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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up and complaint investigation on February 26, 2020 through February 28, 2020.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 9 exit doors accessible for residents' use had a sounding device that activated for safety for 3 of 5 sampled residents (#1, #4, #5) who were all assessed to be intermittently disoriented. The findings are: Observation upon entrance to the facility on 02/26/20 at 9:30 am revealed there was no sounding device when the main front door located near the Administrator's office was opened.	D 067		

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Observations intermittently on 02/26/20 from 10:00 am - 4:15 pm revealed:
-The facility had a total of 9 exit doors.
-When the main front exit door was opened at different intervals observed throughout the day, the door was not locked and there were no audible alarm sounds heard.
-There were no audible alarm sounds observed at the exit door leading to the outside smoking section of the facility on the 100 Hall.

1. Review of Resident #1's current FL-2 dated 01/15/20 revealed:
-Diagnoses included COPD, HTN, generalized muscle weakness, morbid obesity, obstructive sleep apnea, and major depressive disorder.
-The resident was intermittently disoriented.

Review of Resident #1's Assessment and Care Plan dated 01/15/20 revealed:
-The resident was sometimes disoriented and was forgetful needing reminders.
-The resident required the use of assistive devices for ambulation.
-The resident required staff supervision and set-up for ambulation and extensive staff assistance for transferring.

Observation of Resident #1 on 02/28/20 revealed the resident was coming down the hallway in her motorized wheelchair independently.

Refer to the interview with the Resident Care Coordinator (RCC) on 02/26/20 at 3:10 pm and on 02/28/20 at 3:38 pm.

Refer to the interview with the Administrator on 02/26/20 at 4:20 pm.

Refer to the interview with the Administrator on

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D 067	Continued From page 2 02/17/20 at 10:18 am. 2. Review of Resident #4's current FI-2 dated 01/09/20 revealed: -Diagnoses included diabetes mellitus, gastroesophageal reflux disease and chronic obstructive pulmonary disease. -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #4's Assessment and Care Plan dated 05/16/20 revealed: -Resident #4 required extensive assistance with all activities of daily living (ADLs) which included toileting, ambulation, bathing, dressing, grooming, and transferring. -She required limited assistance for eating. Observation of Resident #4 on 02/26/20 at 3:02 pm revealed: -She was moving herself in her wheelchair from the dining room. -She had a cigarette in her hand. -She stated she was going out to smoke. Refer to the interview with the Resident Care Coordinator (RCC) on 02/26/20 at 3:10 pm and on 02/28/20 at 3:38 pm. Refer to the interview with the Administrator on 02/26/20 at 4:20 pm. Refer to the interview with the Administrator on 02/17/20 at 10:18 am. 3. Review of Resident #5's FL-2 dated 01/09/20 revealed: -Diagnosis included muscle weakness. -The resident was intermittently disoriented. -The resident was semi-ambulatory.	D 067		

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D 067	Continued From page 3 Review of Resident #5's Assessment and Care Plan dated 09/12/19 revealed: -The resident was ambulatory with a wheelchair. -The resident had limited strength in her upper extremities. -The resident was oriented. -The resident's memory was forgetful. Refer to the interview with the Resident Care Coordinator (RCC) on 02/26/20 at 3:10 pm and on 02/28/20 at 3:38 pm. Refer to the interview with the Administrator on 02/26/20 at 4:20 pm. Refer to the interview with the Administrator on 02/17/20 at 10:18 am. _____ Interview with the Resident Care Coordinator (RCC) on 02/26/20 at 3:10 pm and on 02/28/20 at 3:38 pm revealed: -All exit doors were equipped with sounding devices and/or were locked except for the facility's main front exit door and the exit door leading to the outside smoking area located on the 100 Hall of the facility. -The main front exit door and the exit door leading to the outside smoking section located on the 100 Hall of the facility was locked nightly at 8:00 pm and unlocked at 6:00 am the next morning. -The main front exit door and the exit door leading to the outside smoking section stayed unlocked during the day because there was so much traffic in and out of those doors during the day. -The main front exit door and the exit door leading to the outside smoking section was accessed multiple times a day by visitors and	D 067		

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D 067	Continued From page 4 residents. -There were residents residing in the facility that had been assessed with different levels of disorientation. -There had never been any past concerns about the main front exit door and the exit door leading to the outside smoking areas not having an audible alarm sound when the door was opened, or the doors being unlocked since she had worked at the facility for the past 13 years. Interview with the Administrator on 02/26/20 at 4:20 pm revealed: -There were no residents that were assessed with a history of wandering, however, there were residents residing at the facility assessed as disoriented and diagnosed with dementia. -The main front exit door and the exit door leading to the outside smoking section was locked at night but was always unlocked each morning. -She was not aware of a regulation requiring all doors to have an audible sounding device on each exit door if there were residents assessed with disorientation.	D 067		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by:	D 079		

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D 079	Continued From page 5 TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the facility was free of hazards as evidence by live roach activity in resident room #227. The findings are: Observation of resident room #227 on 02/28/20 at 9:49 am revealed: -There were scattered black colored specks in the bottom and side boarding of the top drawer of the resident's nightstand. -There were 5 live brown colored roaches crawling on the sides and in the resident's, clothing stored in the top drawer of a chest of drawers. -There were two, flattened, dead roaches adhered to the rubber seal of the resident's personal refrigerator. Interview with the resident assigned to room #227 on 02/28/20 at 9:49 am revealed: -The resident had noticed roaches for months in his room. -The resident saw roaches in his cupcakes stored in his room last night (02/27/20) and had to throw the cupcakes away. -The Administrator knew he had roaches in his room because he had told the Administrator several times. -He purchased insect killer every week to spray the roaches in his room himself. -The Administrator knew he was spraying his room with insect spray he had purchased. -When he reported to the Administrator about the roaches he was asked if he had talked to the housekeeper about the roaches in his room. -All his furniture needed to be sprayed.	D 079		

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-He saw facility staff spray for insects "they call themselves spraying" but the treatment the facility was using was not effective and caused the roaches to have a "party".
-December 2019 was last time his room was treated by an outside pest control provider.
-Roaches get into the rubber piece of his personal refrigerator in his room.
-The resident was in the shower room recently and there was a live roach that crawled out of the T-shirt he was going to wear.
-Another resident (named) also had roaches in her room.
-No staff nor the Administrator had ever gone into his room looking for roach activity after he reported roach activity in his room.

