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	HAL025023	A. BUILDING: _____ B. WING _____	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD HOME FOR THE AGED	603 WEST STREET NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on November 8 through November 9, 2018 and November 13 through November 15, 2018 with an exit conference via telephone on November 16, 2018. The complaint investigation was initiated by the Craven County Department of Social Services on September 5, 2018.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure that bleach, glass cleaner, oven cleaner, furniture polish, floor clean, scouring cleanser, dishwashing liquid, and multipurpose liquid cleaners were stored in locked areas of the facility resulting in hazardous chemicals being unattended and accessible to residents. The findings are: Observation of a storage room located across from resident room #18 during initial tour on 11/08/18 at 9:55am revealed: -The storage room door was unlocked and no	D 056		

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housekeeping staff was seen near the storage room area.
-There was a "Keep Locked" sign posted on the closet.
-The storage room contained glass cleaner, scour cleanser, two bottles of pine cleaner, two cans of furniture polish, two cans of oven cleaner, three bottles of multi-purpose cleaner, two bottles of dishwashing liquid, two bottles of floor cleaner, a bottle of liquid soap, a box of mothballs, a bottle of toilet bowl cleaner, three gallons of bleach, and four boxes that contained six gallons each of bleach.

Interview with a facility's maintenance staff on 11/08/18 at 10:03 am revealed:
-He was not aware the storage closet was unlocked.
-He locked the door.

Observation on 11/08/18 at 10:07am revealed the maintenance staff instructed a housekeeper to lock storage after use.
Observation of the housekeeping storage room on 11/09/18 at 10:35am revealed:
-The door of the housekeeping storage room was unlocked and accessible to residents.
-The housekeeping storage room contained two bottles of stain removers, an unlabeled spray bottle that contained an inch of clear liquid, and an empty pine cleaner bottle that were unsecured.
-There was no housekeeping staff seen near the housekeeping storage room.

Observation of a storage room located across from resident room #18 on 11/09/18 at 10:37am revealed:
-The door of the storage room was unlocked and accessible to residents.

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-The storage room was located next to the housekeeping storage room.
-There was no housekeeping staff seen near the storage room.

Interview with a personal care aide (PCA) on 11/09/18 at 10:45am revealed:
-Both doors of the housekeeping storage room and the storage room were supposed to be locked.
-The housekeeping staff was supposed to keep those doors locked.
-She did not know why the doors of the storage rooms were unlocked on 11/09/18.

Interview with a housekeeper on 11/09/18 at 10:47am revealed:
-She had left the doors of both storage rooms unlocked on 11/09/18.
-When she came to work, the Assistant Manager unlocked the storage rooms' doors for her so she could get her cleaning cart and her cleaning supplies.
-She left the door unlocked to the storage rooms so she could get into them later.
-She did not have keys for the storage rooms' doors and the doors had to be unlocked by the Assistant Manager or the Manager.
-She thought it was dangerous for the storage rooms' doors to be left unlocked because of the cleaning products stored inside.

Interview with the Manager on 11/09/18 at 10:49am revealed:
-She did not know the doors of the housekeeping storage room or the storage room had been left unlocked.
-The Assistant Manager usually handled the housekeeping staff.
-The doors of the housekeeping storage room

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and the storage room both were supposed to be kept locked.
-She and the Assistant Manager had keys to both storage room doors and opened them for the housekeeping staff in the mornings and when staff needed cleaning supplies.
-The doors of the housekeeping storage room and the storage room both were supposed to be locked after the housekeeping staff got their cleaning cart and supplies.

Interview with the Assistant Manager on 11/09/18 at 10:50am revealed:
-She did not know the doors of the housekeeping storage room or the storage room had been left unlocked.
-The housekeeper was supposed to keep the doors of the storage rooms locked.
-She had unlocked the doors of the storage room for the housekeeper earlier on the morning of 11/09/18 and gave the housekeeper the keys.
-The doors of the housekeeping storage room and the storage room needed to be locked to keep the cleaning products stored away from the residents.

Observation of the housekeeping storage room on 11/14/18 at 11:19am revealed:
-The storage room across from resident room #18 door was not locked and a cleaning supply cart was inside.
-The cleaning supply cart contained a partially used bottle of a blue substance labeled glass cleaner, a half full bottle of an unknown substance, a can of scouring cleanser, a can of furniture polish, a clear large spray bottle of deodorizer, and a half full bottle labeled bleach spray.
-On the shelf in the storage room were two

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D 056	Continued From page 4 bottles of stain remover and a can of oil lubricant spray. -There was no housekeeping staff seen near the housekeeping storage room. Interview with the Assistant Manager on 11/14/18 at 11:23am revealed: -She did not know the housekeeping storage room was not locked again -Housekeeping staff was supposed to keep the housekeeping storage room door locked at all times. -The housekeeping staff had a key for the housekeeping storage room. -She had a meeting with the housekeeping staff on 11/13/18 regarding keep the storage rooms locked. Interview with a housekeeper 11/14/18 at 11:25am revealed: -She had left the housekeeping storage room across from resident room #18 unlocked after she pushed her cart in. -She knew the housekeeping storage room was to remain locked at all times but she forgot to lock the housekeeping storage room door once she pushed in her cleaning cart.	D 056		
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	D 067		

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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:
TYPE B VIOLATION

Based on interviews, record reviews, and observations, the facility failed to assure 7 of 7 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 1 sampled residents (Resident #5) who was intermittently disoriented.

The findings are:

Observation made during initial tour of the facility on 11/08/18 revealed:
-The door alarm to the front door of the main entrance did not sound upon entering the facility at 7:45am.
-The door alarm to the back exit door of the dining room did not sound when the exit door was opened at 8:30am.
-The exit door by resident room #15 was not locked and the door alarm did not sound when the exit door was opened at 8:35am.
-The door alarm to the exit door by the resident smoking area, which was accessible to a side street and the main street in the front, did not sound when the exit door was opened at 9:40am.
-The exit door by resident room #5 was not locked and the door alarm did not sound when the exit door was opened at 9:51am.
-The exit door by resident room #36 was not

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locked and the door alarm did not sound when the exit door was opened at 10:00am.
-The exit door in the activity room, which opened to the backside of the facility and was accessible to the street, was not locked and the alarm did not sound when the door was opened at 10:10am

Review of Resident #5's current FL-2 dated 03/07/18 revealed:
-Diagnoses included atherosclerosis, hyperlipidemia, articular gout, autoimmune disorder, pre-diabetes, continued illicit drug use, and dental caries.
-He was ambulatory and intermittently disoriented.

Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility on 03/08/18.

Review of Resident #5's care plan dated 04/25/18 revealed Resident #5 had no problems with ambulation and was oriented with adequate memory.

Review of psychiatric notes for Resident #5 dated 09/08/18 revealed:
-Resident #5 had a history of major depressive disorder, anxiety, and insomnia.
-Resident #5 was easily distracted but cooperative.
-His thought process was disorganized and irrationally but he was alert and oriented.
-Resident #5's insight, judgment, and concentration were described as impaired and he had below average intellectual functioning.

Interview with a medication aide (MA) on 11/08/18 at 9:00am revealed:
-Resident #5 did not have a history of wandering.

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-Resident #5 sometimes left the facility and walked to the local store but he always returned to the facility.
-Resident #5 did not sign out from the facility when he walked to the store.

Observation of Resident #5 on 11/09/18 at 10:20am revealed his room was closest to the exit door by the resident smoking area.

Interview with the Assistant Manager on 11/09/18 at 12:45pm revealed:
-There were alarms on all the exit doors in the facility.
-None of the door alarms had worked in the facility since 11/07/18 when the maintenance man removed a piece from the door alarm system that needed to be replaced.
-She did not know of any problems with any residents who had a history of wandering or being disoriented in the facility.

Interview with a personal care aide (PCA) on 11/09/18 at 12:50pm revealed:
-She had noticed the door alarms had stopped working for the exit doors on 11/08/18.
-She was not sure how long the door alarms had not been working before 11/08/18.
-She did not tell the Manager or the Assistant Manager when she first noticed the door alarms were not working.
-She did not know of any problems with any residents who had history of wandering or being disoriented in the facility.

Interview with the Manager on 11/09/18 at 12:58pm revealed:
-She did not know the door alarms were not working in the facility.
-She did not know the maintenance staff had to

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go to pick up supplies to repair the door alarm bells.
-She did not know of any problems with any residents who had history of wandering or being disoriented in the facility.

Interview with Maintenance Staff on 11/09/18 at 2:20pm revealed:
-He was repairing the exit door alarms on 11/07/18 and had disarm the exit door alarms to replace a part in the alarm system.
-He did not tell the Assistant Manager or the Manager that the exit door alarms were not working on 11/07/18 or since 11/07/18.
-The Manager had alerted him that the exit doors were not alarming on 11/09/18.
-He had replaced the part in the exit door alarm system but he had forgotten to turn up the volume for the door alarms so the door alarms did not sound when activated.
-He had replaced the faulty part in the door alarm system and the volume had been turned up so it could be heard when the exit door alarms were activated.

Interview with Resident #5 on 11/14/18 at 1:24pm revealed:
-He did not have any problems with wandering away from the facility.
-He walked to the store sometimes and he did not tell staff when he left the facility.
-He did sign himself out of the facility to "go to work for few days in June 2018".
-A family friend saw him hitchhiking; picked him up, and brought him back to the facility.
-He had not left the facility like that since June.
-He did not tell any staff when he left the facility "go to work for few days in June 2018".

Attempted telephone interview with Resident #5's

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D 067	Continued From page 9 physician on 11/14/18 at 4:43pm was unsuccessful. Telephone interview with Resident #5's psychiatric provider on 11/15/18 at 2:25pm revealed: -She was not aware of any issues with Resident #5 wandering. -Resident #5 was independent and oriented but still required supervision by staff. -Resident #5 was able to manage his own personal needs but his thought process and reasoning sometimes were unorganized which made him vulnerable. Interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know all the exit door alarms were not sounding at all times. -She would contact the Manager to ensure there would be no future problems with the door alarms sounding. _____ The facility failed to assure 7 of 7 exit doors were equipped with a sounding device that activated when doors were opened with at least one resident living in the facility who was intermittently disoriented. This noncompliance was detrimental to the safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/09/18 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 067		

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D 074	Continued From page 10	D 074		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure that walls, ceilings and floors were kept in good repair as evidenced by a weak area of the floor and a faucet on a piece of pipe protruding from the wall in a common bathroom near resident room #20, weak flooring by an exit door by resident room #5, cracked walls and peeling paint in resident room #15, and bubbled drywall with flaking white paint in resident room #19. The findings are: Observation of the common bathroom near room #20 during initial tour on 11/08/18 between 8:00am and 11:30am revealed: -A piece of pipe approximately 1 1/2 inches in diameter, protruded approximately 10 inches from the wall and approximately 4 feet from the floor. -A faucet was attached to the end of the protruding pipe. -The protruding pipe was directly over the commode. -There was an area of floor near the faucet end of	D 074		

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the bath tub that was spongy when stepped on.
-There was an area of the floor missing a tile approximately 4 inches by 3 inches.
-Plywood was showing in the area missing a tile.
-The spongy area of the floor was approximately 12 inches by 12 inches.

Interview with the Manager on 11/08/18 at 5:20pm revealed:
-The Manager was not aware of the weak floor or the protruding pipe.
-The facility has had numerous leaks since the storm (hurricane).
-A leak was probably the cause of the weak floor.
-She would report both issues to maintenance for repair as soon as possible.

Observation of the floor by the exit door by resident room #5 on 11/08/18 at 9:51am revealed there was an area of the floor that measured approximately 4 feet by 2 feet that felt soft and spongy.

Observation of resident room #15 on 11/09/18 at 9:50am revealed:
-There was a crack in the wall on the right side of the window that measured approximately 2 ½ feet long.
-There was an area of cracked and peeling white paint above the window that measured approximately 18 inches long.
-A cluster of dusty brown spider webs were over the entrance of the door.

Interview with the resident who resided in resident room #15 on 11/09/18 at 9:51am revealed:
-The crack in the wall, the peeling paint around the window, and dusty spider webs had been in the room since she moved to the facility in September 2018 after the hurricane.

