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PINE FOREST REST HOME	3277 HWY 35 WOODLAND, NC 27897

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D 000	Initial Comments The Adult Care Licensure Section and the Northhampton County Department of Social Services conducted an annual and follow-up survey on 09/18/19-09/19/19.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 5 sampled staff (Staff D and Staff B) had a criminal background check completed prior to hire. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired as a medication aide (MA) on 03/01/19. -There was no consent to a criminal background check in the record. -There was no documentation of a criminal background check for Staff D, prior to her hire date of 03/01/19. Attempted telephone interview with Staff D on 09/19/19 at 12:50pm was unsuccessful. Interview with the Administrator on 09/19/19 at 12:45pm revealed: -She was responsible for ensuring criminal background checks were completed prior to hire for all staff. -Staff D's previous hire date at this facility was	D 139		

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D 139	Continued From page 1 09/06/17. -A criminal background check was documented as completed on 10/13/17. -The criminal background check dated 10/13/17 was in Staff D's personnel file. -Upon re-hire, the Administrator thought the original background check for Staff D was sufficient. 2. Review of Staff B's personnel record revealed: -She was hired on 07/15/19. -She was hired as a personal care aide (PCA). -There was no consent for a criminal background check in the record. -There was no criminal background check in the record. Interview with Staff B on 09/19/19 at 12:31pm revealed: -She had not consented to a criminal background check. -She was aware that she needed to have a criminal background check completed. -She was waiting on the Administrator to complete the paperwork for the criminal background check. Interview with the Administrator on on 09/19/19 at 12:15pm revealed: -Background checks were supposed to be completed upon hire. -The background checks that were ordered took two weeks to be completed and she never followed-up with getting the results. -The background check should have been completed before staff were hired, "that is my fault".	D 139		

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D 273	Continued From page 2	D 273		
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, interviews and record reviews, the facility failed to assure referral and follow-up to meet the healthcare needs for 1 of 3 sampled residents (Resident #2) regarding a follow-up appointment with the primary care provider (PCP) for lab work. The findings are: Review of Resident #2's current FL-2 dated 07/12/19 revealed: -Diagnoses included atrial fibrillation, coronary artery disease and hyperlipidemia. -There was a physician's order for warfarin sodium (used to treat and prevent blood clots) 5mg one tablet every Tuesday and Thursday. -There was a physician's order for warfarin sodium 5mg half tablet every Monday, Wednesday, Friday, Saturday, and Sunday. Review of Resident #2's record revealed: -There was an appointment reminder for an endoscopy and colonoscopy on 08/28/19 with a written note stating, "stop blood thinner 08/23/19".	D 273		

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-There was a physician's order written by the general surgeon dated 08/28/19 for Resident #2's coumadin to be held until after appointment with the primary care provider (PCP).
-Resident #2 had an appointment with the PCP on 09/03/19.
-On 09/03/19, there was an order written by the PCP to resume warfarin at prior dose, recheck INR in two weeks (international normalized ratio; a measure of the effectiveness of warfarin to prevent blood clots. Depending on the condition being treated, a desired INR range would be 2.0 to 3.0.).
-Review of a progress note dated 09/03/19 revealed there was a telephone order given by the general surgeon to hold warfarin until follow-up appointment on 09/05/19.
-Review of physician's order dated 09/05/19 by the general surgeon revealed Resident #2 was to resume warfarin as ordered by PCP.
-There was no documentation Resident #2 had an INR within 2 weeks as ordered by the PCP.
-There was no documentation Resident #2 attended an appointment with the PCP within 2 weeks as ordered.

Interview with Resident #2's PCP on 09/19/19 revealed:
-Resident #2 had an appointment scheduled 09/17/19 and the resident did not show up to the appointment.
-The office manager always called to give the facility a reminder of all appointments and the resident still did not attend the appointment.
-The appointment scheduled 09/17/19 was to check the INR result as the resident had recently resumed his warfarin.
-He wanted to ensure the residents INR was within normal range.
-Without checking the INR he was unsure if the

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resident was at risk for a negative outcome.
-Warfarin had some variability; "if the INR was too low there would be at risk for a stroke, too high there would be at risk for bleeding".

Interview with a medication aide (MA)/Supervisor) on 09/19/19 at 10:15am revealed:
-She wrote the progress note on 09/03/19 for Resident #2 to get his INR checked in 2 weeks.
-She did not remember scheduling an appointment for Resident #2 to get his INR checked on 09/17/19.
-She kept up with resident appointments in the communication binder.
-She did not know why Resident #2 did not attend his appointment scheduled 09/17/19.
-Resident #2 drives himself to his appointments, "I don't know what happened".
-MA/Supervisors were responsible for documenting appointments in the black binder and on the facility appointment calendar and ensuring residents attending appointments.

