, and putting it in a box for the RCC or RCD to review.
-She or the RCC were responsible for making sure the medication was available for administration and the order was entered correctly on the eMAR.

Interview with the Administrator on 08/29/19 at 4:50pm revealed:
-She did not know that lorazepam was not available if Resident #3 had needed it.

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D 344	Continued From page 26 -The MAs were responsible for administering medications as ordered by the physician. -The MAs were responsible for processing all new medication orders. -The MAs were responsible for ensuring each medication order was tracked using a new order tracking form.	D 344		
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: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 4 of 6 sampled residents (#1, #4, #5 and #6) related to a medication to treat diabetes (#6), medication to	D 358		

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treat behaviors (#5), a medication used to treat insomnia (#1) and a medication to treat gastro-esophageal reflux disease (#4).

The findings are:

1. Review of Resident #6's current FL2 dated 03/29/19 revealed:
-Diagnoses included diabetes, Alzheimer's Disease, hypertension, and hypothyroidism.
-There was a physician's order for Novolog inject 6 units twice daily (fast acting insulin used to control blood sugar).

Review of Resident #6's physician's orders revealed a physician's order dated 07/29/19 for Novolog 8 units three times daily.

Review of Resident #6's physician's orders revealed a physician's order dated 07/31/19 for Novolog used for sliding scale insulin; if fingerstick blood sugar (FSBS) is 201-250 give 4 units, FSBS 251-300 give 6 units, FSBS 301-350 give 8 units, FSBS 351-400 give 10 units, FSBS 401-450 give 12 units; FSBS 450-500 give 16 units and call provider.

Review of Resident #6's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated physician's order for Novolog inject 6 units twice daily scheduled to be administered at 9:30am and 1:30pm.
-Novolog 6 units was documented as administered twice daily from 07/01/19 to 07/29/19.
-Novolog 6 units was documented as discontinued on 07/29/19
-There was a computer-generated physician's

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order for Novolog inject 8 units three times daily scheduled to be administered at 9:00am, 2:00pm, and 9:00pm.
-Novolog 8 units was documented as administered on 07/30/19 to 2:00pm on 07/31/19.
-Novolog 8 units was documented as administered on 07/31/19.
-FSBS ranged from 155 to 362 at 9:30am, 167 to 449 at 1:30pm, and 168 to 515 at 6:30pm.

Review of Resident #6's August 2019 eMAR revealed:
-There was no computer-generated physician's order for Novolog inject 8 units three times daily or Novolog inject 6 units twice daily.
-FSBS ranged from 130 to 312 at 9:00am, 143 to 343 at 2:00pm, and 226 to 561 at 6:30pm.

Observation of medications on hand for Resident #6 on 08/30/19 at 10:32am revealed:
-There was 1 partially used vial of Novolog opened on 08/09/19 available to administer to Resident #6.
-The Novolog was dispensed from Resident #6's pharmacy on 05/08/19.

Telephone interview with a pharmacy technician at Resident #6's pharmacy on 08/30/19 at 10:08am revealed:
-The pharmacy dispensed a three months supply of Novolog to Resident #6 on 05/08/19 and 08/29/19 with the directions inject 6 units three times daily.
-The pharmacy never received a physician's order increasing Resident #6's Novolog to 8units three times daily.

Interview with a medication aide (MA) on 08/30/19 at 12:10pm revealed:
-She did not know Resident #6 had a physician's

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D 358	Continued From page 29 order for a scheduled dose of Novolog at each meal. -She did not remember Resident #6 having an order for Novolog 6 units twice daily. -Resident #6 usually received insulin on a regular basis because her fingerstick blood sugar (FSBS) was usually elevated. Interview with the Resident Care Director (RCD) on 08/29/19 at 3:40pm revealed: -She knew Resident #6 had an order for a scheduled Novolog dose. -She thought the physician's order for the sliding scale Novolog replaced the order for the scheduled dose. Telephone interview with a nurse from Resident #6's Endocrinology office on 08/29/19 at 4:58pm revealed: -Resident #6 was supposed to receive Novolog 8 units three times daily along with a sliding scale dose at each meal. -Resident #6's Novolog dose was increased due to elevated FSBS readings. -If Resident #6 did not get the correct dose of insulin then it would lead to high blood sugars which could be dangerous for the resident. Refer to the interview with a MA on 08/30/19 at 10:29am. Refer to the interview with the RCC on 08/30/19 at 11:51am. Refer to the Interview with the RCD on 08/29/19 at 3:30pm. Refer to the interview with the Administrator on 08/29/19 at 4:50pm.	D 358		

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2. Review of Resident #5's current FL2 dated 04/04/19 revealed diagnoses included dementia, chronic obstructive pulmonary disease (COPD) and lung cancer.

