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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an Annual and Follow-up survey on October 1-3, 2019. | D 000 | | |
| D 075 | 10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(2) have no chronic unpleasant odors;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to assure there were no chronic urine, feces, and body odors in 2 community bathrooms on the Magnolia hallway.<br><br>The findings are:<br><br>Observation during the initial tour of the facility on 10/01/19 from 9:00am to 10:00am revealed:<br>-A strong urine odor was detected when walking down the Magnolia hallway.<br>-A strong urine odor was detected outside of the 2 community bathrooms located on the Magnolia hallway.<br><br>Review of an Environmental Health Inspection report dated 09/03/19 revealed:<br>-The facility received an overall score of 95.5.<br>-There was documentation of 1 demerit deducted for the bathing facilities not kept clean.<br><br>Observation of the facility on 10/01/19 between | D 075 | | |

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10:00am to 6:00pm revealed the 2 community bathrooms located on the Magnolia hallway continued to have a strong urine odor.

Interview with the Medication Aide (MA) on 10/01/19 at 9:47am revealed:
-The community bathrooms on the Magnolia hallway smelled like urine since she started in April 2019.
-She informed the housekeeper to mop but it did not do any good because the smell still was there.
-She informed the previous Maintenance Director (MD) but was told "it was in the flooring".
-The housekeeper mopped every day, but the smell did not leave.

Observation of the housekeeper on 10/01/19 at 10:20am revealed she was moping one of the community bathrooms with an industrial floor cleaner with a fresh scent/deodorizer.

Interview with the housekeeper on 10/01/19 at 10:20am revealed:
-She was responsible for mopping the floors in the facility.
-She used a floor cleaner with deodorizer in it.
-She mopped the community bathrooms on the Magnolia hallway every day but the urine odor came back right after she mopped.
-Moping the bathrooms every day was the only instruction she was given to get rid of the smell.

Interview with the Regional Executive Director (ED) revealed:
-He had been serving as the Regional ED to assist the Administrator of this facility for a year.
-He was aware of the urine odor in the community bathrooms on the Magnolia hallway.
- The floor in both community bathrooms was replaced after the flooding two years ago but the

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| D 075 | Continued From page 2<br>new flooring needed to be removed.<br>-He notified the flooring representative back on 04/24/19 because the vinyl flooring was not "sticking" and was rolling up.<br>-The representative determined the flooring in the community bathroom were too wet and needed to leave the vinyl down and place a thicker type of flooring over top of it.<br>-He could not put a thicker flooring over the vinyl because i would raise the floor up 1 inch and then the bathroom doors would need to be cut down in order for the doors to open, so he tried to work out something else with the flooring representative.<br><br>Attempted interview with the Administrator on 10/03/19 at 3:00pm was unsuccessful. | D 075 | | |
| D 113 | 10A NCAC 13F .0311(d) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and | D 113 | | |

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| D 113 | Continued From page 3<br>116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures higher than 116°F for 2 of 14 water fixtures (sink and showers) in residents' rooms.<br><br>The findings are:<br><br>Observations of water temperatures on 10/01/19 from 9:15am to 9:40am revealed at 9:22am, the hot water temperature at the sink in the bathroom of Room #11 was 120º F and there was visible steam when the water was running.<br><br>Observations of re-check of water temperatures on 10/01/19 from 4:35pm to 4:49pm revealed:<br>-At 4:37pm, the hot water temperature at the sink in the bathroom of Room #11 was 119.4º F.<br>-At 4:39pm, the hot water temperature at the shower in the shared bathroom of Room #11 was 116.2º F.<br><br>Based on observations, interviews and record reviews it was determined Resident #11 was not interviewable.<br><br>At 9:45am the Maintenance Director (MD) was notified of the hot water temperatures being above 116º F.<br><br>Interview with the MD on 10/01/19 at 9:45am revealed:<br>-He was hired as the MD about three weeks ago.<br>-There was a "tankless" hot water heater for the facility and a separate hot water heater for the kitchen.<br>-He did not check the water temperatures since he was hired at the facility three weeks ago.<br>-He did not have a thermometer to check the water temperatures until after asking the Executive Director (ED) for one. | D 113 | | |

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| D 113 | Continued From page 4<br>-He did not keep a log of the water temperatures.<br>-He did not know there were issues with the hot water temperatures.<br>-He had not received any complaints about the water temperatures.<br>-The staff were to put all issues with the hot water temperatures in a log book.<br>-If there was an immediate issue the staff were to find him so he could fix the issue right then.<br>-He went and began working on the hot water heaters to decrease the temperatures.<br><br>Interview with the ED on 10/02/19 at 5:45pm revealed:<br>-He had not been aware of any hot water issues.<br>-He had contacted the former MD to find out where he had left the water temperature logs.<br>-He had not been able to locate the logs.<br>-There were no reports of any residents receiving burns from the hot water temperatures.<br><br>Attempted telephone interview with the Administrator on 10/03/19 at 3:00pm was unsuccessful.<br><br>The facility failed to assure the hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures higher than 116°F from 2 of 14 water fixtures (sink and shower) in residents' rooms (#11) with hot water temperatures above 116°F, ranging from 116.2°F to 120.0°F. The elevated hot water temperatures were detrimental to the health and safety of the residents which constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/19 for this violation. | D 113 | | |

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| D 113 | Continued From page 5<br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019. | D 113 | | |
| D 165 | 10A NCAC 13F .0506 Training On Physical Restraints<br><br>10A NCAC 13F .0506 Training On Physical Restraints<br><br>(a) An adult care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to provide physical restraint training for 1 of 3 staff sampled (Staff B) who provided care to three residents restrained in geri chairs with lap tops and in beds with ¾ length side rails.<br><br>The findings are:<br><br>Observation of a resident on 10/02/19 from 8:43am revealed:<br>-At 8:43am Staff B took the resident to her room, via the geri chair she was reclined in and placed in her bed on her right side.<br>-One side of the bed was positioned against the wall and the other side had a 3/4-length bed rail in the up position.<br><br>Based on observations, interviews and record reviews it was determined the resident was not | D 165 | | |

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interviewable.

Observation of a second resident on 10/02/19 from 7:00am-9:03am revealed:
-At 7:00am the resident was in the geri chair with a table top over the chair and in the dining room.
-At 8:08am Staff B removed the resident in her geri chair from the dining room to the day room.
-The resident was not released from the geri chair.
-The lap tray was not removed from the resident's geri chair.
-The resident was not repositioned or removed from the geri chair.
-The resident was in constant motion in the geri chair (leaning forward and stretching out).
-At 9:03am Staff B removed the resident's in her geri chair and took the resident to her room to be changed and dried.

Based on observations, interviews and record reviews it was determined the second resident was not interviewable.

