Stacey, Shonda M

From: Guilford House, ADM- [redacted] <guil.adm@affinitylivinggroup.com>
Sent: Monday, January 27, 2020 12:32 PM
To: Stacey, Shonda M
Subject: [External] POC for Guilford
Attachments: Cover Letter for Guilford House .pdf; Plan of Correction.pdf

Good Afternoon
Please see the attached Plan of Correction regarding the Follow-up Survey with exit date of December 6, 2019.
Please let me know if you have any questions or concerns
Thank you
Carla

[redacted]
Executive Director
Affinity Living Group
336-553-0272
guil.adm@affinitylivinggroup.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041077	A. BUILDING: _____ B. WING _____	R-C 12/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HOUSE	5918 NETFIELD RD GREENSBORO, NC 27455

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D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted a follow-up survey and complaint investigation on December 4-6, 2019. The Guilford County Department of Social Services initiated the complaint investigation on November 12, 2019.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule	D 188	Note: Statement of Deficiencies received on 01/06/2020. Facility has implemented daily stand up meetings. Stand up meetings will include all Facility Management Staff. Executive Director will review assisted living and memory care staffing in coordination with Director of Resident Care (DRC) and Memory Care Manager (MCM) during daily stand-up meetings to assure correct staff is in place. Care Managers are responsible for ensuring staff coverage and providing replacement personnel in the event of an absence or emergency situation. Care Managers will communicate with the Executive Director to ensure situational awareness. Facility has been assigned a new Area Director of Opertations (ADO). ADO will review Personal Care and Other Staff for compliance during weekly visits	1/20/2020 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Cotton — TITLE: Executive Director — (X6) DATE: 1/27/2020

Reviewed and accepted- 01/27/2020- SS

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D 188	Continued From page 1 .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 22 sampled shifts for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, and 12/02/19. The findings are: Review of the bed list report from 11/05/19 through 12/02/19 revealed the census ranged from 27-28 residents residing on the Assisted Living (AL) unit, which required eight hours of aide duties on third shift and sixteen hours of aide duty on second shift. Confidential staff interviews with staff revealed: -There were times when there was one medication aide (MA) and one personal care aide	D 188	Continued from page 1 Facility has been assigned a new Area Director of Operations (ADO) who will review compliance in the area of personal Care and Other Staffing during weekly visits SADO will provide support to the Area Director of Opertations and Executive Director with weekly conferance calls. SADO will review the Shift Analysis Report, Al and Memory Care Staffing' schedules during weekly calls and/or visits to ensure compliance Divisional Director of Clinical Services (DDCS) in coordination with the DVPO will montior Personal Care and Other Staffing during weekly confernace calls, site visits and reports. Facility Executive Director, Business Office Manager, DRC and MCM have received training on assuring Personal Care and Other staffing on 12/6/19. Training provided by SADO. Facility Executive Director, DRC, MCM and BOM received additional training on Personal Care and Other Staffing on 1/15/2020. Training provided by ADO	1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 ongoing 1/20/2020 1/20/2020

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D 188	Continued From page 2 (PCA) staffed to cover the entire facility. -Three PCAs were on the schedule to work, but all three PCAs were on light duty for medical reasons and they were not able to assist with personal care. -There were times when the MA was scheduled with one of the PCAs on light duty and the MA had to do MA responsibilities and PCA responsibilities. -There were a lot of residents on the AL side who required assistance with changing incontinence briefs; the residents had to be changed multiple times during the night. -The Administrator worked third shift recently because the MA was in the facility alone; the Administrator was in the facility from 12:00am-5:00am. -The Administrator was not qualified to do personal care or medication administration. Interview with a personal care aide (PCA) on 12/06/19 at 6:26am revealed: -She had not been able to assist with the resident's personal care needs since July 2019 because of a work-related injury. -When she was scheduled to work, she did filing and answered call lights. -If a resident needed assistance with changing, she would have to ask another staff member to tend to the resident. -She had been able to change a catheter bag and empty urinals. -There were a lot of residents who needed changing on her shift, and she felt bad for the other staff members that she was not able to assist. Review of the Individual Employee Time Cards dated 11/05/19 revealed there were .25 aide hours provided on third shift.	D 188		

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D 188	Continued From page 3 Interview with the Supervisor on 12/06/19 at 6:45am revealed: -She was the only medication aide (MA) that worked on 11/05/19. -There were two personal care aides (PCA) that worked with her on 11/05/19. -She thought both of the PCAs that worked on 11/05/19 were both on medical restrictions. Review of the schedule dated 11/05/19 revealed: -There was one MA/SIC assigned to the facility. -There were no PCAs assigned to the AL unit, and there were two PCAs assigned to the special care unit (SCU); one of the two PCAs was on medical restrictions. Review of the Individual Employee Time Cards dated 11/16/19 revealed: -There were 8.17 aide hours provided on second shift leaving the facility short 7.83 aide hours. -There were 8.38 aide hours provided on third shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Review of the Individual Employee Time Cards dated 11/17/19 revealed: -There were 13.63 aide hours provided on second shift leaving the facility short 2.37 aide hours. -There were 8.43 aide hours provided on third shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Review of a third resident's incident report revealed: -The resident resided on the AL portion of the facility. -The resident fell on 11/17/19 at 11:17 pm in the resident's room.	D 188		

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D 188	Continued From page 4 -The resident was injured and had a laceration at the top of the head. -The resident was transferred to the ER, but not hospitalized. -The resident's diagnosis was fall with scalp laceration. Review of the Resident Bed List Report dated 11/29/19 revealed there was a census of twenty-eight residents residing on the assisted living (AL) unit, which required sixteen aide hours on second shift and eight hours of aide duty on third shift. Review of the Individual Employee Time Cards dated 11/29/19 revealed: -There were 10.42 aide hours provided on second shift leaving the facility short 5.58 aide hours. -There were 8.01 aide hours provided on third shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Review of the Individual Employee Time Cards dated 11/30/19 revealed there were 8.24 aide hours provided on second shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Review of the Individual Employee Time Cards dated 12/02/19 revealed: -There were 16.26 aide hours provided on second shift; 3.49 aide hours were provided by a personal care aide (PCA) on medical restriction. -There were 11.5 aide hours provided on third shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Review of the Individual Employee Time Cards dated 12/02/19 revealed: -There were 16.26 aide hours provided on	D 188		

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D 188	Continued From page 5 second shift; 3.49 aide hours were provided by a personal care aide (PCA) on medical restriction. -There were 11.5 aide hours provided on third shift; 8.0 aide hours were provided by a personal care aide (PCA) on medical restriction. Interview with a second personal care aide (PCA) on 12/04/19 at 5:32pm revealed: -The facility did not have enough staff on the Assisted Living (AL) portion of the facility. -She thought the census was 20 something but she was not sure. -She thought the residents did not receive the care needed because of staff shortages. -The AL had two residents who were bed bound. -One the residents who spent most of the day in the bed, was assisted into the wheelchair for meals and the other resident needed assistance with turning, transferring, and toileting. -The family members of the resident who remained in the bed came to feed her. -There was another resident who was admitted less than a month ago and his family member came daily to change him into his pajamas and put him into the bed. -She was told by the Administrator that she was trying to hire staff, but people did not come to the "job fairs" held recently. -She was the only staff for the AL on 11/24/19 for one and a half hours and a medication aide (MA) came in to work on the AL. -She recalled an incident she was monitoring the dinner meal service alone and she had to leave the residents to answer the door. -She attempted to find other staff to assist the family at the door and only located the Administrator who monitored the meal service	D 188		

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while she assisted the resident out of the car.
-She did not recall the exact date but thought it was two weeks ago, approximately 11/20/19, when this occurred.

Telephone interview with a resident's family member on 12/06/19 at 12:09pm revealed:
-She noticed a high level of turn over in the PCAs and in the MAs in the special care unit (SCU).
-She was concerned her family member was not getting out of bed, not prompted for day to day activities and had begun to miss out on direct interaction and attention.
-She voiced her concerns to the Administrator and was told the staff was stretched [thin] because the facility was "short staffed".
Another interview with the second PCA on 12/04/19 at 5:33pm revealed:
-She worked second shift, but sometimes would work until 2:00am.
-"The facility is severely understaffed."
-In late November 2019, she was the only PCA in the facility for 90 minutes.
-She was alone during the dinner meal service on the assisted living (AL) in late November 2019.
-She told the Administrator it was "illegal" to have her working alone.
-The Administrator agreed it was "illegal."
-The facility was short-staffed on 11/16/19 and 11/17/19.
-The Administrator asked her to stay late, but she was unable to.
-In mid-November, the Memory Care Manager (MCM) was the only staff in the entire facility for about two hours.
-One night (date unknown), the MCM was the only staff in the entire facility.
-One night (date unknown), the second shift medication aide (MA) stayed until 2:00am.
-One evening in November 2019 (date unknown),

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the AL residents did not receive medication during second shift.
-The residents were not receiving the care they needed.
-She left a message with the corporate office about lack of staff, but did not get a response.

Interview with a medication aide (MA) on 12/06/19 at 10:55am revealed:
-She worked 12-hour shifts six days a week.
-There was one MA for both units the previous weekend.
-Management was not receptive to the staff's concerns about the lack of staff.

Interview with a third PCA on 12/06/19 at 11:05am revealed:
-She worked first shift.
-She worked on the AL the previous weekend.
-She and the MA were the only ones on the AL.
-The MA gave medication to the residents both the AL and the special care unit (SCU) until the MCM came in halfway through first shift.
-She did not get a break.
-A PCA from the SCU came to help her on the AL side.
-"It's like this every weekend I work."
-The Administrator needed to hire more staff.

Interview with a second MA on 12/06/19 at 12:12pm revealed:
-She worked on both units.
-She usually worked long hours on the weekends.
-She came in early and stayed late.
-MAs were usually asked to stay after scheduled hours on the weekdays.
-Last weekend, a MA and a PCA assigned to the SCU had called out.
-Management did not inform her of the call-outs.
-She went to the SCU to give the residents their

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medication.
-The MCM came in at 10:45am to administer medication to the SCU residents.
-She ended up working 13½ hours and she did not get a break.
-Last month (date unknown), there was one day where she was the only MA in the building from 6:30am-8:30pm.
-Many staff had quit.
-Since June 2019, the facility had been short-staffed.
-Staff quit because of the long hours and having to work six days in a row.
-"I don't think anyone should have to work like this."

Interview with the Administrator on 12/06/19 at 3:13pm revealed:
-She needed more staff.
-She wished she had the budget to hire more staff.
-A realistic estimate for AL staffing would be 2-3 PCAs on each shift based on the heavy care needs of the AL.
-She knew staff said they needed help and that residents were not getting their needs met.
-Three staff were on light duty and were unable to lift residents or assist them with their toileting needs.
-She had to use the staff she had.
-There were not enough staff to call in to work when others called out.
-She came to work on the weekends.
-She worked on 11/16/19, 11/17/19, 11/23/19, and 11/24/19.
-There were two call-outs on 12/01/19.
-She came into work third shift and worked for 12 hours.
-The MCM also worked for 12 hours on 12/01/19.
-She did not perform PCA tasks.

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D 188	Continued From page 9 -She emptied urinals, answered call lights, and cleaned tables. -She was trying to find more staff. -She was having a hard time finding staff because there was no bus line near the building. Interview with the MCM on 12/06/19 at 5:13pm revealed: She had been working at the facility for six weeks. -She had only one weekend off since she had been working at the facility. -She had not worked under 40 hours for any week since she had been working at the facility. -The length of time she worked depended on the shift she worked. -The previous weekend she came in for first shift and had worked 10 hours. -She did whatever needed to be done when she came in. -If an MA called out, she administered medication. -If a PCA called out, she worked on the floor. Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 22 sampled shifts for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, and 12/02/19. This failure was detrimental to the health, welfare, and safety of the residents and constitutes an Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/06/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D 188		

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D 273	Continued From page 10	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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 3 of 5 sampled residents (#1, #2, and #7) including notifying the primary care provider regarding a resident who was not wearing their Thrombo-Embolic-Deterrent hose (TED) who had a history of a blood clots (#1); a resident who had an order to have staples removed from a head wound (#2); and a resident who was sent out to the hospital for hypernatremia and dehydration (#8). The findings are: 1. Review of Resident #2's current FL-2 dated 03/26/19 revealed diagnoses included Alzheimer's, diabetes mellitus, atrial fibrillation, hypertension, hypothyroid, and history of a hip fracture. Review of Resident #2's hospital discharge	D 273	Facility has implemented daily stand up meetings. Stand up meetings will include all Facility Management Staff. Executive Director will review all resident concerns in regrads to Healthcare referrals and follow-up needs during daily stand up meetings. Chart audits were conducted to assure the continuity of care and coordination of health care referral and follow-up needs were met. Identified, unmet needs were forwarded to the primary care provider to review. Residents provider notes, discharge summeries, progress notes and/or provider visit notes have been reviewed for any outstanding referral and follow-up needs. Facility ED, DRC and/or MCM are responible for reviewing residents provider noted, discharge summeries, progress note and/or provider visit notes. Facility has been assigned a new Area Director of Opertations (ADO). ADO will review daily stand up meetings for residents healthcare referral and follow-up needs during weekly site visits.	1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 1/20/2020 Ongoing 1/20/2020 Ongoing

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D 273	Continued From page 11 summary revealed: -Resident #2 was seen at a local hospital on 11/27/19 for a fall. -Resident #2 was diagnosed with a laceration of the scalp. -Resident #2 had staples placed with instructions to have the staples removed in seven days. Observation of Resident #2 on 12/06/19 at 9:59am revealed Resident #2 had four staples in the top of her head. Interview with Resident #2 on 12/06/19 at 9:52am revealed: -She had a fall (she did not recall the date). -She went to the hospital and "got these" indicating staples in the top of her head. -She reported someone looked at the staples the other day (she did not recall the date) and told her the staples were ready to take out, but no one had come in to remove the staples. -She wished someone would remove the staples; her head was itching, and she wanted to wash her hair. Interview with a medication aide (MA) on 12/06/19 at 10:16am revealed: -She did not know Resident #2's staples were supposed to be removed seven days after her fall. (Resident #2 fell on 11/27/19). -The Memory Care Manager (MCM) was responsible for reviewing the discharge summary and scheduling any follow-ups that were required. Interview with the MCM on 12/06/19 at 10:18am revealed: -The receptionist/transportation coordinator was responsible for making appointments. -Discharge summaries were reviewed by the MA/Supervisor on the shift when the residents	D 273	Facility has been assigned a new ADO and Senior Area Director (SADO) who will review compliance with resident healthcare referrals and follow-up needs during weekly calls and/or site visits with Executive Director and/or ADO Twenty-four hour communication log implemented as an avenue for shift personnel to communicate resident needs from shift to shift. Communication log is reviewed by the Care Managers and presented daily to the Executive Director during morning stand up meetings to assure needs are addressed. ADO and/or SADO will review twenty-four hour communitcation logs during site visits. Facility staff have received training HealthCare referral and follow-up. Training provided by SADO and Licensed Health Professional (RN) Training conducted 12/26/19 and included the following subjects: -Healthcare - Contacting the Healthcare Provider -Documentation of provider visits -Importances of reviewing Provider Notes and Dischaged summeries - Residents follow-up needs - 24 hour communitcation logs	1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020

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D 273	Continued From page 12 returned from the hospital. -She did not see Resident #2's discharge summary. -If she had seen Resident #2's discharge summary she would have made sure it was placed in Resident #2's primary care providers (PCP) folder. -The Licensed Health Professional Services nurse (LHPS) had brought the discharge summary to her attention on 12/05/19. -She immediately contacted the PCP who is scheduled to remove Resident #2's staples on 12/11/19. Telephone interview with the receptionist/transportation coordinator on 12/06/19 at 10:30am revealed: -She was not aware Resident #2 had staples that needed to be removed. -If she knew about appointment needs, she would schedule the appointment and provide transportation if needed. -She thought another staff member coordinated having staples removed because other residents had staples before, and she had never transported any resident to have staples removed. Telephone interview with Resident #2's PCP on 12/06/19 at 11:06am revealed: -She was aware Resident #2 had a fall, but she had not seen a discharge summary and did not know Resident #2 had staples until her visit on 12/04/19. -She asked if Resident #2 had an injury and was told about the staples on 12/04/19. -She did not know the staples needed to be removed on 12/04/19 since she had not seen the discharge summary; she did not have a staple removal kit with her.	D 273	Facility DRC and MCM have received additional training regarding Healthcare referral and follow-up. Training conducted by Licensed RN on 12/26/19	1/20/2020

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D 273	Continued From page 13 -She received notification from the SCU Manager on 12/05/19 about removing the staples and she told the SCU Manager she would remove Resident #2's staples on her next visit 12/11/19. -She thought the staples were fine to leave in, however, it did increase the risk of infection and was a resident rights issue because Resident #2 could not wash her hair and the staples were an annoyance. Interview with the Licensed Health Professional Services nurse (LHPS) on 12/06/19 at 1:16pm revealed: -She had seen Resident #2 on 12/04/19 and read in Resident #2's record she had a fall which resulted in a laceration and staples. -The discharge summary had documented the staples needed to be removed in seven days. -She told the MCM the staples needed to be removed on 12/04/19. Interview with the Administrator on 12/06/19 at 3:57pm revealed: -She was aware Resident #2 had staples that needed to be removed. -The PCP was supposed to remove the staples on 12/04/19. -She did not know the PCP was not aware of Resident #2's staples until she was making her rounds at the facility. -The MCM should have told the PCP so the PCP could have been prepared. -She was concerned Resident #2's staples had not been removed because it increased the risk of infection. 2. Review of Resident #1's FL-2 dated 01/02/19 revealed diagnoses included dementia unspecified without behavior disturbances,	D 273		

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D 273	Continued From page 14 difficulty in walking, other lack of coordination, monoclonal gammophies, unspecified fracture of upper end of left humorous. Review of physician's orders dated 08/05/19 revealed TED hose (tight fitting stockings used to prevent blood from clotting) apply to legs every morning and remove every evening at 9:00am and 9:00pm. Observation of Resident #1 on 12/04/19 at 4:11pm revealed she was laying in her bed and did not have TED hose on. Observation of Resident #1 on 12/05/19 at 8:34am revealed she was seated in the dining room she did not have her TED hose on. Observation of Resident #1 on 12/05/19 at 4:00pm revealed she was seated in the common area and she did not have her TED hose on. Observation of Resident #1 on 12/06/19 at 9:43am revealed: -She was seated in the common area and she did not have the TED hose on. -The Special Care Unit (SCU) Manager looked at Resident #1's legs and told staff to put the TED hose on. -The SCU Manager went into Resident #1's room and located a pair of TED hose in the dresser drawer and gave them to a PCA to put on Resident #1. -The SCU Manger was instructing the PCAs to put the TED hose on Resident #1 before she got out of the bed in the morning. -A PCA put Resident #1's TED hose on; Resident #1 did not resist or refuse to having the TED hose applied.	D 273		