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D 074	Continued From page 12 -She had not complained about the crack or the peeling paint. -She asked the housekeeping staff on a daily basis to get rid of spider webs; but it was never done. -She had not complained to anyone about the spider webs besides the housekeeping staff. Interview with a personal care aide (PCA) on 11/09/18 at 10:05am revealed: -She did not know about any problems with cracked walls or peeling paint in resident room #15. -She had not seen the dusty spider webs over the door entrance. -The resident in resident room #15 had never complained to her about the walls, paint, or spider web. Observation of resident room #19 on 11/09/18 at 10:15am revealed: -There was an area of the wall on the left side of the window where the drywall was bubble; covered with large flaky white paint chips and measured approximately 4 feet long x 2 feet wide. -There were scattered piles of white flaking paint chips on top of the lid of a storage bin, on the floor, and inside the air vents of the room's air conditioning and heating unit. Interview with the resident who lived in resident room #19 on 11/09/18 at 10:15am revealed: -He had not noticed the puckered wall area next to the window or the flaky white paint chips. -His vision was not the best. -He denied having any problems breathing. Interview with a housekeeper on 11/09/18 at 10:45am revealed: -She did not know anything about the soft flooring	D 074		

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in front of the exit by resident room #5.
-She did not know about the cracked area or peeling paint in resident room #15.
-The resident had not complained any spider webs that needed to be clean in resident room #15.
-She had cleaned in resident room #19 on 11/09/18, but she had not noticed any flaking white paint chips or the puckered wall area by the window.
-She would have reported the flaky paint areas to the Assistant Manager or the Manager if she had seen it.

Interview with a medication aide on 11/09/18 at 10:55am revealed:
-She did not know about any problems with cracked walls or flaking paint chips in any of the residents' rooms.
-Any problems that she saw in the residents rooms, she reported to the Assistant Manager or the Manager.

Interview with the Assistant Manager on 11/09/18 at 12:20pm revealed:
-She did not know about any problems with the walls in either resident room #15 or resident room #19.
-No staff had reported any issues in either room and there had been no complaints from the residents.
-The wall in resident room #19 "looked like it was some type of water damage coming from the roof".
-The flaky paint chips and puckered wall were not there in resident room #19 when she did a walk-through of the facility about 2 weeks ago.
-She normally did a walk-through of the facility to check for repairs weekly but she missed last week's walk-through.

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D 074	Continued From page 14 -She put in a work order to maintenance for anything that she saw that needed to be repaired. Interview with the Manager on 11/09/18 at 1:15pm revealed: -She did not know about any problems with the walls in either resident room #15 or resident room #19 and issues had not been reported to her by staff or any residents. -She called maintenance right away when she saw things needed to be fixed especially since the last storm came through in September 2018 and the facility suffered a lot of damage to the roof. -She or the Assistant Manager normally did a walk-through of the facility at least once a week to check for any needed reports. -Staff could contact her at any time if they saw anything needed to be fixed.	D 074		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION	D 077		

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D 077	Continued From page 15	D 077		

Based on observations, interviews and record reviews the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above in the kitchen at all times.

The findings are:

Observations on 11/08/18 during tour of facility from 8:00am until 11:30am revealed:
-The facility sanitation score of 90.5 dated 12/07/17 was posted in the foyer.
-The kitchen sanitation score of 73.5 date 07/13/18 was posted in the dining room.
-A live roach was seen on the dining room floor.
-There were multiple flies in dining room.

Review of the facility's kitchen most current Environmental Health inspection dated 11/14/18 revealed:
-The kitchen's sanitation score was 80.5.
-Demerits were noted including the following:
-There was not a certified food protection Manager on duty at time of inspection. At least one employee who has supervisory and management responsibility and control over food preparation shall be a certified food protection Manager.
-Health policy not on file for all food employees and volunteers. Ensure food employees and conditional employees are informed of their responsibility to report in accordance with law.
-Employee was observed about to dump soiled sanitizer bucket into hand washing sink.
-Soap was missing from hand washing sink in the kitchen.
-Can opener blades observed soiled with buildup.
Several utensils and plates observed in clean storage are that were visibly soiled with grease and red debris.

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D 077	Continued From page 16	D 077		

-Noodle soup made yesterday per the cook had not cooled to 45 degrees Fahrenheit or less after being in walk in cooler overnight. Soup was discarded.
-Ready to eat potentially hazardous food not dated; observed cut ham, bologna and salad not dated. Food was discarded.
-Two spray bottles of unknown chemicals unlabeled.
-Several live roaches were seen in numerous areas of kitchen include equipment and on baseboards. Observed dead rodent under dry storage rack.
-Kitchen staff was wearing prohibited jewelry-except for a plain ring such as a wedding band, while preparing food, employees may not wear jewelry.
-Sanitizing solution was not mixed correctly.
-Wiping cloths were not stored properly.
-Remove blackened debris from cookware.

Interview with the Manager on 11/08/18 at 3:15pm revealed:
-The exterminator was scheduled to visit the facility on 11/12/18.
-The exterminator was scheduled to visit monthly, but due to the recent storm, has not been since August 2018.

Telephone interview with exterminator on 11/13/18 at 10:30am revealed:
-He had sprayed the facility on 11/12/18.
-The date of the previous extermination service was 08/28/18.
-Extermination services were not provided the months of September and October 2018 because of extensive flooding after the hurricane.
-He had seen a "few" roaches in resident's rooms but none in the kitchen.
-The chemical he used to spray the facility was

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D 077	Continued From page 17 multipurpose and it "would kill everything". Interview with environmental health inspector on 11/14/18 at 11:40am revealed: -The facility had repeated demerits from the last inspection conducted on 07/13/18. -Some of the repeat demerits were considered risk factors for foodborne illnesses which could have serious outcomes to highly susceptible populations such as assisted living facilities. -The repeat demerits that increase the risk of foodborne illness include the following: -There was no certified food protection Manager on duty at time of inspection. -Health policy was not on file for all food employees and volunteers. -Food employees were using sinks other than designated hand washing sink. -Food equipment and food contact surfaces were visibly soiled including can opener blades, utensils and plates. -Ready to eat to eat foods and foods prepared in the facility were not dated. Interview with Assistant Manger on 11/14/18 at 9:25pm revealed: -The Assistant Manger had seen several live roaches since the exterminator treated the facility on 11/12/18. -She would contact the exterminator as soon as possible to report the live roaches. A second interview with the Manager on 11/14/18 at 12:06pm revealed: -A new cook was hired since the previous environmental health inspection dated 07/13/18. -The new cook had lots of experience and should have known how things should be done. -The Assistant Manger was to attend a ServSafe class conducted by the local Environmental	D 077		

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D 077	Continued From page 18 Health inspectors on 11/15/18. -The Assistant Manger would conduct training with food service staff on proper food service once she completes SerSafe class. -The facility had contracted a local exterminator to visit monthly. -The exterminator treated the facility on 11/12/18. -The extermination company was sending someone out today, 11/14/18, to discuss fly control measures. The facility failed to maintain a sanitation score of 85 or above in the kitchen at all times. The facility's failure resulted in repeated demerits in areas which increased the risk for foodborne illness 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 (2) on 11/14/18. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 077		
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.	D 079		

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D 079	Continued From page 19	D 079		

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to assure the facility was free of hazards as evidenced by flies and live roaches observed in the kitchen, dining room, one resident room, and two common resident bathrooms.