Interview with the resident assigned to room #111 on 02/26/20 at 10:45 am revealed:
-The resident had lived at the facility for 8 ½ years.
-The resident was blind.
-The resident had gone out of the facility about a week ago and when her family brought her back there was a roach on her pillow.
-Her family tried to catch the roach but was unsuccessful.
-The resident thought the facility was sprayed last week for roaches.

Interview with a personal care aide (PCA) on 02/27/20 at 9:05 am revealed:
-She referred residents to the medication aide/supervisor in charge and Resident Care Coordinator (RCC) for reporting any issues with pests.
-The facility had an outside company that comes to spray for pests.
-The roaches "had gotten a lot better".
-Recently, she saw a few roaches, but she could

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D 079	Continued From page 7 tell they sprayed. Interview with the Administrator on 02/27/20 at 8:45 am revealed: -Residents report directly to the Administrator or other staff for pest issues. -Maintenance staff set up the pest control provider services to come to the facility. Review of the facility's pest control service report history revealed: -On 12/18/19, resident rooms #101, #113, #132, #223, #224, #227, #228 and dietary storage was treated for roaches with crack/crevices and complete surfaces circled as the treatment type. The pest control service technician and the Administrator signed the service report. -On 12/02/19, resident rooms #132, #113, #223, #224, #227, #228 was treated for roaches with crack/crevices and spot "surfacesres" complete surfaces circled as the treatment type. The pest control service technician and the Administrator signed the service report. Administrator signed the service report. -On 10/02/19, there was a one-time visit for "pest control" with documentation roaches were treated with crack/crevices and complete surfaces was circled as the treatment type. The pest control service technician and the Administrator signed the service report. Interview with the Housekeeper on 02/28/20 at 9:00 am revealed: -He was the lead housekeeper and reported directly to the RCC and Administrator. -There were no issues with roaches or any other pests at the facility. -Approximately 3 months ago there was a "little issue" with roaches in the facility and an outside contracted pest control provider came to facility to	D 079		

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treat the facility.
-The facility had a process which included asking residents if they had saw any pests and if it was reported to him he was responsible for informing the Administrator.
-A resident told him this week she had saw a baby roach crawling on the wall, so he sprayed an insect killer in the residents' room this week when the resident left for a medical appointment.

Interview with the RCC on 02/28/20 at 3:38 pm revealed:
-She saw some roaches recently and thought a pest control provider came out to treat the facility.
-When residents reported any issues of roaches or other pests to staff, then staff were responsible for notifying management to "get people out here".
-Housekeepers used an over the counter insect spray (named) which helped.

Telephone interview with the facility's previous pest control provider on 02/28/20 at 10:16 am revealed:
-The facility did not have a contract for pest services and rendered services on as needed basis.
-The facility received services multiple times from October- December 2019.

Interview with Administrator on 02/28/20 at 9:35 am revealed:
-The resident assigned to room #221 reported there was a baby roach in her room when an outside provider was at the facility on 02/25/20 checking for bed bugs but she never saw the roach.
-The facility did not have a current contract with a pest control provider.
-The resident assigned to room #227 complained

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D 079	Continued From page 9 about roaches daily. -An outside pest control provider last sprayed the facility in December 2019 for roaches. -The outside pest control provider treated resident room #227 in December 2019. -She was aware that housekeeping staff were using over the counter insect sprays to treat pest buts should not use scented sprays in order to avoid odors that could be sensitive to any residents breathing conditions. -The previous outside pest control provider came monthly to spray. Outside of that she had to report it. -The facility was no longer with the previous pest control provider. -They had a new pest control provider contract now. Review of a letter from an outside pest control provider dated 02/27/20 revealed: -The first week of March 2020, the outside pest control provider would provide pest control services for the facility. -If the facility needed any further inspections of treatment "please don't hesitate to call". _____ The facility failed to ensure the facility's environment was free of hazards including roaches in resident room #227 and roach carcasses along the seal of the resident's personal room refrigerator which increases the risk for the resident to contract disease from an insect known to carry the risk of disease-causing germs and health hazards. The facility's failure to ensure an environment free of hazards 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. 131D-34 on 02/28/20 for	D 079		

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D 079	Continued From page 10 this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 13, 2020	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 1 of 5 residents sampled (#5) with multiple falls resulting in injuries including bruises, an elbow abrasion, a skin tear, and a swollen eye. The findings are: Review of Resident #5's FL-2 dated 01/09/20 revealed: -Diagnosis included muscle weakness. -The resident was intermittently disoriented.	D 270		

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-The resident needed personal care assistance with feeding, bathing, and dressing.
-The resident was semi-ambulatory and needed a wheel chair.
-The resident required the use of glasses.
-The resident was incontinent of bladder and bowel.
-The resident could verbally communicate her needs.
-There was a handwritten entry to see the attached signed physician's order in the medication section of the FL-2 form.

Review of Resident #5's care plan dated 09/12/19 revealed:
-The resident was ambulatory with a wheelchair.
-The resident had limited strength in her upper extremities.
-The resident was oriented.
-The resident's memory was forgetful.
-The resident required limited assistance with eating, ambulation, and transferring.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.

Review of Resident #5's Licensed Health Professional Support (LHPS) dated 02/17/20 revealed:
-The resident's transferring status was semi-ambulatory.
-The resident could ambulate using assistive devices.
-The resident had a history of falls.
-The resident needed a walker/wheelchair.
-The resident needed personal care assistance.

a. Review of an accident/incident report for Resident #5 dated 09/09/19 revealed:
- The resident was found sitting on the floor in her room on 09/09/19 at 8:30 pm by the medication

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aide (MA).
-The resident stated she lost her balance when reaching for her walker and she fell.
-There were no documented injuries.
-The facility faxed the report to the Primary Care Provider (PCP).
-There were PCP orders to check vital signs for 3 days every shift (09/10/19 to 09/13/19).
-There were PCP orders to monitor status for 72 hours (09/10/19 to 09/13/19) for bruising, change in mental status/condition, pain or other injuries related to fall. Special instructions were to document any changes.

b. Review of an accident/incident report for Resident #5 dated 09/11/19 revealed:
-The resident was found lying on the floor in her room on 09/11/19 at 6:30 pm by the personal care aide(PCA).
-The resident stated she reached for her walker and lost her balance.
-There were no documented injuries.
-The facility faxed the report to the Primary Care Provider (PCP).

c. Review of an accident/incident report for Resident # 5 dated 09/14/19 revealed:
-The resident was found sitting on the floor on 09/13/19 at 7:18 pm in her room by the personal care aide (PCA).
-The resident stated her foot slipped and she fell.
-There were no documented injuries.
-The facility faxed the report to Primary Care Provider (PCP).