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D 273	Continued From page 15 Review of Resident #1's electronic medication administration record (eMAR) for October 2019 revealed: -There was an entry for TED hose twice daily, apply to legs every morning and remove every evening scheduled at 9:00am and remove at 9:00pm. -There was documentation Resident #1 refused the TED hose six times on 10/05/19, 10/07/19, 10/10/19, 10/19/19, 10/21/19 and 10/29/19. -There was no documentation the resident's primary care physician (PCP) was notified the resident refused the TED hose. Review of Resident #1's eMAR for November 2019 revealed: -There was an entry for TED hose twice daily, apply to legs every morning and remove every evening scheduled at 9:00am and remove at 9:00pm. -There was documentation Resident #1 refused the TED hose on 11/02/19, and on 11/05/19 her legs were sore. -There was documentation on 11/06/19 at 9:25am Resident #1 complained of pain in legs with TED hose on and at 8:38pm the resident's hose were documented as "not on". -There was documentation on 11/07/19 at 9:36am Resident #1 complained of leg pain and at 9:14pm TED hose were not on. -There was documentation on 11/15/19 at 8:03pm no TED hose on. -There was documentation on 11/18/19 at 8:32am TED hose were ordered and waiting on delivery. -There was documentation on 11/25/19 at 9:36am (TED hose) were too tight and at 8:32pm (TED hose) were not on. -There was no documentation the resident's PCP was notified the resident refused the TED hose.	D 273		

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D 273	Continued From page 16 Review of Resident #1's eMAR for December 2019 revealed: -There was an entry for TED hose twice daily, apply to legs every morning and remove every evening scheduled at 9:00am and remove at 9:00pm. -There was documentation Resident #1 refused TED hose on 12/02/19. -There was documentation Resident #1 was out to the hospital on 12/03/19. Review of progress notes for Resident #1 revealed: -There was an entry dated 11/04/19 at 11:45am, Resident #1 complained of pain between her legs and pain in her legs from TED stockings; staff did not put TED stocking on her today due to the pain in her legs. -There was no documentation staff contacted Resident #1's PCP about her pain or staff not applying the TED hose. -There was an entry dated 11/09/19 at 3:58pm, Resident #1 was sent to the local hospital. Review of Resident #1 hospital discharge notes dated 11/11/19 revealed: -The resident had been admitted on 11/09/19. -The discharge diagnosis was pulmonary emboli (a condition in which a lung artery becomes clogged with a clot from a different part of the body, usually the legs); right upper lobe pulmonary embolism with bilateral lower extremity deep vein thrombosis (DVT) (a bood clot deep in a vein that can dislodge and lodge in the lungs). Review of a progress note for Resident #1 on 11/28/19 at 6:35am revealed she complained of leg pain and was administered 500mg of acetaminophen.	D 273		

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D 273	Continued From page 17 Interview with Resident #1 on 12/04/19 at 4:11pm revealed she did not like the TED hose because they were tight and hurt her legs. Interview with a personal care aide (PCA) on 12/06/19 at 9:11am revealed: -She tried to put Resident #1's TED hose on but the resident complained they hurt; she would try once to put the TED hose on and then go back in fifteen minutes and try to put them on again. -Resident #1 did not want to wear the TED hose because her toes were curved over on each other and that was why it hurt to wear them. -She notified the MA and the next shift PCA when Resident #1 refused to wear the TED hose. Interview with a medication aide (MA) on 12/05/19 at 3:19pm revealed: -Resident #1 complained her TED hose were too tight; a larger size was ordered but she still complains they are too tight. -Resident #1 refused to wear the TED hose and took them off herself. -The evening MA should document on the eMAR when Resident #1 did not have the TED hose on. -The MAs should have documented on the eMAR or made a progress note when Resident #1 refused to wear the TED hose or removed them. -MAs were responsible for calling the primary care physician (PCP) when a resident refused to wear TED hose after three days. -The MA should have documented in the progress notes when the PCP was notified. Interview with a second MA on 12/05/19 at 4:00pm revealed: -She worked in the evenings on the second shift. -She had not removed TED hose from Resident #1 in a while, she did not know if Resident #1 removed the TED hose herself or she refused to	D 273		

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D 273	Continued From page 18 put them on. -Refusals should be documented on the eMAR; she only documented when she removed the TED hose or when Resident #1 did not have on hose to remove. Interview with a third MA on 12/06/19 at 9:15am revealed: -The PCAs put Resident #1's TED hose on her every day; she double checked behind the PCAs to see if Resident #1 had the TED hose on. -Resident #1 could not remove the TED hose herself because they were tight, and she could not get them over her toes. -Resident #1's TED hose "went missing" about a month ago. -She let the Administrator know the TED hose were missing but she had only told the Administrator once. -She still documented the TED hose were put on Resident #1 everyday; she went down the eMAR and clicked on the "prep" button without looking. -She "dropped the ball" by not following up with the Administrator about the missing TED hose for Resident #1. Interview with the Special Care Unit (SCU) Manager on 12/06/19 at 9:21am revealed: -When residents refused to wear TED hose three times the PCP was notified. -Refusals were documented on the eMAR and calls to the PCP were documented on the progress reports. -She knew Resident #1 had new TED hose because she had measured her and ordered them. -She had instructed the staff to put Residents #1's TED hose on before she got out of bed and before her legs swelled; then removed at night when the resident laid down to go to bed.	D 273		

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D 273	Continued From page 19 -Staff had told her the day before that Resident #1 had a pair of TED hose but she did not see them, she was just told by the staff Resident #1 had a pair of the TED hose. Telephone interview with Resident #1's PCP on 12/05/19 at 11:08am revealed: -She knew that Resident #1 did not want to wear her TED hose; it had been an "off and on issue". -When she would see Resident #1 in the facility it would be "hit or miss" for Resident #1 to have the TED hose on; she believed Resident #1 refused to wear the TED hose because they were uncomfortable. -She had informed the family Resident #1 refused to wear the TED hose; she had no concerns about Resident #1 refusing her TED hose. 3. Review of Resident #7's FL-2 dated 01/08/19 revealed diagnoses included dementia without behavior disturbances, healthcare associated pneumonia, history of falls, hypoxia, interstitial lung disease, artrial flutter, and positive rhinovirus. Observation of the dining room in the SCU on 12/04/19 from 11:52am to 12:28pm revealed: -Resident #7 was seated at a counter in the corner of the second dining room; she had her back to the rest of the dining room and she had a full plate of food setting in front of her. -Resident #7 was sitting with her head hanging down and appeared to be asleep; Resident #7 was not eating or drinking anything. -At 12:15pm, Resident #7 still had a full plate of food and a full glass of water and iced tea; none of the staff were assisting or encouraging Resident #7 to eat or drink during the meal. -At 12:24pm, Resident #7 was still sitting with her head hung down, hair in her face and her hands	D 273		

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in her lap.
-At 12:28pm the PCA removed Resident #7 from the dining room and took her to her room.
-Resident #7 ate less than one percent of her meal and drank less than one percent of her beverages.

Observation of Resident #7 on 12/04/19 at 3:55pm revealed Resident #7 was sitting in the common area with her pants legs were above her knees and she was not able to speek.

Observation of Resident #7 in the facility's lobby on 12/04/19 at 4:30 pm revealed:
-She was sitting in a wheelchair with her head slumped down.
-She was assessed by the emergency medical technician (EMT) and verbally provided the pulse oximeter measurement (92%) and heart rate (130's) to the Paramedic.
-Resident #7 was assisted onto a gurney by the EMTs and Paramedic and transported at 4:40 pm.

Review of Resident #7's hospital discharge documents dated 12/04/19 revealed a diagnoses of dehydration and hypernatremia.

Review of Resident #7's progress notes revealed:
-There was documentation on 12/04/19 at 6:11pm Resident #7 was sitting in her wheel chair with her head down, she responded when spoken to and she was "glassy eyed"; Resident #7's was sent to the hospital and the family was notified.
-There was documentation on 12/05/19 at 12:05am Resident #7 returned from the hospital with a diagnosis of hypernatremia and significant dehydration and a possible urinary tract infection (UTI).

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D 273	Continued From page 21 Interview with a personal care aide (PCA) on 12/06/19 at 9:05am revealed: -On 12/04/19, Resident #7 was "normal" in the morning; she did not eat or drink anything at breakfast but that was "normal" for Resident #7. -At lunch time on 12/04/19, Resident #7 wanted to go to her room to sleep. -She did not let Resident #7 go to her room because "we try to keep them [the residents] up". -Resident #7 was tired but that was normal behavior for her, and she seemed okay. Interview with a second PCA on 12/06/19 at 12:22pm revealed: -She did not notice a change in Resident #7 on the day the resident was sent to the hospital, 12/04/19. -Resident #7 usually drank milk everyday for breakfast and only liked to drink a clear diet soda the family brought in for her to drink; the clear soda the family brought in was kept in the resident's room. -Resident #7 did not really eat; she tried to get Resident #7 to eat but the resident would spit the food out. -Resident #7 could feed herself but would only eat about two spoons of food. Interview with the Activities Director on 12/05/19 at 8:20am revealed: -Around 4:15pm on 12/04/19, she was on her way to clock out at the end of her shift when she noticed Resident #7 was not her normal baseline. -Resident #7 was sitting in the wheel chair with her pants legs above her knees, her shirt was raised up and her head was down. -She went over to Resident #7 to adjust her clothes and noticed the resident could not respond verbally, the resident was gazing up and did not make eye contact; Resident #7 usually	D 273		

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would maintain eye contact and make conversation.
-Her main concern was Resident #7 could not maintain contact and had slurred speech.
-She notified the SCU Manager of her concerns for Resident #7; the SCU Manager assessed Resident #7 and contacted EMS.

Interview with the Special Care Unit (SCU) Manager on 12/04/19 at 7:21pm revealed:
-Resident #7 could eat her meal herself but needed to be assisted and encouraged to eat.
-The PCAs were responsible for documenting on the progress note the percentage of food eaten by residents; she tried to review the progress notes daily to look for concerns.
-She was notified by the Activities Director of the change in Resident #7's condition on 12/04/19 around 4:30pm ; she called Resident #7's family and then contacted emergency medical services (EMS) for transport to the hospital.
-It concerned her she was not notified by the a medication aide (MA) Resident #7 did not eat or drink anything for lunch and dinner.

Telephone interview with Resident #7's primary care provider (PCP) on 12/06/19 at 10:59am revealed:
-Resident #7 needed assistance with all daily living skills and should be encouraged and cued to eat.
-She would be concerned if Resident #7 was not eating or drinking at meal times because it could contribute to dehydration.

Interview with Resident #7's family member on 12/05/19 at 8:46am revealed:
-She thought Resident #7 should be drinking more milk and water; the kitchen served water and milk in small four-ounce glasses.

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D 273	Continued From page 23 -Resident #7 was supposed to be assisted when eating. -Resident #7 liked to drink a certain diet soda so the family provided Resident#7 with diet sodas to keep in the refrigerator in the room, but the staff did not give them to Resident #7 to drink. -She had witnessed the staff not interacting with Resident #7 at meal times; she was concerned for Resident #7 and tried to help Resident #7 eat when she visited at meal times. The facility failed to assure Resident #1's physician was notified concerning refusals to wear TED hose which caused the resident to have blood clots and pulmonary embolus, Resident #2 did not have staples removed as ordered which placed the resident at an increased risk for infection per her primary care provider, and Resident #7 who did not receive assistance with meal services and did not eat or drink due to the lack of assistance was transferred to the hospital and had a diagnosis of dehydration and elevated sodium level. This failure of the facility was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/10/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D 273		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service	D 287		

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D 287	Continued From page 24 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents were provided with a non-disposable place setting, including a fork, a spoon, a knife, and a non-disposable plate. The findings are: 1. Observation of the special care unit (SCU) on 12/04/19 at 11:48am revealed there were 2 dining rooms. Observation of the SCU's large dining room on 12/04/19 between 5:19pm-5:24pm revealed: -There were 15 residents seated in the dining room. -The meal consisted of a chicken cheesesteak sandwich on french bread and potato chips. -There was one resident who was served a mechanical soft chicken cheesesteak sandwich. -No one was provided with a place setting of silverware. -There was one resident who used a potato chip to scoop the meat out of his sandwich. -There was a second resident who used her hands to eat the meat out of her sandwich.	D 287	ED, DRC, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then will monitor meals randomly to assure all residents have correct place settings. Facility has implemented daily stand up meetings Any resident dietary concerns will be reviewed and addressed during daily stand up meetings. Facility has been assigned an ADO and SADO who will monitor compliance with meals and meal place settings during on-site visits. Facility staff have received training on Dining Experience. Training was provided by CDP and Included the following topics: -What is Dementia -The Dining Experience and Dementia -How to assist with meal time and feeding	1/20/2020 1/20/2020 1/20/2020 1/20/2020

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D 287	Continued From page 25 Observation of the SCU large dining room on 12/04/19 between 5:24pm-5:27pm revealed: -A resident with the mechanical soft diet asked for silverware. -The resident with the mechanical soft diet tried to pick her food up with her hands; she dropped the food on her clothing and floor. -The resident with the mechanical soft diet asked a second time for staff to bring her silverware by calling out to the staff in the small dining room. Observation of the SCU large dining room on 12/04/19 at 5:29pm revealed a personal care aide (PCA) brought silverware to all the residents. Interview with a resident on 12/05/19 at 11:38am revealed: -She had to ask for silverware last night at dinner because there was nothing to eat with on the table. -The staff did not respond to her when she asked for silverware. -She needed "something" to eat her meals with. Interview with a medication aide (MA) on 12/05/19 at 3:01pm revealed: -Residents should have silverware at every meal. -All staff were responsible for making sure silverware was provided to all the residents. -She did not give silverware at dinner last night (12/04/19), "I just did not think the residents needed silverware with a sandwich." -It made sense that residents might need silverware if they wanted to eat the sandwich with a fork or to use a knife to cut the sandwich up. Interview with a PCA on 12/05/19 at 3:22pm revealed: -The PCAs usually put silverware on the table. -Sometimes the dietary staff put silverware on the	D 287		

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D 287	Continued From page 26 table. -She always gave a spoon to residents with a mechanical soft diet. -She did not know a resident with a mechanical soft diet did not have a spoon last night (12/04/19). -She thought the residents did not need silverware last night because they had sandwiches. Interview with the cook on 12/05/19 at 5:00pm revealed: -Everyday she rolled a fork, a knife and a spoon into napkins for each resident in the SCU to have silverware. -The PCAs set the tables, including the rolls of silverware; she rolled extra silverware "just in case". -She placed the rolls of silverware in a basket just inside of the kitchen for the PCAs to have access for setting the dining room tables. -She did not know why the PCAs did not use the rolled silverware at dinner the night before; maybe the PCAs "ran out of time or were in a hurry". -She knew the residents were always supposed to get a fork, a knife and a spoon no matter what was served for the meal; even when she made sandwiches the residents were should get silverware. Interview with the Kitchen Manager (KM) on 12/06/19 at 10:22am revealed: -He knew residents were supposed to have a fork, knife and spoon for every meal, no matter what the menu was. -The kitchen staff rolled a fork, knife and a spoon into disposable napkins for every meal; there were always extras.	D 287		

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D 287	Continued From page 27 -The PCAs set the dining room tables in the SCU so they were responsible for placing the silverware out the tables for the residents. -He did not know why the PCAs did not use the silverware rolled into napkins when sandwiches were served; he had never noticed residents were not given silverware at meals. Interview with the Administrator on 12/06/19 at 4:20pm revealed: -She expected the residents to have an entire set-up of silverware at every meal no matter what was served, even when residents were served "finger foods". -She was not aware the PCAs had not given residents silverware when they had a sandwich to eat. 2. Observation of the lunch meal in the second dining room in the Special Care Unit (SCU) on 12/04/19 at 11:50am revealed a personal care aide (PCA) asked the kitchen staff for a paper plate for a resident; the resident was served her meal on a paper plate. Observation of the breakfast meal in the second dining room in the SCU on 12/05/19 at 8:06am revealed the same resident as the day before was served her breakfast on a disposable plate. Interview with the medication aide (MA) on 12/04/19 at 12:33pm revealed: -The resident was given a disposable plate because she would pull plates off the table and break them. -The Kitchen Manager (KM) made the decision to give paper plates to the resident; the kitchen staff started providing paper plates about a month or two ago.	D 287		

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D 287	Continued From page 28 Interview with the KM on 12/04/19 at 12:39pm revealed: -He made the decision to give a paper plate to one of the residents because she had broken about ten plates when she pulled them off the table. -He did not know he had to serve the resident on a non-disposable plate; he thought he could make the decision himself. -He did not think the resident had an order for a sectional plate or non-disposable plate. Interview with the Administrator on 12/06/19 at 4:20pm revealed: -She knew residents were not supposed to be served on disposable plates at every meal; she knew it was a dignity concern for a resident to eat on a disposable plate "all the time". -She did not know a resident was served on a disposable plate until today, 12/06/19; she was told the kitchen staff gave the resident a disposable plate because the resident would break the plates.	D 287		
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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3	D 310	ED, DRC, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then will monitor meals randomly to assure residents are receiving correct diets as ordered by licensed health practitioner Facility has implemented daily stand up meetings Any resident dietary concerns will be reviewed and addressed during daily stand up meetings.	1/20/20 1/20/2020 Ongoing

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D 310	Continued From page 29 sampled residents were served therapeutic diets as ordered regarding a resident with an order for a regular diet and received a pureed diet (#7) and a resident with an order for chopped meats was served whole meat (#9). The findings are: 1. Review of Resident #9's current FL-2 dated 01/08/19 revealed: -Diagnoses included dementia, acute respiratory failure, gastroesophageal reflux disease, major depression, urinary tract infection, and hypoxemia. -There was a diet order for mechanical soft meats. Review of Resident #9's diet order form dated 10/04/19 revealed a diet order of mechanical soft with chopped meats. Review of the resident diet list posted in the kitchen revealed the list had been last updated on 07/12/19; Resident #9's diet was listed as a mechanical meats except fish. Review of the lunch menu for 12/04/19 revealed honey roasted chicken thigh, roasted yams, mixed vegetables, baked roll, and an apple crisp was to be served. Observation of the lunch meal service on 12/04/19 between 11:48am and 12:34pm revealed: -Resident #9 was served one whole boneless chicken breast, baked sweet potato, mixed vegetables, a roll, and water. -At 12:10pm, Resident #9 began to eat. -At 12:24pm, Resident #9 ate all of her mixed vegetables, sweet potato, and roll.	D 310	Facility has completed an audit and update, as needed, of all residents diet orders. Diet orders have been signed by residents Provider Facility has updated all resident diet orders with dietary staff and posted updated list. Facility DRC, MCM and/or ED will assure that all staff notified when a diet order changes for a resident. Updates will also be noted in 24 hour commuication log Facility DRC, MCM, Dietary Manager and/ or ED will be responisble for updating and posting updated diet list in kitchen Facility staff have received training on the Therrapeutic Diets and Aspiration Precautions. Training provided by Speech Therapy on 12/16/19 Facility staff have received training on Dining Experience. Training completed on 1/15/2020 Training was provided by CDP and Included the following topics: -What is Dementia -The Dining Experience and Dementia -How to assist with meal time and feeding Facility staff received training on Feeding Techniques on 12/5/19. Training provided by Licensed RN. Facility has been assigned an ADO and SADO who will monitor compliance with meals, review diet orders posted and feeding theniques during on-site visits	1/20/2020 1/20/2020 1/20/2020 1/20/2020 1/20/2020 1/20//2020 1/20/2020 1/20/2020

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-At 12:24pm, the personal care aides (PCA) began cleaning the dining room tables off and moving residents to the living room area; Resident #9 was moving her whole boneless chicken breast around the plate with her fork.
-At 12:34pm, Resident #9 she slid the whole boneless chicken breast to the edge of her plate, leaned her head down into the plate, and took bites of her chicken.
-At 12:39pm, a PCA rolled Resident #9's wheelchair away from the dining room table; Resident #9 had taken 2 bites of her chicken.
-No staff member offered to cut Resident #9's chicken into bite-size pieces.