Review of the facility appointment calendar on 09/19/19 revealed Resident #2's appointment scheduled 09/17/19 had not been documented.

Review of the facility's communication binder revealed appointment for Resident #2 was scheduled with the PCP on 09/17/19.

Interview with the Administrator on 09/19/19 at 10:45am revealed:
-She expected residents to attend appointments as scheduled.
-She did not know Resident #2 had an appointment scheduled 09/17/19 for lab work.
-Resident #2's appointment should have been recorded on the facility calendar by the MA/supervisor.

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D 273	Continued From page 5 -Resident #2 should have been reminded of his appointment. Attempted interview with Resident #2 on 09/19/19 at 11:45am revealed the resident was unavailable.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were free from contamination related to food packages that were not labeled or dated and food stored on the floor. The findings are: Observation of the dry food storage area in the kitchen on 09/18/19 at 8:20am revealed: -There was a bag of cereal unsealed, open to air without a date to indicate when the bag was opened. -There was a bag of chips open to air, unsealed without a date to indicate when the bag was opened. -There was a bag of non-fat milk powder open and folded without a date to indicate when the bag was opened. -There was a bag of chips ripped open, unsealed without a date to indicate when the bag was	D 283		

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opened.
-There was a bag of grits opened and folded exposed to air without a date to indicate when the bag was opened.

Observation of the kitchen on 09/18/19 at 8:30am revealed:
-There was two 50-pound bags of potatoes stored on the kitchen floor.
-There was a large cardboard box of sweet potatoes stored on the kitchen floor.

Observation of the freezer in the kitchen on 09/18/19 at 8:30am revealed:
-There was frozen chicken and pork on the bottom shelf with a dried red substance underneath the meat.
-There were frozen vegetables that had been opened with a seal that did not include a package date or a date to indicate when the bag was opened.

Observation of the refrigerator on 09/18/19 at 8:32am revealed:
-There were 10 crates of raw eggs stored above thawing meat.
-There was seven individually wrapped cakes that were sealed with plastic wrap that did not indicate a date for when the cakes were prepared.
-There was a large sliced watermelon wrapped with plastic, that did not include a date to indicate when the watermelon was sliced open.

Interview with the cook on 09/18/19 at 2:42pm revealed:
-She knew that all items opened were supposed to be dated and labeled.
-She did not know why there was undated and expired food in the refrigerator.
-She had been off three days and had not been

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D 283	Continued From page 7 able to get a complete an observation of the kitchen. -She completed a thorough observation of the kitchen when she had time. -She knew food could not be stored on the floor, she would move the items when another staff member could help her. -She did not know why the bottom of the refrigerator was dirty underneath the meat, she had not noticed the red substance. -She and another cook were responsible for ensuring food was free of contamination. -She did not realize eggs had to be stored on the bottom shelf. Interview with the Administrator on 09/19/19 at 10:45am revealed: -The cook was responsible for cleaning the refrigerator/freezer every two days. -She expected the cooks to date all food when it was opened and ensure that food was sealed in a container. -She expected staff to ensure food was not stored on the floor and was placed on a shelf. -She expected eggs to be stored on the bottom shelf to prevent contamination of other food.	D 283		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by:	D 292		

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D 292	Continued From page 8 Based on observations, interviews, and record review the facility failed to appropriately substitute foods as listed on the scheduled menu that were of equal nutritional value. The findings are: Review of the substitutions log book on 09/19/19 revealed: -There were menu substitution forms completed by the cook for various dates. -A substitution form completed on 08/17/19 for the dinner meal listed chips were served in place of sweet potatoes. -A substitution form completed on 08/31/19 for the lunch meal listed butter beans was served in place of cabbage. -A substitution form completed on 09/01/19 for the lunch meal listed cake was served in place of baked apples. -A substitution form completed on 09/01/19 for the dinner meal listed pizza was served in place of vegetable friatta, and a tossed salad was served in place of rice and tomatoes. -A substitution form completed on 09/04/19 for the lunch meal listed cupcakes were served in place of "berry up". -A substitution form completed on 09/05/19 for the lunch meal revealed onion rings were served in place of rice. Interview with a resident on 09/18/19 at 9:39 am revealed the food was unhealthy and the fruit and vegetables served was limited. Review of the breakfast menu for 09/19/19 revealed cereal of choice, fresh fruit, eggs, bacon, pancakes, milk, coffee and tea were to be served.	D 292		