Observation of a third resident on 10/02/19 from 7:00am-9:03am revealed:
-At 7:00am the resident was in the geri chair with a lap tray over the chair and in the dining room.
-At 8:08am Staff B removed the resident in her geri chair from the dining room to the day room.
-The resident was not released from the geri chair.
-The lap tray was not removed from the resident's geri chair.
-The resident was not repositioned or removed from the geri chair.
-The resident did not make any major positional changes or attempt to get out of the geri chair.

Based on observations, interviews and record

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reviews it was determined the third resident was not interviewable.

Review of Staff B's Record on 10/02/19 revealed:
-Staff B date of hire was 09/11/19.
-Staff B did not have Restraint Usage training.

Interview with Staff B on 10/02/19 at 10:15am revealed:
-She started work on 09/11/19.
-She did not do anything differently with a resident in restraints than she did with any other resident.
-She made sure residents in restraints were comfortable and repositioned them with 2 pillows as needed, but not on any schedule.
-She was not aware that every two hours she needed to reposition a resident who was in restraints.
-She had not received restraint usage training.

Interview with the Resident Care Coordinator on 10/02/17 at  revealed:
-She was responsible for the personnel records to make sure all PCA's and MA's met all qualifications and requirements.
-Staff B had not completed the restraint usage requirements.
-Staff B was responsible for the removal and application of restraints as a part of her daily duties.

Interview with the Regional Executive Director on 10/02/19 at 2:00pm revealed:
-The MAs and PCAs were trained by an Registered Nurse (RN) when hired on how to apply, remove and check restraints.
-He could not find documentation on Staff B received training on restraints.
-Staff B should not remove, apply or sign off on the checks with restraints because she was not

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| D 165 | Continued From page 8<br>trained and checked off on restraint usage.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful. | D 165 | | |
| D 283 | 10A NCAC 13F .0904(a)(2) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to ensure food being prepared and served was protected from contamination related to food being served at unsafe temperature and not sanitizing dishes in a 3-compartment sink.<br><br>The findings are:<br><br>1. Review of the facility's Food Establishment Inspection Report dated 09/03/19 revealed the sanitation score was 96.0.<br><br>Observation of lunch preparation on 10/01/19 from 12:10pm to 1:45pm revealed:<br>-Pureed chicken was prepared at 12:15pm, plated and then placed on a counter, uncovered, and remained there until 1:15pm while other meals were plated and served. | D 283 | | |

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-The non-pureed food served was not kept in a warming device which maintained safe food serving temperatures.
-The cook did not remove or change gloves between touching dirty items like door knobs and dishes and clean objects such as food being plated.
-The cook only changed gloves upon request of the surveyor.

Observation of lunch meal service on 10/02/19 at 1:27pm revealed:
-The puréed diet plates were brought out of the kitchen to be served to residents.
-The Executive Director (ED) was notified puree plates were being served after sitting on the counter in the kitchen for over an hour.
-The ED checked the food temperatures on one of the puree plates, which revealed a temperature of 80 degrees Fahrenheit.
-The plates were returned to the kitchen and new food was prepared.

Interview with a cook on 10/01/19 at 9:57am revealed she did not have a food thermometer and did not check food temperatures.

Telephone interview with a sanitarian from the local health department on 10/02/19 at 1:20pm revealed:
-Hot food holding temperature should be at least 135 degrees and all hot food must be maintained at this temperature until food was plated in order to prevent growth of harmful bacteria.
-Food should not be plated and then left on the counter at room temperature for any length of time.
-Not following proper cooking procedures increased the risk of developing harmful pathogens and placed residents at high risk for

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developing food-borne illnesses.
-Residents who resided in long term care facilities were considered immune compromised and at high risk for developing a food borne illness.

Interview with the ED on 10/01/19 at 1:35pm revealed:
-Staff had not been using the oven to keep food warm until it was served.
-He did not know why the staff were not using the oven to keep food warm instead of leaving food on the counter, uncovered and unheated.
-Cooks should put covered food in the oven so the food stayed warm until serving time.
-He had a probe thermometer in the kitchen for testing food temperatures, but he did not know how to calibrate it.
-He did not know why a cook was unaware that a thermometer was available to check food temperatures.
-The kitchen did not have a warming table, so the oven was the only option staff had to keep food warm.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

2. Observation of lunch preparation on 10/01/19 from 12:10pm to 1:45pm revealed:
-The 3-compartment sink did not contain a sanitizing solution.
-Only 2 compartments of the 3 compartment sink had water in it.
-Staff were washing and rinsing dishes with water but not sanitizing the dishes.

Interview with a cook on 10/01/19 at 9:57am revealed:
-The only dish sanitizing products they had

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available were dish detergent and bleach.
-She could mix bleach with [brand name] detergent because it did not make fumes like other brands did.

Interview with a second cook on 10/02/19 at 7:08am revealed:
-When using the 3-compartment sink she "usually put a splash of bleach in the sanitizing compartment".
-No sanitizing solution mixing instructions were available for reference.

Telephone interview with a sanitarian from the local health department on 10/02/19 at 1:20pm revealed:
-When using a 3-compartment sink, the 3rd compartment must be filled with an approved sanitizing solution.
-A sanitizing solution can be made from bleach using a measured ratio of bleach to water for mixing or the solution would not sanitize appropriately.
-If dishes were not sanitized properly there was risk of food contamination and growth of harmful bacteria which can lead to food borne illnesses.

Interview with the Executive Director (ED) on 10/02/19 between 8:45am and 3:04pm revealed:
-The kitchen staff had been properly trained in sanitation procedures.
-He was not aware staff were using the 3-compartment sink incorrectly.
-He monitored staff when he was in the building and corrected them when he saw staff doing things incorrectly.
-He expected kitchen staff to follow proper procedures and do as they had been trained.