Review of Resident #5's record revealed a signed physician's order dated 05/21/19 for Seroquel 25mg take 1 tablet at bedtime (used to treat behaviors).

Review of Resident #5's June, July, and August 2019 electronic Medication Administration Records (eMARs) revealed there was no physician's order for Seroquel 25mg.

Observation of medications on hand for Resident #5 on 08/29/19 at 3:12pm revealed there was no Seroquel 25mg available to administer.

Telephone interview with a pharmacist from Resident #5's pharmacy on 08/30/19 at 9:20am revealed the pharmacy did not have a physician's order for Seroquel dated 05/21/19 for Resident #5.

Telephone interview with Resident #5's Power of Attorney on 08/30/19 at 9:15am revealed:
-Resident #5 was having disruptive behaviors "recently."
-He had gotten in an argument with his roommate in July that resulted in two broken bones in his hand.
-She had requested a room change and Resident #5 was currently not having any problems with his new roommate.

Interview with a medication aide (MA) on 08/29/19 at 3:22pm revealed:
-Resident #5 did not have a physician's order for Seroquel.

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-She had never administered Seroquel to Resident #5.
-She did not remember seeing the physician's order for Seroquel dated 05/21/19.

Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 3:12pm revealed she did not know Resident #5 had a physician's order for Seroquel dated 05/21/19.

Interview with the Resident Care Director (RCD) on 08/29/19 at 3:30pm revealed:
-She knew Resident #5 had a physician's order for Seroquel.
-She remembered Resident #5's Hospice Nurse discussing the resident having behaviors and needed the medication.
-Resident #5 was refusing showers and had pushed his walker into the Activities Director.

Interview with a nurse from Resident #5's Hospice provider's office on 08/29/19 at 3:37pm revealed:
-She did not know Resident #5 was not being administered Seroquel.
-Resident #5 was prescribed Seroquel because he was having behaviors.
-Resident #5 needed to be on the medication because it would help reduce his behaviors and help with his cooperation.
-She was considering the need to increase the dose of the medication because the resident had continued having behaviors.
-Seroquel was important to calm the resident down and keep his behaviors controlled.

Based on observations, record reviews, and interviews, it was determined that Resident #5 was not interviewable.

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Refer to the interview with a MA on 08/30/19 at 10:29am.

Refer to the interview with the RCC on 08/30/19 at 11:51am.

Refer to the Interview with the RCD on 08/29/19 at 3:30pm.

Refer to the interview with the Administrator on 08/29/19 at 4:50pm.

3. Review of Resident #1's current FL2 dated 07/22/19 revealed diagnoses included Alzheimer's Disease, anxiety, diabetes, and atrial fibrillation.

Review of Resident #1's physician's order dated 08/26/19 revealed an order for temazepam 15mg take 1 tablet at bedtime as needed for insomnia.

Review of Resident #1's August 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a order for temazepam 15mg take 1 tablet daily as needed for insomnia with a start date of 08/27/19.
-There were no doses of temazepam documented as administered from 08/27/19 to 08/30/19.

Observation of medication on hand for Resident #1 on 08/29/19 at 3:30pm revealed there was no temazepam 15mg available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/30/19 at 11:01am revealed:
-The pharmacy had never dispensed temazepam to Resident #1.

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-The pharmacy had received an order on 08/28/19 for temazepam 15mg but the order did not contain a quantity to dispense.
-The pharmacy had contacted the facility to let them know the physician's order could not be filled without a quantity.
-The facility was responsible for contacting the physician to get the medication corrected so the pharmacy could dispense the medication.

Interview with a medication aide (MA) on 08/30/19 at 12:50pm revealed:
-She did not think Resident #1 was having any problems sleeping.
-No notes were documented on the last 24-hour report regarding Resident #1 having trouble sleeping.
-She did not know why the temazepam was not available to administer to Resident #1.
-She did not know Resident #1 had an order for temazepam.
-The MAs were responsible for faxing new medication orders to the pharmacy for the medications to be delivered to the facility.

Interview with the Resident Care Coordinator (RCC) on 08/30/19 at 11:50am revealed she did not know Resident #1 had an order for temazepam and the medication was not available to be administered.

Interview with the Resident Care Director (RCD) on 08/29/19 at 4:45pm revealed:
-She knew Resident #1 had a new medication order for temazepam.
-She remembered faxing the order to the pharmacy.
-She did not know why the pharmacy did not deliver the medication to the facility.
-The MAs were responsible to let her or the RCC

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know if a medication was not available so they could call the pharmacy.