Review of the breakfast menu for 12/05/19 revealed Texas French toast, breakfast ham, fresh fruit, juice, and milk was to be served.

Observation of the breakfast meal service 12/05/19 between 8:06am and 8:45am revealed:
-Resident #9 was served scrambled eggs, a piece of uncut sausage, a piece of toast, a small container of grapes and a glass of juice.
-Resident #9 ate grapes, and four bites of her scrambled egg.
-Resident #9 used her fork to pick up the entire piece of sausage and took one bite.
-Resident #9 did not eat any of her toast.
-At 8:43am, a PCA rolled Resident #9's wheelchair away from the dining room table.
-No staff member offered to cut Resident #9's sausage into bite-size pieces.

Telephone interview with Resident #9's Primary Care Provider (PCP) on 12/05/19 at 12:12pm revealed:
-Resident #9 had a diet order for chopped meats.
-Resident #9 was not able to cut her meats up.
-If Resident #9's diet order was for chopped

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meats, she expected the meats to be chopped.
-She was concerned because she did not know if Resident #9 may have had a swallowing problem.

Interview with a PCA on 12/05/19 at 2:46pm revealed:
-When she was working in the dining room, she made sure residents were eating their meals and if any assistance was needed, she would provide.
-Resident #9 needed assistance cutting up "big" meats; she cut-up Resident #9's pork chop today, 12/05/19, because Resident #9 was trying to cut the pork chop with her fork.
-When she started working at the facility other PCAs told her what residents had special diets.
-She did not know Resident #9 had a diet order for chopped meats.
-She thought there was a lack of communication.

Interview with a medication aide (MA) on 12/05/19 at 3:45pm revealed:
-The kitchen manager was responsible for making sure therapeutic diets were served as ordered.
-The MCM and/or the Administrator gave the diet orders to the kitchen manager.
-She did not know Resident #9 had an order for chopped meats.
-The PCAs should cut-up a resident's meat if they saw a resident having trouble with eating the meat that was served.

Interview with a PCA on 12/06/19 at 9:41am revealed she had cut-up Resident #9's sausage at breakfast (12/06/19) and Resident #9 ate "every bite."

Interview with the Kitchen Manager (KM) on 12/06/19 at 10:07am revealed:
-He was responsible for keeping a current list of

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residents and their diets and made changes as needed himself.
-He received diet orders and changes for diet orders from the SCU Manager.
-When there was a new resident, he would contact the resident's physician himself and get a diet order.
-Sometimes the medication aide (MA) would bring him physician's orders or notes.

Telephone interview with Resident #9's family member on 12/06/19 at 3:22pm revealed:
-Resident #9's meat was never cut-up.
-She always cut-up Resident #9's meat when she was visiting at mealtimes.
-Resident #9 could not use a fork and a knife to cut her meats.
-Resident #9 had swallowing problems in 2018 after being hospitalized and had an order for meals to be chopped.
-She spoke to the kitchen manager about Resident #9's meals a couple of weeks after the hospitalization because Resident #9's meals had been "emulsified" and were not appetizing to Resident #9.
-She did not want Resident #9's meats processed in a blender, "just cut-up."

Interview with the Administrator on 12/06/19 at 3:57pm revealed:
-She did not know Resident #9 had an order for chopped meats.
-She did not know Resident #9's meat had not been chopped.
-Diet orders should be updated every time there was a change and reviewed weekly.
-Staff should assist residents with meals, including cutting up meats when needed.

Based on observations, interviews, and record

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D 310	Continued From page 33 reviews it was determined Resident #9 was not interviewable. 2. Review of Resident #7's FL-2 dated 01/08/19 revealed diagnoses included dementia without behavior disturbances, healthcare associated pneumonia, history of falls, hypoxia, interstitial lung disease, arterial flutter, and positive rhinovirus. Review of a signed diet order dated 10/04/19 revealed Resident #7 was ordered a regular diet. Review of the resident diet list posted in the kitchen dated 07/12/19 revealed Resident #7 was listed as a pureed diet. Review of the lunch menu for 12/04/19 revealed honey roasted chicken thigh, roasted yams, mixed vegetables and a dinner roll were to be served. Observation of the dining room in the Special Care Unit (SCU) on 12/04/19 from 11:52am to 12:28pm revealed: -Resident #7 was seated at a counter in the corner of the second dining room; she had a plate of pureed food setting in front of her. -At 11:52am, Resident #7 was served pureed chicken, pureed sweet potatoes, pureed mixed vegetables and a dinner roll; Resident #7 was not eating anything. -At 12:15pm, Resident #7 still had a full plate of pureed food. -At 12:28pm, a personal care aide (PCA) removed Resident #7 from the dining room and took her to her room. -Resident #7 ate less than one percent of her meal.	D 310		

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D 310	Continued From page 34 Review of the breakfast menu for 12/05/19 revealed French toast, breakfast ham, and fresh fruit were to be served. Observation of the breakfast meal in the dining room in the SCU on 12/05/19 at 8:06am revealed Resident #7 was served pureed eggs, pureed bread, pureed sausage, a yogurt cup and a can of diet soda. Based on observations, interviews and record reviews it was determined Resident #7 was not interviewable. Interview with a personal care aide (PCA) on 12/05/19 at 12:54am revealed Resident #7 was on a pureed diet because she did not eat; Resident #7 had always been on a pureed diet. Interview with the Kitchen Manager (KM) on 12/06/19 at 10:07am revealed: -He was responsible for keeping a current list of residents and their diets and made changes as needed himself. -He received diet orders and changes for diet orders from the SCU Manager. -When there was a new resident, he would contact the resident's physician himself and get a diet order. -Sometimes the medication aide (MA) would bring him physician's orders or notes. -He changed the diet list without a documented diet order; he was told by a previous physician that he could make diet decisions himself and change resident's diets as he saw the need. -He was told he could change a diet without an order for one week but would need an order from a physician after the one week. -He held a degree from a culinary school and a	D 310		

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nationally recognized food safety certification but had no other credentials.
-The PCAs would come to him and tell him a resident was not eating and he would make the decision to downgrade the diet to a mechanically chopped or a pureed diet.
-He would recognize when a resident was not eating and would change the diet based on his observations; he usually changed the diet to a chopped or a pureed diet.
-He could not recall the residents diets he had changed himself; he changed the diets without an order because he wanted the residents to eat.
-He thought Resident #7 had been on a pureed diet for almost a year.

Interview with Resident #7's primary care physician (PCP) on 12/06/19 at 10:59pm revealed:
-Resident #7 was ordered a regular diet, not a pureed diet.
-She had been aware Resident #7 had a decrease in appetite for about the last three weeks.
-She thought maybe the change to a pureed diet could be the reason for the decrease in appetite; "nobody wanted to eat a pureed diet if they did not have too".
-Resident #7's diet should not have been changed without a physician's order from her or an evaluation from a Speech Therapist with a recommendation to change the diet order.
-Maybe the facility staff changed Resident #7's diet because they thought the resident needed a pureed diet, but it did not matter because there was not an order for a pureed diet for Resident #7.

Interview with the SCU Manger on 12/06/19 at 11:48am revealed:

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D 310	Continued From page 36 -Staff should come to her when there was a concern with a resident's diet and then she would contact the PCP with the concern; only the PCP could make diet changes. -She did not know who made the resident diet list or made changes to the diet list for the kitchen to follow. -The SCU resident diet list should be made by her, the diet list should be updated when a new resident was admitted and when there was a change in a resident's diet. -She did not know if the kitchen was following the SCU residents' diets, but she expected them too. -A resident's diet should never be changed without a physician's order. -She was not aware residents' diets had been changed without orders; she was concerned diets were changed without orders. Interview with the Administrator on 12/06/19 at 4:09pm revealed: -She was made aware on 12/06/19 of concerns with the resident . -The diet list should have been reviewed every six months and updated when a resident had a physician's order for a diet change. -She thought the KM could change a diet without an order based on concerns the PCAs and MAs had with residents and eating. -The physician would sign the orders on the next visit, after the diet was changed and tried by the facility staff. -She understood that a diet change without orders could be a dignity issue for a resident and a resident's rights issue, but she thought it was better than having a resident choke on their food. -She observed meals when she could; the last time she observed a meal in the SCU was in April 2019.	D 310		

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D 310	Continued From page 37 The facility failed to assure residents were served diets as ordered by their primary care physician, Resident #9 who was ordered a chopped meats diet and did not have meats chopped and Resident #7 who was ordered a regular diet but was given a pureed diet and not eating. The facility's failure was detriment to the health and safety of th the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, and interviews, the facility failed to assure residents in the Special Care Unit (SCU) who required assistance with eating, were assisted upon receipt of the meal in a timely manner.	D 312	ED, DRC, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then will monitor meals randomly to assure residents who require feeding assistance recieve assistance in an unhurried manner that maintains or enhances residents dignity and respect. Facility has been assigned an ADO and SADO who will monitor compliance with meals and feeding assistance during on-site visits. Facility has implemented daily stand up meetings Any resident dietary concerns will be reviewed and addressed during daily stand up meetings.	1/20/2020 1/20/2020 1/20/2020

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D 312	Continued From page 38 The findings are: Observation of the special care unit (SCU) on 12/04/19 at 11:48am revealed: -There were two dining rooms. -The large dining room and a second smaller dining room. Observation of the lunch meal in the SCU large dining room on 12/04/19 from 11:48am to 12:39pm revealed: -At 11:48am, there were 17 residents served a lunch meal service. -There was one table with seven residents and a personal care aide (PCA) seated; the PCA was viewing her cell phone. -At 11:48am, a resident was seated in her wheelchair with a plate that contained a whole boneless chicken breast, mixed vegetables, a sweet potato and a roll; she was at a four-top table. -At 11:48am, a second resident was seated in her wheelchair was served a plate that contained a whole boneless chicken breast, mixed vegetables, a sweet potato and a roll; she was at a second four-top table. -At 11:52am, the second resident was not eating, and no assistance or prompting had been provided. -At 11:57am, both the first and second residents were not eating, and no assistance or prompting had been provided. -At 11:59am, a PCA walked over to the first resident, and while standing, asked her if she was going to eat, took the resident's fork, stuck the fork into a piece of cauliflower, put the cauliflower into the resident's mouth, handed the resident the fork and told her to eat and walked away. -At 12:10pm, the second began eating her sweet potato and mixed vegetables.	D 312	Facility has conducted review of care plans for all residents to assure residents who require feeding will receive assistance as needed Facility staff have received training on the Therrapeutic Diets and Aspiration Precautions. Training provided by Speech Therapy on 12/16/19 Facility staff have received training on Dining Experience. Training conducted on 1/15/2020 Training was provided by CDP and Included the following topics: -What is Dementia -The Dining Experience and Dementia -How to assist with meal time and feeding Facility staff received training on Feeding Techniques on 12/5/19. Training provided by Licensed RN.	1/20/2020 1/20/2020 1/20/2020 1/20/2020

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D 312	Continued From page 39 -At 12:18pm, the PCA called out to the medication aide (MA) to watch the dining room and left; the MA was at the medication cart working. -At 12:19pm, a second PCA walked into the room and asked the first resident if she wanted her chicken cut-up; the PCA cut the chicken into bite-size pieces and left the dining room. -The second resident attempted to use her fork to get a bite of chicken; she was only able to move the chicken around her plate. -At 12:22pm, the first PCA returned to her seat at the long table; she did not stop at any residents' tables to offer any assistance or prompting. - At 12:24pm, the PCAs began moving residents into the living room and cleaning the tables. -At 12:25pm, the PCAs removed cups off the table in front of the second resident who was trying to eat her chicken, leaving the resident with no beverage while she was still eating. -At 12:30pm, a PCA took the first resident's plate away while the resident was still holding her fork; the resident ate less than five percent of her meal. -At 12:31pm, a PCA moved the first resident's wheelchair into the living room area. -At 12:34pm, the second resident slid the whole boneless chicken breast to the edge of her plate, leaned her head down into the plate, and took bites of her chicken. -At 12:39pm, a PCA rolled the second resident's wheelchair away from the dining room table; the resident had taken two bites of her chicken; the resident was not given anything to drink. Observation of the dinner meal in the SCU large dining room on 12/04/19 from 5:19pm to 5:55pm revealed: -There were 15 residents seated in the dining room.	D 312		

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D 312	Continued From page 40 -The meal consisted of a chicken cheesesteak sandwich on french bread and potato chips. -Between 5:19pm and 5:27pm, there were no staff in the large dining room. -At 5:22pm, a resident could not reach her plate of food on the dining room table from her wheelchair; the resident was approximately 24 inches from the table and was not able to reposition her wheelchair without assistance. -At 5:27pm, a PCA went into the large dining room. -At 5:33pm, the PCA moved the resident closer to the table and cut-up the resident's sandwich, placed a piece of the sandwich on the fork and placed the fork into the resident's hand. -Between 5:37pm and 5:41pm, there was no staff in the large SCU dining room. -At 5:41pm, the resident had only eaten the one bite of her sandwich; the resident was using her fork to try to pick up a potato chip. -At 5:42pm, a PCA began moving residents from the dining room into the living room and cleaning off tables. -At 5:43pm, a second PCA took sherbet into the dining room and gave a cup of sherbet to the seven residents who were seated at the tables. -There was no staff in the dining room between 5:44pm-5:55pm to offer any assistance or to encourage residents to eat. -At 5:55pm, a PCA went into the dining room and began cleaning the tables and taking residents into the living room. Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -The PCAs were responsible for setting the tables, getting residents to the tables, making sure residents were eating and drinking, and general observations. -She expected the SCU staff to encourage	D 312		

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residents to eat and help if needed.
-There were 4-5 residents who needed encouragement to eat because their focus gets taken away.

Observation of the breakfast meal in the SCU large dining room on 12/05/19 from 8:06am to 8:50am revealed:
-At 8:06am, residents were served plates.
-The meal consisted of scrambled eggs, a piece of sausage, a piece of toast, and a small container of grapes.
-The resident who did not eat her meals independently on 12/04/19 was sitting at the long table with a PCA encouraging her to eat; the resident ate all of her breakfast meal with prompting and assistance from the PCA.
-At 8:11am, a second resident slid her plate to the side.
-At 8:13am, the second resident pulled her plate in front of her, ate one bite and stopped eating.
-At 8:14am, a third resident was asleep in her wheelchair at a four-top dining room table.
-At 8:18am the first resident started coughing and was pushed away from the table by the PCA; the PCA patted the resident on the back until the resident stopped coughing.
-At 8:22am, the third resident was still asleep, and the second resident was not eating her breakfast.
-At 8:22am, the PCA told the first resident to eat smaller bites so she did not get choked again.
-At 8:23am, the PCA hollered across the room and told the third resident she had food in front of her.
-At 8:24am, the PCA went to the second resident's table, put the sausage on the piece of toast, handed it to the resident, and told her it was a sausage sandwich.
-The resident laid the "sausage sandwich" back

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down on the plate.
-At 8:24am, the PCA went to the third resident's table and woke the resident up; the resident said she wanted a cup of coffee.
-At 8:26am, the PCA started cleaning the tables.
-At 8:28am, a second PCA took a cup of coffee to the third resident's table who was asleep, woke the resident up and encouraged the resident to eat.
-At 8:30am, the second began to eat her grapes.
-At 8:31am, the third pushed herself away from the table.
-At 8:32am, a PCA asked the third resident if she wanted her coffee and pushed her back to the table; the resident fell back asleep.
-At 8:40am, the third resident was woken up by a PCA and encouraged to eat; the resident ate 3 bites of toast, 1 bite of eggs and 1 bite of sausage and stopped eating.
-At 8:44am, the second resident left the table; the second resident ate approximately ten grapes and two bites of her eggs.
-At 8:45am, the third resident started back eating.
-At 8:48am, the third resident pushed herself away from the table; the resident ate less than fifty-percent of her breakfast meal.

Interview with a hospice nurse on 12/05/19 at 11:54am revealed:
-One of the residents who was observed needing assistance was a hospice patient.
-The hospice patient needed prompting to eat her meals.
-She was concerned the hospice resident would continue to lose weight if she was not assisted at meals.
-The resident weighed 136.5 on 09/01/19, 131.5 on 10/01/19, and 130.0 on 11/01/19.

Interview with a Primary Care Provider (PCP) on

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D 312	Continued From page 43 12/05/19 at 12:12pm revealed: -Two of the three residents observed at meals were her patients. -Residents in late-stage dementia tend to lose weight and therefore needed assistance/prompting at meals. -She expected residents in the SCU to be prompted at meals. Interview with a PCA on 12/05/19 at 2:46pm revealed: -There should be a PCA in the large dining room at meals. -The PCA should make sure the residents were eating their meals. -It was important for the residents to get the right intake. -No one told her to assist the residents; she just did it. Interview with a second PCA on 12/05/19 at 3:22pm revealed: -At meal times, she passed out the plated food, and drinks. -She helped feed residents that needed to be fed. -She always asked if residents needed assistance and made sure everyone was eating. Interview with a MA on 12/05/19 at 3:45pm revealed: -She expected at least one PCA to be in the large dining room with the residents during meals. -There were residents who needed assistance and prompting in the large dining room. -She was concerned residents would lose weight if they were not eating because they needed prompting and/or assistance that they were not getting. Confidential staff interviews revealed:	D 312		

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D 312	Continued From page 44 -There was not enough staff to assist the residents at meals. -The ratio of staff versus residents who needed assistance showed there was not enough staff. b. Observation of the lunch meal in the second dining room on 12/04/19 from 11:48 to 12:48pm revealed: -There were seven residents that ate in second dining room. -There were two residents seated at a counter with their backs facing the rest of the dining room; there was a table with five residents seated at it. -At 11:52am, a personal care aide (PCA) redirected a resident back to the second dining room to eat. -At 11:53am, a resident was served her food and a medication aide (MA) sat next to her and began to encourage her to eat; the MA alternated between assisting the resident with eating and prompting the resident to eat. -At 11:57am, a second resident was served her food and PCA sat beside her and assisted her with eating her meal. -At 12:04pm, a third resident was served a pureed meal and she put her fingers in her food; at 12:15pm a MA sat next to the resident and assisted the resident with eating her food. -At 12:11pm, one of the residents who was seated at the counter pushed herself away from the counter; a PCA who was passing plates told the resident to go back to the "table" to eat her food. -At 12:14pm, a resident fell asleep and was removed from the second dining room. -At 12:15pm, one of the residents seated at the counter had a plate of food but still was not eating. -At 12:21pm, a PCA that was assisting one	D 312		

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resident with eating moved to another resident at the table and began to assist that resident; the resident the PCA left had not eaten all her food and waited for the PCA to come back to assist her again at 12:25pm.
-At 12:24pm, a PCA stood beside a resident and assisted the resident to eat but moved away before the resident was done eating to clear plates from the dining rooms.
-At 12:27pm, a PCA removed the resident that was seated at the counter and not eating from the dining room; the resident had eaten less than one percent of her food.