The findings are:

Observation of the dining room on 11/08/18 at 7:55am revealed:
-There was a live roach crawling across a table and a live roach crawling on the floor of the dining area.
-Two flies were crawling on table and three flies were on the floor in the dining room.
-No residents were present.

Observation during the initial tour on 11/08/18 at 8:27am revealed a live roach on the floor in the common bathroom near room #20.

Observation of common resident bathroom between resident room #6 and resident room #8 on 11/08/18 at 8:56am revealed a live roach that measured approximately 1½ inch, lying on its back on the bathroom floor.

Interview with a resident on 11/08/18 at 9:15am revealed that roaches have been seen in the bathroom.

Observation of resident room #19 on 11/08/18 at 10:15am revealed there were 2 live roaches crawling from under the resident's bed towards the resident's nightstand.

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Interview with the resident in resident room #19 on 11/08/18 at 10:15am revealed:
-The roaches were bad in his room and he saw roaches crawling "a lot" across the floor in his room.
-The roaches were worse at night and the roaches crawled up on the legs of his pants so he brushed them off.
-He had not complained about the roaches because he was not sure what could be done about the roaches.
-He did not know if the facility had ever been sprayed for roaches.

Confidential interview with a previous staff member revealed:
-"The facility had problems with roaches in the facility and use to have problems with bedbugs."
-"Roaches were everywhere in the facility, in the resident rooms, dining room, activity room, just everywhere."
-The staff member was careful not to bring in personal items because the staff did not want to risk taking any roaches home.
-The facility was supposed to be sprayed by an exterminator every other month.
-The facility had not been sprayed by an exterminator in at least 3 months.
-Staff had complained to the previous manager several times about roaches in the facility.

Interview with the Manager on 11/08/18 at 10:33am revealed:
-There was a problem with roaches in the facility.
-She knew about the problem with the roaches since she became the manager at the facility in September 2018.
-The exterminator could not service the facility in September 2018 due to the hurricane.
-The last time the exterminator serviced the

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D 079	Continued From page 21	D 079		

facility was in August 2018.
-She did not know when the exterminator was coming to spray the facility because the exterminator so backed up with work.

Interview with the Manager on 11/08/18 at 3:15pm revealed:
-The exterminator was scheduled to visit the facility on 11/12/18.
-The exterminator was scheduled to visit monthly, but due to the recent storm, had not been since August 2018.

Observation of the dining room on 11/09/18 at 9:45am revealed:
-There was a live roach crawling across the dining room table.
-Four flies were flying around in the dining room areas.

Review of a Food Establishment Inspection report completed by the county environment health inspector on 07/13/18 revealed:
-Several live roaches were observed inside unused equipment and baseboards in the kitchen.
-Several dead roaches were observed throughout the kitchen including the sinks, prep table, and floor in the kitchen.

Review of a Food Establishment Inspection report completed by the county environment health inspector on 11/14/18 revealed "several" small and large live roaches were observed in numerous area of kitchen including equipment and baseboards.

Telephone interview with the office manager at a local exterminating company on 11/13/18 at 10:26am revealed:

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D 079	Continued From page 22 -The facility had a contract for monthly exterminating visits beginning 06/19/06. -Other than the 11/12/18 service, the last service date was 08/28/18. -The exterminating company had closed for a week after the recent hurricane (09/14/18). -The exterminating company had reopened 1 week later but some of employees did not return immediately due to storm damage and road conditions. -The exterminating company was unable to provide service September 2018 due to the effects of the hurricane. -She remembers "something" about the facility refusing service for November 2018. -The exterminating technician will have the specific information. Telephone interview with an exterminating technician on 11/13/18 at 10:35am revealed: -He was unable, due to extensive flooding after the recent hurricane, to provide service to the facility September 2018. -He visited the facility in October 2018 to provide the monthly service. -The technician stated that the "new manager" instructed him to wait until the first of November 2018 to treat the facility to allow her to become acclimated to everything. -The technician sprayed the facility on 11/12/18 with a multipurpose chemical that kills "everything." -The technician was unable to provide the date of the October 2018 visit because if service was not provided, specifics were not recorded in their system. Interview with the Manager on 11/13/18 at 10:58am she was adamant that she had not refused exterminating service during October	D 079		

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D 079	Continued From page 23 2018. Interview with Assistant Manager on 11/14/18 at 9:25am revealed: -She had seen several live roaches since the exterminator treated the facility on 11/12/18. -She would contact the exterminator as soon as possible to report the live roaches. Interview with the Manager on 11/14/18 at 12:06pm revealed the facility was sprayed by the exterminator on 11/12/18. Interview with a resident on 11/14/18 at 1:24pm revealed: -He had seen roaches in several places in the facility. -He had seen roaches in the dining room, activity room, and common resident bathroom. -He had not seen any roaches in his room but he had just moved in his room a few days ago. -He did not know how often the facility was sprayed for roaches. -He had not noticed any problems with flies except in the dining room. -He thought the flies in the dining were there because residents were constantly in and out the doors	D 079		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.	D 131		

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D 131	Continued From page 24	D 131		

Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure 2 of 6 staff sampled (Staff A and E) were tested upon hire for tuberculosis (TB) disease with the two-step TB skin test in compliance with control measures adopted by the Commission for Health Services.

The findings are:

1.Review of Staff A's personnel record revealed:
-The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA).
-There was no documentation of a 2 step TB skin test.

Telephone interview with Staff A on 11/15/18 at 1:30pm revealed:
-She had been working at the facility as a PCA for three years.
-She had worked as a MA for the last 6 months.
-She had a TB skin test done at the facility in October 2018, but "never got it read" (the TB skin test).
-The last TB skin test she had read was in 2013 and it was negative.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff A did not have a TB skin test.

Refer to Interview with the Assistant Manager on 11/14/18 at 4:50pm.