Interview with the Administrator on 08/29/19 at 4:50pm revealed:
-The MAs were responsible for faxing new medication orders to the pharmacy by 5pm daily to make sure the medication was delivered in the nightly delivery.
-She did not know Resident #1 had a new medication order for temazepam written on 08/26/19 and then medication was still not available to administer on 08/29/19.

Based on observations, record reviews, and interviews, it was determined that Resident #1 was not interviewable.

Attempted telephone interview with Resident #1's primary care provider on 08/30/19 a 11:16am was unsuccessful.

Refer to the interview with a MA on 08/30/19 at 10:29am.

Refer to the interview with the RCC on 08/30/19 at 11:51am.

Refer to the Interview with the RCD on 08/29/19 at 3:30pm.

Refer to the interview with the Administrator on 08/29/19 at 4:50pm.

4. Review of Resident #4's current FL2 dated 06/11/19 revealed diagnoses included diabetes, hypothyroidism, and constipation.

Review of a clarification order for Resident #4 dated 06/11/19 revealed a physician's order for

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Zantac 150mg take 1 tablet at bedtime.

Review of Resident #4's July 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Zantac 150mg take 1 tablet daily scheduled to administer at 9:00pm.
-Zantac 150mg was documented as administered at 9:00pm daily from 07/01/19 to 07/31/19.

Review of Resident #4's August 2019 eMAR revealed:
-There was a entry for Zantac 150mg take 1 tablet daily scheduled to administer at 9:00pm.
-Zantac 150mg was documented as administered at 9:00pm daily from 08/01/19 to 08/13/19, 08/15/19, 08/20/19 to 08/21/19, 08/24/19, and 08/27/19.
-Zantac 150mg was not documented as administered for 9 out of 27 opportunities and was documented on either "on hold" or "see nurses notes."

Observation of medications on hand for Resident #4 on 08/29/19 at 10:18am and 8/30/19 at 10:32 am revealed there was no Zantac 150mg available to administer.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/30/19 at 11:01am revealed:
-The pharmacy had last dispensed a 30-day supply of Zantac to Resident #4 on 07/22/19.
-This was the only time the pharmacy had dispensed Zantac to Resident #4.

Interview with the Resident Care Coordinator (RCC) on 08/29/19 at 10:28am and 08/30/19 at 11:51am revealed:

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-Zantac for Resident #4 was "on order" from the pharmacy and should be in before the next scheduled dose.
-The Zantac had been ordered on 08/29/19.
-She did not know the Zantac was still not available to be administered to Resident #4 on 08/30/19.
-She had ordered a refill of Zantac for Resident #4 from the pharmacy on 08/29/19 and did not know why it was not delivered.

Interview with the Administrator on 08/29/19 at 4:50pm revealed she did not know Resident #4 did not have Zantac available to be administered.

Based on observations, record reviews, and interviews, it was determined that Resident #4 was not interviewable.

Attempted telephone interview with Resident #4's primary care provider on 08/30/19 a 11:16am was unsuccessful.

Refer to the interview with a MA on 08/30/19 at 10:29am.

Refer to the interview with the RCC on 08/30/19 at 11:51am.

Refer to the Interview with the RCD on 08/29/19 at 3:30pm.

Refer to the interview with the Administrator on 08/29/19 at 4:50pm.

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Interview with a medication aide (MA) on 08/30/19 at 10:29am revealed:
-She and other MAs were responsible for processing new medication orders.

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-She was responsible for entering the order on the electronic Medication Administration Record (eMAR) and attaching the order to a new order tracking form.
-She and other MAs were responsible for faxing medication refill request to the pharmacy when a resident's medication was running out.
-The medications could be refilled through the eMAR but the refill request needed to be faxed to the pharmacy also.
-She audited to the medication carts every Wednesday that she worked to make sure all medications were available for each resident.
-She was not sure all the MAs audited the carts.

Interview with the Resident Care Coordinator (RCC) on 08/30/19 at 11:51am revealed:
-The MAs were responsible for letting her or Resident Care Director (RCD) know if a resident had a new physician's order.
-The facility did not have a set audit procedure to review new physician's orders.
-She and the RCD relied on the MA's to let them know about new physician's orders.
-She or the RCD was responsible for auditing the medication cart weekly.
-The MAs were responsible for contacting the pharmacy to refill medications.
-The third shift MA was responsible for making sure all medications that was ordered from the pharmacy was delivered.