Review of Resident #5's Progress notes dated 10/01/19 at 2:33 pm revealed:
-The resident was found siting on the floor next to her bed.
- Resident stated she was on the side of her bed

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trying to put her sock on when she slid off.
-The resident was checked for abrasions and bruises but none were found.

Review of Resident #5's progress notes dated 10/29/19 at 6:59 pm revealed:
-The resident was found on the floor in her room.
-The resident had an abrasion on her right elbow that was bleeding.
-First aid was administered.
-The resident stated she was trying to put her dirty clothes in the closet and her hand slipped off the walker.
-The resident was not sent to the emergency room.
-The facility notified the PCP.
-Vital signs were taken.

d. Review of an accident/incident report for Resident #5 dated 11/04/19 revealed:
-The resident was found on her knees holding on to the bed and bedside commode in her room on 11/04/19 at 3:50 pm by the medication aide.
-The resident stated she slipped off the bed trying to get on her bedside commode.
-There were no documented injuries.
-There were PCP orders to check vital signs for 3 days (11/05/19 to 11/08/19) every shift.

e. Review of an accident/incident report for Resident #5 dated 11/05/19 revealed:
-The resident was found on her knees holding on to her wheelchair in her room
on 11/05/19 at 4:15 pm.
-The resident stated she was trying to get her night clothes out.
-There were no documented injuries.
-The PCP was notified.

f. Review of an accident/incident report for

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SOMERSET COURT OF ROCKY MOUNT	918 WESTWOOD DRIVE ROCKY MOUNT, NC 27802

(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 270	Continued From page 14 Resident #5 dated 11/21/19 revealed: -The resident rung her call light and staff went to her room to find her on the floor by her bed in her room on 11/21/19 at 6:15 pm by the medication aide. -The resident stated she slid down. -There were no documented injuries. -The facility faxed the report to PCP. -Physician's orders to check vital signs for 3 days (11/21/19 to 11/24/19) every shift. -Physician's orders to monitor status for 72 hours (11/21/19 to 11/24/19) for bruising, change in mental status/condition, pain, or other injuries related to fall. Document any changes or no changes. g. Review of an accident/incident report for Resident #5 dated 11/29/919 revealed: -The resident was found on her knees holding on to her bed and bedside commode in her room on 11/29/19 at 5:30 pm by the medication aide. -The resident stated her legs gave out on her when she was trying to go to the bedside commode. -There was no documentation of injuries. -The facility contacted the PCP. -There were PCP orders to check vital signs for 3 days (11/30/19 to 12/03/19) every shift. -There were PCP orders to monitor status for 72 hours (11/30/19 to 12/03/19) for bruising, change in mental status/condition, pain, or other injuries related to fall. Document any changes or no changes. Review of Resident #5's progress notes dated 12/01/19 at 2:50 pm revealed: -The resident was found lying on the floor in front of her bedside commode in her room. -The resident stated she was walking to her bedside commode and slipped.	D 270		

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-There were no documented injuries.
-Hospice was notified.
-The facility notified the PCP.

Review of Resident #5's progress notes dated 12/05/19 at 3:26 pm revealed:
-The medication aide (MA) heard a loud bang.
-The MA found the resident sitting on the floor between her nightstand and bed with a walker sitting on top of her.
-The resident said her foot slipped.
-Vital signs were taken.
-There were no documented injuries.
-The facility notified the PCP.

Review of Resident #5's progress notes dated 12/09/19 at 2:44 pm revealed:
-The resident was heard yelling "someone help me please".
-The MA found the resident on the floor in between her nightstand and bed.
-The resident stated she was trying to walk to her bedside commode and her foot slipped.
-Vitals were taken.
-There were no documented injuries.
-The facility notified the PCP.
-Hospice was contacted.

Review of a PCP progress note for Resident #5 dated 12/16/19 revealed:
-Resident #5 had frequent falls.
-Resident #5 was on Hospice.

h. Review of an accident/incident report for Resident #5 dated 01/12/20 revealed:
-The resident was found lying on the floor near her bed in her room on 01/12/20 at 4:11 am by the medication aide.
-The resident stated she was trying to use the bedside commode when her foot slipped away

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from under her.
-There were no documented injuries.
-The PCP was contacted.
-Physician's orders to check vital signs for 3 days (01/12/19) to (01/15/19) every shift.
-Physician's orders to monitor status for 72 hours (01/12/19) to (01/15/19) for bruising, change in mental status/condition, pain, or other injuries related to fall. Document any changes or no changes.

Review of Resident #5's progress notes dated 02/17/20 written by a MA at 4:55 pm revealed:
-The resident fell trying to use the bedside commode.
-There were no bruises or abrasions found.
-Hospice was notified.
-The facility contacted the PCP.

Review of Resident #5's progress notes dated 02/18/20 written by a MA at 9:19 pm revealed:
-The resident had fallen at 6:10 pm.
-The resident's left eye was swollen shut and bruising, skin tear.
-Hospice was contacted and came to check her eye.
-The resident refused to go to hospital.
-The medication administration record (MAR) for February 2020 revealed that ice packs were ordered by the physician to apply to both eyes.

i. Review of accident/incident report or Resident #5 dated 02/21/20 revealed:
-The resident was found sitting on the floor leaning against her bedside commode in her room on 02/21/20 at 10:45 am by the personal care aide.
-The resident stated she was trying to use the bedside commode.
-There were no documented injuries.