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D 292	Continued From page 9 Observation of the breakfast meal service on 09/19/19 from 8:00am-8:45am revealed the residents were served 2 hash brown patties in place of pancakes. Interview with the cook on 09/19/19 at 8:24am revealed: -She came into work late and did not have time to prepare pancakes. -She did not know if the hash browns were of equal nutrition value to pancakes. Observation of the kitchen on 09/19/19 revealed there was pancake mix available to be prepared to be served to the residents. Interview with the cook on 09/18/19 at 2:42pm revealed: -She substituted meals when she did not have time to serve what was on the menu or if foods were not available. -There were times when the residents did not want what was on the menu and she prepared something different. -She did not have any reference sheet to help her determine appropriate substitutions. -She did not know the contracted dietician and had never reached out to her regarding appropriate substitutions. Interview with the Administrator on 09/19/19 at 10:45am revealed: -She knew there was a problem with appropriate substitutions. -"We try to order based on the menus and sometimes the residents don't like what is on the menu". -Recipes were made available for the cook to follow and the cook would not follow the menus. -She expected the cook to discuss with her when	D 292		

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D 292	Continued From page 10 she was substituting foods to ensure that it was of equal nutritional value. Attempted telephone interview with the contracted Registered Dietician on 09/19/19 at 10:10am was unsuccessful.	D 292		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water was served to residents during the breakfast meal, in addition to other beverages. The findings are: Observation of the breakfast meal service on 09/18/19 at 8:25am revealed: -There were 18 place settings prepared for the residents by staff. -There were pre-poured beverages on the dining tables prior to residents entering the dining room. -All place settings had one serving of orange or cranberry juice. -Residents received a cup of coffee upon request. -One resident was pre-poured water. -None of the other 17 residents served in the dining room received water in addition to their	D 306		

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D 306	Continued From page 11 other beverages. Observation of the breakfast meal service on 09/19/19 from 8:00am to 8:45am revealed: -There were 18 place settings prepared for the residents by staff. -There were pre-poured beverages were on the dining tables prior to residents entering the dining room. -All place settings had one serving of orange or cranberry juice. -Residents received a cup of coffee upon request. -One resident was pre-poured water. -None of the other 17 residents served in the dining room received water in addition to their other beverages. Interviews with three residents on 09/18/19 revealed: - "We are served water sometimes, but not at every meal" - "I like water, I would drink it at every meal". - "We get water every other day, a lot of people don't drink it". - "I feel like I get enough to drink, I will drink water sometimes". Interview with the cook on 09/19/19 at 10:00am revealed: -She knew residents were supposed to receive water at each meal. - "I can't believe I forgot to serve them water, it was my fault it was an oversight". -She was responsible for preparing drinks and giving them to the personal care aides (PCAs) to put on the table. Interview with the Administrator on 09/19/19 at 10:45am revealed:	D 306		

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D 306	Continued From page 12 -She expected residents to receive water at each meal. -The cook was responsible for preparing the drinks for residents and ensure that water was served. -She had not noticed water was not served during breakfast. -The cooks knew that water was supposed to be served at each meal.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure a therapeutic diet list was maintained for the guidance of dietary staff for 1 of 5 sampled residents (Resident #5) who had a physician's order for a 2-gram sodium diet. The findings are: Review of Resident #5's current FL2 dated 06/27/19 revealed diagnoses included prostate cancer, neuropathy, constipation, acid reflux. Review of hospital discharge paperwork for Resident #5 dated 08/08/19 revealed:	D 309		

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D 309	Continued From page 13 -Resident #5 had a diagnosis of transient ischemic attack and essential hypertension. -There was a diet order for a low sodium (2-gram sodium) diet. Review of the therapeutic diet list (undated) posted in the kitchen on 09/18/19 revealed Resident #5 was to be served no pasta, white rice, milk, or cheese. Interview with the cook on 09/18/19 at 2:42pm revealed: -She thought Resident #5 was ordered a regular diet with pasta, white rice, milk, and cheese restrictions as listed on the diet list. -She did not know Resident #5 was ordered a 2-gram sodium diet. -She relied on the MA/supervisors and the Administrator to update her with new diet orders. Interview with the medication aide(MA)/Supervisor on 09/19/19 at 10:15am revealed: -When a new diet order was received, she made a copy of the order and gave it to the cook and to the Administrator. -She worked as the MA/Supervisor on 08/08/19 when the updated diet order was received for Resident #5. -She knew about the updated diet order for Resident #5, however was not sure why the diet order did not make it to the cook or the Administrator. -She could not remember if she gave the updated diet order to the Administrator. Interview with the Administrator on 09/19/19 at 10:45am revealed: -She did not know Resident #5 was ordered a 2-gram sodium diet.	D 309		