Attempted telephone interview with the

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| D 283 | Continued From page 12<br>Administrator on 10/02/19 at 3:00pm was unsuccessful.<br>_____<br><br>The facility failed to ensure foods being prepared and served at the facility were protected from contamination. The failure of the facility to follow safe and sanitary food handling practices, serve foods at proper temperatures and use a 3-compartment sink properly placed the residents at risk for developing a food borne illness which was a detriment to the health, safety and welfare of the residents and constitutes a Type B violation.<br>_____<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/19 for this violation.<br><br>CORRECTIVE DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019 | D 283 | | |
| D 287 | 10A NCAC 13F .0904(b)(2) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition And Food Service<br>(b) Food Preparation and Service in Adult Care Homes:<br>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. | D 287 | | |

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| D 287 | Continued From page 13<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews the facility failed to ensure all residents were provided with a non-disposable place setting, including a knife.<br><br>The findings are:<br><br>Observation of the lunch meal service on 10/01/19 at 12:00pm revealed:<br>-Twenty-nine meals were served.<br>-The residents that lived at the facility were not capable of requesting a knife.<br>-The table setting consisted of a napkin, spoon and fork in addition to the plate and cup.<br>-The meal consisted of boiled chicken with a slice of cheese on top, mashed potatoes, boiled cabbage, a dinner roll and a slice of strawberry cheesecake.<br>-Personal care aides (PCAs) used the side of spoons to assist several residents to cut their chicken.<br>-Two residents were observed using the side of their fork to cut the meat into bite-sized pieces.<br><br>Interview with a PCA on 10/01/19 at 12:58pm revealed:<br>-The kitchen did not have knives for resident use.<br>-She always used the side of the fork or the spoon to cut foods.<br><br>Interview with a cook on 10/02/19 at 7:08am revealed:<br>-She had been working there since November 2018.<br>-The cook was responsible for wrapping the silverware in the napkin.<br>-She had never given residents a knife because the kitchen did not stock knives. | D 287 | | |

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| D 287 | Continued From page 14<br>-She did not know why the kitchen did not stock knives for resident use.<br>-Kitchen staff were responsible for cutting food when a resident had an order for chopped food.<br><br>Interview with the Executive Director (ED) on 10/02/19 at 3:04pm revealed:<br>-They did not currently have knives in the kitchen for resident use nor had they ever in the past.<br>-For safety reasons, he did not think residents that had dementia should be allowed to use a knife.<br>-None of the residents had a physician's order to withhold a knife at mealtimes.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful. | D 287 | | |
| D 292 | 10A NCAC 13F .0904(c)(3) Nutrition And Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(c) Menus In Adult Care Home:<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews the facility failed to document the foods actually served to residents when substitutions to the menu occurred.<br><br>The findings are:<br><br>Review of the facility's lunch menu for 10/01/19 | D 292 | | |

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| D 292 | Continued From page 15 | D 292 | | |

revealed Chicken Cordon Bleu, roasted garlic potatoes, creamed Brussell Sprouts, dinner roll or bread, strawberry shortcake, milk and a beverage of choice.

Observation of the lunch meal service on 10/01/19 at 12:30pm revealed boiled chicken with a slice of cheese on top, boiled cabbage, mashed potatoes, dinner roll, strawberry cheesecake and a beverage of choice.

Review of the facility's breakfast menu for 10/02/19 revealed juice of choice, cereal of choice, fresh fruit, baked omelet, bacon, wheat english muffin, milk and coffee or tea.

Observation of the breakfast meal service on 10/02/19 at 7:08am revealed juice, grits, scrambled eggs, sausage pattie, white toast, milk and coffee.

Review of the facility's substitution book in the kitchen revealed there was no documentation of any food substitutions since April 2019.

Interview with the cook on 10/01/19 at 12:10pm revealed:
-Menu substitutions happened "every once in a while".
-She filled out a paper in the substitution book when a substitution was made to the menu.
-She had not filled out the paperwork regularly like she had been trained to do.

Interview with the Executive Director (ED) on 10/02/19 at 8:45am revealed:
-A substitution book was maintained in the kitchen.
-Substitutions occur a "couple times a month".
-Sometimes substitutions were made because

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| D 292 | Continued From page 16<br>they did not have the food on the menu and sometimes they were made because residents liked to have things that were not ever on the menu.<br>-Staff "usually" substituted ground beef for beef tips and pork loin for pork chops because the residents preferred those items.<br>-Dietary staff had been trained to document when substations were made.<br>-He did not know why the substitution papers had not been completed since April 2019.<br>-He remembered seeing completed substitution papers but didn't know where they were now.<br>-He expected dietary staff to follow procedures and complete all food substitution documentation as they had been trained.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful. | D 292 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews the facility failed to assure therapeutic diets were served as ordered for 2 of 3 sampled residents (#1 and #3) who had physician orders for a No Added Salt (NAS), low concentrated | D 310 | | |

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sweets (LCS) diet.

The findings are:

1. Review of Resident #1's current FL-2 dated 05/13/19 revealed:
-Diagnoses included dementia, hypertension, coronary artery disease and type 2 diabetes.
-There was an order for a NAS, LCS diet.
-There was an order to check finger stick blood sugars (FSBS) three times a day.

Attempted review of the facility's menus on 10/01/19 at 10:00am revealed therapeutic menus for the LCS or the NAS diet were not made available.

Review of the facility's diet list posted in the kitchen revealed Resident #3 was to be served a NAS, LCS regular texture diet with chopped meats.

Review of the lunch menu for 10/01/19 revealed residents were to be served Chicken Cordon Bleu, Brussell Sprouts, roasted garlic potatoes, a dinner roll and reduced sugar strawberry shortcake.

Review of the therapeutic diet menus provided by the Executive Director (ED) on 10/02/19 at 3:04pm revealed:
-The LCS diets were to be served the same menu as the regular diets except for a diet dessert.
-The NAS diets were to be served the same items as the regular diets but were not to use a salt shaker at the table.

Observation of Resident #1's lunch meal service on 10/01/19 at 12:40pm revealed:

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| D 310 | Continued From page 18<br>-Resident #1 had water and milk and was served chopped chicken with a slice of cheese, cabbage, mashed potatoes, a dinner roll.<br>-For dessert the resident was served a half slice of store bought strawberry cheesecake.<br>-Resident #1 ate 100% of his meal, including the half slice of cheesecake.<br>-Resident #1 should not have been served a half slice of store-bought strawberry cheesecake.<br><br>Observation of the Strawberry cheesecake package revealed the total sugar content was 12 grams and total carbohydrate content was 21 grams per serving.<br><br>Review of Resident #1's September 2019 medication administration record (MAR) revealed Resident #1's finger stick blood sugar (FSBS) results were as follows:<br>-There was an entry to check the FSBS before meals and at bedtime (7:30am, 11:30am, 4:30pm and at 8:00pm).<br>-FSBS results for 7:30am ranged from 82-155.<br>-FSBS results for 11:30am ranged from 102-260.<br>-FSBS results for 4:30pm ranged from 93-217.<br>-FSBS results for 8:00pm ranged from 115-206.<br><br>Telephone interview with Resident #1's physician on 10/03/19 at 9:25am revealed:<br>-A NAS, LCS diet was ordered for the Resident #1 to help keep his FSBS low and high blood pressure under control.<br>-She did not know Resident #3 was served a NAS, LCS diet.<br>-The health issues that could develop from having Type 2 diabetes were heart disease, nerve damage, kidney disease, eye problems and stroke.<br>-The diet was one important way to control type 2 diabetes to keep the FSBS low and his blood | D 310 | | |

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pressures under control resulting in the amount of medications he would take and help prevent the health issues associated with having type 2 diabetes.