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D 270	Continued From page 17 -The facility faxed the report to PCP. -There were PCP orders to check vital signs for 3 days (02/21/20 to 02/24/20) every shift. -There were PCP orders to monitor status for 72 hours (02/21/20 to 02/24/20) for bruising, change in mental status/condition, pain, or other injuries related to fall. Document any changes or no changes -Hospice was notified. Interview with Resident #5 on 02/27/20 at 10:12 am revealed: -Staff told her if she had to use the bathroom she should press the button for someone to help her get on the toilet. -She felt good and did not have any pain. -The physician came there to see her. - She fell a little while back when her foot slipped. -She did not think she fell much. Interview with the Director of Hospice concerning Resident #5 on 02/28/20 at 8:48 am revealed: -Hospice visited the resident once weekly. -Alarms were placed on the bed and wheelchair on 11/11/19. -A fall mat was placed on the floor on 11/11/19. -The resident did not like the alarms. -The resident pulled the alarms off and pushed the fall mat under the bed. -The resident had been instructed to use the call button before she gets up but she refuses to. -The facility staff moved her closer to the nurse's station about a month and a half ago. -She spoke to the resident's relative about placing her mother in a higher care facility. -The relative did not want her to change facilities. -The next step for this resident would be a high/low bed. -The resident wanted to be independent.	D 270		

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D 270	Continued From page 18 Telephone interview with Resident #5's relative on 02/28/20 at 9:02 am revealed: -She had no concerns about the care her mother received. -She had received telephone calls about the resident falling on many occasions. -The resident wanted to be independent and walk on her own. -The resident's feet slipped a lot and had falls. -She had no idea of how to prevent the falls. -She could not state the number of times the resident had fallen. -The last call she received to report a fall was from the Resident Care Coordinator (RCC) about 2 weeks ago. -She received the call to report the fall in which she hurt her eye. -The resident refused to go to the emergency room. -Hospice came to see the resident each week at the facility. -Hospice mentioned moving the resident to a facility that could better meet the resident's needs but the resident liked it at this facility. Interview with the PCP concerning Resident #5 on 02/28/20 at 8:25 am revealed: -He had recommended safety techniques, strengthening exercises, monitoring and education. -The fall prevention program was put in place to prevent future falls. -Last week Resident #5 had 2 large hematomas. -Hospice visited each week. Interview with a PCA concerning Resident #5 on 02/28/20 at 8:39 am revealed: -The third shift PCA sat with the resident last night and went home at 7:00 am. -The resident was very independent.	D 270		

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-She tried to walk by herself.
-A call bell was attached to Resident #5's watch on her arm for accessibility while lying in bed about 2 weeks ago. Before then, it was attached to her wheelchair.
-She checked on Resident #5 every hour during her shift prior to the one on one care directive.
-The Hospice nurse would come in to check on the resident after each fall.
-Supervised one on one care for Resident #5 was started yesterday (02/27/20) per the Administrator.

Interview with the Administrator concerning Resident #5 on 02/28/20 at 2:40 pm revealed:
-They contacted the physician when the falls occurred for Resident #5 which was protocol.
-Staff were expected to report all falls to her.
-They put preventions in place including the monitor for the bed and chair.
-Hospice checked on the Resident #5 concerning the falls.
-On 01/16/20 the Resident #5 was moved to a room closer to the nurse's station.

Interview with the RCC concerning Resident #5 on 02/28/20 at 2:53 pm revealed:
-The facility put alarms and fall mat in the resident's room on 11/11/19.
-The resident was moved closer to nurse's station on 01/16/20.

Interview with a MA concerning Resident #5 on 02/28/20 at 10:16 am revealed.
-A fall mat was on the floor but was removed by Hospice because Resident #5 would push it under the bed.
-The resident refused the mat.
-The resident took the bed alarm and chair alarm off.

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D 270	Continued From page 20 -The call bell was attached to her watch now so she did not have to lean over to press it. -She had not fallen since the bell was moved to her watch. -Her commode was moved closer to her bed. -They made sure her room was uncluttered. The facility had no written policy for falls. The facility had no written policy for supervision. The Hospice agency submitted no written progress notes. The facility's failure to provide supervision to 1 of 5 residents sampled with 16 falls occurring between 09/09/19 and 02/21/20 resulted in Resident #5 sustaining bruises, an elbow abrasion, a skin tear, and a swollen eye. This non-compliance constitutes a TYPE A2 VIOLATION for substantial risk that death or serious harm will occur. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/27/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 29, 2020	D 270		
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:	D 273		

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Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) of refused medications for asthma, cardio pulmonary disease, constipation, liver disease, overactive bladder, depression, PTSD, anxiety disorder, pain, edema, high blood pressure, and diabetes for 1 of 5 sampled residents (#1).

The findings are:

Review of Resident #1's current FL-2 dated 01/15/20 revealed:
-The diagnoses were cardio pulmonary disease, Chronic Bin Syndrome, hypertension, generalized muscle weakness, morbid obesity, obstructive sleep apnea, and major depressive disorder.
-She was intermittently disoriented.
-She was semi-ambulatory with a motorized wheelchair.
-There was a handwritten entry to see the attached signed physician's order in the medication section of the FL-2.

a. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Zafirlukast 20mg - 1 tablet by mouth once daily (Zafirlukast is used to treat asthma).

Review of the February 2020 Medication Administration Record (MAR) revealed:
-Zafirlukast was documented as refused with a parenthesis around the MA's initials for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused.

Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration.

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D 273	Continued From page 22 b. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Breo Ellipta 100-25mcg/dose - 1 puff by mouth once daily (Breo Ellipta is used to treat cardio pulmonary disease). Review of the February 2020 Medication Administration Record (MAR) revealed: -Breo Ellipta was documented as refused for 02/01/20, 02/08/20, 02/09/20 through 02/10/20. The MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. c. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Enulose 10mg/15ml - 30 ml by mouth each morning (Enulose is used to treat constipation and liver disease). Review of the February 2020 Medication Administration Record (MAR) revealed: -Enulose was documented as refused for 02/01/20, 02/02/20, 02/07/20, 02/09/20, and 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. d. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Solifenacin 10mg - 1 tablet	D 273		

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by mouth once daily (Solifenacin is used to treat overactive bladder).

Review of the February 2020 Medication Administration Record (MAR) revealed:
-Solifenacin was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused.

Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration.

e. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Myrbetriq 50mg - 1 tablet by mouth once daily (Myrbetriq is used for overactive bladder).

Review of the February 2020 Medication Administration Record (MAR) revealed:
-Myrbetriq was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused.

Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration.

f. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Sertraline 50mg - 1 tablet by mouth in the morning (Sertraline is used for depression, post-traumatic stress disorder, and anxiety disorder).

Review of the February 2020 Medication Administration Record (MAR) revealed:

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D 273	Continued From page 24 -Sertraline was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. g. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Oxycodone-acetaminophen 5-325mg - 1 tablet by mouth 3 times daily (Oxycodone-acetaminophen is used for pain). Review of the February 2020 Medication Administration Record (MAR) revealed: -Oxycodone-acetaminophen was documented as refused for 02/01/20 at 6:00 am, 2:00 pm, 8:00 pm; 02/02/20 at 2:00 pm and 8:00 pm; 02/09/20 at 2:00 pm and 8:00 pm; and 02/10/20 at 2:00 pm. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. h. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Hydrochlorothiazide 25mg - 1 tablet by mouth once daily (Hydrochlorothiazide is used for edema). Review of the February 2020 Medication Administration Record (MAR) revealed: -Hydrochlorothiazide was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused.	D 273		

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D 273	Continued From page 25 Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. i. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Toviaz 4mg - 1 tablet by mouth every morning after breakfast (Toviaz is used as a bladder relaxant). Review of the February 2020 Medication Administration Record (MAR) revealed: -Toviaz was documented as refused with a parenthesis around the MA's initials for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. j. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Amlodipine 5mg - 1 tablet by mouth once daily (Almodipine is used to treat high blood pressure). Review of the February 2020 Medication Administration Record (MAR) revealed: -Amlodipine was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. k. Review of Resident #1's FL-2 with the	D 273		

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D 273	Continued From page 26 attached signed physician's orders dated 01/15/20 revealed an order for Propanolol 10mg - 1 tablet by mouth once daily (Propanolol is used to treat high blood pressure). Review of the February 2020 Medication Administration Record (MAR) revealed: Propanolol was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. l. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Losartan 100mg - 1 tablet by mouth once daily (Losartan is used to treat diabetes). Review of the February 2020 Medication Administration Record (MAR) revealed: -Losartan was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused. Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration. m. Review of Resident #1's FL-2 with the attached signed physician's orders dated 01/15/20 revealed an order for Celecoxib 100mg - 1 capsule by mouth twice daily (Celecoxib is used to treat inflammation and pain). Review of the February 2020 Medication	D 273		

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Administration Records (MAR) revealed:
-Celecoxib was documented as refused for 02/01/20 through 02/10/20. MAR notes documented not administered because it was refused.

Observation of meds on hand on 02/27/20 at 3:47 pm revealed this medication was available for administration.

Review of Resident #1's Plan of Care dated 01/15/20 revealed:
-Resident #1 was sometimes disoriented.
-Resident #1 was forgetful and needed reminders.
-Resident #1 required limited assistance with eating, dressing, and grooming.
-Resident #1 required extensive assistance with toileting, bathing, and transferring.
-Resident #1 required supervision with ambulation.

Interview with Resident #1 on 02/26/20 at 9:32 am revealed:
-She ran out of medicines for pain, ointments, and asthma.
-She went through withdrawal symptoms including cursing, short-tempered, frustration, pain, exhaustion and headaches about 3 times. She cannot recall which month it happened.
-The last time was a couple of weeks ago and she let the RCC know but the RCC did not respond.

Interview with a Medication Aide (MA) on 02/27/20 at 4:31 pm revealed:
-Resident #1 refused medications for over a week.
-Resident #1 said the medications made her sick.
-She reported the refusal to the Resident Care

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D 273	Continued From page 28 Coordinator (RCC). Interview with the RCC on 02/28/20 at 8:10 am revealed: -Resident #1 visited the PCP on 02/12/20 and discussed medication refusals. -She did not document the refusals for the first 2 weeks of February. -She did not send a notification to the PCP. -She was responsible for notifying the PCP. Interview with Resident #1's PCP on 02/28/20 at 2:11 pm revealed: -She had no idea how to make adults take medications. -The facility might call and tell her about refusals but not every time. -"If the resident was going weeks without taking medications she probably does not need them". -She may need less doses of medications if she's refusing them. -"If not taking medications made her sick then I would worry". -It's possible she could not get all the medications down. -We cannot give her medicines that she does not want to take. -She stated she had not received many calls from the facility about Resident #1 not taking medications. -Medication refusals by Resident #1 were not presented to her as a problem. Interview with the Administrator on 02/28/20 at 2:31 pm revealed: -She had called Resident #1's PCP to notify her of the medication refusals for 02/01/20 through 02/10/20. -There were no changes in Resident #1's behavior or medical condition as a result of	D 273		

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D 273	Continued From page 29 medication refusals. -There was no policy for reporting refused medications. -The staff were given verbal instructions. -She stated she documented in the matrix system that she discussed it with the (PCP). -She could not provide verification of this documentation. Interview with Resident #1 on 02/28/20 at 3:03 pm revealed: -She was not getting her medications. -She refused medications recently because she kept getting sick. -She started refusing medications to see if she would feel better.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure foods were free from contamination related to build-up of a substance in the ice machine and a clear bag of chicken that was thawing in warm water. The findings are: 1. Observation of the ice machine in the kitchen on 02/26/20 at 2:00 pm revealed:	D 283		

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D 283	Continued From page 30 -There was a build up of a wet pink, brown and black colored substance on the lower portion of the white shield and a heavier concentration of a black and brown substance on the upper portion of the white shield that separated the ice bin from the upper vaulted section of the ice machine. -Water was dripping into the stored ice from the white shield with the build-up. Interview with the Dietary Manager (DM) on 02/26/20 at 2:17 pm revealed: -The maintenance person cleaned the ice machine a month ago. -The ice machine did not have an automatic cleaning cycle. -The ice machine was cleaned every other month by the maintenance person. -The dietary only cleaned the outside of the ice machine daily. -The dietary staff did not clean the inside of the ice machine. -He did not have a written policy about cleaning the ice machine. -He was not aware water was dripping down the white shield inside the ice machine and into the ice stored in the bin. -He had used the ice from the ice machine for the lunch meal service on 02/26/20. Interview with the maintenance person on 02/26/20 at 2:40 pm revealed: -He was responsible for fixing anything that had broken in the facility. -He had never cleaned the ice machine. -He was not aware that it was his responsibility to clean the ice machine. -He assumed it was the responsibility of the dietary staff to clean the ice machine. -He had checked the ice machine on 02/24/20 and was not aware water was dripping down the	D 283		

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white shield inside the ice machine and into the ice stored in the bin.
-He looked for scale and buildup when he had checked the ice machine.
-If he had noticed scale and build up, he would clean the ice machine with the DM.
-He was not aware if the ice machine had an automatic cleaning cycle.