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D 309	Continued From page 14 -The MA/Supervisors were responsible for notifying her when there was an updated diet. -She always asked the MA/Supervisors of new diet orders in morning meetings and no one informed her of the change. -She was responsible for updating the diet list and providing an updated list to the cook when new diet orders were received. -She did not go through resident's records; she expected her staff to notify her if there was a change.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure 3 of 5 sampled residents with therapeutic diet orders for a no concentrated sweets (NCS) (#1 and #3), a 2-gram sodium diet (#5) were served as ordered. The findings are: Observation of the kitchen during the initial tour on 09/18/19 at 8:30am revealed there was a binder with the regular menu and therapeutic extension spreadsheets on the counter across from the food preparation area. 1. Review of Resident #1's current FL2 dated 08/29/19 revealed:	D 310		

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-Diagnoses included diabetes mellitus, chronic obstructive pulmonary disease (COPD) and acquired hemolytic anemia.
-There was a diet order for a mechanical soft diet.

Review of a physician's order for Resident #1 dated 09/07/19 revealed an order for a NCS diet.

Review of the therapeutic diet list (undated) posted in the kitchen on 09/18/19 revealed Resident #1 was listed to be served a NCS diet.

Review of the facility's therapeutic diet extensions spreadsheet for lunch on 09/18/19 revealed residents ordered a NCS diet were to be served beef stir fry with vegetables, fried rice, wheat dinner roll/bread, diet chocolate pudding parfait, and a diet beverage of choice.

Observation of the lunch meal service on 09/18/19 between 12:00pm and 12:41pm revealed:
-Resident #1 was served cubed steak, green beans, roll, rice, chocolate pudding, unsweetened tea, and water.
-Resident #1 consumed the lunch meal without difficulty.

Observation of the nutrition facts on the back of the chocolate pudding container revealed there were 16 grams of sugar per serving.

Interview with the cook on 09/18/19 at 2:42pm revealed:
-She followed the regular menu to prepare meals for residents ordered a NCS diet.
-She did not have a matching therapeutic menu for the NCS diet.
-She did not realize the therapeutic extension spreadsheet were instructions for a NCS diet.

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D 310	Continued From page 16	D 310		

-Residents ordered a NCS diet received desserts and unsweetened tea with their meal.
-She was instructed by the previous cook regarding how to prepare meals for residents ordered a NCS diet.
-She gave residents ordered a NCS diet regular chocolate pudding on 09/18/19 during lunch because she did not have sugar free pudding.
-She had other sugar free dessert options in the pantry, "I don't know why I gave them regular pudding".

Interview with the Administrator on 09/18/19 at 10:30am revealed:
-There was only a regular menu to reference in the facility.
-She did not know of therapeutic menus that were available.
-She thought residents who received a NCS diet were to only have unsweetened drinks and sugar free desserts.

Interview with the Administrator on 09/19/19 at 10:45am revealed:
-She did not know the therapeutic diet menu was available in the kitchen.
-She did not know a therapeutic menu was required, "I never paid attention to the rule".
-The facility was not using the menus provided by the contracted food service company "to the full extent".

Attempted telephone interview with Resident #1's primary care physician (PCP) on 09/19/19 at 9:47am was unsuccessful.

Attempted telephone interview with contracted registered dietician the 09/19/19 at 10:10am was unsuccessful.

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D 310	Continued From page 17 2. Review of Resident #3's current FL2 dated 04/30/19 revealed diagnoses included hypertension, diabetes, chronic pain. Review of physician's order dated 04/18/19 revealed there was a physician's order for a NCS diet. Review of the therapeutic diet list (undated) posted in the kitchen on 09/18/19 revealed Resident #3 was listed to be served a NCS diet. Review of the facility's therapeutic diet extensions spreadsheet for lunch on 09/18/19 revealed residents ordered a NCS diet were to be served beef stir fry with vegetables, fried rice, wheat dinner roll/bread, diet chocolate pudding parfait, and a diet beverage of choice. Observation of the lunch meal service on 09/18/19 between 12:00pm and 12:41pm revealed: -Resident #3 was served cubed steak, green beans, roll, rice, chocolate pudding, unsweetened tea, and water. -Resident #3 consumed the lunch meal without difficulty. Observation of the nutrition facts on the back of the chocolate pudding container revealed there were 16 grams of sugar per serving. Review of the facility's therapeutic diet extensions spreadsheet for breakfast on 09/19/19 revealed residents ordered a NCS diet were to be served cereal of choice, fresh fruit, egg, bacon, pancakes, skim milk, coffee or hot tea. Observation of the breakfast meal service on 09/19/19 from 8:00am to 8:45am revealed:	D 310		

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-Resident #3 was served cereal with whole milk, a6 oz. glass of whole milk, cranberry juice, eggs, bacon, and 2 hash brown patties.
-Resident #3 consumed the breakfast meal without difficulty.