Based on observations and record reviews on 10/02/19, Resident #1 was not interviewable.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

Refer to interview with a cook on 10/01/19 at 10:00am.

Refer to interview with a second cook on 10/02/19 at 7:10am.

Refer to interview with the Executive Director (ED) on 10/02/19 at 3:04pm.

2. Review of Resident #3's current FL-2 dated 09/04/19 revealed:
-The diagnoses included dementia, Schizophrenia, hypertension, hyperlipidemia and diabetes mellitus type 2.
-The resident was documented as intermittently disoriented.
-There was a diet order for a No Added Salt (NAS), Low Concentrated Sweets (LCS) with chopped meats.
-There was an order to check finger stick blood sugars (FSBS) three times a day before meals.

Review of a physician's order dated 09/04/19 for Resident #3 revealed the diet as No Added Salt (NAS), Low Concentrated Sweets (LCS) texture regular with chopped meats.

Review of the facility's diet list posted in the

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kitchen revealed Resident #3 was to be served a NAS, LCS regular texture diet with chopped meats.

Review of the lunch menu for 10/01/19 revealed residents were to be served Chicken Cordon Bleu, Brussell Sprouts, roasted garlic potatoes, a dinner roll and reduced sugar strawberry shortcake.

Observation of Resident #3 on 10/01/19 at 10:44am revealed he was served fresh-made chocolate chip cookies and milk for a snack.

Attempted review of the facility's menus on 10/01/19 at 10:00am revealed there were no therapeutic menus for the LCS or the NAS made available.

Review of the therapeutic diet menus provided by the Executive Director (ED) on 10/02/19 at 3:04pm revealed:
-The LCS diets were to be served the same menu as the regular diets except for a diet dessert.
-The NAS diets were to be served the same items as the regular diets.

Observation of Resident #3's lunch meal service on 10/01/19 at 12:45pm revealed:
-Resident #3 had water, tea, and was served chopped chicken with a slice of cheese, cabbage, mashed potatoes, and a dinner roll.
-For dessert, the resident was served a half slice of store bought strawberry cheesecake.
-Resident #3 ate 100% of his meal, including a half slice of the cheesecake.

Observation of the Strawberry cheesecake package revealed the total sugar content was 12

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grams and total carbohydrate content was 21 grams per serving.

Telephone interview with Resident #3's physician on 10/03/19 at 9:25am revealed:
-A NAS, LCS diet was ordered for Resident #3 to help keep their FSBS low and high blood pressure under control.
-She did not know Resident #3 was not served a NAS, LCS diet.
-The health issues that could develop from having Type 2 diabetes were heart disease, nerve damage, kidney disease, eye problems and stroke.
-The diet was one important way to control type 2 diabetes to keep the FSBS low and his blood pressures under control resulting in the amount of medications he would take and help prevent the health issues associated with having type 2 diabetes.

Review of Resident #3's September 2019 medication administration record (MAR) revealed Resident #3's finger stick blood sugar (FSBS) results were as follows:
-There were entries for FSBS's for 7:00am which ranged from 102-128.
-There were entries for FSBS's for 12:00pm which ranged from 104-355.
-There were entries for FSBS's for 5:00pm which ranged from 76-560.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

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| D 310 | Continued From page 22<br>Refer to interview with a cook on 10/01/19 at 10:00am.<br><br>Refer to interview with another cook on 10/02/19 at 7:10am.<br><br>Refer to interview with the Executive Director (ED) on 10/02/19 at 3:04pm.<br><br>_____<br>Interview with a cook on 10/01/19 at 10:00am revealed:<br>-The facility had one menu, which they used to serve every diet.<br>-They served every resident the same food, regardless of diet because they used some "low sugar" items.<br><br>Interview with another cook on 10/02/19 at 7:10am revealed:<br>-The facility had one menu, which they used for every diet<br>-They did not have a menu for any therapeutic diets.<br>-At breakfast she served coffee with sugar to everyone "except one person who is a brittle diabetic".<br><br>Interview with the Executive Director (ED) on 10/02/19 at 3:04pm revealed:<br>-He did not know why the cooks were not referencing the therapeutic diet menus when serving meals.<br>-They had therapeutic menus in the kitchen.<br>-The cooks had been trained to reference the therapeutic menus in the kitchen.<br>-He expected the cooks to prepare foods and serve foods according to the therapeutic menus.<br><br>Attempted telephone interview with the | D 310 | | |

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| D 310 | Continued From page 23<br>Administrator on 10/02/19 at 3:00pm was unsuccessful.<br><br>The facility failed to serve therapeutic diets as ordered by a physician. The failure of the facility to serve therapeutic diets as ordered placed residents at risk for developing type 2 diabetes related complications due to elevated blood glucose levels which was a detriment to the health, safety and welfare of the residents and constitutes a Type B violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019. | D 310 | | |
| D 484 | 10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives<br><br>10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives<br>(c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:<br>(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's | D 484 | | |

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responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.
(2) The assessment shall include consideration of the following:
(A) medical symptoms that warrant the use of a restraint;
(B) how the medical symptoms affect the resident;
(C) when the medical symptoms were first observed;
(D) how often the symptoms occur;
(E) alternatives that have been provided and the resident's response; and
(F) the least restrictive type of physical restraint that would provide safety.
(3) The care plan shall include the following:
(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
(B) the type of restraint to be used; and
(C) care to be provided to the resident during the time the resident is restrained.

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

Based on observations, interviews, and record reviews, the facility failed to ensure implementation of the restraint plan set forth by the assessment, care plan and physician's order related to the checks every 30 minutes and the release every two hours for 3 of 3 sampled residents (Residents #2, #4, and #5) with bed

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| D 484 | Continued From page 25<br>rails and/or geri chairs.<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated 04/01/19 revealed:<br>-Diagnoses included Alzheimer's dementia and anxiety.<br>-The restraints to be used were long bed rails.<br>-Resident #2 was documented as being constantly disoriented.<br>-Resident #2 was documented as non-ambulatory and needing total care.<br><br>Review of the physician's restraint order for Resident #2's dated 07/10/19 revealed:<br>-Resident #2 had an order for a geri chair with a lap tray and long bed rails.<br>-Resident #2 was to be in the geri chair whenever she was out of bed.<br>-Resident #2 was to have the long bed rails at all times while in bed.<br>-The restraints were to be checked every thirty minutes.<br>-The restraints were to be removed every two hours for exercise or mobility.<br><br>Review of Resident #2's restraint care plan dated 07/10/19 revealed Resident #2 was to be observed for safety while in restraints.<br><br>Review of Resident #2's restraint assessment dated 07/10/19 revealed:<br>-It was signed by the Resident Care Coordinator (RCC).<br>-It was documented that she had a diagnosis of Alzheimer's dementia with disorientation.<br>-Resident #2 was documented as unable to sit upright consistently.<br>-Resident #2 was documented as unable to | D 484 | | |

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stand.
-Physical therapy, Occupational Therapy and a lap buddie with a wheelchair had previously been tried to enhance abilities but had been unsuccessful.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 08/13/19 revealed:
-It was completed by a Registered nurse.
-Staff competency validation was marked yes for geri chair, ambulation and transitions.