Interview with a PCA on 12/04/19 at 12:28pm revealed:
-The MAs did not help with meal service because they were busy passing medication to residents; the lunch meal that day was the first time a MA had helped to assist residents with eating.
-The resident seated at the counter would have eaten her meal if the PCA who took her out of the dining room had assisted her with eating her food.
-She could usually assist two residents with eating and could encourage others at the table to eat.
-There needed to be more staff to help assist residents during meal time.
-All the residents who needed assistance with eating or prompting to eat were placed into the second dining room together.

Interview with a MA on 12/04/19 at 12:33pm revealed:
-She usually did not have time to help serve residents in the dining room because she usually passed medication at meal times.
-There were about three residents that needed to be assisted with eating and three to four residents

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D 312	Continued From page 46 needed to be prompted to eat. Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -PCAs should be feeding residents and assisting residents during meal times; MAs should be passing medication during meal times. -If a resident refused to eat the meal the PCA should wait five to ten minutes and should have tried again to assist the resident; if a resident completely refused to eat then dietary should have held the plate for the resident. -There were three to four residents that needed assistance with eating and a "handful" that needed to be prompted to eat. -She tried to observe meals when they were served; she observed ten to fifteen minutes of the dinner meal the day before. -All residents should be observed and assisted by the staff while they are eating. -She did not have concerns about residents being assisted while they were eating; she saw residents eating and drinking during meal times. Interview with the Administrator on 12/04/19 at 6:43pm revealed: -She knew there were six residents that needed to be assisted with eating at meal times. -All the residents that needed assistance with eating were seated in the same dining room so the staff could assist them. -All staff, PCAs and MAs, should have helped serve residents at the meal time and should have assisted residents with eating at the meals. -The last time she observed the dining room was around April 2019. Based on observations, interviews, and record reviews, the facility failed to assure all residents in	D 312		

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D 312	Continued From page 47 the special care dining room that required assistance with eating, prompting, encouragement and general aide at meal time were asisted timely. The failure resulted in residents leaving the dining room before they ate a full meal, and put resdents at risk for choking while they were eating. The facility's failure placed residents at substantial risk for serious harm and neglect and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/10/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews and interviews, the facility failed to administer	D 358	Facility ED, DRC and MCM have conducted a full medication cart audit to assure accuracy of orders, medications on hand, and accuracy of medications. Facility ED, MCM and DRC completed an audit of all physician orders compared to EMARS for accuracy. Facility SICs and/or Medication Techs will conduct weekly medication cart audits Facility ED,DRC, and/or MCM will review weekly cart audits which are completed by SICs/Med Techs. Review will be done weekly Facility DRC and/or MCM will conduct additional monthly medication cart audits for 3 months, then randomly there after Facility has implemented stand up meeting daily. ED, DRC and/or MCM will discuss compliance with medication cart audits during daily stand up meetings	12/27/19 12/27/19 12/27/19 Ongoing 12/27/19 Ongoing 12/27/19 12/27/19 Ongoing

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D 358	Continued From page 48 medications as ordered for 1 of 4 residents (#11) observed during the medication pass, including errors with a laxative and a vitamin B12; and for 3 of 8 residents (#2, #4, and #5) sampled for record review including errors with sliding scale insulin (#5), ophthalmic antibiotic and anti-inflammatory drops, and a thyroid hormone replacement (#2), a medication to treat dementia and a medication to treat depression and generalized anxiety (#4). The findings are: 1. The medication pass error rate was 6.45% as evidenced by the observation of 2 errors out of 31 opportunities during the 8:00 am medication pass on 12/05/19. a. Observation of the 8:00 am Special Care Unit (SCU) medication pass on 12/05/19 revealed: -The medication aide reviewed the list of medications for Resident #11 and pulled each one from the medication cart. -She located Resident #11's polyethylene glycol in a separate area of the medication cart after looking for the medication. -There was one packet remaining in a plastic bag with the medication label attached. -Resident #11's polyethylene glycol was mixed with water and administered to Resident #11 at 7:59 am. Review of Resident #11's current FL-2 dated 01/08/19 revealed diagnosis included dementia without behavioral disturbances. -There was a medication order for polyethylene glycol (used to treat occasional constipation) mix one packet in fluid and take by mouth every 3 days. Review of Resident #11's October 2019 printed	D 358	ED, DRC and/or MCM, along with ADO have conducted chart and physicians orders for accuracy. Contact was made with physicians with any needed changes, follow-up and/or concerns Facility LHPS RN, DRC (LPN), and/or DDCS (RN) will conduct random medication pass observations with different Medication techs over the next 2 months, then randomly there after Registered Nurse provided training on 12/26/19 to include, but not limited to the following; -Complete orders -Window of administration -Do not crush -Unavailable medications -Pharmacy interactions -Ordering -Notifying Physicians -Refusals -Errors -Documentation -Incident Reporting -Infection Control -Hot Box & 72 hour Charting -Progress Notes -Antibiotics -Pain Medications -Follow up Training provided to SICs and Medication Tech on how to complete medication cart audits. Training provided on 12/12/19 by ADO. ADO and/or SADO in coordination with DDCS will monitor compliance through system reviews and weekly onsite visits.	12/27/19 12/27/19 Ongoing 12/27/19 12/27/19 12/27/19 Ongoing

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D 358	Continued From page 49 electronic medication administration record (eMAR) revealed: -There was an entry for polyethylene glycol mix one packet in fluid every 3 days, scheduled for 9:00 am. -There was documentation of administration on 10/03/19 and 10/06/19 at 9:00 am. -There were "Xs" documented on 10/01/19, 10/02/19, 10/04/19, and 10/05/19. -There was a second entry for polyethylene glycol mix one pack in fluid every 3 days, scheduled for 8:00 am which started on 10/09/19. -There was documentation of daily administration from 10/09/19 to 10/31/19 at 8:00 am. Review of Resident #11's November 2019 printed eMAR -There was an entry for polyethylene glycol mix one pack in fluid every 3 days, scheduled for 8:00 am. -There was documentation of daily administration from 11/01/19 to 11/30/19 at 8:00 am. Review of Resident #11's December 2019 printed eMAR -There was an entry for polyethylene glycol mix one pack in fluid every 3 days, scheduled for 8:00 am. -There was documentation of daily administration from 12/01/19 to 12/05/19 at 8:00 am. Review of Resident #11's polyethylene glycol medication label revealed: -There were 3 boxes dispensed with a dispensed date of 12/05/19. -The instructions for administering Resident #11's polyethylene glycol were to mix one packet in fluid and take by mouth every 3 days. Observation of medications on hand for Resident	D 358		

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D 358	Continued From page 50 #11 on 12/05/19 at 7:57 am revealed there was one packet of polyethylene glycol in a plastic bag with a pharmacy label available for administration and was used for the 12/05/19 8:00 am medication pass. Observation of medication on hand for Resident #11 on 12/06/19 at 10:35 am revealed there were three boxes with 14 packets per box available for administration with a dispense date of 12/05/19. Based on observations, record reviews, and interviews, Resident #11 was not interviewable. Telephone interview with a representative from the facility contracted pharmacy on 12/05/19 at 11:55am revealed: -There was an active order for Resident #11 for polyethylene glycol mix one packet in fluid daily and take every 3 days. -She did not know why the facility saw the medication on the eMAR daily because the facility had to set -up Resident #11's polyethylene glycol for every three days. -Resident #11's polyethylene glycol was dispensed on 08/16/19 for 30 packets and 12/05/19 for 30 packets. Telephone interview with Resident #11's physician on 12/05/19 at 12:07pm revealed: -She was notified by the facility concerning the polyethylene glycol given every day instead of every 3 days on 12/05/19. -Resident #1 was prescribed the polyethylene glycol to help with constipation and if he received it daily he may have diarrhea. -Resident #1 also took a stool softner. -Resident #1 had polyethylene glycol ordered for a while, but she did not know the exact date.	D 358		

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D 358	Continued From page 51 Telephone interview with the facility contracted pharmacist who completed the pharmacy reviews on 12/06/19 at 8:52am revealed: -The first-time polyethylene glycol was ordered for Resident #11 was May 2018. -There was a new order dated 08/16/19 with directions to administer every 3 days. -The facility was responsible for scheduling the medication every 3 days. Interview with the MA who conducted the medication pass on 12/06/19 at 10:15am revealed: -She gave Resident #11 polyethylene glycol daily when she worked and she did not know it was ordered for every 3 days. -She did read the screen and label but did not notice it said every 3 days for the frequency. -Administering polyethylene to Resident #11 explained Resident #11's 2 to 3 loose stools daily and complaints of his buttocks burning. Interview with a first shift Supervisor on 12/05/19 at 2:31pm revealed: -She had worked at the facility for four years and assisted with filing paperwork into resident records, administered medications, and assisted with resident personal care. -She did not recall Resident #11's polyethylene glycol as a medication to administer every 3 days. -If the medication popped up on the computer screen in the eMAR system then she administered the medication. -She assumed it the medication appeared on the screen it was supposed to be given at that time and frequency. -She was able to enter medication orders, verify them, and change the times if she had a written physician's order and given permission by the Memory Care Manager (MCM) or Administrator.	D 358		

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D 358	Continued From page 52 -She received orders from the Administrator to enter into the eMAR system, but she was not the only shift Supervisor. -She faxed orders to the pharmacy and placed a copy of the order in the resident's record, the original was placed in the MCM's box. -Before the MCM, began working at the facility the orders were given to the former AL Care Manager or the Administrator. -She did not know why Resident #11's polyethylene glycol was being administered daily other than if it appeared on the eMAR screen, the MAs gave it. -Now the MCM, reviewed and verified the orders. -The MCM went through the eMARs and new orders to ensure accuracy. Interview with the MCM on 12/05/16 at 4:36pm revealed: -She expected the MAs to fax all medication orders given to them to the pharmacy and place a copy of the order in the resident's chart. -She received the original order written by the physician and she reviewed the order for accuracy. -The pharmacy placed the orders into the system and Resident #11's polyethylene glycol should have been entered correctly to appear on the screen every three days not daily. -She did not know Resident #11's polyethylene glycol was appearing daily in the eMAR system and documented as given daily. -She and three Supervisors were able to verify medication orders in the eMAR system after the medication order was entered into the system by pharmacy. -She did not know who verified Resident #11's polyethylene glycol order in the eMAR system. -If there was an error with a medication appearing on the screen at the wrong intervals, staff was	D 358		

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supposed to communicate that to her.
-She did not know Resident #11's polyethylene glycol was incorrect because she primarily administered medications on the Assisted Living unit.

Interview with the Administrator on 12/06/19 at 3:13pm revealed:
-She expected the MAs to administer medications as ordered by the physician and read the screen and the label.
-She did not know Resident #11 was administered polyethylene glycol daily and not as ordered every 3 days.
-Resident #11's polyethylene glycol order was entered incorrectly.
-She expected staff to notify the MCM or herself if there was an error with an entry in eMAR.

b. Observation of the 8:00 am Special Care Unit (SCU) medication pass on 12/05/19 revealed:
-The medication aide reviewed the list of medications for Resident #11 and pulled each one from the medication cart.
-She placed Resident #11's methylcobalamin tablet in the pill cup with his other tablets and crushed all the tablets to include methycobalamin.
-The crushed medication was mixed with applesauce and fed to Resident #11 at 7:59 am.
-There were no medications administered to Resident #11 sublingually.

Review of Resident #11's current FL-2 dated 01/08/19 revealed there was a medication order for cyanocobalamin (a synthetic form of vitamin B-12) 5000 mcg take one tablet sublingually daily.

Review of Resident #11's October 2019 printed electronic medication administration record

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D 358	Continued From page 54 (eMAR) -There was an entry for methylcobalamin 5 mg (another form of vitamin B-12) take one tablet sublingually daily, scheduled for 9:00 am. -There was documentation of administration from 10/01/19 to 10/08/19 at 9:00 am. -There was a second entry for methylcobalamin 5 mg take one tablet sublingually daily, scheduled for 8:00 am. -There was documentation of administration with staff initials from 10/09/19 to 10/31/19 at 8:00 am. Review of Resident #11's November 2019 printed eMAR -There was an entry for methylcobalamin 5 mg take one tablet sublingually daily, scheduled for 8:00 am. -There was documentation of administration with staff initials from 11/01/19 to 11/30/19 at 8:00 am. Review of Resident #11's December 2019 printed eMAR -There was an entry for methylcobalamin 5 mg take one tablet sublingually daily, scheduled for 8:00 am. -There was documentation of administration with staff initials from 12/01/19 to 12/05/19 at 8:00 am. Observation of Resident #11's medications on hand on 12/05/19 at 8:04 am revealed there were 13 of 30 tablets of methylcobalamin available for administration with a dispensed date of 11/11/19. Based on observations, record reviews, and interviews, Resident #11 was not interviewable. Interview with the medication aide (MA) who conducted the medication pass on 12/05/19 at 7:58 am revealed she crushed all of Resident #11's tablets and placed them into applesauce	D 358		

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because that was what she was taught during orientation with another MA.

A second interview with the MA who conducted the medication pass on 12/05/19 at 8:10 am revealed:
-She worked for the facility for four months.
-She always crushed Resident #11's tablets because when she first oriented with another MA she made a list of SCU residents who had medications crushed and a list of SCU residents who did not have their medications crushed.
-She saw the instructions to administer Resident #11's methylcobalamin sublingually but she still crushed it with his other tablets and mixed it with applesauce because that was what she was taught to do with Resident #11's medications.
-She did not call the pharmacy to ask about crushing Resident #11's methylcobalamin.
-She did not discuss crushing Resident #11's methylcobalamin with the Supervisor or Memory Care Manager (MCM).

Telephone interview with a representative from the facility contracted pharmacy on 12/05/19 at 11:36am revealed:
-There was an order for Resident #11's methylcobalamin dated 01/08/19 with instructions to take one tablet sublingually daily.
-She did not know the affects may be if the medication was crushed instead of given sublingually.

Telephone interview with the facility contracted pharmacist who completed the pharmacy reviews on 12/05/19 at 8:52 revealed:
-The methycobalmin was very similar to the cyanocobalamin and was a vitamin B-12 supplement.
-The reason for crushing the methycobalmin was

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D 358	Continued From page 56 so it would be absorbed quicker. -There would be no affect if the medication was crushed versus administered sublingually. Telephone interview with Resident #11's physician on 12/05/19 at 12:07pm revealed: -The medication was requested by Resident #11's family member and she wrote the order for cyanocobalamin. -The medication was prescribed for Resident #11 a while and it was vitamin B-12. -She thought giving Resident #11's methycobalamin crushed was not significant and she thought it would not affect Resident #11. -She discontinued the medication on 12/05/19. A second interview with a first shift Supervisor on 12/05/19 at 2:36 pm revealed: -She saw Resident #11's methylcobalamin indicated it was to be administered sublingually she still crushed it to administer medications to him, because that was what she was taught. -She did not think Resident #11 was able to take the medication sublingually because of his diagnosis but she did not discuss the route of the medication with anyone. -Sublingual meant under the tongue. -She read the label and the screen but she still crushed Resident #11's methylcobalamin when she gave him medications. Interview with the Memory Care Manager (MCM) on 12/05/16 at 4:36pm revealed she was not aware MAs were crushing Resident #11's methylcobalamin. Interview with the Administrator on 12/06/19 at 3:13pm revealed: -She did not know MAs were crushing Resident #11's methylcobalamin and not administering as	D 358		

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instructed, sublingually.
-Staff were expected to notify the MCM when there were questions about a medication order, the instructions, or the eMAR entry.
-The MAs and Care Managers were responsible for ensuring medications were administered accurately.

2. Review of Resident #5's current FI-2 dated 01/08/19 revealed:
-Diagnoses included Alzheimers disease, diabetes mellitus, vitamin D deficiency, hypertension, esophagitis, and sino-arterial node dysfunction.
-There was no order for sliding scale insulin.

Review of Resident #5's subsequent physician orders revealed:
-There was an order dated 06/03/19 for Novolog flexpen 100 units/milliliter per sliding scale, if blood sugar less than 80, call physician, if blood sugar 0 to 150 give 0 units, if blood sugar 151-200 give 2 units, if blood sugar 201-250 give 3 units, if blood sugar 251-300 give 5 units, if blood sugar 301-350 give 7 units, if blood sugar 351-400 give 9 units, if blood sugar 401-450 give 11 units, if blood sugar is over 450 call physician. Special instructions inject per sliding scale every evening at 4:30 pm.
-There was an order dated 12/02/19 to discontinue sliding scale.

Observation of Resident #5's medications on hand on 12/05/19 at 4:00 pm revealed there was a Humalog 100 unit/ml flex pen available for administration and a Humalog 200 unit flex pen available for administration.