Observation of the kitchen on 09/18/19 at 8:25am revealed there was no skim milk available.

Interview with Resident #3's Primary Care Physician (PCP) 09/19/19 at 10:38am revealed:
-Resident #3 was ordered a NCS diet to keep diabetes maintained.
-Resident #3's blood sugars were maintained and well-controlled.
-He expected the NCS diet order to be followed.

Interview with Resident #3 on 09/18/19 at 9:21am revealed:
-She did not know if she was on a special diet.
-She received the same meals as everyone at her table.

Interview with the cook on 09/18/19 at 2:42pm revealed:
-She followed the regular menu to prepare meals for residents ordered a NCS diet.
-She did not have a matching therapeutic menu for the NCS diet.
-She did not realize the therapeutic extension spreadsheet were instructions an NCS diet.
-She was instructed by the previous cook regarding how to prepare meals for residents ordered a NCS diet.
-She gave residents ordered a NCS diet regular chocolate pudding on 09/18/19 during lunch because she did not have sugar free pudding.
-She had other sugar free dessert options in the pantry, "I don't know why I gave them regular pudding".

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D 310	Continued From page 19	D 310		

-She did not know residents ordered a NCS diet were to be served skim milk.

Interview with the Administrator on 09/18/19 at 10:30am revealed:
-There was only a regular menu to reference in the facility.
-She did not know of therapeutic menus that were available.
-She thought residents who received a NCS diet were to only have unsweetened drinks and sugar free desserts.
-She did know residents ordered a NCS diet was supposed to have only skim milk.

Interview with the Administrator on 09/19/19 at 10:45am revealed:
-She did not know the therapeutic diet menu was available in the kitchen.
-She did not know a therapeutic menu was required, "I never paid attention to the rule".
-The facility was not using the menus provided by the contracted food service company "to the full extent".

Attempted telephone interview with contracted registered dietician the 09/19/19 at 10:10am was unsuccessful.

3. Review of Resident #5's current FL2 dated 06/27/19 revealed diagnoses included prostate cancer, neuropathy, constipation, acid reflux.

Review of the hospital discharge paperwork dated 08/08/19 revealed:
-Resident #5 had a diagnosis of transient ischemic attach and essential hypertension.
-There was diet order for low sodium (2-gram sodium) diet.

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D 310	Continued From page 20 Review of the therapeutic diet list (undated) posted in the kitchen on 09/18/19 revealed Resident #5 was to be served no pasta, white rice, milk, or cheese. Review of the facility's therapeutic diet extensions spreadsheet for lunch on 09/18/19 revealed residents ordered a 2-gram sodium diet was to be served beef tips with vegetables, rice, no bread, a chocolate chip cookie instead of chocolate budding, and a beverage of choice. Observation of the lunch meal service on 09/18/19 from 12:00pm to 12:41pm revealed Resident #5 received cubed steak, green beans, brown rice, a dinner roll, water, tea, and chocolate pudding. Review of the facility's therapeutic diet extensions spreadsheet for breakfast on 09/19/19 revealed residents ordered a 2-gram sodium diet was to be served cereal of choice, fresh fruit, egg, no bacon, slice French toast, milk, coffee or tea. Observation of the breakfast meal service on 09/19/19 from 8:00am-8:45am revealed Resident #5 was served 1 slice of bacon, eggs, 2 has brown patties, orange juice, and coffee. Interview with the cook on 09/18/19 at 2:42pm revealed: -She followed the regular menu to prepare meals for Resident #5. -She thought Resident #5 was ordered a regular diet with pasta, white rice, milk, and cheese restrictions. -She did not know Resident #5 was ordered a 2-gram sodium diet. -She did not think the facility had a menu to follow for a 2-gram sodium diet.	D 310		

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D 310	Continued From page 21 -She relied on the MA/supervisors and the Administrator to update her with new diet orders. Interview with the Administrator on 09/19/19 at 10:45am revealed: -She did not know Resident #5 was ordered a 2-gram sodium diet. -She always asked the MA/supervisors of new diet orders in morning meetings and no one informed her of the change. -She was responsible for updating the diet list when new diet orders were received. -She did not go through resident's charts, she expected her staff to notify her if there was a change. Attempted telephone interview with contracted registered dietician the 09/19/19 at 10:10am was unsuccessful. Attempted telephone interview with Resident #5's PCP on 09/19/19 at 10:35am was unsuccessful. Attempted interview with Resident #5 on 09/19/19 at 11:15 revealed the resident was unavailable.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with dignity and respect regarding a staff member (Staff A) treating and speaking to residents in a	D 338		