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D 131	Continued From page 25 Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know that Staff A did not have a 2 step TB skin test. Refer to Interview with the Manager on 11/15/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2. Review of the Assistant Manager's personnel record revealed: -There was no documentation of a hire date. -There no documentation of a 2 step TB skin test administered. Interview with Assistant Manager on 11/14/18 at 4:50pm revealed: -She had worked at the facility as a MA for the last five months and the Assistant Manager for the last four weeks. -She had worked for the facility's sister facility since 02/14/12 with no break in service. -She could not remember if the facility administered her a TB skin test since 2012. -She knew that she had a TB skin test in 2012 but was unable to provide documentation. -She did not know that she did not have a TB skin test in her personal record. -The documentation for the TB skin test was in the sister facility's file but was unable to provide documentation. Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know the Assistant Manager did not have documentation of a 2 step TB skin test. Refer to Interview with the Manager on 11/15/18 at 4:55pm.	D 131		

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D 131	Continued From page 26 Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She thought all the staff records were complete. -She thought all the staff that had been hired prior to her becoming the Assistant Manager had all the documentation needed. -She and the Manager were responsible for auditing staff records. -She had not audited any staff charts since being the Assistant Manager. Interview with the Manager on 11/15/18 at 4:55pm revealed: -She thought all staff records were complete (had all the needed documentation). -Staff from a sister facility had come in this week and audited all the staff records. -She and the Assistant Manager were responsible for auditing the staff records. -She had not audited any staff records since being the Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there any problems with the staff records and their TB skin test. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 27 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 3 of 6 sampled staff (staff A, B and D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256 upon hire. The findings are: 1.Review of Staff A's personnel record revealed: -The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA). -There was no documentation of a HCPR check was completed upon hire. Telephone interview with Staff A on 11/15/18 at 1:30pm revealed: -She had been working at the facility as a PCA for three years. -She had worked as a MA for the last 6 months. -She did not know if the HCPR was checked by management prior to her being hired. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff A did not have a HCPR check.	D 137		

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D 137	Continued From page 28 Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know Staff A did not have a HCPR check. Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2. Review of Staff B's personnel record revealed: -The date of hire was documented as 10/01/18 as a medication aide (MA). -There was no documentation of a HCPR check was completed upon hire. Telephone interview with Staff B on 11/14/18 at 5:10pm revealed: -She had been working at the facility as a medication aide (MA) since October 2018. -She did not know if the HCPR was checked by management prior to her being hired. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff B did not have a HCPR check. Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/15/18 at 4:55pm revealed: -She did not know Staff B did not have a HCPR check. -Staff B had left in 03/14/18 and was rehired on 10/01/18.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 29 Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 3.Review of Staff D's personnel record revealed: -The date of hire was documented as 10/24/17 as a Personal Care Aide (PCA). -There was no documentation of a HCPR check was completed upon hire. Attempted telephone interview with Staff D on 11/15/18 at 5:20pm was unsuccessful. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff D did not have a HCPR check. Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know Staff D did not have a HCPR check. Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. A HCPR check was not completed for Staff A, B and C by the end of the survey. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She thought all the staff records were complete. -She thought all the staff that had been hired prior to her becoming the Assistant Manager had all	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 30	D 137		

the documentation needed.
-She and the Manager were responsible for auditing staff records.
-She had not audited any staff records since being the Assistant Manager.

Interview with the Manager on 11/15/18 at 4:55pm revealed:
-She thought all staff records were complete (had all the needed documentation).
-Staff from a sister facility had come in this week and audited all the staff records.
-She and the Assistant Manager were responsible for auditing the staff records.
-She had not audited any staff records since being the Manager.

Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed:
-She did not know there any problems with the staff records and their HCPR check prior to hire.
-The facility had recently changed management and they were in the process of reviewing staff records.
-She had a management team who was coming to the facility to help the current Manager update any needed records.

The facility failed to assure 3 of 6 sampled staff (Staff A, B and D) had a North Carolina Health Care Personnel Registry check upon hire. This failure was detrimental to the safety and welfare of the residents, by not verifying Staff A, B and D had no substantiated findings listed on the registry upon hire, which constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/18 for this violation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 137	Continued From page 31 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 3 of 6 sampled staff (Staff A, B, and D) had a criminal background check completed in accordance with G.S. 114-19.10 and D-40 upon hire. The findings are: 1. Review of Staff A's personnel record revealed: -The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA). -There was no signed consent for a criminal background check. -There was no documentation that a criminal background check had been completed. Telephone interview with Staff A on 11/15/18 at 1:30pm revealed: -She worked at the facility as a PCA for three years, left and came back to work the end of August 2018. -She had worked as a MA for the last 6 months.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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-She had signed a consent for criminal background check upon hire when she first started in 2013.
-She had signed a consent for criminal background check upon hire when she came back to work the end of August 2018.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff A did not have a criminal background check in her personal records for her rehire on 09/12/18.

Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm.

Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know Staff A did not have a criminal background check in her personal records for her rehire on 09/12/18.

Refer to Interview with the Manager on 11/15/18 at 4:55pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

2. Review of Staff B's personnel record revealed:
-The date of hire was documented as 10/01/18 as a medication aide (MA).
-There was no signed consent for a criminal background check.
-There was no documentation that a criminal background check was completed.

Telephone interview with Staff B on 11/14/18 at 5:10pm revealed:
-She had been working at the facility as a MA since October 2018.
-She did not know if a criminal background was checked by management.

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D 139	Continued From page 33 -She had not signed a consent for a criminal background check in October 2018. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff B did not have a criminal background check in her personal records. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know that Staff B did not have a criminal background check in her personal records. Refer to Interview with the Manager on 11/15/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 3.Review of Staff D's personnel record revealed: -The date of hire was documented as 10/24/17 as a personal care aide (PCA). -There was a signed consent for a criminal background check dated 08/17/17. -There was no documentation that a criminal background check was completed. Attempted interview with Staff D on 11/15/18 at 5:20pm was unsuccessful. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff D did not have a criminal background check in her personal records. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 139	Continued From page 34 Interview with the Manager on 11/15/18 at 4:55pm revealed she did not know Staff D did not have a criminal background check in her personal records for her rehire on 10/24/17. Refer to Interview with the Manager on 11/15/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Criminal back ground checks were completed by the corporate office. -The corporate office reviewed the results, then would let her know if the person could be hired. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assistant Manager. -There was no scheduled or allotted time for the staff records to be audited. Interview with the Manager on 11/15/18 at 4:55pm revealed: -Criminal back ground checks were completed and reviewed by the corporate office. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Manager had all the required documentation. -She and the Assistant Manager were responsible	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 139	Continued From page 35 for auditing staff records. -She had not audited any staff records since being the Manager. -Staff from a sister facility had come in this week and audited all the staff records. -There was no scheduled or allotted time for the staff records to be audited. -She would immediately request that corporate perform the state and national criminal background checks ran on each employee needing one. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there any problems with the staff records and their criminal background being done prior to hire. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records. The facility failed to assure 3 of 6 sampled staff (Staff A, B, and D) had a state wide criminal background check upon hire. The facility's failure resulted in the facility being unaware of any criminal history, which 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 11/15/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 139		