Review of the facility's Restraint Use Disclosure Statement dated 07/10/19 revealed:
-Restraints were only to be used for the safety and well-being of the resident.
-Restraints were used only on residents with medical symptoms that warrant the use of such.
-A full assessment was done, and a care plan developed which was individualized for the resident.
-A physician order was obtained that specified all considerations regarding the use of restraints for that resident.
-The resident was to be checked every 30 minutes and repositioned/exercised every two hours.
-All measures would be taken to minimize the risks associated with the use of restraints, such as limited, mobility, reduced social contact, and the development of pressure ulcers.

Observation of Resident #2 on 10/01/19 from 9:00am-11:00am revealed:
-The resident was in the day room in a geri chair with a lap-tray across the chair.
-Resident #2 was laying on her right side in the geri chair with the geri chair reclined back.
-Resident #2 was not released from the geri chair

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lap-tray or removed/repositioned from the geri chair.
-Resident #2 was in the same position in the geri chair.
-Resident #2 did not make any major positional changes or attempt to get out of the geri chair.

Observation of Resident #2 on 10/02/19 from 8:43am - 11:30am revealed:
-At 8:43am Resident #2 was in her bed on her right side.
-One side of the bed was positioned against the wall and the other side had a 3/4-length bed rail in the up position.
-Resident #2 did not make any major positional changes or attempt to get out of the bed.
-At 11:30am the medication aide (MA) entered Resident #2's room and turned Resident #2 onto her left side and administered a breathing treatment.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

Telephone interview with Resident #2's primary physician on 10/03/19 at 9:25am revealed:
-She ordered restraints for Resident #2 for safety due to a history of Alzheimer's dementia and falls.
-Resident #2 was followed by the Hospice nurse, three times a week, since admission.
-She last saw Resident #2 last month.
-Resident #2 was very weak and could not remove herself if she became trapped between the mattress and side rail, she could sufficate.

A telephone interview with the Hospice Nurse on 10/03/19 at 10:00am revealed:
-She saw Resident #2, three times a week.
-Resident #2 was considered very weak, moved

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around some and could become trapped between the mattress and the side rails and she could not get out by herself which could lead to suffication.
-Resident #2 couold not pull herself up if she slid down and became trapped under the lap tay on the geri chair.
-Resident #2 prefered to lay on her right side in the fetal position and slides down in the geri chair even with the lap tray on.
-Resident #2 had a geri chair with a lap tray and bedrails that were considered restraints.
-She saw Resident #2 slid down in the geri chair last month and was trapped with the lap tray on her chest.

Refer to interview with the medication aide (MA) on 10/02/19 from 9:34am.

Refer to interview with a PCA on 10/02/19 at 10:15am.

Refer to telephone interview with the facility's primary physician on 10/03/19 at 9:25am.

Refer to interview with the Hospice Nurse on 10/03/19 at 10:00am.
2. Review of Resident #4's current FL-2 dated 09/16/19 revealed:
-Diagnoses included dementia, hypertension, hepatitis C, hyperlipidemia, anxiety, gastro-esophageal reflux disease (GERD), peptic ulcer disease, and aphasia.
-Resident #4 was documented as semi-ambulatory with no assistive device listed.
-Resident #4 was documented as constantly disoriented.
-Resident #4 was documented as non-verbal and required total care.

Review of Resident #4's Resident Register

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revealed she was admitted to the facility on 03/25/19.

Review of the physician's restraint order for Resident #4 dated 07/10/19 revealed:
-There was an order for a geri-chair with lap-tray and recliner.
-The reason for the restraint was due to falls secondary to dementia and agitation.
-The resident was unable to sit appropriately in a wheelchair especially when agitated.
-The resident was at risk for falling out of a wheelchair.
-The resident was not able to call for assistance due to her aphasia.
-The geri-chair was to be used when the resident was out of bed.
-The restraint was to be checked every 30 minutes, released every 2 hours and as needed and range of motion on upper and lower extremities to be performed when released.

Review of Resident #4's restraint use disclosure statement revealed:
-The responsible party was unable to sign consent for restraint usage as she was unable to travel to the facility on 04/29/19.
-She gave telephone consent.

Review of the facility's Restraint Use Disclosure Statement revealed:
-Restraints were only to be used for the safety and well-being of the resident.
-Restraints were used only on residents with medical symptoms that warrant the use of such.
-A full assessment was done, and a care plan developed which was individualized for the resident.
-A physician order was obtained that specified all considerations regarding the use of restraints for

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that resident.
-The resident was to be checked every 30 minutes and repositioned and exercised every two hours.
-All measures would be taken to minimize the risks associated with the use of restraints, such as limited, mobility, reduced social contact, and the development of pressure ulcers.

Review of Resident #4's restraint assessment dated 07/10/19 revealed:
-The Restraint Use Disclosure Statement was completed by the Resident Care Coordinator (RCC).
-Medical symptoms that warranted the use of the restraint included: Dementia, agitation, falls and not being able to call for assistance due to the aphasia.
-Medical symptoms that warranted the use of the restraint (dementia, agitation, and aphasia) occurred daily.
-Previous alternatives were listed as wheelchair and floor mat.
-The resident was "unable to stand or follow any commands of PT/OT" (physical therapy/occupational therapy).

Review of Resident #4's Licensed Health Professional Support (LHPS) assessment on 07/16/19 revealed:
-Resident #4 was in a geri-chair.
-Staff competency validation was marked no for the geri-chair task.

Observation of Resident #4 on 10/01/19 at 9:05am revealed the resident was in her geri-chair sitting up at a ninety-degree angle with lap tray on the chair.