Interview the Administrator on 02/26/20 at 3:21 pm revealed:
-She was not aware of the brown and black substance build up in the ice machine.
-The health inspector had inspected the kitchen a month ago and reported no concern with the ice machine.
-The Administrator provided a copy of the health inspectors report.
-She expected the ice machine to be cleaned regularly by the maintenance person.

2. Observation of the kitchen sink on 02/26/20 at 2:20 pm revealed:
-There were two separate sinks.
-Each sink was filled with water and contained a clear bag of chicken.
-The water in the sink on the left was warm to touch and the chicken in the bag felt warm and mushy.
-The bag of chicken in the left sink was filled with water from the sink.
-The water in the sink on the right was cold to touch and the chicken in the bag felt cold and hard.

Interview with the DM on 02/26/20 at 2:23 pm revealed:
-Both sinks were supposed to be filled with cold water to thaw frozen meat with running cold water over.

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D 283	Continued From page 32 -The water did not always come out of the faucet cold, it would feel lukewarm to touch. -The bags of chicken had just been placed in the sink by the cook. -He was not aware the bag of chicken in the left sink had filled up with water from the sink. Interview with the cook on 02/26/20 at 2:27 pm revealed: -He had just placed the bags of chicken in each sink to thaw to be used for the dinner meal service. -He was not aware the water was warm to touch in the left sink. -He was not aware the bag of chicken had filled with water from the sink. -He had thrown the water filled bag of chicken in the trash. -He had usually thawed meat by removing it from freezer and placed it in the cooler. -When he had to thaw meat quickly if there had been a change in menu, he would thaw the meat in the sink filled with cold water. Interview with the Administrator on 02/26/20 at 3:13 pm revealed: -She expected the dietary staff to thaw frozen meat in the appropriate amount of time to be ready for the meal service it had been needed for. -She expected the dietary staff to prepare in advance by placing frozen meat in the cooler to thaw the day before the meat needed to be used for the meal service.	D 283		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes:	D 296		

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D 296	Continued From page 33 (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic menu for 2 of 5 sampled residents with a physician's order for a mechanical soft with ground meat diet (#4) and mechanical soft with chopped meats diet (#1). The findings are: 1. Review of Resident #4's current FL-2 dated 01/09/20 revealed: -Diagnoses included diabetes mellitus, gastroesophageal reflux disease and chronic obstructive pulmonary disease. -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #4's physician diet order dated 01/09/20 in the resident's chart revealed a mechanical soft with ground meats diet. Review of the "Weekly Menu" diet menu spreadsheet revealed there was no therapeutic menu the lunch meal consisted of 1 cup baked macaroni and cheese, ½ cup capri blend and 2 slices of marinated tomatoes, and 1 garlic breadstick. Interview with the Dietary Manager (DM) on 02/26/20 at 10:01 am revealed: -The facility did not have a therapeutic diet menu. -He had a few residents that were on chopped or	D 296		

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ground meat diets.
-He only chopped food for two of the residents that were on a chopped or ground meat diet.
-He used the regular menu signed by a Dietician to prepare meals.

Observation of the lunch meal service on 02/27/20 from 11:49 am - 12:45 pm revealed:
-Resident #4 was served 2 pieces of garlic bread, 1 cup of macaroni and cheese, 1 cup mixed steamed vegetables served whole, ½ cup of candied yams, and 4 chicken fingers not ground, tea and coffee.
-Resident #4 ate 100% macaroni and cheese, 100% chicken fingers, 100% sweet tea, and 100% coffee.
-Resident #4 did not eat any of the mixed steamed vegetables or candied yams.
-The resident consumed the lunch meal without difficulty.

Based on observations it could not be determined if Resident #4 was not served the appropriate food consistency because review of physician order called for ground meats and we observed 4 chicken fingers not ground.

Interview with Resident #4 on 02/27/20 at 2:00 pm revealed:
-She did not have difficulty with eating the chicken fingers at the lunch meal service.
-She did not have an issue eating any meat that she was served except baked pork chop that was not ground.

Review of the "Weekly Menu" diet menu spreadsheet revealed the dinner meal consisted of 1 cup baked beef vegetable stew, ½ cup delicious rice, ½ cup parsley carrots, and 5 crackers.

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D 296	Continued From page 35 Observation of the dinner meal service on 02/27/20 from 5:00 pm - 5:18 pm revealed: -Resident #4 was served 2 baked chicken legs not ground. -Resident #4 consumed the chicken legs at the dinner meal service without difficulty. Interview with the DM on 02/28/20 at 9:17 am revealed: -It was his responsibility to ensure diets were served as ordered. -There was a list of diet orders in the kitchen that he followed for each resident. -The Resident Care Coordinator (RCC) posted the diet list in the kitchen. -He did not know why he had not followed the residents diet order. Interview with the Administrator on 02/28/20 at 8:31 am revealed: -She was not aware that physician diet orders had not been followed as ordered. -She expected the DM to follow physician diet orders. 2. Review of Resident #1's current FL-2 dated 01/15/20 revealed diagnoses included generalized muscle weakness, morbid obesity, obstructive sleep apnea, and major depressive order. Review of Resident #1 physician diet order dated 01/15/20 revealed an order for a mechanical soft diet with meats only chopped. Review of the "Weekly Menu" diet menu spreadsheet revealed the lunch meal consisted of 1 cup baked macaroni and cheese, ½ cup capri blend and 2 slices of marinated tomatoes, and 1	D 296		