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D 150	Continued From page 36	D 150		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to assure 2 of 3 sampled staff (staff D and F) who provided personal care to residents, had successfully completed an 80 hour personal care training and competency evaluation program, within 6 months after hire. The findings are:	D 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 150	Continued From page 37 1. Review of Staff D's personnel record revealed: -The hire date was documented as 10/24/17 as a personal care aide (PCA). -There was no documentation that Staff D had completed 80 hours of personal care training or that she was a certified nursing assistant. Interview with Staff D on 11/08/18 at 12:15pm revealed: -She worked and a personal care aide (PCA). -She reports giving baths. Observation on 11/08/18 at 12:40 pm revealed Staff D was caring for residents by providing feeding assistance. Interview with Assisted Manager on 11/08/18 revealed Staff D was in a resident room providing personal care. Observation of Staff D on 11/08/18 at 4:30pm revealed staff preforming incontinent care on a resident requiring incontinent briefs. Attempted telephone interview with Staff D on 11/15/18 at 5:20pm was unsuccessful. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff D worked at the facility as a cook on some days and as a PCA on the other days. -She expected Staff D to assist residents with activities of daily living which included eating, ambulating, toileting, bathing, dressing and to do laundry on the days she worked as a PCA. -She did not know Staff D had not completed the 80 hours of personal care training. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm.	D 150		

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D 150	Continued From page 38 Interview with the Manager on 11/14/18 at 4:55pm revealed: -Staff D worked as a cook and as a PCA at the facility. -She expected Staff D to assist residents with activities of daily living which included eating, ambulating, toileting, bathing, dressing, and to do laundry on the days she worked as a PCA. -She did not know Staff D had not completed the 80 hours of personal care training. Refer to interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2. Review of Staff F's personnel record revealed: -The hire date was documented as of 12/22/17 as a personal care aide (PCA). -There was no documentation Staff D had completed 80 hours of personal care training or that she was a certified nursing assistant. Interview with Staff F on 11/08/18 at 4:10pm revealed: -Staff F's had been working at the facility as a PCA for about a year. -She assist residents with activities of daily living which included eating, ambulating, toileting, bathing, dressing, and do laundry. Observation of Staff F on 11/08/18 at 4:30pm revealed staff preforming incontinence care on a resident requiring incontinent briefs. Attempted telephone interview with Staff F on 11/15/18 at 5:55pm was unsuccessful.	D 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 150	Continued From page 39 Attempted telephone interview with Staff F on 11/16/18 at 8:12am was unsuccessful. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff D worked at the facility as a PCA. -She expected Staff F to assist residents with activities of daily living which included eating, ambulating, toileting, bathing, dressing and to do laundry. -She did not know Staff F had not completed the 80 hours of personal care training. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -Staff F worked as a PCA at the facility. -She expected Staff F to assist residents with activities of daily living which included eating, ambulating, toileting, bathing, dressing, and to do laundry. -She did not know Staff F had not completed the 80 hours of personal care training. Refer to interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. _____ Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She thought all the staff records were complete (had all the needed documentation). -She thought all the staff that had been hired prior to her becoming the Assistant Manager had all the training and documentation needed for their job titles.	D 150		

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D 150	Continued From page 40 -She and the Manager were responsible for auditing staff records. -She had not audited ant staff records since being the Assistant Manager. Interview with the Manager on 11/15/18 at 4:55pm revealed: -She thought all the staff records were complete (had all the needed documentation). -Staff from a sister facility had come in this week and audited all the staff records. -She and the Assistant Manager were responsible for auditing the staff records. -She had not audited any staff records since being the Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there any problems with the staff records and their personal care training. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records.	D 150		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 161	Continued From page 41	D 161		

Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 4 of 6 sampled staff (Staff A, B, C and D) personal care aide (PCA) Staff D and medication aide (MA) Staff A, B and C were competency validated for Licensed Health Professional Support (LHPS) tasks related to blood glucose monitoring, insulin injections, and providing personal care services.

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was documented as hired as a personal care aide (PCA)/medication aide (MA) on 09/12/18.
-The documentation on the LHPS competency dated 09/26/18 validation in the record for collection and testing of finger stick blood samples were marked as non-applicable (N/A).
-The documentation on the LHPS competency dated 09/26/18 validation in the record for insulin injections (mixing and measuring insulin: subcutaneous (SQ) injection: abnormal blood sugar) were marked as non-applicable (N/A).

Telephone interview with Staff A on 11/15/18 at 1:30pm revealed:
-She had been working at the facility as a PCA for three years, left and came back the end of August 2018.
-She had worked as a MA for the last 6 months.

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GOOD SHEPHERD HOME FOR THE AGED	603 WEST STREET NEW BERN, NC 28560

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D 161	Continued From page 42 -She routinely worked second shift. -She had not done any LHPS skill check list. -She had not been assessed for competency by a Registered Nurse (RN) for LHPS tasks. -She assisted with meals, personal care, transferring residents from bed to the chair, and transferring residents from wheelchair to bed and chair. -Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff A was hired as a MA. -MAs were expected to cover the floor and provide personal aide to residents when the PCAs had to leave the floor. -She was expected to perform all the duties of a MA including administering insulin injections and finger stick blood sugars (FSBS). -She did not know Staff A had not completed the Licensed Health Professional Support (LHPS) tasks checklist and training. -She did not know Staff A's LHPS tasks checklist was not completed. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -She did not know Staff A had not completed the Licensed Health Professional Support (LHPS) tasks checklist and training. -She did not know Staff A's Licensed Health Professional Support (LHPS) tasks checklist was not complete.	D 161		