Observation of Resident #4 on 10/01/19 from

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| D 484 | Continued From page 31<br><br>9:00am-11:00am revealed:<br>-The resident was in the day room in a geri chair with a lap tray across the chair.<br>-Resident #4 was not released from the geri chair or lap tray nor removed or repositioned from the geri chair.<br>-Resident #4 was in constant motion in the geri chair (leaning forward and stretching out).<br><br>Observation of Resident #4 on 10/02/19 from 7:00am-9:03am revealed:<br>-At 7:00am Resident #4 was in the geri chair with a lap tray over the chair and in the dining room.<br>-At 8:08am a personal care aide (PCA) removed Resident #4 from the dining room to the day room.<br>-Resident #4 was not released from the geri chair.<br>-The lap tray was not removed from Resident #4's geri chair.<br>-Resident #4 was not repositioned or removed from the geri chair.<br>-Resident #4 was in constant motion in the geri chair (leaning forward and stretching out).<br>-At 9:03am a PCA removed Resident #4's geri chair and took Resident #4 to her room to be toileted.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.<br><br>Telephone interview with Resident #4's primary care provider on 10/03/19 at 9:25am revealed:<br>-She ordered restraints for Resident #4 for safety due to a history of dementia and falls.<br>-Resident #4 was followed by the Hospice nurse, three times a week, since admission.<br>-She last saw Resident #4 last month. | D 484 | | |

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Telephone interview with the Hospice Nurse on 10/03/19 at 10:00am revealed:
-She saw Resident #4, three times a week.
-Resident #4 was considered weak but moved around in the bed and chair a lot.
-Resident #4 walked with assistance and would stretch out and would slide down in the geri chair.
-Resident #4 had a geri chair with a lap tray and bedrails that were considered restraints.

Refer to interview with the medication aide (MA) on 10/02/19 from 9:34am.

Refer to interview with a PCA on 10/02/19 at 10:15am.

Refer to telephone interview with Resident #4's primary care provider on 10/03/19 at 9:25am.

Refer to telephone interview with the Hospice Nurse on 10/03/19 at 10:00am.

3. Review of Resident #5's current FL-2 dated 08/03/19 revealed:
-Diagnoses included dementia, hypertension and atrial fibrillation.
-Documentation the resident was constantly disoriented and non-ambulatory.

Review of the Resident Register revealed Resident #5 was admitted to the facility on 06/05/18.

Observation of Resident #5 on 10/01/19 from 9:00am-11:00am revealed:
-The resident was in the day room in a geri chair with a lap tray across the chair with the geri chair reclined back.
-Resident #5 was not released from the geri chair lap-tray, removed or repositioned from the geri

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chair.
-Resident #5 was in the same position in the geri chair.
-Resident #5 remained in the same position and did not attempt to get out of chair.

Observation of Resident #5 on 10/02/19 from 7:00am-9:03am revealed:
-At 7:00am Resident #5 was in the geri chair with a lap tray over the chair and in the dining room.
-At 8:08am a personal care aide (PCA) removed Resident #5 from the dining room to the day room.
-Resident #5 was not released from the geri chair.
-The lap tray was not removed from Resident #5's geri chair.
-Resident #5 was not repositioned or removed from the geri chair.
-Resident #5 did not make any major positional changes or attempt to get out of the geri chair.
-At 9:03am a PCA removed Resident #5's geri chair and took Resident #5 to her room to be toileted.

Review of the physician's restraint order for Resident #5 dated 07/10/19 revealed:
-There was an order for a geri-chair, recline and lap tray and long bed rails.
-The reason for the restraint was due to dementia and disorientation.
-The geri-chair was always to be used when the resident was out of bed.
-The bed rails were always to be used when in the bed awake or asleep.
-The restraint was to be checked every 30 minutes, released every 2 hours for exercise and mobility and repositioning.

Review of the facility's Restraint Use Disclosure

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| D 484 | Continued From page 34<br><br>Statement revealed:<br>-Restraints were only to be used for the safety and well-being of the resident.<br>-Restraints were used only on residents with medical symptoms that warrant the use of such.<br>-A full assessment was done, and a care plan developed which was individualized for the resident.<br>-A physician order was obtained that specified all considerations regarding the use of restraints for that resident.<br>-The resident was to be checked every 30 minutes and repositioned/exercised every two hours.<br>-All measures would be taken to minimize the risks associated with the use of restraints, such as limited, mobility, reduced social contact, and the development of pressure ulcers.<br><br>Review of Resident #5's restraint use disclosure statement revealed the responsible party did not sign the restraint disclosure statement.<br><br>Review of Resident #5's restraint assessment dated 07/10/19 revealed:<br>-The Restraint Use Disclosure Statement was completed by the Resident Care Coordinator (RCC).<br>-Medical symptoms that warranted the use of the restraint included: decline of physical mobility of legs due resident's diagnoses of dementia with disorientation.<br>-Medical symptoms that warranted the use of the restraint (dementia with disorientation) occurred daily.<br>-Previous alternatives were listed as wheelchair and floor mat.<br>-The resident was "unable to stand or follow any commands of PT/OT" (physical therapy/occupational therapy). | D 484 | | |

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| D 484 | Continued From page 35<br><br>Review of Resident #5's Licensed Health Professional Support (LHPS) assessment on 06/05/19 revealed:<br>-It was performed by a Registered Nurse.<br>-Resident #5 was in a geri-chair.<br>-Staff competency validation was marked no for the geri-chair task.<br><br>Review of Resident #5's Care Plan dated 03/18/19 revealed:<br>-Resident #5 required total assistance with toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and transfers.<br>-Resident #5 required a geri chair for ambulation/locomotion.<br>-The section for LHPS and other special care needs was blank.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.<br><br>Telephone interview with Resident #5's primary physician on 10/03/19 at 9:25am revealed:<br>-She ordered restraints for Resident #5 for safety due to a history of dementia and falls.<br>-Resident #5 was followed by the Hospice Nurse, three times a week, since 09/28/18.<br>-She considered Resident #5 weak and in the event if Resident #5 became trapped between the mattress and side rail, she would be unable to physically remove herself, and the same if Resident #5 slid down in the geri chair and became trapped by the lap tray.<br>-She last saw Resident #5 last month.<br><br>Telephone interview with Resident #5's family member on 10/03/19 at 12:27pm revealed: | D 484 | | |

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| D 484 | Continued From page 36<br>-He visited Resident #5 every month.<br>-He was aware Resident #5 used restraints (geri chair and bed rails) while at the facility.<br>-Resident #5 used to move around a lot but in the last two months the medication she received "sedates her" more.<br>-The restraints were used to keep Resident #5 from falling and getting hurt, for her "safety."<br><br>Telephone interview with the Hospice Nurse on 10/03/19 at 10:00am revealed:<br>-She saw Resident #5, three times a week.<br>-Resident #5 was considered weak but moved around in the bed and chair a lot but was not stong enough to remove herslf after becomming trapped between the mattress and side rail or by the lap tray on the geri chair..<br>-Resident #5 had a geri chair with a lap tray and bedrails that were considered restraints.<br><br>Refer to interview with the medication aide (MA) on 10/02/19 from 9:34am to 10:13am.<br><br>Refer to interview with a PCA on 10/02/19 at 10:15am.<br><br>Refer to telephone interview with the facility's primary physician on 10/03/19 at 9:25am.<br><br>Refer to interview with the Hospice Nurse on 10/03/19 at 10:00am.<br><br>_____<br>Interview with the medication aide (MA) on 10/02/19 from 9:34am revealed:<br>-The MAs were responsible for documenting on the electronic medication administration record (eMAR) that restraints were used.<br>-The MAs initials on the eMAR was an indication that the restraints were used appropriately by the Personal care aide (PCA), not that the MA had | D 484 | | |

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personally checked and repositioned a resident.
-PCAs documented in a book, at the end of their shift when they bathed, changed and removed residents from restraints.
-The MA checked that book at the end of their shift to be sure restraint use was documented by PCAs.
-PCAs would come and tell the MAs if a resident was put to bed, bathed or changed.
-There was not a specific time listed for restraint usage in the book but PCAs checked residents every two hours.