Review of physician's prescriptions faxed by the facility's contracted pharmacy for Resident #5

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D 358	Continued From page 58 revealed: -There was a prescription dated 06/20/19 for Humalog sliding scale insulin 200 unit/ml inject below the skin as directed; as directed per sliding scale for 12 refills. -There was a note at the bottom of the prescription order indicating "discontinue Novolog". Review of Resident #5's October 2019 printed electronic medication administration record (eMAR) revealed: -There was no documentation of Novolog or Humalog sliding scale insulin. -There was an entry for fingerstick blood sugar three times daily before meals, scheduled at 7:30 am, 11:30 am, and 4:30 pm. -The FSBS ranged from 80 to 286 and there were 12 opportunities when Resident #5 would have received 2 units of insulin according to the sliding scale. -There were 14 opportunities when Resident #5 would have received 3 units of insulin according to the sliding scale. -There was 1 opportunity when Resident #5 would have received 5 units of insulin according to the sliding scale. Review of Resident #5's November 2019 printed eMAR -There was an entry for Humalog sliding scale 200 unit/ml insulin amount to administer per sliding scale; if blood sugar was less than 80, call physician; if blood sugar was 0 to 150, give 0 units; if blood sugar is 151 to 200, give 2 units; if blood sugar was 201 to 250, give 3 units; if blood sugar was 251 to 300, give 5 units; if blood sugar was 301 to 350, give 7 units; if blood sugar was 351 to 400, give 9 units; if blood sugar was 401 to 450, give 11 units; if blood sugar was greater than	D 358		

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D 358	Continued From page 59 450, call physician. For eMAR scheduling please complete order with package instructions, inject subcutaneously every evening at 4:30 pm, scheduled for 9:00 am. -There was documentation of daily administration according to the sliding scale from 11/26/19 to 11/30/19 at 9:00 am. -There was an entry for fingerstick blood sugar three times daily before meals, scheduled at 7:30 am, 11:30 am, and 4:30 pm. -The FSBS ranged from 61 to 315 and there were 9 opportunities when Resident #5 would have received 2 units of insulin according to the sliding scale. -There were 5 opportunities when Resident #5 would have received 3 units of insulin according to the sliding scale. -There were 5 opportunities when Resident #5 would have received 5 units of insulin according to the sliding scale Review of Resident #5's December 2019 printed eMAR -There was an entry for Humalog sliding scale 200 unit/ml insulin amount to administer per sliding scale; if blood sugar was less than 80, call physician; if blood sugar was 0 to 150, give 0 units; if blood sugar is 151 to 200, give 2 units; if blood sugar was 201 to 250, give 3 units; if blood sugar was 251 to 300, give 5 units; if blood sugar was 301 to 350, give 7 units; if blood sugar was 351 to 400, give 9 units; if blood sugar was 401 to 450, give 11 units; if blood sugar was greater than 450, call physician. For eMAR scheduling please complete order with package instructions, inject subcutaneously every evening at 4:30 pm, scheduled for 9:00 am. -There was documentation of administration of 0 units on 12/02/19 at 9:00 am for a FSBS of 88 according to the sliding scale.	D 358		

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D 358	Continued From page 60 -There was documentation of administration of 0 units on 12/03/19 at 9:00 am for a FSBS of 130 according to the sliding scale. -There was documentation of "not administered" on 12/01/19 at 9:00 am. Based on observations, record reviews, and interviews, Resident #5 was not interviewable. Telephone interview with a representative from the facility's contracted pharmacy on 12/05/19 at 11:36am revealed: -There were active orders for two different concentrations of Humalog insulin for Resident #5. -There was an order dated 07/24/19 for Humalog 100 units/ml 4 units three times daily with meals and an order for Humalog 200 units/ml sliding scale insulin to be given at 4:30 pm only. -Resident #5's Humalog 200 units/ml was dispensed for one flexpen on 07/08/19 and 11/24/19. -The order was keyed into the pharmacy computer system and scheduled for 4:30 pm. -She did not know why it appeared on the facility eMARs for 9:00am or why the order did not appear on the October 2019 eMAR and part of November 2019 eMAR. -She knew the facility had issues with the computer system that managed the eMAR but the pharmacy did not manage that system. -The sliding scale insulin was not discontinued and there was no discontinue order in the pharmacy computer system to discontinue the sliding scale insulin. Telephone interview with the facility's contracted pharmacist who completed the pharmacy reviews on 12/06/19 at 8:52am revealed: -There was a discontinue order for Resident #5's	D 358		

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GUILFORD HOUSE	5918 NETFIELD RD GREENSBORO, NC 27455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 61 sliding scale insulin in the computer system for 12/03/19. -The start date for Resident #5's sliding scale insulin was 07/24/19. -She did not know why Resident #5's sliding scale would not appear on the October 2019 eMAR and a portion of November 2019. -She did not see it in the system for October 2019. -Her understanding of the system was that the orders came from the eMAR system into the pharmacy's computer system. -She was last at the facility on 10/21/19 and Resident #5's FSBS was as high as 286. -She did not know the effect to Resident #5's blood sugar levels without viewing her most recent HgbA1C. Telephone interview with Resident #5's physician on 12/05/19 at 12:07pm revealed: -She did not have the documentation for Resident #5 to refer to but she tried to discontinue all sliding scale insulins for all residents she cared for in facilities. -She was "befuddled" about some of the order changes for Resident #5 because she had difficulty receiving copies of Resident #5's eMARs and fingerstick blood sugars (FSBS) to review during Resident #5's examinations. -She was in the dark and not sure what happened in October 2019 and November 2019 with Resident #5's sliding scale insulin. -She preferred to see a hemoglobin A1C (HgbA1C) of 7 or 8 in elderly residents. -She thought Resident #5's HgbA1C was 8 the last time she reviewed Resident #5's labs but she was not sure. -If Resident #5 did not receive the sliding scale insulin in October and part of November 2019 she was not concerned because she thought	D 358		

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D 358	Continued From page 62 Resident #5's HgbA1C was within range. Interview with the MA who conducted the medication pass on 12/06/19 at 10:15am revealed: -She did not know Resident #5 had a sliding scale insulin order but Resident #5 had an order for scheduled Humalog insulin. -She did not require the scheduled Humalog insulin the morning of 12/05/19 and 12/06/19 because her blood sugar did not meet the parameter for administering insulin. -The MAs faxed orders to the pharmacy but the MAs did not verify the orders once placed into the eMAR system. -The Memory Care Manager (MCM) and the Supervisors verified the orders. Interview with a first shift Supervisor on 12/05/19 at 2:50pm revealed: -Resident #5's physician reached out to her frequently to send orders to her because of the changes in staffing. -She sent Resident #5's physician a text message to clarify Resident #5's insulin order in July 2019. -She did not know the reason Resident #5's sliding scale insulin did not appear on the October and a portion of the November eMAR. -She thought someone, she did not know who, took the order out of the system or there was an order change. -The MCM went through the eMARs and reviewed new orders to ensure accuracy. -She and the other Supervisors were assigned to do medication cart audits but she had not completed one in 3 months. -The Cart audits were assigned by the MCM and none had been assigned in the past 3 months.	D 358		

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D 358	Continued From page 63 Interview with the Memory Care Manager (MCM) on 12/05/16 at 4:36pm revealed: -She had noticed a sliding scale appear on Resident #5's eMAR profile in late November 2019. -She called the physician to ask about the sliding scale and Resident #5's physician discontinued the sliding scale for Resident #5 on 12/02/19. -She did not know a reason that Resident #5's sliding scale did not appear in October 2019 and November 2019, until 11/25/19. Review of a faxed physician's order for Resident #5 provided by the MCM revealed: -The order was electronically signed on 07/24/19. -The order was to discontinue Novolog sliding scale insulin due to insurance coverage and Humalog was the insulin covered by Resident #5's insurance. Interview with the Administrator on 12/06/19 at 3:13pm revealed: -She did not know Resident #5's sliding scale did not appear on the October and November 2019 eMARs, until 11/25/19. -She did not know a reason that would cause orders to be removed and reappear. -There had been other incidents of medication orders reappearing on the eMAR after discontinued. -She was not able to provide specific incidents or dates of the incidents. -Medication orders were entered by the pharmacy but the MCM and the Supervisors were supposed to verify the orders prior to administration to ensure the order matched the physician's order. -The MCM and future AL Care Manager were responsible for ensuring medications were given as ordered as well as the MAs.	D 358		

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D 358	Continued From page 64 3. Review of Resident #2's current FL-2 dated 03/26/19 revealed diagnoses included Alzheimer's, diabetes mellitus, atrial fibrillation, hypertension, hypothyroid, and history of a hip fracture. a. Review of Resident #2's physician's orders dated 03/26/19 revealed an order for Prednisolone Acetate drops, instill one drop in both eyes twice a day. (Prednisolone eye drops is a steroid use to treat swelling in the eye). Review of Resident #2's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:00am and 8:00pm. - Prednisolone Acetate drops were documented as administered at 8:00am and 8:00pm from 10/01/19-10/31/19. Review of Resident #2's November 2019 eMAR revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:00am and 8:00pm. -Prednisolone Acetate drops were documented as administered at 8:00am and 8:00pm from 11/01/19-11/16/19. -Prednisolone Acetate drops were documented as administered at 9:00am and 9:00pm from 11/17/19-11/30/19. Review of Resident #2's December 2019 eMAR revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day	D 358		

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with a scheduled administration time at 9:00am and 9:00pm.
-Prednisolone Acetate drops were documented as administered at 9:00am and 9:00pm from 12/01/19-12/04/19.

Observation of Resident #2's medications on hand on 12/04/19 at 12:51pm revealed:
-There was a bottle of Prednisolone Acetate drops dispensed on 09/13/19; the bottle contained liquid when shook and was solid in color and could not assess the number of drops remaining in the bottle.
-There was a second bottle of Prednisolone Acetate eye drops dispensed on 10/24/19; the bottle was unopened.

Telephone interview with a representative from the facility's contracted pharmacy on 12/04/19 at 3:07pm revealed:
-Prednisolone Acetate was filled for Resident #2 on 09/13/19 and again on 10/24/19.
-Each bottle contained 200 drops; the bottle would last for fifty days at the current dosage.

Second telephone interview with a representative from the facility's contracted pharmacy on 12/06/19 at 8:57am revealed:
-Prednisolone Acetate eye drops had been dispensed on 03/25/19 (5ml bottle that would last 25 days); 06/08/19, 09/13/19 and 10/24/19 (10ml bottle each dispensed date that would last 50 days.)
-Prednisolone Acetate eye drops were not a cycle medication and refills had to be requested by the facility staff.

Interview with a medication aide (MA) on 12/05/19 at 3:01pm revealed:
-She administered Resident #2's Prednisolone

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Acetate eyedrops when she worked.
-Resident #2 had never refused her eye drops.
-She did not know why there were more Prednisolone eye drops available than should be if the eye drops had been administered correctly.
-She would not document the medication had been administered if it had not been; she could not say what others on the medication cart did.

Interview with the Supervisor on 12/05/19 at 3:45pm revealed:
-She thought maybe the MAs were not giving enough of the eye drops when it was administered.
-She was concerned Resident #2 was not receiving the correct number of drops.
-She expected Resident#2's eye drops to be administered as ordered.

Interview with the Memory Care Manager (MCM) on 12/05/19 at 4:10pm revealed:
-If there were more eye drops on hand than should be it was because the eye drops were not being administered correctly or maybe there was another bottle that had been used.
-She was concerned if Resident #2's Prednisolone Acetate eye drops had not been administered correctly.
-She expected the medication to be administered as ordered.

Interview with a MA on 12/06/19 at 9:29am revealed:
-Resident #2 never refused her eye drops.
-There may be more Prednisolone eye drops on hand than should be because there had been a MA who documented administering medication that they did not administer; that MA was no longer working at the facility.

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D 358	Continued From page 67 Interview with Resident #2 on 12/06/19 at 9:52am revealed: -She got eye drops "just about every day." -Most of the time her eye drops were administered mid-morning. -She did not get eye drops twice a day; she did not get eye drops in the evening. -She thought her vision was "very bad right now"; her visions was blurry. Telephone interview with a medical assistant from Resident #2's ophthalmologist office on 12/06/19 at 8:42am revealed: -It was very important Resident #2 received her Prednisolone Acetate eye drops as ordered. -If Resident #2's Prednisolone Acetate eye drops were not administered as ordered Resident #2 could have decreased vision. Second telephone interview with a medical assistant from Resident #2's ophthalmologist office on 12/06/19 at 12:02pm revealed: -Resident #2 was started on Prednisolone Acetate eye drops after a corneal transplant. -Resident #2 had bilateral corneal transplants. -It was important for Resident #2 to receive her Prednisolone Acetate eye drops as ordered because she would be at risk to have swelling in her eye and rejection of the corneal transplant. Interview with the Administrator on 12/06/19 at 3:57pm revealed: -She did not know Resident #2's Prednisolone Acetate had not been administered as ordered. -She expected medications to be administered as ordered. -She was concerned if Resident #2's Prednisolone Acetate was not administered as ordered Resident #2 could experience eye problems.	D 358		

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b. Review of Resident #2's physician's orders dated 03/26/19 revealed and order for Levothyroxine 75mg daily. (Levothyroxine is used to treat an underactive thyroid (hypothyroidism).

Review of Resident #2's October 2019 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 75mg daily with a scheduled administration time at 5:00am.
-Levothyroxine 75mg was documented as administered at 5:00am from 10/01/19-10/31/19.

Review of Resident #2's November 2019 eMAR revealed:
There was an entry for Levothyroxine 75mg daily with a scheduled administration time at 5:00am.
-Levothyroxine 75mg was documented as administered at 5:00am from 11/01/19-11/14/19; Levothyroxine was documented as unavailable on 11/15/19.
-Levothyroxine 75mg was documented as administered at 5:00am from 11/16/19-11/30/19.

Review of Resident #2's December 2019 eMAR revealed:
There was an entry for Levothyroxine 75mg daily with a scheduled administration time at 5:00am.
- Levothyroxine 75mg was documented as administered at 5:00am from 12/01/19-12/04/19.

Observation of Resident #2's medications on hand on 12/04/19 at 12:51pm revealed:
-There was a punch card for Levothyroxine 75mg that was dispensed on 10/30/19.
-There was a handwritten date of 11/04/19 above the first tablet in the punch card.
-There were twelve of thirty tablets available to be

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D 358	Continued From page 69 administered. Telephone interview with a representative from the facility's contracted pharmacy on 12/04/19 at 3:07pm revealed: -Levothyroxine 75mg had been dispensed on 09/29/19 for 30 tablets. -Levothyroxine 75mg had been dispensed on 10/30/19 for 30 tablets. Telephone interview with Resident #2's primary care provider (PCP) on 12/05/19 at 5:08pm revealed: -Levothyroxine was prescribed for Resident #2 to treat hypothyroidism. -She was concerned if Resident #2's Levothyroxine had not been administered as ordered because she would have to readjust the dosage the next time Resident #2's TSH level was done. (A TSH [thyroid-stimulating hormone] test is done to find out if the thyroid gland was working the way it should). -Resident #2 could experience symptoms to include irregular heart rate, hot flashes, and cold spells if Levothyroxine was not administered correctly. Interview with Resident #2 on 12/06/19 at 9:52am revealed: -She took medication every day; she did not know what "pills" she took. -She was cold all the time. Interview with a third shift MA on 12/06/19 at 7:00am revealed: -Resident #2 had refused her Levothyroxine medication. -She did not recall how often Resident #2 refused Levothyroxine or the last time Resident #2 refused the Levothyroxine.	D 358		

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-She may have forgotten to document Resident #2's refusals.
-She prepped the Levothyroxine and when Resident #2 refused, she forgot to change it in the eMAR.

Interview with the Memory Care Manager (MCM) on 12/05/19at 4:10pm revealed:
-She wrote 11/04/19 on the Levothyroxine punch card because she administered the medication that day and it was the day the punch card was started.
-Levothyroxine was not sent in Resident #2's multidose medication packs.
-She thought there was a second Levothyroxine punch card on the medication cart; if not the medication must have not been administered correctly.

Interview with the Administrator on 12/06/19 at 3:57pm revealed:
-She did not know Resident #2's Levothyroxine had not been administered as ordered.
-She expected medications to be administered as ordered.

c. Review of Resident #2's hospital discharge summary dated 08/09/19 revealed:
-Resident #2 was seen in the emergency department because of eye pain.
-Resident #2 was referred to an ophthalmologist's office with instructions to go immediately to the ophthalmologist's office upon discharge from the hospital emergency department.

Review of Resident #2's prescription dated 08/09/19 revealed Resident #2 was prescribed Erythromycin ophthalmic ointment three times a day for three days. (Erythromycin ophthalmic ointment is used to treat eye infections).

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D 358	Continued From page 71 Review of Resident #2's August 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Erythromycin ophthalmic ointment apply topically to the left eye three times daily for three days with a scheduled administration time of 9:00am, 1:00pm, and 9:00pm. -Erythromycin ophthalmic ointment was documented as unavailable on 08/10/19 for 9:00am, 1:00pm, and 9:00pm. -Erythromycin ophthalmic ointment was documented as unavailable on 08/11/19 for 9:00am, and 1:00pm. -Erythromycin ophthalmic ointment was documented as administered on 08/11/19 at 9:00pm. Review of a verbal order dated 08/14/19 at 1:44pm revealed: -There was an order to administer Erythromycin ophthalmic ointment apply topically three times daily with a scheduled administration time of 9:00am, 1:00pm, and 9:00pm with a start date of 08/15/19 and an end date of 08/17/19. -The order was initiated by the Administrator and signed by Resident #3's Primary Care Provider, not the ophthalmologist who prescribed the medication. Review of Resident #2's August 2019 electronic medication administration record (eMAR) revealed: -There was a second entry for Erythromycin ophthalmic ointment apply topically to the left eye three times daily for three days with a scheduled administration time of 9:00am, 1:00pm, and 9:00pm. -Erythromycin ophthalmic ointment was	D 358		

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D 358	Continued From page 72 documented as administered on 08/15/19 at 9:00am and 9:00pm; The 1:00pm dose was not documented as administered. -Erythromycin ophthalmic ointment was documented as administered on 08/16/19 and 08/17/19 at 9:00am, 1:00pm and 9:00pm. Telephone interview with a medical assistant from Resident #2's ophthalmologist office on 12/06/19 at 8:42am revealed Resident #2's Erythromycin ophthalmic ointment should have been administered when it was ordered. Telephone interview with a representative from the facility's contracted pharmacy on 12/06/19 at 8:57am revealed: -A fax was received from the facility on 08/09/19 for Erythromycin ophthalmic ointment. -The prescription was filled and was dispensed to the facility on 08/10/19; it would have been delivered to the facility by noon on 08/10/19 to be administered. -Erythromycin ophthalmic ointment should have been administered consecutively for three days for it to have been most effective. Interview with Resident #2 on 12/06/19 at 9:52am revealed: -Her left eye was hurting "really bad" and she went to the hospital "a while back". -She received treatment and the eye got better. -She did not recall how many days had passed before the treatment was started. Interview with the Administrator on 12/06/19 at 3:57pm revealed: -She did not recall anything about the Erythromycin ophthalmic ointment. -If she put the order in the eMAR, someone told her to do it on that date.	D 358		

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D 358	Continued From page 73 -She was concerned if Resident #2 did not get the medication as ordered originally the issue was not resolved in a timely manner. 4. Review of Resident #4's current FL-2 dated 06/19/19 revealed: -Diagnoses included Alzheimer's disease, anemia, and osteoarthritis. -There was an order for escitalopram 2.5mg daily (10mg tablet, 1/4 tablet daily). (Escitalopram is used to treat depression and generalized anxiety disorder.) -There was an order for memantine 10mg, two tablets at bedtime. (Memantine is used to treat moderate to severe Alzheimer's disease.) Review of Resident #4's subsequent physician orders revealed there was an order written by Resident #4's neurologist dated 09/04/19 to increase escitalopram to 10mg daily. Review of Resident #4's Physician Order Report dated 09/17/19 revealed there was an order from Resident #4's internist for escitalopram 10mg, take 0.25 tab (2.5mg) every day. Review of Resident #4's pharmacy consultation report for October 2019 revealed on 10/22/19, the pharmacist requested the facility clarify the escitalopram order. a. Review of Resident #4's electronic medication administration record (eMAR) for October 2019 revealed: -There was an entry for escitalopram 10mg take 0.25 tab (2.5mg) daily. -From 10/01/19-10/31/19, there was documentation escitalopram 2.5mg had been administered at 9:00am.	D 358		