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D 296	Continued From page 36 garlic breadstick. Observation of the lunch meal service on 02/27/20 from 11:49 am - 12:45 pm revealed: -Resident #1 was served 2 pieces of garlic bread, 2 cups of macaroni and cheese, 1/2 cup mixed steamed vegetables, and 7 chicken fingers not chopped. -Resident #1 ate in her room. -Resident #1 ate 50% macaroni and cheese, 50% chicken fingers, and 25% mixed steamed vegetables. -The resident consumed the lunch meal without difficulty. Based on observations it could not be determined if Resident #4 was served the appropriate meal she had an order for chopped meat we saw the meat was not chopped. Interview with the DM on 02/28/20 at 9:17 am revealed: -It was his responsibility to ensure diets were served as ordered. -It was the RCC's responsibility to update the resident diet list in the kitchen. -He did not know why he had not followed the residents diet order. Interview with the Administrator on 02/28/20 at 8:31 am revealed: -She was not aware that physician diet orders had not followed. -She expected the DM to follow physician diet orders.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 37 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 residents sampled (#1,#3, #4) who had a physician's orders for a no added table salt (NATS) diet(#3), physician's order for a mechanical soft with ground meat diet (#4), and mechanical soft with chopped meats diet (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 01/14/20 revealed diagnoses included diabetes mellitus, hypertension, venous insufficiency, lymphedema, amnesia, anemia, and hypothyroidism. Review of a physician diet order dated 01/14/20 revealed a NATS diet order. Interview with the Dietary Manager (DM) on 02/26/20 at 10:01 am revealed: -The facility did not have a therapeutic diet menu. -He did not have any residents on a therapeutic diet. Observation of the breakfast meal on 02/27/20 from 8:00 am - 8:45 am revealed: -Resident #3 had a small bowl of condiments at his table that included table salt.	D 310		

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D 310	Continued From page 38 -Resident #3 was eating 1 bowl of oatmeal, 2 pieces of toast, 1 sausage patty, and 2 boiled eggs. -Resident #3 was observed adding table salt to his 2 boiled eggs. -Resident #3 ate the 2 boiled eggs. Interview with Resident #3 on 02/28/20 at 7:51 am revealed: -He added salt to his food whenever he wanted to. -He got the salt packets from the small bowl on the dining room table. -The dietary staff did tell him not to eat salt. -He was not on a special diet. Observation of the dining room on 02/27/20 from 8:00 am - 8:45 am revealed: -The dining room had a total 17 tables. -There were 8 of the tables with a small bowl of condiments on each table that included small packets of table salt. -There was a large container of small table salt packets on the window ledge of the kitchen. Interview with Administrator on 02/28/20 at 8:49 am revealed: -The dietary aides provide the table salt to the residents if they asked for it. -The dietary aides add the salt packets to the small condiment bowls on each table in the dining room. -She was aware that aware that Resident #3 used table salt. -The facility did not report Resident #3's table salt use to his Physician. Interview with the Dietary Manager (DM) on 02/28/20 at 9:17 am revealed: -The dietary staff did not monitor residents that	D 310		

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had a NATS diet.
-The dietary staff had not monito
-The table salt was accessible to residents on their tables and on the ledge of the kitchen window.
-He was aware that Resident #3 added table salt to his food.
-He had not reported Resident #3's table salt usage to anyone.

Interview with Resident #3's Primary Care Physician (PCP) on 02/27/20 at 10:30 am revealed:
-He was unaware that Resident #3 had added table salt to his food.
-He was concerned that the increase in salt could have caused Resident #'3 legs to swell.
-He was also concerned that the use of table salt could have caused Resident #3's blood pressure to have raised.

2. Review of Resident #4's current FL-2 dated 01/09/20 revealed:
-Diagnoses included diabetes mellitus, gastroesophageal reflux disease and chronic obstructive pulmonary disease.
-The resident was semi-ambulatory and intermittently disoriented.

Review of Resident #4's physician diet order dated 01/09/20 in the residents chart revealed a mechanical soft with ground meats diet.

Review of the "Weekly Menu" diet menu spreadsheet revealed there was no therapeutic menu the lunch meal consisted of 1 cup baked macaroni and cheese, ½ cup capri blend and 2 slices of marinated tomatoes, and 1 garlic breadstick.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 40 Interview with the Dietary Manager (DM) on 02/26/20 at 10:01 am revealed: -The facility did not have a therapeutic diet menu. -He had a few residents that were on chopped or ground meat diets. -He only chopped food for two of the residents that were on a chopped or ground meat diet. -He used the regular menu signed by a Dietician to prepare meals. Observation of the lunch meal service on 02/27/20 from 11:49 am - 12:45 pm revealed: -Resident #4 was served 2 pieces of garlic bread, 1 cup of macaroni and cheese, 1 cup mixed steamed vegetables served whole, ½ cup of candied yams, and 4 chicken fingers not ground, tea and coffee. -Resident #4 ate 100% macaroni and cheese, 100% chicken fingers, 100% sweet tea, and 100% coffee. -Resident #4 did not eat any of the mixed steamed vegetables or candied yams. -The resident consumed the lunch meal without difficulty. Based on observations it could not be determined if Resident #4 was not served the appropriate food consistency because review of physician order called for ground meats and we observed 4 chicken fingers not ground. Interview with Resident #4 on 02/27/20 at 2:00 pm revealed: -She did not have difficulty with eating the chicken fingers at the lunch meal service. -She did not have an issue eating any meat that she was served except baked pork chop that was not ground. Review of the "Weekly Menu" diet menu	D 310		

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	HAL064029	A. BUILDING: _____ B. WING _____	R-C 02/28/2020

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D 310	Continued From page 41	D 310		

spreadsheet revealed the dinner meal consisted of 1 cup baked beef vegetable stew, ½ cup delicious rice, ½ cup parsley carrots, and 5 crackers.

Observation of the dinner meal service on 02/27/20 from 5:00 pm - 5:18 pm revealed:
-Resident #4 was served 2 baked chicken legs not ground.
-Resident #4 consumed the chicken legs at the dinner meal service without difficulty.