Interview with a PCA on 10/02/19 at 10:15am revealed:
-She did not do anything differently with a resident in restraints than she did with any other resident.
-She made sure residents in restraints were comfortable and repositioned them with 2 pillows as needed, but not on any schedule.
-She was not aware that every two hours she needed to reposition a resident who was in restraints.
-PCAs documented in the resident books when the resident was changed, put in bed or bathed.

Telephone interview with the facility's primary physician on 10/03/19 at 9:25am revealed:
-The facility was to check the residents in restraints every 30 minutes and reposition them to prevent skin breakdown and to remove the restraints every 2 hours for exercise/mobility to prevent contractures.
-Due to the resident's overall heath, if the residents in restraints were not repositioned every 30 minutes and released for exercise/mobility, they could develop skin breakdown that could furthur result in an infection.
-Not removing the restraints every 2 hours and providing exercise or range of motion could result

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| D 484 | Continued From page 38<br>in contractures.<br><br>A telephone interview with the Hospice Nurse on 10/03/19 at 10:00am revealed when the Residents were in restraints, they needed to be checked on every 30 min to prevent skin break down but more so "to prevent" suffication and or strangulation if they became trapped between the mattress and the side rails or trapped if they slid down in their geri chairs and became strangled by the lap tray.<br><br>The facility failed to implement the restraint plan set forth by the assessment, care plan and physician's order for (Resident #2, #4 and #5), related to the checks every 30 minutes which could result in skin breakdown that could further result in an infection, and not removing the restraints every 2 hours, providing exercise or range of motion could result in contractures and the risk of suffication and or strangulation. This failure was detrimental to the health and safety of the residents which constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/01/19 for this violation.<br><br>CORRECTIVE DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2019 | D 484 | | |
| D 486 | 10A NCAC 13F .1501 (e) Use Of Physical Restraints And Alternatives<br><br>10A NCAC 13F .1501Use Of Physical Restraints And Alternatives | D 486 | | |

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| D 486 | Continued From page 39<br><br>(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:<br>(1) restraint alternatives that were provided and the resident's response;<br>(2) type of restraint that was used;<br>(3) medical symptoms warranting restraint use;<br>(4) the time the restraint was applied and the duration of restraint use;<br>(5) care that was provided to the resident during restraint use; and<br>(6) behavior of the resident during restraint use.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record review, the facility failed to assure documentation of a restraint while it was in use for 3 of 3 resident sampled with restraints related to geri- chair and bed rails (Resident #2), geri-chair, lap tray and recliner (Resident #4) and geri-chair, lap tray and long bed rails (Resident #5).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated 04/01/19 revealed :<br>-Diagnoses included Alzheimer's dementia and anxiety.<br>-There was an order for bedrails to be used as restraints.<br>-Resident #2 was documented as being constantly disoriented.<br>-Resident #2 was documented as non-ambulatory | D 486 | | |

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| D 486 | Continued From page 40<br>and needing total care.<br><br>Review of Resident #2's restraint assessment dated 07/10/19 revealed:<br>-Resident #2 had a diagnosis of Alzheimer's dementia with disorientation.<br>-Resident #2 was documented as unable to sit upright consistently.<br>-Resident #2 was documented as unable to stand.<br>-Physical therapy, Occupational Therapy and a lap buddie with a wheelchair had previously been tried to enhance abilities but had been unsuccessful.<br><br>Review of the physician's restraint order for Resident #2 dated 07/10/19 revealed:<br>-Resident #2 had an order for a geri chair with a lap tray and long bed rails.<br>-Resident #2 was to be in the geri chair whenever she was out of bed.<br>-Resident #2 was to have the long bed rails at all times while in bed.<br>-The restraints were to be checked every thirty minutes.<br>-The restraints were to be removed every two hours for exercise or mobility.<br><br>Review of the facility's Restraint Use Disclosure Statement revealed:<br>-Restraints were only to be used for the safety and well-being of the resident.<br>-Restraints were used only on residents with medical symptoms that warrant the use of such.<br>-A full assessment was done, and a care plan developed which was individualized for the resident.<br>-A physician order was obtained that specified all considerations regarding the use of restraints for that resident. | D 486 | | |

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-The resident was to be checked every 30 minutes and repositioned/exercised every two hours.
-All measures would be taken to minimize the risks associated with the use of restraints, such as limited, mobility, reduced social contact, and the development of pressure ulcers.

Telephone interview with Resident #2's Power of Attorney on 10/02/19 at 11:46am revealed:
-The facility kept him informed of any decisions that needed to be made in regards to his family member.
-He knew that she had restraints and had given his approval.

Review of Resident #2's restraint care plan dated 07/10/19 revealed she was to be observed for safety while in restraints.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 08/13/19 revealed staff competency validation was marked yes for the geri-chair.

Review of the facility's July - September 2019 restraint and release records revealed there was no documentation for Resident #2.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

Refer to interview with the medication aide (MA) on 10/02/19 at 9:34am.

Refer to interview with a PCA on 10/02/19 at 10:15am.

Refer to telephone interview with the facility's

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primary physician on 10/03/19 at 9:25am.
2. Review of Resident #4's current FL-2 dated 09/16/19 revealed:
-Diagnoses included dementia, hypertension, hepatitis C, hyperlipidemia, anxiety, gastro-esophageal reflux disease (GERD), peptic ulcer disease, and aphasia.
-Resident #4 was documented as semi-ambulatory with no assistive device listed.
-Resident #4 was documented as constantly disoriented.
-Resident #4 was documented as non-verbal and required total care.

Review of Resident #4's Resident Register revealed she was admitted to the facility on 03/25/19.

Observation of Resident #4 on 10/01/19 at 9:05am revealed the resident was in her geri-chair sitting up at a ninety-degree angle with lap tray on the chair.