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D 338	Continued From page 22 disrespectful manner. Confidential interview with a resident on 09/18/19 revealed: -There was one staff member (Staff A) that did not do anything to help. -Staff A was present at the facility on 09/18/19. -The resident felt Staff A had an attitude and did not feel that she wanted to help residents. -Staff A often did not bring ice when requested. Interview with a 2nd resident on 09/18/19 at 8:45am revealed: -Staff had spoken "rude to me". -When I asked her for help, she told me "that's not my job". - "I didn't like how she [Staff A] spoke to me". Interview with a 3rd resident on 09/19/19 at 8:45am revealed: -The best staff was scheduled to be back on duty in the facility the following day. -The staff that was there at the time was "okay." -The staff on that day "was too busy spending time on their phone and going outside to smoke." Interview with a 4th resident on 09/19/19 at 10:30am revealed: -Staff A was nice to her most of the time. -Sometimes Staff A would get "flared up and get angry" with her. -Staff A was "snappy like" at times. -Staff that were on duty all go out to smoke at the same time. She did not think that they should do that since they never knew when the residents might need them. -Staff spent too much time of their phones. Interview with Staff A on 09/19/19 at 12:01pm revealed:	D 338		

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D 338	Continued From page 23 -She worked in the facility as a personal care aide (PCA). -There were residents in the facility that were difficult and impatient, but she understood everyone had different needs. -She had not discussed how to deal with the difficult and impatient residents with the Administrator. -She tried to "keep the peace" among residents. -She assisted residents when they requested help. -She never argued with the residents, she was quiet when there were disagreements. -She knew the resident rights. -She remembered resident rights being discussed in the staff meeting "a few months ago". Interview with the Administrator on 09/19/19 at 12:15pm revealed: -She knew Staff A had an attitude, "she is the problem". -She had at least three conversations since becoming the Administrator about Staff A's attitude. -She would hear comments from residents stating the weekend went well when Staff A was not present, "the good staff was here". -She discussed treating residents with respect in weekly staff meetings. -She expected staff to treat residents with respect and complete tasks as asked.	D 338		
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	D912		

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D912	Continued From page 24 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to adult care home infection prevention requirements. The findings are: Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with Centers for Disease Control and Prevention guidelines regarding procedures to be followed when staff was exposed to bodily fluids of a resident that posed significant risk of transmission of pathogens (Resident #1) [Refer to Tag 932 10A NCAC 13F 131D-4.4(A) Adult Care Home Infection Prevention Requirements (Type B Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne	D932		

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D932	Continued From page 25 pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.	D932		

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D932	Continued From page 26	D932		

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

Based on observations, interviews, and record reviews, the facility failed to implement a written infection control policy consistent with Centers for Disease Control and Prevention guidelines regarding procedures to be followed when staff were exposed to bodily fluids of a resident that posed significant risk of transmission of pathogens (Resident #1).

The findings are:

Review of Resident #1's FL2 dated 08/29/19 revealed diagnoses included diabetes mellitus, chronic obstructive pulmonary disease (COPD) and acquired hemolytic anemia.

Observation during the initial tour on 09/18/19 at 8:10am revealed:
-Resident #1's door was closed.
-There was a computer generated sign on Resident #1's door "Isolation Precautions : Do Not Enter room without protective equipment."
-There was no direction as to the location of the protective equipment.

Review of Resident #1's record revealed:
-There was a hospital discharge summary dated 09/09/19.
-Resident #1 was sent to the emergency

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D932	Continued From page 27	D932		

department on 09/09/19 for elevated blood sugar levels.
-Resident #1 was diagnosed with hyperglycemia.
-He returned to the facility on 09/09/19 on second shift with an order for metronidazole, (an antibiotic used to treat Clostridium-Difficile-an infection of the colon).

Interview with the Administrator on 09/18/19 at 10:45am revealed:
-Resident #1 was admitted on 09/04/19 from another assisted living facility.
-The Administrator completed an assessment of Resident #1 by phone.
-Resident #1's blood sugar was very unstable, "running very high-in the 500's at times" and he was having multiple bowel movements daily.
-The Administrator sent him to the emergency department (ED) to be evaluated on 09/09/19.
-Resident #1 was diagnosed with hyperglycemia and the assessed level of care was SNF.
-The 2nd shift staff received a call from the hospital staff the following morning with a report Resident #1 was positive for Clostridium Difficile (C-Difficile).
-The hospital nurse directed the facility staff to keep Resident #1 isolated from the other residents and to be followed by a physician.