Interview with the DM on 02/28/20 at 9:17 am revealed:
-It was his responsibility to ensure diets were served as ordered.
-There was a list of diet orders in the kitchen that he followed for each resident.
-The Resident Care Coordinator (RCC) posted the diet list in the kitchen.
-He did not know why he had not followed the residents diet order.

Interview with the Administrator on 02/28/20 at 8:31 am revealed:
-She was not aware that physician diet orders had not been followed as ordered.
-She expected the DM to follow physician diet orders.

3. Review of Resident #1's current FL-2 dated 01/15/20 revealed diagnoses included generalized muscle weakness, morbid obesity, obstructive sleep apnea, and major depressive order.

Review of Resident #1 physician diet order dated 01/15/20 revealed an order for a mechanical soft diet with meats only chopped.

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D 310	Continued From page 42 Review of the "Weekly Menu" diet menu spreadsheet revealed the lunch meal consisted of 1 cup baked macaroni and cheese, ½ cup capri blend and 2 slices of marinated tomatoes, and 1 garlic breadstick. Observation of the lunch meal service on 02/27/20 from 11:49 am - 12:45 pm revealed: -Resident #1 was served 2 pieces of garlic bread, 2 cups of macaroni and cheese, 1/2 cup mixed steamed vegetables, and 7 chicken fingers not chopped. -Resident #1 ate in her room. -Resident #1 ate 50% macaroni and cheese, 50% chicken fingers, and 25% mixed steamed vegetables. -The resident consumed the lunch meal without difficulty. Based on observations it could not be determined if Resident #4 was served the appropriate meal she had an order for chopped meat we saw the meat was not chopped. Interview with the DM on 02/28/20 at 9:17 am revealed: -It was his responsibility to ensure diets were served as ordered. -It was the RCC's responsibility to update the resident diet list in the kitchen. -He did not know why he had not followed the residents diet order. Interview with the Administrator on 02/28/20 at 8:31 am revealed: -She was not aware that physician diet orders had not followed. -She expected the DM to follow physician diet orders.	D 310		

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D 338	Continued From page 43	D 338		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that 11 out of 26 residents in the dining room were treated with respect and dignity as evidenced by the kitchen not having enough plates to serve all 54 residents during meal times. The findings are: Observation of the lunch meal service in the dining room 02/27/20 between 12:00 pm-12:45 pm revealed: -There 30 residents seated in the dining room. -The meal service consisted of baked macaroni and cheese, vegetable blend, chicken fingers, candied yams, and garlic bread. -The first plate was served to a resident seated at the front of the dining room at 12:05 pm. -The Dietary Manager (DM) told the dietary aide (DA) that he did not have any clean plates at 12:18 pm. -At 12:18 pm 11 residents who were seated in the dining room were still waiting to be served their lunch meal. -The DA had cleared dirty plates left on the tables by other residents that had finished their lunch meal. -The DA took the dirty plates and washed them. -The DA gave the clean plates to the DM to be plated with the lunch meal for the remaining residents.	D 338		

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D 338	Continued From page 44 -The last plate was served at 12:26 pm to the last resident that had been waiting. Interview with the DM on 02/27/20 at 12:22 pm revealed: -He did not have enough plates to serve all 54 residents in the facility at the same time. -He did not know exactly how many plates he had on hand. -He had 80 plates in the past few months. -Many plates had been broken or taken out of the dining room by the residents. -He was not sure how many plates he had on hand. -He was short of plates for "a week". -He ordered plates on 02/24/20 through the facilities dining room equipment supplier. -He submitted the plate order along with his food order to the corporate headquarters to be approved. -He was notified that his order of plates had been rejected, he did not know why. Review of the 02/24/20 plate order form completed by the DM on 02/27/20 revealed. -The order of 9 plates was rejected by a corporate headquarters representative. -There had been a note left by the corporate headquarters representative stating, "the order for plates must be completed separately from the food order". Interview with a resident on 02/28/20 at 8:55 am revealed: -It always had took a long time for him to be served his meal during meal times. -He did not know why it took so long. -He had to wait 20 minutes or longer to be served his meal during meal times.. -He had not notified any staff member about his	D 338		

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D 338	Continued From page 45	D 338		

wait.
-He would like to have received his meal at the same time as the residents that received their meal earlier than he did.

Interview with another resident on 02/28/20 at 8:59 am revealed:
-She was aware that the facility did not have enough plates.
-The facility had not had enough plates for a couple weeks.
-She had known that it took several minutes to be served the meal at meal times.
-She did not know if the shortage of plates had to do with how long it took to be served her meals.

Interview with a third resident on 02/28/20 at 9:22 am revealed:
-Residents were served at the same time if there as enough plates clean.
-He was told by a staff from dietary two days ago after he asked for some oatmeal that they did not have anything clean to serve him his oatmeal.
-The resident was served his oatmeal but only ate a little of it because it took a long time to get it.

Interview with the Business Office Manager (BOM) on 02/28/20 at 7:50 am revealed:
-She was not aware of any residents having to wait to be seated for a meal.
-She thought the residents mostly "stagger" in to eat their meals at different times.
-She knew the DM needed to order more plates for the residents use, but she was not sure if if the DM ever ordered the plates.

Interview with the Administrator on 02/28/20 at 8:31 am revealed:
-She observed a meal service each day that she had worked.

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D 338	Continued From page 46 -She had observed to make sure residents had been served beverages, hot food, and she had observed to make sure residents had received the correct diet as ordered by the Physician. -She had last observed the lunch meal service on 02/27/20. -She had not noticed there had been a shortage of plates on hand. -She was not aware that the DM did not have enough plates to serve all the residents at the same time. -She expected to be notified immediately that they did not have enough plates. -It was the DM responsibility to ensure there were enough plates in the kitchen. -She had bought a box of plates for the facility on 12/23/19 from a local restaurant equipment supplier.	D 338		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to supervision and housekeeping and furnishings. The findings are:	D912		

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D912	Continued From page 47 1.Based on observations, record reviews, and interviews, the facility failed to provide supervision in accordance with the resident's assessed needs and current symptoms for 1 of 5 residents sampled (#5) with multiple falls resulting in injuries including bruises, an elbow abrasion, a skin tear, and a swollen eye. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to ensure the facility was free of hazards as evidenced by live roach activity in resident room #227..[Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		