Review of the physician's restraint order for Resident #4 dated 07/10/19 revealed:
-There was an order for a geri-chair with lap-tray and recliner.
-The reason for the restraint was due to falls secondary to dementia and agitation.
-The resident was unable to sit appropriately in a wheelchair especially when agitated.
-The resident was at risk for falling out of a wheelchair.
-The resident was not able to call for assistance due to her aphasia.
-The geri-chair was to be used when the resident was out of bed.
-The restraint was to be checked every 30 minutes, released every 2 hours and as needed and range of motion on upper and lower

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extremities to be performed when released.

Review of the facility's Restraint Use Disclosure Statement revealed the residents were to be checked every 30 minutes and repositioned and exercised every two hours.

Review of the facility's July - September 2019 restraint and release records revealed there were none available for Resident #4.

Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.

Telephone interview with Resident #4's primary care provider (PCP) on 10/03/19 at 9:25am revealed she ordered restraints for Resident #4 for safety due to a history of dementia and falls.

Refer to interview with the medication aide (MA) on 10/02/19 at 9:34am.

Refer to interview with a PCA on 10/02/19 at 10:15am.

Refer to telephone interview with the PCP on 10/03/19 at 9:25am.

3. Review of Resident #5's current FL-2 dated 08/03/19 revealed:
-Diagnoses included dementia, hypertension and atrial fibrillation.
-Documentation the resident was constantly disoriented and non-ambulatory.

Observation of Resident #5 on 10/01/19 from 9:00am-11:00am revealed:
-The resident was in the day room in a geri chair with a lap-tray across the chair with the geri chair

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| D 486 | Continued From page 44<br>reclined back.<br>-Resident #5 was not released from the geri chair lap-tray or removed/repositioned from the geri chair.<br>-Resident #5 was in the same position in the geri chair.<br>-Resident #5 did not make any major positional changes or attempt to get out of the geri chair.<br><br>Observation of Resident #5 on 10/02/19 from 7:00am-9:03am revealed:<br>-At 7:00am Resident #5 was in the geri chair with a lap-tray over the chair and in the dining room.<br>-At 8:08am a personal care aide (PCA) removed Resident #5 from the dining room to the day room.<br>-Resident #5 was not released from the geri chair.<br>-The lap tray was not removed from Resident #5's geri chair.<br>-Resident #5 was not repositioned or removed from the geri chair.<br>-Resident #5 did not make any major positional changes or attempt to get out of the geri chair.<br>-At 9:03am a PCA removed Resident #5's geri chair and took Resident #5 to her room to be toileted.<br><br>Review of the physician's restraint order for Resident #5 dated 07/10/19 revealed:<br>-There was an order for a geri-chair, recline and lap-tray and long bed rails.<br>-The geri-chair was always to be used when the resident was out of bed.<br>-The bed rails were always to be used when in the bed awake or asleep.<br>-The restraint was to be checked every 30 minutes, released every 2 hours for exercise or mobility and repositioning. | D 486 | | |

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| D 486 | Continued From page 45<br>Review of the facility's Restraint Use Disclosure Statement revealed the resident was to be checked every 30 minutes and repositioned or exercised every two hours.<br><br>Review of the facility's July - September 2019 restraint and release records revealed there were no records available for Resident #5.<br><br>Attempted telephone interview with the Administrator on 10/02/19 at 3:00pm was unsuccessful.<br><br>Telephone interview with Resident #5's primary physician on 10/03/19 at 9:25am revealed she ordered restraints for Resident #5 for safety due to a history of dementia and falls.<br><br>Refer to interview with the medication aide (MA) on 10/02/19 at 9:34am.<br><br>Refer to interview with a PCA on 10/02/19 at 10:15am.<br><br>Refer to telephone interview with the facility's primary physician on 10/03/19 at 9:25am.<br><br>_____<br>Interview with the medication aide (MA) on 10/02/19 from 9:34am.<br>-The MAs were responsible for documenting on the electronic medication administration record (eMAR) that restraints were used.<br>-The MAs initials on the eMAR was an indication that the restraints were used appropriately by the Personal care aide (PCA), not that the MA had personally checked and repositioned a resident.<br>-PCAs documented in a book, at the end of their shift when they bathed, toileted and removed residents from restraints.<br>-The MA checked that book at the end of their | D 486 | | |

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| D 486 | Continued From page 46<br>shift to be sure restraint use was documented by PCAs.<br>-PCAs would come and tell the MA's if a resident was put to bed, bathed or toileted.<br>-There was not a specific time listed for restraint usage in the book but PCAs checked residents every two hours.<br><br>Interview with a PCA on 10/02/19 at 10:15am revealed:<br>-She made sure residents in restraints were comfortable and repositioned them with 2 pillows as needed, but not on any schedule.<br>-She was not aware that every two hours she needed to reposition a resident who was in restraints.<br>-PCA's charted in the resident books that the resident was changed, put in bed or bathed.<br>-She did not document every 30 minute checks or every 2 hours when in restraints were released out of the restraints because she was not told to do so.<br><br>Telephone interview with the facility's primary physician on 10/03/19 at 9:25am revealed:<br>-The facility was to check and document the residents in restraints every 30 minutes and reposition them to prevent skin breakdown and to remove the restraints every 2 hours for exercise or mobility to prevent contractures.<br>-She did not know the facility was not following the order and documentation for restraints. | D 486 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with | D912 | | |

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| D912 | Continued From page 47<br>relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, 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 and regulations in the areas of training on the care of diabetic residents, infection prevention requirements and medication aides training and competency.<br><br>The findings are:<br><br>1. Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 and 116 degrees (°) Fahrenheit (F) as evidenced by hot water temperatures higher than 116°F for 2 of 14 water fixtures (sink and showers) in residents' rooms. [ Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation.)]<br><br>2. Based on observations, interviews and record reviews, the facility failed to ensure food being prepared and served was protected from contamination related to food being served at unsafe temperature and not sanitizing dishes in a 3-compartment sink. [Refer to Tag 283 .0904(a)(2) Nutrition and Food Services (Type B Violation.)]<br><br>3. Based on observations, interviews and record reviews the facility failed to assure therapeutic | D912 | | |

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| D912 | Continued From page 48<br>diets were served as ordered for 2 of 3 sampled residents (#1 and #3) who had physician orders for a No Added Salt (NAS), low concentrated sweets (LCS) diet. [Refer to Tag 310 .0904(e)(4) Nutrition and Food Services (Type B Violation).]<br><br>4. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of the restraint plan set forth by the assessment, care plan and physician's order related to the checks every 30 minutes and the release every two hours for 3 of 3 sampled residents (Residents #2, #4, and #5) with bed rails and/or geri chairs. [Refer to Tag 484 .1501(c) Use of Restraints and Alternatives (Type B Violation).] | D912 | | |