Review of the facility Care Notes revealed:
-On 09/09/19 Resident #1 returned to the facility on second shift with an order for metronidazole to treat the diarrhea.
-On 09/10/19, at 5:00am, a hospital nurse contacted the facility staff and reported Resident #1 had tested positive for C-Difficile (a bacterial infection of the colon).
-The facility staff were further instructed to isolate Resident #1 from the other residents, to institute contact precautions and to follow up with a

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D932	Continued From page 28 physician. Observation of the medication pass on 09/18/19 at 11:40am revealed: -The personal protective equipment (PPE), disposable gowns, mask and gloves, were located at the nurses station. -The medication aide (MA) put on the PPE and proceeded to Resident #1's room. -Resident #1 was lying on his right side on the bed. -Resident #1 shared a bathroom with the resident next door. -There were no biohazard bag for disposable items or a biohazard bag for the laundry in the bedroom. -The MA administered the medication to Resident #1, left the room with the protective equipment on, and returned to the medication room. -The MA removed the gown, gloves and mask and disposed of them in a green plastic trash bag. -The trash bag was draped over a cabinet and held down with a wooden decorative box. -The trash bag was left open with visible trash exposed, including the used PPE. Observation of the medication room on 09/18/19 at 2:55pm revealed the green trash bag draped over the cabinet was open with additional trash and protective equipment exposed. Interview with the first shift personal care aide (PCA) on 09/18/19 at 3:15pm revealed: -She did not know who placed the Isolation sign on Resident #1's door. -The MA instructed her to wear a disposable gown, mask and 2 pair of gloves when she entered Resident #1's room. -She put the PPE on in the medication room and	D932		

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	HAL066001	A. BUILDING: _____ B. WING _____	R 09/19/2019

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removed the PPE in the medication room after leaving Resident #1's room.
-Resident #1's soiled linens and clothes were removed in a green trash bag and brought to the community washer.
-Resident #1's clothing was washed separately from the other residents in the community.
-The clothes were washed with warm water and a small amount of bleach.
-After starting the wash cycle,she would remove the gown, gloves and mask and put them in the green trash bag in the medication room.
-When the wash cycle was completed, and while the clothes and linens were drying, she would run a rinse cycle with bleach in the washing machine.
-Resident #1 was in a room with a shared bathroom, but he was too weak to get out of bed to use the bathroom.
-He was incontinent of bowel and bladder.
-Resident #1's briefs were doubled bagged in clear plastic in his room and put in the green trash bag or taken to the dumpster.
-The kitchen prepared his meal and she brought the meal on a tray to his room.
-The kitchen staff do not use disposable utensils or dishware for residents who ate meals in their room.
-The Registered Nurse (RN) that assessed the licensed health professional services (LHPS) conducted training in infection control to the staff.
-There was a section in the training on infectious disease and PPE.

Observation of the medication room on 09/18/19 at 4:15pm revealed the green trash bag draped over the cabinet was open almost touching the floor with additional trash and protective equipment exposed.

Interview with the housekeeper on 09/19/19 at

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8:00am revealed:
-She had worked at the facility for 12 years.
-When Resident #1 was diagnosed with an illness, the MA and PCA told her to wear PPE when she went into his room to clean.
-He had urine and feces all over the room when he first arrived.
-She was not instructed as to the protocol to clean his room.
-She had a bleach and water mixture she used to clean urine and feces in the resident's rooms.
-She had not been instructed as to the ratio of bleach to water that she should use for infectious diseases-"I just add a little bleach" to the quart spray bottle used to dispense the solution.

Observation of the bleach solution in the housekeeping closet on 09/19/19 at 8:07am revealed:
-The directions on the bleach container stated it was effective in killing C-Difficile spores.
-The directions on the bleach container did not specify the ratio of bleach to water in cleaning C-Difficile contaminated surfaces.

Interview with the Administrator on 09/19/19 at 8:35 am.
-The infection control policy had not been updated "for years."
-She had assumed the position of Administrator at this facility "about a year ago."
-She has had to update all the policies and procedures during this time.
-The infection control policy was on her list to do, but she had not reviewed it as of this date.

Review of the current infection control policy revealed:
-There should be an explanation of the appropriate methods for recognizing tasks that

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may involve exposure to potentially infectious material.
-Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment (PPE) should be available (to staff).
-Hazardous waste containers were located in the linen closet.
-Infectious waste should be placed in a closeable, leakproof container or bag over the outside of the first container or bag, and color coded.
-Laundry must be bagged at the location where it was used.
-Contaminate laundry must be transported in bags or containers which are color coded according to OSHA standards.
-Contaminated laundry should be washed with 1 cup of bleach added per load.
-The washing machine will be decontaminated by running a cycle with bleach after the contaminated laundry has been washed.
-Housekeeping staff will wear PPE during cleaning areas contaminated with infectious material.
-An approved hospital disinfectant diluted between 1:10 and 1:100 with water, should be used to clean contaminated areas.