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D 161	Continued From page 43 Refer to interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2 Review of Staff B's personnel record revealed: -The date of hire was 10/01/18 as a medication aide (MA). -The documentation on the LHPS competency validation in the record did not have a date of completion and was not complete. -The satisfactory completion dates were all blank. -The documentation on the LHPS competency validation in the record for collection and testing of finger stick blood samples were marked as non-applicable (N/A). -The documentation on the LHPS competency validation in the record for insulin injections (mixing and measuring insulin: subcutaneous (SQ) injection: abnormal blood sugar) were marked as non-applicable (N/A). Review of Resident #11's November 2018 medication administration records revealed: -Staff B documented performing diabetic care including finger stick blood sugars and administering insulin injections on 11/04/18, 11/07/18, 11/08/18, 11/09/18 and 11/14/18. -Staff B documented administering insulin injections in the amounts of 5 units of insulin. Telephone interview with Staff B on 11/14/18 at 5:10pm revealed: -She had been working at the facility as a MA since October 2018. -Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 161	Continued From page 44 -She had not worked at any other facility as a MA. -She received all her training for MA in three days from the facility's former manager, who was also a MA and a current MA. -Her training consisted of having been shown how to give residents pills for the first two days, giving residents insulin injections and checked finger stick blood sugars on the third day (trained by another current MA). -After her three days of training she was put on the medication cart alone. -She had not trained with or had any check offs with a register nurse (RN). -She had not signed any paper work regarding any kind of skill check off list. -She had not completed LHPS competency validation training. -It was her name on the LHPS competency validation checklist, but the signature was not her signature on the LHPS competency validation checklist in her personal record. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff B was hired as a MA. -Staff B was expected to perform all the duties of a MA including administering insulin injections and FSBS. -She did not know Staff B had not completed the LHPS competency validation checklist. -She did not know Staff B's LHPS competency validation checklist was not completed and had missing completed dates on all the competency skills. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed:	D 161		

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D 161	Continued From page 45 -She did not know Staff B had not completed the LHPS competency validation training. -She did not know Staff B's LHPS competency validation checklist was not completed and had missing completed dates all the competency skills. Refer to interview with The Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 3. Review of the Manager's Staff C personnel record revealed: -The date of hire was 08/02/18 as a MA. -There was documentation of a LHPS competency validation dated 08/02/18. -The documentation on the LHPS competency validation in the record for chest physiotherapy or postural drainage, medication administration through a well-established gastrostomy feeding tube, oral suctioning, care for well-established tracheostomy, and administering and monitoring of tube feedings through well-established gastrostomy tube were all marked as "explained". Interview with the Manager (staff C) on 11/14/18 at 4:55pm revealed: -She was hired on 08/02/18 as a MA. -She had worked as a MA until the end of September, 2018 when she became the manager. -She was a physician up until she relinquished her license in February 2018 after which she started working at the facility as a MA. -She did not know that the LHPS competency validation skill check sheet could not be verbal and had to be a return demonstration. -She had not worked as MA since becoming the	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 161	Continued From page 46	D 161		

manager.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:
-Manager was hired as a MA.
-The Manager no longer worked as a MA.
-She did know the Manager had relinquished her license in February 2018.
-She did not know that the Manager's LHPS competency validation skill check sheet had skills that were marked as "explained".

Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

4. Review of Staff D's personnel record revealed:
-The date of hire was documented as 10/24/17 as a personal care aide (PCA).
-There was documentation of a LHPS competency validation dated 11/21/17.
-The documentation on the LHPS competency validation in the record for chest physiotherapy or postural drainage, medication administration through a well-established gastrostomy feeding tube, oral suctioning, care for well-established tracheostomy, and administering and monitoring of tube feedings through well-established gastrostomy tube were all marked as "explained".

Observation of Staff D on 11/08/18 at 4:38pm revealed she was providing perineal care to Resident #3.

Attempted interview with Staff D on 11/15/18 at 5:20pm was unsuccessful.

Interview with the Assistant Manager on 11/14/18

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D 161	Continued From page 47 at 4:50pm revealed: -Staff D was hired as a PCA. -She did not know Staff D's LHPS competency validation skill check sheet had skills that were marked as "explained". Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -She did not know that Staff D had not completed the LHPS competency validation training. -She did not know Staff D's LHPS competency validation skill check sheet had skills that were marked as "explained". Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. _____ Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -MAs were expected to cover the floor and provide personal care and assistance to residents when the PCAs had to leave the floor. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assistant Manager. -There was no scheduled or allotted time for the staff records to be audited by her or the Manager.	D 161		

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D 161	Continued From page 48 Interview with the Manager on 11/14/18 at 4:55pm revealed: -She thought all the staff records were complete and included all the required documentation. -She thought that all the staff that were hired prior to her becoming the Manager had all the required documentation. -She and the Assistant Manager were responsible for auditing staff records. -She had not audited any staff records since being the Manager. -Staff from a sister facility had come in this week and audited all the staff records. -There was no scheduled or allotted time for the staff records to be audited by her or the Assistant Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there were any problems with the staff records and completion of LHPS training for staff. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered	D 164		

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D 164	Continued From page 49 nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure 2 of 4 medication aides (Staff A and B) received diabetic training prior to the administration of insulin. The findings are: 1. Review of Staff A's personnel record revealed: -The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA). -There was no documentation of diabetes care training. Review of Resident # 11's November 2018 medication administration record (MAR) revealed Staff A documented performing finger stick blood sugars and administration insulin of five units on 11/05/18.	D 164		

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D 164	Continued From page 50 Telephone interview with Staff A on 11/15/18 at 1:30pm revealed: -She had been working at the facility as a PCA for three years, then I left and came back to work the end of August 2018. -Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars. -She had not worked at any other facility as a MA. -She received all her training for MA in two weeks from the facility's former manager, who was also a MA. -Her training consisted of having been shown how to give residents pills for the first two day, giving residents insulin injections and checked finger stick blood sugars for the next two days. -She had not completed the diabetic care training. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff A was hired as a medication aide (MA). -She was expected to perform all the duties of a MA including administering insulin injections and checking FSBS. -She did not know Staff A had not completed the diabetic care training. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed she did not know that Staff A had not completed the diabetic care training. Refer to interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the	D 164		

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D 164	Continued From page 51 Administrator on 11/16/18 at 3:22pm. 2. Review of Staff B's personnel record revealed: -The date of hire was documented as 10/01/18 as a medication aide (MA). -There was no documentation of diabetes care training. Review of a resident's November 2018 medication administration records revealed: -Staff B documented performing diabetic care including administering insulin injections on 11/02/18, 11/04/18, 11/07/18, 11/08/18, 11/09/18 and 11/14/18. -Staff B documented administering insulin injections in the amounts of between four to eight units. Telephone interview with Staff B on 11/14/18 at 5:10pm revealed: -She had been working at the facility as a medication aide (MA) since October, 2018. -Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars. -She had not worked at any other facility as a MA. -She received all her training for MA in three days from the facility's former manager, who was also a MA and a current MA. -Her training consisted of having been shown how to give residents pills for the first two days, giving residents' insulin injections and checked finger stick blood sugars on the third day (trained by another current MA). -She had not completed the diabetes care training. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:	D 164		