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D 358	Continued From page 74 Review of Resident #4's eMAR for November 2019 revealed: -There was an entry for escitalopram 10mg take 0.25 tab (2.5mg) daily. -From 11/01/19-11/30/19, there was documentation escitalopram 2.5mg had been administered at 9:00am. Review of Resident #4's eMAR for December 2019 revealed: -There was an entry for escitalopram 10mg take 0.25 tab (2.5mg) daily. -From 12/01/19-12/03/19, there was documentation escitalopram 2.5mg had been administered at 9:00am. Observation of Resident #4's medication on hand on 12/04/19 at 11:38am revealed: -There was one bottle of escitalopram 10mg tablets with a label indicating it was filled on 10/10/19. -There were 18 whole tablets and 5 half tablets in the bottle. -There was a label on the bottle with instructions to take one-half tablet once a day. Observation of Resident #4's medication on hand on 12/05/19 at 3:27pm revealed: -There was one bottle of escitalopram 10mg tablets in the overstock drawer of the medication cart. -There was a label on the bottle indicating the order was filled on 11/20/2019. -There was a label on the bottle with instructions to take one tablet once a day. Telephone interview with the pharmacist on 12/04/19 at 3:36pm revealed: -She completed Resident #4's quarterly medication review on 10/22/19.	D 358		

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D 358	Continued From page 75 -She did not compare the order for escitalopram on the eMAR to the label on the medication bottle. -She wrote a recommendation to the facility to have the physician clarify the dose of the escitalopram. Telephone interview with a representative from Resident #4's pharmacy on 12/05/19 at 9:42am revealed: -Resident #4's current escitalopram order was for 10mg daily as written 11/12/19. -On 11/20/19, 90 tablets of escitalopram 10mg were dispensed. -The escitalopram 10mg tablets dispensed on 11/20/19 should have been at the facility. Interview with Resident #4 on 12/05/19 at 10:03am revealed: -He did not know the names of the medications he was prescribed. -He knew he took half a pill each day after breakfast. Interview with a medication aide (MA) on 12/05/19 at 2:33pm revealed: -The MAs faxed orders to the pharmacy. -A copy of the order was filed in the resident's record and the original was given to the Memory Care Manager (MCM). -The previous Resident Care Coordinator (RCC) had been responsible for verifying orders on the eMAR. -The MCM checked the eMARs at the beginning of the month. -Cart audits were supposed to be done at the end of each month. -Cart audits included making sure the available medication was the same as the order on the eMAR.	D 358		

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D 358	Continued From page 76 -She had not done a cart audit in three months. -The instructions on the medication bottle and the order on the eMAR should have matched. -She did not notify anyone of the discrepancy between Resident #4's escitalopram order on the eMAR and the instructions on the medication bottle because she thought they indicated the same amount. Interview with the MCM on 12/05/19 at 4:36pm revealed: -The MA and the supervisor faxed orders to the pharmacy. -Resident #4's escitalopram order must have changed to 10mg daily after his November physician appointment. -Resident #4 should have given the paperwork from his physician visit to the MA so the escitalopram order could have been faxed to the pharmacy. -She or the newly-hired RCC was going to contact the pharmacy to get a copy of Resident #4's current escitalopram order. -The order on the eMAR was going to be followed until they clarified the new escitalopram order. Interview with a MA on 12/06/19 at 8:55am revealed: -She gave Resident #4 1/4 of an escitalopram 10mg tablet this morning. -Before today, she had been administering 1/2 of an escitalopram 10mg tablet. -She or the MCM was going to call the pharmacy to clarify Resident #4's escitalopram order. Interview with the Administrator on 12/06/19 at 3:13pm revealed: -The MCM was responsible for making sure orders were accurate. -Weekly cart audits would have revealed	D 358		

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discrepancies between orders on the eMARs and instructions on the medication labels.
-The audit process included making sure the available medications matched the orders and identifying orders that needed clarification.
-Her expectation was for cart audits to be done weekly and monthly to ensure accuracy.
-Cart audits had not been done in "a while," possibly since October 2019.
-Staff should have informed management of the discrepancy between the order on the eMAR and the instructions on the medication label so the order could have been clarified.

Interview with a registered nurse from Resident 4's neurologist's office revealed:
-There was an order for escitalopram 10mg written and faxed to the facility on 09/04/19.
-Resident #4's current escitalopram order was for 10mg daily as written on 11/12/19.

Attempted telephone interview with Resident #4's internist on 12/04/19 at 1:31pm was unsuccessful.

b. Review of Resident #4's electronic medication administration record (eMAR) for October 2019 revealed:
-There was an entry for memantine 10mg take 2 tablets at bedtime.
-From 10/01/19-10/31/19, there was documentation memantine 10 mg, 2 tablets had been administered at 9:00pm.

Review of Resident #4's eMAR for November 2019 revealed:
-There was an entry for memantine 10mg take 2 tablets at bedtime.
-From 11/01/19-11/30/19, there was documentation memantine 10mg, 2 tablets had

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D 358	Continued From page 78 been administered at 9:00pm. Review of Resident #4's eMAR for December 2019 revealed: -There was an entry for memantine 10mg take 2 tablets at bedtime. -From 12/01/19-12/03/19, there was documentation memantine 10mg, 2 tablets had been administered at 9:00pm. Observation of Resident #4's medication on hand on 12/04/19 at 11:38am revealed: -There were five bottles of memantine tablets available. -The label indicated each bottle held 60 tablets of memantine 10mg. -There was a bottle with a label indicating it was filled in April. (The rest of the label was missing.) -There were 39 pills in the bottle. -A second bottle had a label indicating it was filled on 07/10/19; "3 of 3" was written on the lid. -There were 46 tablets in the second bottle. -There were three bottles with labels indicating they were filled on 10/10/19. -Two of the three bottles were unopened. -The label indicated each bottle held 60 tablets of memantine 10mg. -The third bottle contained 59 tablets. -There were 264 memantine tablets available. Telephone interview with a representative from Resident #4's pharmacy on 12/05/19 at 9:42am revealed: -On 04/24/19, 07/10/19, and 10/10/19 each, the pharmacy dispensed 180 tablets of memantine. -The pharmacy was scheduled to dispense 180 tablets on 01/10/20. -With 264 tablets available, the resident either was not taking the medication as directed or not taking the medication at all.	D 358		

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D 358	Continued From page 79 -The consequence of not taking memantine as prescribed would possibly be further memory deterioration. Interview with Resident #4 on 12/05/19 at 10:03 am revealed: -He did not know the names of the medications he was prescribed. -He knew he took seven tablets at night. Interview with a medication aide (MA) on 12/05/19 at 3:30pm revealed: -She gave Resident #4 two memantine tablets when she administered his medication. -She did not know why there were so many memantine tablets on hand. -It looked like Resident #4's memantine was not being administered correctly. Interview with the Memory Care Manager (MCM) on 12/05/19 at 4:36pm revealed: -She gave Resident #4 two memantine tablets the previous night. -She did not know why there were so many memantine tablets on hand. -No one reported the excess medication to her. -Excess medication should have been sent back to the pharmacy. -She did not know if the supervisor-in-charge (SIC) and the MAs were completing weekly medication audits. Interview with the Administrator on 12/06/19 at 3:13pm revealed: -She expected all physician orders to be followed. -The MAs were responsible for administering medications as ordered. -It looked like the MAs were not following the order for administering Resident #4's memantine.	D 358		

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D 358	Continued From page 80 Interview with a registered nurse from Resident #4's neurologist's office on 12/06/19 at 4:30pm revealed: -The neurologist was working on finding the most effective doses of Resident #4's medication based on reports from his family members. -There were concerns about further memory deterioration if the memantine was not administered as ordered. Attempted telephone interview with Resident #4's family member on 12/05/19 at 4:29pm was unsuccessful. The facility failed to assure medications were administered as ordered to Resident #11 resulting in frequent loose stools, Resident #5 with fluctuating blood sugars ranging from 61 to 315, Resident #4 with an increased risk of memory deterioration, depression, and anxiety, and eye drops for Resident #2 which increased the risk of corneal transplant rejection. This was detrimental to the health, welfare, and safety of the residents and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/06/19.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	D 367	ED, DRC and/or MCM, along with ADO have conducted EMARs and physicians orders for accuracy. DRC and MCM will review and approve all orders in EMAR system as prescribed by residents physician DRC and MCM will audit EMAR verses Physicians Orders monthly for 2 months then randomly there after	1/20/2020 1/20/2020 Ongoing 1/20/2020

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D 367	Continued From page 81 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the medication administration records were accurate for 3 of 8 sampled residents (#1, #2, and #12). The findings are: 1. Review of Resident #12's current FL-2 dated 01/08/19 revealed: -Diagnoses included Alzheimer's disease, insomnia, anxiety, acute cerebrovascular insufficiency, cerebral ischemia, organic affective syndrome, age-related osteoporosis, and late effect of stroke. -There was a medication order for aspirin 81 mg take one tablet daily.	D 367	Facility LHPS RN, DRC (LPN), and/or DDCS (RN)will conduct random medication pass observations with different Medication techs, observations will include assuring EMARS are accurate, over the next 2 months, then randomly there after Facility Medication Techs, DRC, and MCM have received training on reviewing and auditing EMARS againts Physicians Orders for accuary. Training provided by ADO and Licensed RN	1/20/2020 1/20/2020

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D 367	Continued From page 82 Observation of Resident #12's medication on hand on 12/05/19 at 8:45 am revealed there was one package of aspirin with 30 tablets dispensed on 09/06/19 with 4 tablets remaining for administration. Review of Resident #12's October 2019 printed electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81 mg take one tablet daily, scheduled for 8:30 am. -There was documentation of administration with staff initials from 10/01/19 to 10/31/19 at 8:30 am. Review of Resident #12's November 2019 printed eMAR revealed: -There was an entry for aspirin 81 mg take one tablet daily, scheduled for 8:30 am. -There was documentation of administration with staff initials from 11/01/19 to 11/30/19 at 8:30 am. Review of Resident #12's December 2019 printed eMAR revealed: -There was an entry for aspirin 81 mg take one tablet daily, scheduled for 8:30 am. -There was documentation of administration with staff initials from 12/01/19 to 12/05/19 at 8:30 am. Based on observation, record reviews , and interviews, Resident #12 was not interviewable. Telephone interview with a representative from the facility contracted pharmacy on 12/05/19 at 11:55am revealed: -There was no active order in the computer system for aspirin for Resident #12. -The pharmacy dispensed aspirin 81 mg for Resident #12 on 09/06/19 for 30 tablets. -There was a discontinue order in the computer	D 367		

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system dated 09/18/19 for Resident #12.
-Resident #12's eMARs should not have an entry for aspirin because it was discontinued.
-She did not know why it was still appearing on the eMAR and it may be due to the computer system that manages the eMAR.

Interview with a first shift Special Care Unit (SCU) medication aide (MA) on 12/06/19 at 10:15am revealed:
-She did not know Resident #12's aspirin was discontinued.
-She thought she had given Resident #12 each day she worked on the SCU and documented administering aspirin to Resident #12.
-She saw her initials on the December 2019 MAR on 12/03/19 and 12/05/19 at 8:00 am.
-She and the other MAs were not responsible for the eMAR entries, the Supervisors, Memory Care Manager (MCM) and the Administrator were responsible for ensuring the eMARs were accurate.

Interview with a first shift Supervisor/MA on 12/05/19 at 2:58pm revealed she had the ability to change the times and stop medications in the eMAR system, but she did not change anything without a written physician's order and permission from the MCM or Administrator.

Telephone interview with Resident #12's physician on 12/05/19 at 12:07pm revealed:
-She did not recall the order for Resident #12, but the order was supposed to be for chewable aspirin.
-She was not concerned if Resident #12 was not receiving the medication because of recent research that elderly residents did not need a daily aspirin.
-Resident #12 had aspirin prescribed by a

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previous provider, and she continued the order for aspirin once she assumed care of Resident #12.

Interview with the Memory Care Unit Manager (MCM) on 12/05/19 at 4:36pm revealed:
-She expected the MAs to document on the eMAR after administering a medication.
-She did not know Resident #12's aspirin was discontinued.
-She did not know why the MAs were documenting administering a medication that was not dispensed since 09/06/19.
-She thought Resident #12's family brought in the medication as an over the counter product.

Interview with the Administrator on 12/06/19 at 3:13pm revealed:
-She expected the Supervisors and/or MCM to verify the medication orders on the eMARs prior to administration.
-She expected the Care Managers to ensure discontinued medications were removed from the eMAR.
-She did not know Resident #12's aspirin order was discontinued, and she did not know the MAs were documenting on the eMAR administering Resident #12's aspirin.

2. Review of Resident #2's current FL-2 dated 03/26/19 revealed diagnoses included Alzheimer's, diabetes mellitus, atrial fibrillation, hypertension, hypothyroid, and history of a hip fracture.

a. Review of Resident #2's physician's orders dated 03/26/19 revealed an order for prednisolone acetate drops, instill one drop in both eyes twice a day. (Prednisolone eye drops is a steroid used to treat swelling in the eye).

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D 367	Continued From page 85 Review of Resident #2's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:00am and 8:00pm. - There was documentation 31 days of Prednisolone Acetate eye drops were administered from 10/01/19-10/31/19. Review of Resident #2's November 2019 eMAR revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day with a scheduled administration time at 8:00am and 8:00pm. -There was documentation 30 days of Prednisolone Acetate eye drops were administered from 11/01/19-11/30/19. Review of Resident #2's December 2019 eMAR revealed: -There was an entry for Prednisolone Acetate drops, instill one drop in both eyes twice a day with a scheduled administration time at 9:00am and 9:00pm. -There was documentation 4 days of Prednisolone Acetate eye drops were administered from 12/01/19-12/04/19. Observation of Resident #2's medications on hand on 12/04/19 at 12:51pm revealed: -There was a bottle of Prednisolone Acetate drops dispensed on 09/13/19; the bottle contained liquid when shook and was solid in color and could not assess the number of drops remaining in the bottle. -There was a second bottle of Prednisolone	D 367		

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D 367	Continued From page 86 Acetate eye drops dispensed on 10/24/19; the bottle was unopened. Telephone interview with a representative from the facility's contracted pharmacy on 12/04/19 at 3:07pm revealed: -Prednisolone Acetate was filled for Resident #2 on 09/13/19 and again on 10/24/19. -Each bottle contained 200 drops; the bottle would last for fifty days at the current dosage. Second telephone interview with a representative from the facility's contracted pharmacy on 12/06/19 at 8:57am revealed: -Prednisolone Acetate eye drops had been dispensed on 03/25/19 (5ml bottle that would last 25 days); 06/08/19, 09/13/19 and 10/24/19 (10ml bottle each dispensed date that would last 50 days.) Interview with Resident #2 on 12/06/19 at 9:52am revealed: -She got eye drops "just about every day." -Most of the time her eye drops were administered mid-morning. -She did not get eye drops twice a day; she did not get eye drops in the evening. Interview with the Administrator on 12/06/19 at 3:57pm revealed: -MAs should not document administering Resident #2's eye drops if they did not administer the eye drops. -If a MA documented they administered eye drops when they did not, she was concerned the MA was falsifying records. b. Review of Resident #2's physician's orders dated 03/26/19 revealed and order for Levothyroxine 75mg daily. (Levothyroxine is used	D 367		

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D 367	Continued From page 87 to treat an underactive thyroid (hypothyroidism). Review of Resident #2's November 2019 eMAR revealed: -There was an entry for Levothyroxine 75mg daily with a scheduled administration time at 5:00am. -There was documentation Levothyroxine was administered from 11/04/19-11/30/19. Review of Resident #2's December 2019 eMAR revealed: -There was an entry for Levothyroxine 75mg daily with a scheduled administration time at 5:00am. - There was documentation 4 doses of Levothyroxine was administered from 12/01/19-12/04/19. Observation of Resident #2's medications on hand on 12/04/19 at 12:51pm revealed: -There was a punch card for Levothyroxine 75mg that was dispensed on 10/30/19. -There was a handwritten date of 11/04/19 above the first tablet in the punch card. -There were twelve of thirty tablets available to be administered. Interview with the Memory Care Manager (MCM) on 12/05/19 at 4:10pm revealed she wrote 11/04/19 on the Levothyroxine punch card because she administered the medication that day and it was the day the punch card was started. Telephone interview with a representative from the facility's contracted pharmacy on 12/04/19 at 3:07pm revealed Levothyroxine 75mg had been dispensed on 10/30/19 for 30 tablets. Interview with a third shift medication aide on 12/06/19 at 7:00am revealed:	D 367		

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D 367	Continued From page 88 -Resident #2 had refused her Levothyroxine medication. -She did not recall how often Resident #2 refused Levothyroxine or the last time Resident #2 refused the Levothyroxine. -She may have forgotten to document Resident #2's refusals. -She prepped the medication and when Resident #2 refused, she forgot to change it in the eMAR. Interview with the Administrator on 12/06/19 at 3:57pm revealed: -MAs should not document administering Resident #2's Levothyroxine if they did not administer the medication. -If a MA documented they administered the medication when they did not, she was concerned the MA was falsifying records. 3. Review of Resident #1's FL-2 dated 01/02/19 revealed diagnoses included dementia unspecified without behavior disturbances, difficulty in walking, other lack of coordination, monoclonal gammophies, unspecified fracture of upper end of left humerus. Review of physician's orders dated 08/05/19 revealed TED hose (tight fitting stockings used to prevent blood from clotting) apply to legs every morning and remove every evening at 9:00am and 9:00pm. Observation of Resident #1 from 12/04/19 to 12/06/19 revealed: -On 12/04/19 at 4:11pm, Resident #1 was laying in her bed and did not have TED hose on. -On 12/05/19 at 8:34am, Resident #1 was seated in the dining room and she did not have her TED hose on. -On 12/05/19 at 4:00pm, Resident #1 was seated in the common area and she did not have her	D 367		