Interview with the primary care physician (PCP's) RN on 09/19/19 at 8:40am revealed:
-The physician's expectation when a resident was diagnosed with C-Difficile was isolation in a private room with contact precautions and a dedicated toilet.
-These precautions should continue for at least 48 hours after the diarrhea has stopped.
-A stool culture should be repeated.

Telephone interview with a second shift MA on 09/19/19 at 9:05am revealed:

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D932	Continued From page 32 -The MA wore PPE when she provided care or administered medications to Resident #1. -She put on the PPE in the medication room and removed these items after leaving the resident's room in a green trash bag in the medication room. -The green trash bag was on the counter, across from the medication cart, held in place with a decorative box. -If it was light outside, she brought the green trash bag to the dumpster in the back after each usage of PPE. -If it was dark outside, she waited until the end of her shift (7:00am), and brought the green trash bag to the dumpster. -When the staff removed the linens from his bed, those items, along with his soiled clothing, were placed in a plastic bag and brought to the community washing machine. -After the MA loaded the washer and set the hot water with added bleach, she removed the PPE in the medication room and disposed of the items in the green trash bag. Interview with the MA/ Supervisor on 09/19/19 at 9:45am revealed: -She knew there was something wrong with Resident #1 due to his frequent diarrhea episodes. -The MA did not know the protocol for washing clothes and linens with a resident on contact precautions in isolation. -The MA contacted a friend who worked for a Home Health agency and asked her for the protocol. -The protocol she followed was to put the clothes and the linens in a washing machine with hot water and a small amount of bleach. Then put them in the dryer. -The MA removed her PPE after placing the	D932		

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clothes in the washing machine and starting the cycle.
-She disposed of the gown, gloves and mask in the green trash bag in the medication room.
-She would take the trash bag immediately to the dumpster in the back.
-She had been following this procedure since she contacted the staff person in Home Health on 09/12/19.
-The MA would also leave Resident #1's room after performing personal care or administering medications and remove her PPE in the medication room.

Interview with the LHPS nurse on 09/19/19 at 9:55am revealed:
-She taught the North Carolina state approved infection control curriculum.
-She demonstrated how to apply and remove PPE in accordance with infection control procedures.
-She focused on gowns, gloves and masks, since that was generally used in assisted living facilities when needed.
-She instructed the staff to wash their hands before and after applying gloves.
-She gave examples of infectious disease processes where PPE may be necessary, but did not specifically go over C-Difficile.
-She covered contact precautions and isolation protocols.
-A color coded biohazard bag should be inside the room by the door of a resident on contact precautions and in isolation.
-Staff should apply clean PPE before entering the resident's room and remove PPE before leaving the resident's room.
-The PPE inside the room should be placed in a biohazard bag for disposable items.
-There should be a second biohazard bag for

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D932	Continued From page 34 soiled clothing and linens. -The clothing and linens should be brought to the laundry room in the biohazard bag and washed following Center for Disease Control (CDC) guidelines. -She did not instruct the staff to "double" glove when providing care to a resident on contact precautions. -She did not tell the staff to leave a resident's room with protective equipment on and remove the gown, gloves and mask in the medication room. -She did not tell the staff disposable PPE could be discarded in an open trash bag in the medication room. _____ The facility failed to implement a written infection control policy consistent with Centers for Disease Control and Prevention guidelines regarding procedures to be followed when staff were exposed to bodily fluids of a resident while performing personal care, administration of medication and washing of his clothing, and were disposing of contaminated articles in a manner that posed significant risk of transmission of pathogens (Resident #1). This failure was detrimental to the health, safety and welfare of the residents receiving FSBS checks and insulin injections and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S, 131D-34 on 09/19/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2019.	D932		

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D992	Continued From page 35	D992		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992		

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This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed 1 of 5 sampled staff (Staff B).

Record review of Staff B's personnel record revealed:
-She was hired on 07/15/19.
-She was hired as a personal care aide (PCA).
-There was no documentation of the examination and screening for the presence of controlled substances.

Interview with Staff B on 09/19/19 at 12:31pm revealed:
-She had not had a screening for controlled substances since starting work at the facility.
-She knew a screening for controlled substances was needed prior to employment.
-She was waiting on the Administrator to send her to get her drug screen.

Interview with the Administrator on 09/19/19 at 12:15pm revealed:
-All staff were supposed to have a controlled substance screening prior to employment.
-She knew a controlled substance screening had to be completed, however she did not get it completed.
-"I know it should have been done, it was my fault".