Interview with the RCD on 08/29/19 at 3:30pm revealed:
-The MAs were responsible for processing new physician orders.
-The MAs were responsible for faxing the order to the pharmacy and entering the order into the eMAR.
-The MAs were responsible for copying the

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physician's order, attaching it to a new order tracking form, and putting it in a box for the RCC or RCD to review.
-She or the RCC were responsible for making sure the medication was available for administration and the order was entered correctly on the eMAR.

Interview with the Administrator on 08/29/19 at 4:50pm revealed:
-The MAs were responsible for administering medications as ordered by the physician.
-The MAs were responsible for processing all new medication orders.
-The MAs were responsible for ensuring each medication order was tracked using a new order tracking form.
-The RCD or the RCC were responsible for checking that each medication order was entered on the eMAR correctly and to make sure the medication was delivered to the facility.

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The facility failed to administer medications as ordered for Resident #5 that did not have a medication for behaviors available and continued to refuse personal care and had an altercation with a roommate, Resident #6 was not administered the correct dose of insulin and had multiple elevated fingerstick blood sugar readings, Resident #1 had a medication for insomnia and Resident #4 a medication for acid reflux that was not available for administration. This failure was detrimental to the health, safety and welfare for the residents and constitutes a Type B violation.

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A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 08/29/19 for this violation.

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D 358	Continued From page 39 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 14, 2019.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to administering medication as ordered by a physician and serving meals based on therapeutic diets ordered by physician. The findings are: 1. Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 4 of 6 sampled residents (#1, #4, #5 and #6) related to a medication to treat diabetes (#6), medication to treat behaviors (#5), a medication used to treat insomnia (#1) and a medication to treat gastro-esophageal reflux disease (#4). [Refer to Tag 358, 10A NCAC 13F 0.1004(a) Medication	D912		

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D912	Continued From page 40 Administration (Type B Violation)]. 2. Based on observations, interviews and record reviews the facility failed to assure therapeutic diets were served as ordered for 4 of 5 sampled residents (#1, #2, #4 and #5) who had physician orders for a carbohydrate controlled diet (#1 and #4), a puree diet (#2) and a no added salt diet (#5) [Refer to Tag 310, 10A NCAC 13F 0.0904(e)4 Nutrition and Food Service (Type B Violation)].	D912		
D922	G.S. 131D-21(12) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide accessible lockable space to residents related to locking closet doors in bedroom and not providing keys to residents. The findings are: Interviews with residents during the initial tour of the facility on 08/28/19 between 10:00am and 11:16am revealed: -"I don't understand why they locked my closet."	D922		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049021	A. BUILDING: ______ B. WING ______	R 08/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D922	Continued From page 41	D922		

-"My most valuable items are in the closet and I can't get to them."
-"It is really important to me that I get my closet door open today."
-She was not told why her closet door was locked.

Interview with a personal care aide (PCA) on 08/28/19 at 10:25am revealed:
-All the closets in the facility were supposed to be locked to prevent a resident's personal belongings from being stolen by another resident.
-They had "always kept the closet doors locked."
-If a resident needed something from their closet then a staff member would open it for them.
-The staff would make sure the residents had a coat if they were cold.

Observation of multiple resident rooms on 08/28/19 and 08/30/19 revealed 7 of 8 rooms checked had the closet door locked.

Interview with a medication aide (MA) on 08/30/19 at 10:32am revealed:
-The closet doors inside the resident's room should always be locked.
-The closet doors were locked so the residents "do not steal each other's stuff."
-The MA's, Personal Care Aide's (PCA), and the managers had keys to the residents' closet.
-The resident just had to ask to get access to the items inside the closet.

Telephone interview with a resident's guardian on 08/30/19 at 10:00am revealed
-Her family members closet was always locked.
-She never requested that the closet remain locked.
-She was informed that it was the facility policy to keep closet doors locked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D922	Continued From page 42	D922		

Interview with a housekeeper on 08/30/19 at 11:17am revealed all closets should be locked so residents can not wander into someone elses room and take clothes that are not theirs.

Interview with a resident's Power of Attorney revealed she had requested her family members closet door be locked but did not remember filling out any paperwork.

Interviews with the Resident Care Coordinator (RCC) on 08/28/19 at 10:05am and 08/30/19 at 11:51am revealed:
-The residents families had to request to have the closet door locked and it should be documented in the resident's record.
-There were only four families that had requested for the closet door to be locked.
-All the other closet doors in the facility should be unlocked.

Review of multiple residents' records revealed no documentation regarding a Power of Attorney or responsible person's request to have the closet door locked.

Interview with the Administrator on 08/30/19 at 12:30pm revealed:
-The closet door in each of the resident's room should be unlocked.
-The family can request for the closet door to be locked in a resident's room.
-This request should be documented in the resident's record.