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D 367	Continued From page 89 TED hose on. -On 12/06/19 at 9:43am, Resident #1 was seated in the common area and she did not have the TED hose on. Review of Resident #1's electronic medication administration record (eMAR) for December 2019 revealed: -There was an entry for TED hose twice daily, apply to legs every morning and remove every evening scheduled at 9:00am and remove at 9:00pm. -There was documentation Resident #1 refused TED hose on 12/02/19 and there was documentation Resident #1 was out to the hospital on 12/03/19. -There was documentation Resident #1 had her TED hose applied on 12/04/19, 12/05/19 and 12/06/19. Interview with a medication aide (MA) on 12/05/19 at 3:19pm revealed: -Resident #1 refused to wear the TED hose and took them off herself. -The evening MA should have documented on the eMAR when Resident #1 did not have the TED hose on. -The MAs should have documented on the eMAR when Resident #1 refused to wear the TED hose or removed them during the day. Interview with a second MA on 12/05/19 at 4:00pm revealed: -She had not removed TED hose from Resident #1 in a while, she did not know if Resident #1 removed the TED hose herself or she refused to put them on. -Refusals should have been documented on the eMAR.	D 367		

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D 367	Continued From page 90 Interview with a third MA on 12/06/19 at 9:15am revealed: -She did not put the TED hose on Resident #1; she just checked behind the personal care aides (PCAs) to see if they put them on. -Resident #1's TED hose "went missing" about a month ago; she just "went down the list" on the eMAR and clicked on the task as done. Interview with the Memory Care Manager (MCM) on 12/06/19 at 9:21am revealed she knew Resident #1 had TED hose and she expected the MAs to document on the eMAR as "resident refused" when Resident #1 refused to wear her TED hose. Interview with the Administrator on 12/06/19 at 4:20am revealed: -The MAs should have documented refusals on the eMAR and not documenting that something was completed or done when it was not. -She was concerned that the MAs were knowingly documenting incorrectly on the eMAR; she said it was "falsifying documentation".	D 367		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.	D 465	Facility has implemented daily stand up meetings. Stand up meetings will include all Facility Management Staff. Executive Director will review Special Care Unit staffing in coordination with Director of Resident Care (DRC) and Memory Care Manager (MCM) during daily stand-up meetings to assure required sufficient number of staffing is in place.	1/20/2020 1/20/2020 Ongoing

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D 465	Continued From page 91 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 22 shifts sampled for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, 12/02/19, and 12/03/19. The findings are: Confidential interviews with staff revealed: -There were times when there was one medication aide (MA) and one personal care aide (PCA) staffed to cover the entire facility. -Three PCAs were on the schedule to work, but all three PCAs were on light duty for medical reasons and they were not able to assist with personal care. -There were times when the MA was scheduled with one of the PCAs on light duty and the MA had to do MA responsibilities and PCA responsibilities. -There were a lot of residents who required assistance with changing incontinence briefs; the residents had to be changed multiple times during the night. -The Administrator worked third shift recently because the MA was in the facility alone; the Administrator was in the facility from 12:00am-5:00am. -The Administrator was not qualified to do personal care or medication administration. -There were not enough staff to meet the needs of the residents in the SCU.	D 465	Care Managers are responsible for ensuring staff coverage and providing replacement personnel in the event of an absence or emergency situation. Care Managers will communicate with the Executive Director to ensure situational awareness. Facility has been assigned a new Area Director of Operations (ADO) who will review compliance in the area of Special Care Unit Staffing during weekly visits SADO will provide support to the Area Director of Opertations and Executive Director with weekly conferance calls and/or site visits SADO will review the Shift Analysis Report, Special Care Unit Staffing' schedules during weekly calls and/or visits to ensure compliance Facility Executive Director, Business Office Manager (BOM) ,and MCM have received training on assuring Special Care Unit Staffing ratios on 12/6/19. Training provided by SADO. Facility Executive Director, DRC, MCM and BOM received additional training on Special Care Unit Staffing 1/15/2020. Training provided by ADO	1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 Ongoing 1/20/2020 1/20/2020

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D 465	Continued From page 92 -There were not enough staff to assist residents at meal times in the SCU. Interview with a personal care aide (PCA) on 12/06/19 at 6:26am revealed: -She had medical restrictions for providing resident care. -She had not been able to assist with the resident's personal care needs since July 2019 because of a work-related injury. -When she was scheduled to work, she did filing and answered call lights. -If a resident needed assistance with changing, she would have to ask another staff member to tend to the resident. -She had been able to change a catheter bag and empty urinals. -There were a lot of residents who needed changing on her shift, and she felt bad for the other staff members that she was not able to assist. Interview with a personal care aide (PCA) on 12/06/19 at 10:30 am revealed: -There were seven "high-need" residents in the special care unit (SCU). -Sometimes two PCAs worked in the SCU. -Each PCA would take care of residents on one of the two halls. -The SCU was short-staffed when there two PCAs . Telephone interview with a family member on 12/06/19 at 2:05pm revealed: -The SCU was always short-staffed. -He was at the facility on a Saturday, he did not recall the date, and observed one staff member in the SCU. -The staff member was trying to get all of the residents into the dining room.	D 465		

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-His family member complained there were not enough staff in the SCU.

Telephone interview with a second family member on 12/06/19 at 3:22pm revealed:
-There have been multiple times she had visited the facility and there were 2 staff members in the SCU and 1 staff member on the AL side of the facility.
-There was one evening in November 2019, she did not recall the date when there were only two staff members in the entire facility.
-The MA was passing medications in the SCU and the PCA came to get the MA because a resident in AL had a fall.
-She thought her family member was in danger if she continued to live at the facility.

Review of the facility's current license effective 01/01/19 revealed:
-The facility was licensed for a total capacity of 60 residents.
-The facility was licensed for 32 residents in the SCU.

Review of the Resident Bed List Report dated 11/05/19 revealed there was a SCU census of twenty-eight residents, which required 22.4 staff hours on third shift.

Review of the Individual Employee Time Cards dated 11/05/19 revealed:
-There were 24.29 staff hours provided on third shift; 8.00 staff hours of the 24.29 staff hours were provided by a personal care aide (PCA) on medical restriction.

Interview with the Supervisor on 12/06/19 at 6:45am revealed:
-She was the only medication aide

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D 465	Continued From page 94 (MA)/Supervisor that worked on 11/05/19. -There were two personal care aides (PCA) that worked with her on 11/05/19. -She thought both of the PCAs that worked on 11/05/19 were both on medical restrictions. Review of the Employee Time Cards dated 11/05/19 revealed: -There was one MA/Supervisor assigned to the facility. -There were no PCAs assigned to the AL unit, and there were two PCAs assigned to the special care unit (SCU); one of the two PCAs was on medical restrictions. Review of the Resident Bed List Report dated 11/16/19 revealed there was a SCU census of 26 residents, which required 26 staff hours on first and second shift, and 20.8 staff hours on third shift. Review of the Individual Employee Time Cards dated 11/16/19 revealed: -There were 27.78 staff hours provided on first shift; 7.88 staff hours of the 27.78 staff hours were provided by a personal care aide (PCA) on medical restriction. Review of the Resident Bed List Report dated 11/17/19 revealed there was a SCU census of 26 residents, which required 26 staff hours on first and second shift, and 20.8 staff hours on third shift. Review of the Individual Employee Time Cards dated 11/17/19 revealed: -There were 28.44 staff hours provided on second shift; 7.25 staff hours of the 28.44 staff hours were provided by a personal care aide (PCA) on medical restriction.	D 465		

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D 465	Continued From page 95 -There were 16.24 staff hours provided on third shift leaving the shift short 4.56 staff hours; .12 staff hours were provided by a PCA on medical restriction. Review of the Resident Bed List Report dated 11/29/19 revealed there was a SCU census of 27 residents, which required 27 staff hours on first and second shift, and 21.6 staff hours on third shift. Review of the Individual Employee Time Cards dated 11/29/19 revealed: -There were 19.30 staff hours provided on second shift leaving the shift short 7.7 staff hours; 8.00 staff hours of the 19.30 staff hours were provided by a PCA on medical restriction. -There were 16.66 staff hours provided on third shift leaving the shift short 4.94 staff hours; .33 staff hours were provided by a PCA on medical restriction. Review of the Resident Bed List Report dated 11/30/19 revealed there was a SCU census of 27 residents, which required 27 staff hours on first and second shift, and 21.6 staff hours on third shift. Review of the Individual Employee Time Cards dated 11/30/19 revealed: -There were 23.55 staff hours provided on second shift leaving the shift short 3.45 staff hours; 5.22 staff hours of the 23.55 staff hours were provided by a PCA on medical restriction. -There were 16.24 staff hours provided on third shift leaving the shift short 5.20 staff hours. Review of the Resident Bed List Report dated 12/01/19 revealed there was a SCU census of 26 residents, which required 26 staff hours on first	D 465		

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and second shift, and 20.8 staff hours on third shift.

Review of the Individual Employee Time Cards dated 12/01/19 revealed:
-There were 13.43 staff hours provided on first shift leaving the shift short 12.57 staff hours.
-There were 27.67 staff hours provided on second shift; 4.00 staff hours of the 27.67 staff hours were provided by a PCA on medical restriction.
-There were 9.56 staff hours provided on third shift leaving the shift short 11.04 staff hours.

Review of the Resident Bed List Report dated 12/02/19 revealed there was a SCU census of 27 residents, which required 27 staff hours on first and second shift, and 21.6 staff hours on third shift.

Review of the Individual Employee Time Cards dated 12/02/19 revealed:
-There were 27.57 staff hours provided on second shift; 9.66 staff hours of the 27.57 staff hours were provided by a PCA on medical restriction.
-There were 21.7 staff hours provided on third shift; 3.48 staff hours of the 21.7 staff hours were provided by a PCA on medical restriction.
-During the hours of 2:48am-4:58am there was only MA/Supervisor in Charge (SIC) in the facility and one PCA on duty in the SCU.

Review of the Resident Bed List Report dated 12/03/19 revealed there was a SCU census of 26 residents, which required 26 staff hours on first and second shift, and 20.8 staff hours on third shift.

Review of the Individual Employee Time Cards

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D 465	Continued From page 97 dated 12/03/19 revealed 21.29 staff hours were provided on second shift leaving the shift short 4.71 staff hours; 8 staff hours of the 21.29 staff hours were staffed by a PCA on medical restriction. Interview with a second MA on 12/06/19 at 12:12pm revealed: -She worked on both units. -She usually worked long hours on the weekends. -She came in early and stayed late. -MAs were usually asked to stay after scheduled hours on the weekdays. -Last weekend, a MA and PCA assigned to the SCU had called out. -Management did not inform her of the call-outs. -She went to the SCU to give the residents their medication. -The MCM came in at 10:45am to administer medication to the SCU residents. -She ended up working 13½ hours and she did not get a break. -Last month (date unknown), there was one day where she was the only MA in the building from 6:30am-8:30pm. -Many staff had quit. -Since June 2019, the facility had been short-staffed. -Staff quit because of the long hours and having to work six days in a row. Interviews with the MCM on 12/06/19 at 5:13pm revealed: -She had been working at the facility for six weeks. -She had only one weekend off since she had been working at the facility. -She had not worked under 40 hours for any week since she had been working at the facility.	D 465		

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D 465	Continued From page 98 -The length of time she worked depended on the shift she worked. -The previous weekend she came in for first shift and had worked 10 hours. -She did whatever needed to be done when she came in. -If an MA called out, she administered medication. -If a PCA called out, she worked on the floor. _____ The facility failed to assure aide hours met the minimum requirements for a special care unit (SCU) and staff on duty were present at all times for 15 of 22 sampled shifts for 9 days in November 2019, and December 2019. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED January 20, 2019.	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 99 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation related to personal care staffing and other services, health care, nutrition and food service, medication administration, Special Care Unit staffing, and implementation. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 4 residents (#11) observed during the medication pass, including errors with a laxative and a vitamin B12; and for 3 of 8 residents (#2, #4, and #5) sampled for record review including errors with sliding scale insulin (#5), ophthalmic antibiotic and anti-inflammatory drops, and a thyroid hormone replacement (#2), a medication to treat dementia and a medication to treat depression and generalized anxiety (#4). [Refer to Tag D 358, 10A NCAC 13F .1004 (a) Medication Administration (Unabated Type B Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 22 sampled shifts for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, and 12/02/19. [Refer to Tag D 188. 10A NCAC 13F .0604 (e) Personal Care and Other Staffing (Type B Violation)]	D912	Facility has new Area Director of Operations(ADO), who will work in cooridnation with Senior Area Director of Operations (SADO),Divisional Director of Clinical Services (DDCS), and Executive Director to assure all residents recieve care and services which are adequate, appropriate, and in compliance with relevent federal and state laws and rules and regulations. Facility has implemented daily stand up meetings. Stand up meetings will include all Facility Management Staff. Facility SICs and/or Med Techs will conduct weekly medication cart audits. Facility ED,DRC, and/or MCM will review weekly cart audits which are completed by SICs/Med Techs. Review will be done weekly Facility DRC and/or MCM will conduct additional monthly medication cart audits for 3 months, then randomly there after Facility LHPS RN, DRC (LPN), and/or DDCS (RN) will conduct random medication pass observations with different Medication techs over the next 2 months, then randomly there after ADO and/or SADO in coordination with DDCS will monitor compliance through system reviews and weekly onsite visits. Executive Director will review assisted living and memory care staffing in coordination with Director of Resident Care (DRC) and Memory Care Manager (MCM) during daily stand-up meetings to assure require number of staff are in place.	1/20/2020 1/20/2020 12/27/19 12/27/19 12/27/19 1/20/2020 1/20/2020 1/20/2020

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D912	Continued From page 100 3. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 3 of 5 sampled residents (#1, #2, and #7) including notifying the primary care provider regarding a resident who was not wearing their Thrombo-Embolic-Deterrent hose (TED) who had a history of a blood clots (#1); a resident who had an order to have staples removed from a head wound (#2); and a resident who was sent out to the hospital for hypernatremia and dehydration (#8). [Refer to Tag D 273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)] 4. Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3 sampled residents were served therapeutic diets as ordered regarding a resident with an order for a regular diet and received a pureed diet (#7) and a resident with an order for chopped meats was served whole meat (#9). [Refer to Tag D 310, 10A NCAC 13F .0904 (e) (4) Nutrition and Food Service (Type B Violation)] 5. Based on observations, and interviews, the facility failed to assure residents in the Special Care Unit (SCU) who required assistance with eating, were assisted upon receipt of the meal in a timely manner. [Refer to Tag D 312, 10A NCAC 13F .0904 (f) (2) Nutrition and Food Service (Type B Violation)] 6. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 22 shifts sampled for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, 12/02/19, and 12/03/19. [Refer to Tag D 465, 10A NCAC 13F	D912	Executive Director will review all resident concerns in regrads to Healthcare referrals and follow-up needs during daily stand up meetings. Facility has implemented a twenty-four hour communitcation log. DRC, ED and/or MCM will review communication log daily for any needed health care referral and follow-up. ED, DRC, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then will monitor meals randomly to assure all residents have correct place settings, are served the correct/prescribed diets, and feeding assistance when needed. Executive Director will review any resident dietary concerns and/or needs during daily stand up meetings Facility staff have received training on Declaration of Residents Rigths on 1/6/2020. Training conducted by Ombusman. Facility staff have received training on Resident Rights and Dignity on 12/26/19. Training provided by Senior Area Director of Operations.	1/20/2020 1/20/2020 1/20/2020 1/20/2020 1/20/2020

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D912	Continued From page 101 .1308 Special Care Unit Staffing (Type B Violation)] 7. Based on observations, record reviews, and interviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care staffing and other services, health care, nutrition and food service, medication orders, medication administration, Special Care Unit staffing, and resident rights. [Refer to Tag D 980, G.S. 131 D-25 Implementation (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 3 sampled residents (#7, #8, and #1) were free from neglect related to not having a plate of food served for the lunch and dinner service (#1 and #8), and downgrading a diet without a physician's order and isolating one resident (#7) from the other residents during meal times in the Special Care Unit dining room. The findings are: 1. Review of Resident #7's FL-2 dated 01/08/19	D914	Facility has new Area Director of Operations(ADO), who will work in cooridnation with Senior Area Director of Operations (SADO),Divisional Director of Clinical Services (DDCS), and Executive Director to assure all residents are free of mental and physical abuse, neglect and exploitation. ED, DRC, and/or Memory Care Manager will monitor no less than 5 meals pre week for 2 months, then will monitor meals randomly to assure all residents have correct place settings. Area Director of Operations and Senior Aera Director of Operations will monitor compliance with meals,meal place settings,diets and feeding assistance during on-site visits. Facility staff have received training on Dining Experience. Training was provided by CDP and Included the following topics: -What is Dementia -The Dining Experience and Dementia -How to assist with meal time and feeding	1/20/2020 1/20/2020 1/20/2020 1/15/2020

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D914	Continued From page 102 revealed -Diagnoses included dementia without behavior disturbances, healthcare associated pneumonia, history of falls, hypoxia, interstitial lung disease, arterial flutter, and positive rhinovirus. -Documented under personal care and assistance included feeding with a note "Prompting". -There was a diet order for chopped meats. Review of a signed diet order dated 10/04/19 revealed Resident #7 was ordered a regular diet. Review of Resident #7 care plan dated 11/05/19 revealed Resident #7 "Needed prompting to complete meals and snacks". Observation of the dining room in the SCU on 12/04/19 from 11:52am to 12:28pm revealed: -Resident #7 was seated at a counter in the corner of the second dining room; she had her back to the rest of the dining room; she had a plate of pureed food setting in front of her. -Resident #7 was sitting with her head hanging down and appeared to be asleep; Resident #7 was not eating or drinking anything. -At 12:15pm Resident #7 still had a full plate of pureed food and a full glass of water and iced tea; none of the staff were assisting or encouraging Resident #7 to eat or drink during the meal. -At 12:21pm a PCA went over to Resident #7 and told her to eat her food; the PCA pulled a chair to the counter and assisted Resident #7 a spoonful of food and a sip of water. -At 12:24pm the PCA left Resident #7 and began removing plates from the dining room; Resident #7 was still sitting with her head hung down, hair in her face and her hands in her lap. -At 12:28pm the PCA removed Resident #7 from	D914	Facility staff have received training on Declaration of Residents Rigths on 1/6/2020. Training conducted by Ombusman. Facility staff have received training on Resident Rights and Dignity on 12/26/19. Training provided by Senior Area Director of Operations.	1/20/2020 1/20/2020

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D914	Continued From page 103	D914		

the dining room and took her to her room.
-Resident #7 ate less than one percent of her meal and drank less than one percent of her beverages.
-Resident #7's plate was cleared from the dining room.

Interview with a PCA on 12/04/19 at 12:28pm revealed Resident #7 would have eaten more if she had been fed by the PCA that took her back to her room.

Observation of the breakfast meal in the dining room in the SCU on 12/05/19 at 8:06am revealed:
-Resident #7 was brought to the dining room and placed at a counter in the back corner of the dining room and positioned with her back to the dining room.
-Resident #7 was served pureed eggs, pureed bread, pureed sausage, a yogurt cup and a can of diet soda; staff did not assist or encourage Resident #7 to eat but moved away from her to assist with other residents.
-At 8:14am Resident #7 called out "help me"; a PCA repositioned her in front of her plate and walked away.

Observation of Resident #7 in facility lobby on 12/04/19 at 4:30 pm revealed:
-She was sitting in a wheelchair with her head slumped down.
-She was assessed by the emergency medical technician (EMT) and verbally provided the pulse oximeter measurement (92%) and heart rate (130's) to the Paramedic.
-Resident #7 was assisted onto a gurney by the EMTs and Paramedic and transported at 4:40 pm.

Review of Resident #7's hospital discharge

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D914	Continued From page 104 documents dated 12/04/19 revealed a diagnosis of dehydration and hypernatremia. Interview with a PCA on 12/05/19 at 12:46pm revealed: -Resident #7 sat at the counter to eat because she threw food and beverages on the floor and would hit other residents. -Resident #7 could eat without assistance until about two weeks ago, now she needed to be prompted to eat or assisted to eat. -Resident #7 had always been served pureed food. Interview with the Kitchen Manager (KM) on 12/06/19 at 10:07am revealed: -He was responsible for keeping a current list of residents and their diets and made changes as needed himself. -He changed the diet list without a documented diet order. -The PCAs would come to him and tell him a resident was not eating and he would make the decision to downgrade the diet to a mechanically chopped or a pureed diet. -He would recognize when a resident was not eating and would change the diet based on his observations; he usually changed the diet to a chopped or a pureed diet. -He thought Resident #7 had been on a pureed diet for almost a year. -Resident #7 sat at the counter because she threw her food and beverages and the staff could watch her better at the counter. Interview with Resident #7's primary care physician (PCP) on 12/06/19 at 10:59pm revealed: -Resident #7 was ordered a regular diet, not a pureed diet.	D914		

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D914	Continued From page 105 -She had been aware Resident #7 had a decrease in appetite for about the last three weeks. -She thought maybe the change to a pureed diet could be the reason for the decrease in appetite; "nobody wanted to eat a pureed diet if they did not have too". -Resident #7's diet should not have been changed without a physician's order from her or an evaluation from a Speech Therapist with a recommendation to change the diet order. -She was concerned about the diet change and Resident #7's decrease in appetite. Interview with the Memory Care Manager (MCM) on 12/05/19 at 12:19pm revealed: -She thought Resident #7 could eat on her own but had declined in the last week or two. -She was concerned Resident #7 was seated alone at the counter with her back to the rest of the dining room because "it was not a good location"; she was concerned Resident #7 was isolated, distanced and could not socialize with any of the other residents in the dining room. -She knew it could be a dignity issue because Resident #7 was "isolated". -She was also concerned staff could not see Resident #7 if she choked on her food or was not eating. -She did not know Resident #7 was not ordered a pureed diet; she thought the diet order was correct because it was on the diet list in the kitchen. -She thought the pureed diet could be contributing to Resident #7's decreased appetite and could also be a dignity issue without a physicians order. Based on observations, interviews and record reviews it was determined Resident #7 was not	D914		

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D914	Continued From page 106 interviewable. Refer to the interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm. Refer to the interview with the Administrator on 12/04/19 at 6:43pm. 2. Review of Resident #8's FL-2 dated 07/09/19 revealed diagnoses included molybdenum cofactor deficiency disorder, dementia with behaviors, small vessel cerebrovascular disease, acquired cerebral ventriculomegaly history, hypertension, epilepsy, and chronic diastolic heart failure. Observation of Resident #8 on 12/04/19 at 9:27am and 11:52am revealed Resident #8 was laying asleep in the bed on her left side. Observation of the dining room on the Special Care Unit (SCU) on 12/04/19 at 12:08pm revealed: -A personal care aide (PCA) asked the KM for a tray for Resident #8; at 12:10pm the PCA took Resident #8's lunch tray down the hall to Resident #8's room. -At 12:14pm the PCA returned to the dining room and told the KM that Resident #8 "refused to eat; she spit the spoonful of food out of her mouth". Observation of Resident #8 on 12/04/19 at 12:14pm revealed Resident #8 was laying asleep in the bed on her left side. Observation of the dining room in the SCU on 12/04/19 at 5:57pm revealed the PCAs were clearing the dinner tables, wiping tables, sweeping the floor and escorting residents to the common area.	D914		

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D914	Continued From page 107 Observation of Resident #8 on 12/04/19 at 6:00pm revealed she was on her left side asleep in the bed. Observation of the dining room on 12/04/19 at 6:17pm revealed: -A PCA took a plate of pureed food to Resident #8's room, the PCA did not take any beverages. -The PCA raised the bed, raised the head of the bed and positioned Resident #8 into a sitting position. -The PCA assisted Resident #8 with eating her dinner meal. -Resident #8 ate 100% of her sherbet. Interview with a personal care aide (PCA) on 12/04/19 at 6:06pm revealed she did not know who was assigned to Resident #8. Interview with a second PCA on 12/04/19 at 6:08pm revealed: -She had come in to work today at 4:00pm. -She was probably assigned to Resident #8. -She had not done anything with Resident #8 since she had come to work. Interview with a second PCA on 12/04/19 at 6:08pm revealed: -Resident #8 was usually at the feeding table. -She would take a plate to Resident #8's room since she did not come to the dining room. -She would take Resident #8 her plate to assist her with eating about 30 minutes after the residents in the dining rooms were done eating. -It took about 30 minutes to position Resident #8 and for her to eat the meal. Interview with the third PCA on 12/04/19 at 6:19pm revealed: -She worked with Resident #8 every day that she	D914		

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D914	Continued From page 108	D914		

worked.
-Resident #8 had not been out of bed in "about a week" because she was a fall hazard.
-Resident #8 required two people to transfer her; she was very weak and on hospice care.
-Resident #8 took a long time to eat her foods.
-Resident #8 had been eating "about ½ of her meal."
-The PCAs talk to each other to know who was going to care for which residents.
-She had checked on Resident #8 when she made her rounds at 3:15pm; she had not been back to check on Resident #8 until now (6:16pm).

Interview with a second PCA on 12/04/19 at 6:26pm revealed she would take Resident #8 her dinner meal after she swept the floor in the dining room.

Interview with a PCA on 12/05/19 at 9:15am revealed:
-Resident #8 was "bed bound" and on hospice.
-She usually assisted Resident #8 with her eating her meals; Resident #8 would only eat three to four bites before she would swat your hand away or say "no".
-It took her no more than five minutes for her to assist Resident #8 with eating the meal.
-The day before, on 12/04/19 at lunch she raised the bed, sat Resident #8 up, turned the resident towards her and then gave her a bite of her food on her lips but Resident #8 spit the food out.
-She tried to give her water through a straw but Resident #8 would not suck on the straw, so she gave her a sip right from the cup and the resident let it roll out of her mouth.
-She spent five to six minutes when she assisted Resident #8 with eating at lunch on 12/04/19; that included positioning Resident #8 in the bed.

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D914	Continued From page 109 Interview with Resident #8's hospice Registered Nurse (RN) on 12/05/19 at 4:32pm revealed: -Resident #8 had an order to be in the bed for feeding; she needed to be repositioned into a seated position for eat. -She had instructed the MAs and the PCAs to place Resident #8 in a seated position to eat. -The facility staff had informed hospice Resident #8 had gradually declined and was only eating about 25 percent of her meal and had pocketed food. -She expected Resident #8 to be served three meals a day and to be assisted with eating meals three times a day. -Resident #8 could not be repositioned and assisted with eating in three to five minutes; it would take her five to ten minutes just to reposition Resident #8. -If Resident #8 was not eating because facility staff was not taking the time to properly assist Resident #8 then the resident will decline more rapidly. Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -Resident #8 could not be assisted to eat one bite in only three minutes. -Resident #8 needed to be sat up in the bed prior to eating, positioning the residents would take at least three minutes. -She was disappointed to know Resident #8 did not eat or drink anything at lunch that day. Interview with the Administrator on 12/04/19 at 6:43pm revealed she did not know Resident #8 did not receive a lunch and dinner meal, but she knew Resident #8 was bed bound. Based on observations, reviews and interviews it was determined Resident #8 was not	D914		

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D914	Continued From page 110 interviewable. Refer to the interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm. Refer to the interview with the Administrator on 12/04/19 at 6:43pm. 3. Review of Resident #1's FL-2 dated 01/02/19 revealed diagnoses included dementia unspecified without behavior disturbances, difficulty in walking, other lack of coordination, monoclonal gammopathies, unspecified fracture of upper end of left humerus. Observation of the dining room in the special care unit (SCU) on 12/04/19 at 11:46am revealed: -A personal care aide (PCA) said that Resident #1 was not coming to the dining room to eat; "it is her right not to come down due to her head injury". -The Kitchen Manager (KM) told the PCA to ask Resident #1 if she wanted anything to eat; the PCA said Resident #1 did not want to eat. Observation of the PCAs in the SCU on 12/04/19 at 5:57pm revealed the PCAs were sweeping the floors, clearing plates from the tables and moving residents into the common area. Observation of Resident #1 on 12/04/19 at 6:19pm revealed: -She had not been to the dining room to eat. -She was laying on the bed under the covers in the dark; she was awake. Observation of the dining room on 12/04/19 at 6:26pm revealed: -The medication aide (MA) reminded a PCA Resident #1 had not eaten dinner.	D914		

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D914	Continued From page 111 -The PCA went into the kitchen and got a half of a deli sandwich and took it to Resident #1's room; the PCA had nothing else in her hands. -The PCA sat Resident #1 up in the bed and handed her the sandwich; the PCA left the room and returned with a cup of water. -The PCA never offered Resident #1 a hot plate of food. Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -Residents only ate in their rooms when they were sick, and they should be served before the residents in the dining room were served. -If a resident needed to be assisted with eating then the PCAs served them after the meal when there was more time to spend with the resident. Interview with Resident #1 on 12/04/19 at 6:19pm revealed she "could eat a little something"; she could not answer if she wanted to go to the dining room to eat. Interview with the medication aide (MA) on 12/04/19 at 5:51pm revealed Resident #1 would eat when she was asked if she wanted to eat in her room. Interview with a PCA on 12/04/19 at 6:07pm revealed Resident #1 did not come to the dining room for every meal because her legs were often sore; she would be served after the PCAs were done assisting and cleaning in the dining room. Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -She did not know Resident #1 did not eat lunch; she did not tell the PCAs it was okay for Resident #1 to refuse to eat due to her head injury. -Residents had the right to refuse to come to the	D914		

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D914	Continued From page 112 dining room; residents should be encouraged to come to the dining room. -She was concerned Resident #1 was only served half a sandwich; Resident #1 would not recognize she was hungry due to her dementia diagnosis. Interview with the Administrator on 12/04/19 at 6:43pm revealed she did not know Resident #1 did not receive a lunch and dinner meal. Refer to the interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm. Refer to the interview with the Administrator on 12/04/19 at 6:43pm. --- Interview with the Memory Care Manager (MCM) on 12/04/19 at 7:00pm revealed: -Residents could eat in their rooms when they were sick but were encouraged to come to the dining room to eat with the rest of the residents. -Residents that ate in their rooms should be served before the residents in the dining room were served. -If a resident ate in their room and needed to be assisted with eating then they would be served after the residents in the dining room were served. -After residents were done with the meal in the dining room the PCAs were responsible for clearing the plates from tables, wiping the tables clean, sweeping the floors and then did rounds to check on residents. -Residents needed to be encouraged not to refuse but encouraged to eat due to the diagnosis dementia and memory loss. -When residents refuse to eat, they should be asked again if they want to eat, after they refused	D914		

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D914	Continued From page 113	D914		

to eat a second meal the MA should have notified her, the hospice nurse or the physician and the refusals documented in the progress notes.

Interview with the Administrator on 12/04/19 at 6:43pm revealed:
-Staff on the Special Care Unit (SCU) worked as a team and communicated with each other to ensure all tasks were completed.
-She expected them to communicate with each other when the shift started to determine who would do tasks for the residents; the staff would communicate resident needs during "rounds".
-Rounds were when the PCAs would go from resident room to resident room together and discuss the residents while checking on them to see if they were dry or needed anything.
-The process "sounds unorganized" but it worked; PCAs usually communicated with the same PCA from shift to shift.
-There was no formal process of assigning who would be responsible for the care of specific residents on the SCU.
-She was not concerned residents got missed or were overlooked because they were checked every two hours.
-All residents were brought to the dining rooms for meal times.
-She expected meals to be offered to residents with dementia three times at approximate 5-minute intervals.
-Her expectation when offering food to a resident with dementia eating in their room was to offer food every 15 minutes and offer at least three times before giving up.
-The MA was responsible for making sure all the residents were fed at every meal; residents should eat three meals a day, "no exceptions".
-She was concerned that residents did not receive a meal and were not fed or assisted as

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D914	Continued From page 114 needed with the meal. -She expected all residents to be assisted to the dining room for meal service. -If a resident did not feel well, the resident could be fed in their room and assisted in their room as needed with the meal. -She knew there were not enough aides to feed the number of feeders on the SCU. -She expected staff to serve the plates when they were ready to assist the residents. -At this time there, were three aides available to feed the residents and one aide was expected to monitor the dining room. -She expected staff to assist residents with meals in their rooms immediately after the meal service was complete in the dining room and served the same meal. -She thought 6:15 pm was too late for a resident to be assisted with meal. -The MAs were responsible for ensuring residents received a meal and assistance with the meal if the resident was unable to feed themselves. The facility failed to assure Resident #7 was assisted or prompted with eating because she was seated in an isolated area, Resident #7 was also served a pureed meal that was not ordered and was not eating which resulted in the resident being transferred to the hospital for dehydration and increased sodium levels, Resident #8 was not being feed which could have contributed to her rapid decline, Resident #1 missing two meals due to staff failing to offer her meals after she refused. This failure of the facility was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/10/19.	D914		

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D914	Continued From page 115 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care staffing and other services, health care, nutrition and food service, medication administration, Special Care Unit staffing, and resident rights. The findings are: Confidential telephone interview with a resident's physician revealed: -There was difficulty at the facility with having a contact person due to staff changes. -There were changes in the Care Managers who started working at the facility and then left. -She established contact with one Supervisor who she sent orders to and received information from	D980	Facility has been assigned a new Area Director of Operations(ADO), who will work in cooridnation with Senior Area Director of Operations (SADO),Divisional Director of Clinical Services (DDCS), and Executive Director to oversee and provide guidance with the management, operations, and policies of the facility. Facility has hired new Director of Resident Care (LPN) to assist with management of all resident care asspects of the facility Area Director and/or Senior Area Director of Operations will conduct resident and/or staff interviews, complete rounds of facility, and monitor at least one meal during weekly visits. ADO and/or SADO will communication via weekly conferance calls with Divisional VP of Operations.	1/20/2020 1/20/2020 1/20/2020 1/20/2020

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D980	Continued From page 116 concerning residents. -She had difficulty receiving copies of the eMARs, vital signs, fingerstick blood sugar and other resident data to review for residents. Telephone interview with a family member on 12/06/19 at 9:57 am revealed: -She came on the weekends most of the time to see her family member on the Special Care Unit (SCU). -Her family member had lived there for years and she had seen a change in services. -Staff turnover was high and she did not get the "warm fuzzies" when interacting with staff. -She had requested to speak with the Administrator before but never received a call back. -She did not know when she requested to speak with her, she now asked the Activities Director because she seemed to be a long-term staff and sought answers to her questions. Telephone interview with a personal care aide (PCA) on 12/06/19 at 12:01pm revealed: -There were many things happening in the facility. -Staff came to work and announced they were doing nothing for the residents. -She thought there were difficulties with staff completing job tasks because some of the staff were related to one another but she was not able to recall who was related to whom. -Staff were unprofessional when speaking near residents and there was not enough staff in the facility to complete the tasks needed for residents. -Staff were supposed to have a meeting with Administration on the fifteenth of each month, but the meeting did not occur each month. Interview with Administrator on 12/06/19 at 3:13	D980		

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D980	Continued From page 117 pm revealed: -She had worked at the facility since May 2018 and she was responsible for overseeing diets, clinical management, business office, housekeeping, and other tasks required by her Supervisor. -She met with staff once a month and addressed different issues. -She had staff who left the facility, a Assisted Living Care Manager left some months ago and she was attempting to do some of the Care Manager duties. -She was not able to do everything herself. Non-compliance was identified in the following rule areas at the violation level: 1. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 4 residents (#11) observed during the medication pass, including errors with a laxative and a vitamin B12; and for 3 of 8 residents (#2, #4, and #5) sampled for record review including errors with sliding scale insulin (#5), ophthalmic antibiotic and anti-inflammatory drops, and a thyroid hormone replacement (#2), a medication to treat dementia and a medication to treat depression and generalized anxiety (#4). [Refer to Tag D 358, 10A NCAC 13F .1004 (a) Medication Administration (Unabated Type B Violation)] 2. Based on observations, interviews, and record reviews, the facility failed to assure the minimum requirements for aide hours were met on 14 of 22 sampled shifts for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, and 12/02/19. [Refer to Tag D 188. 10A NCAC 13F .0604 (e) Personal Care and Other Staffing (Type B Violation)]	D980		

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D980	Continued From page 118 3. Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 3 sampled residents (#7, #8, and #1) were free from neglect related to not having a plate of food served for the lunch and dinner service (#1 and #8), and downgrading a diet without a physician's order and isolating one resident (#7) from the other residents during meal times in the Special Care Unit dining room. [Refer to Tag D 914, G.S. 131D-21(4) Declaration of Resident Rights (Type B Violation)]. 4. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 3 of 5 sampled residents (#1, #2, and #7) including notifying the primary care provider regarding a resident who was not wearing their Thrombo-Embolic-Deterrent hose (TED) who had a history of a blood clots (#1); a resident who had an order to have staples removed from a head wound (#2); and a resident who was sent out to the hospital for hypernatremia and dehydration (#8). [Refer to Tag D 273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)] 5. Based on observations, record reviews, and interviews, the facility failed to assure 2 of 3 sampled residents were served therapeutic diets as ordered regarding a resident with an order for a regular diet and received a pureed diet (#7) and a resident with an order for chopped meats was served whole meat (#9). [Refer to Tag D 310, 10A NCAC 13F .0904 (e) (4) Nutrition and Food Service (Type B Violation)] 6. Based on observations, and interviews, the facility failed to assure residents in the Special Care Unit (SCU) who required assistance with	D980		

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D980	Continued From page 119 eating, were assisted upon receipt of the meal in a timely manner. [Refer to Tag D 312, 10A NCAC 13F .0904 (f) (2) Nutrition and Food Service (Type B Violation)] 7. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 22 shifts sampled for 9 days sampled on 11/05/19, 11/16/19, 11/17/19, 11/29/19, 11/30/19, 12/01/19, 12/02/19, and 12/03/19. [Refer to Tag D 465, 10A NCAC 13F .1308 Special Care Unit Staffing (Type B Violation)] The Administrator failed to assure responsibility for the overall management, administration, supervision and operation of the facility which was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131 D-34 on 12/10/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 20, 2020.	D980		