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D 164	Continued From page 52 -Staff B was hired as a MA. -Staff B was expected to perform all the duties of a MA including administering insulin injections and diabetic care. -She did not know Staff A had not completed the diabetic care training. -She was not aware Staff B only had 3 days of medication aide training that was given by the former Manager and a current MA. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed she did not know that Staff A had not completed the diabetic care training. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assistant Manager. -There was no scheduled or allotted time for the staff records to be audited by her or the Manager. Interview with the Manager on 11/14/18 at 4:55pm revealed: -She thought all the staff records were complete and included all the required documentation. -She thought that all the staff records were complete and included all the required documentation.	D 164		

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D 164	Continued From page 53 -She thought that all the staff that were hired prior to her becoming the Manager had all the required documentation. -She and the Assistant Manager were responsible for auditing staff records. -She had not audited any staff records since being the Manager. -Staff from a sister facility had come in this week and audited all the staff records. -There was no scheduled or allotted time for the staff records to be audited by her or the Assistant Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there were any problems with the staff records and completion of diabetic training for staff. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records.	D 164		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented	D 167		

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certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 2 of 6 sampled staff (Staff A, and B) .

The findings are:

Review of the staffing schedule dated 10/22/18-11/15/18 revealed:
-There were three 8 hour shifts (7am-3pm, 3pm-11pm and 11pm-7am).
-21 days out of 28 days there was no staff scheduled who had any documentation of CPR certification.
-On second shift 19 out of 28 days there was no staff scheduled who had any documentation of CPR certification.
-On third shift 2 out of 28 days there was no staff scheduled who had any documentation of CPR certification.
-There were three 8 hour shifts (7am-3pm, 3pm-11pm and 11pm-7am).
-There were only two staff scheduled to work on 3pm-11pm shift.
-Staff A, the MA who had no documentation of CPR training within the last 24 months worked on 10/24/18, 10/25/18, 10/27/18, 10/29/18, 10/31/18, 11/01/18, 11/02/18, 11/06/18, 11/09/18, 11/10/18,

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11/12/18 and 11/13/18, on second shift (3pm-11pm) with a PCA that was not CPR trained.
There was no staff scheduled to work with Staff A that had CPR training in the last 24 months on the dates listed above.
-There were only two staff scheduled to work on (11pm-7am) shift.
-Staff B, worked as a PCA on second shift (3pm-11pm) on 10/24/18 and11/01/18 with a MA that did not have CPR training.
-Staff B, the MA worked second shift (3pm-11pm) on 11/11/18, 11/14/18 and 11/15/18 with PCA that did not have CPR training.
-Staff B, the MA who had no documentation of CPR training within the last 24 months worked third shift (11pm-7am) on 10/26/18 and 11/13/18 with a PCA that did not have CPR training.
-There was no staff scheduled to work with Staff B that had CPR training in the last 24 months on the dates listed above.

1. Review of Staff A's personnel record revealed:
-The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA).
-There was no documentation of CPR training within the last 24 months.

Telephone interview with Staff A on 11/15/18 at 1:30pm revealed:
-She had been working at the facility as a PCA for three years, left and came back the end of August 2018.
-She had worked as a MA for the last 6 months.
-She routinely worked second shift.
-The last time she had CPR training was in 2013.

Interview with the Assistant Manager on 11/14/18 at 4:40pm revealed she did not know Staff A did

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D 167	Continued From page 56 not have CPR training. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2. Review of Staff B's personnel record revealed: -The date of hire was documented as 10/01/18 as a medication aide (MA). -There was no documentation of CPR training within the last 24 months. -There was no documentation of a current or any expired CPR training. Telephone interview with Staff B on 11/14/18 at 5:10pm revealed: -She had been working at the facility as a medication aide (MA) since October 2018. -She had never had any CPR training. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed she did not know Staff B did not have CPR training. Refer to Interview with the Assistant Manager on 11/14/18 at 4:50pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. _____ Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She did not know the staff did not have CPR training. -She thought all the staff records were complete and included all the required documentation and training required.	D 167		

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D 167	Continued From page 57 -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assistant Manager. -There was no scheduled or allotted time for the staff records to be audited by her or the Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there were any problems with the staff records and completion of CPR training. -She did not know there were shifts being covered by staff that were not CPR trained and were the only staff in the building for those shifts. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records. The facility failed to assure there was at least one staff person on duty for 17 of the 23 shifts from 10/22/18-11/15/18 , who had completed a course on CPR and choking management, within the previous 24 months. This failure was detrimental to the health, safety and welfare of the residents by not having adequately trained staff available in the event of cardiopulmonary arrest or choking, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 167		

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D 167	Continued From page 58 31, 2018.	D 167		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) 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 .0606 of this Subchapter.)	D 201		

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D 201	Continued From page 59	D 201		

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

Based on observations, interviews, and record reviews, the facility failed to assure there was enough staff on duty to meet and assist with the needs of the residents according to the facility's census for 62 of 63 shifts sampled from 10/22/18-11/11/18.

The findings are:

Review of the daily census report for October 2018 and November 2018 revealed:
-The total census for 10/22/2018 - 11/11/2018 ranged from 33-34.
-The staffing requirements for a census of 31-40 residents was 16 aide hours for first, second, and third shifts.

Review of first shift staff time sheets and the facility census records for 10/22/18-10/28/18 revealed:
-There were 34 residents in the facility from 10/22/18-10/28/18 which required 16 aide hours for first shift.
-There were 8.75 hours of aide hours for first shift on 10/22/18, leaving the facility short 7.25 hours of aide hours.
-There were 6.75 hours of aide hours for first shift on 10/23/18, leaving the facility short 9.25 hours of aide hours.
-There were 7.5 hours of aide hours for first shift on 10/24/18, leaving the facility short 8.5 hours of aide hours.
-There were 7.5 hours of aide hours for first shift

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D 201	Continued From page 60 on 10/25/18, leaving the facility short 8.5 hours of aide hours. -There were 7 hours of aide hours for first shift on 10/26/18, leaving the facility short 9 hours of aide hours. -There were 6.5 hours of aide hours for first shift on 10/27/18, leaving the facility short 9.5 hours of aide hours. -There were 6.75 hours of aide hours for first shift on 10/28/18, leaving the facility short 8.25 hours of aide hours. Review of second shift staff time sheets and the facility census records for 10/22/18-10/28/18 revealed: -There were 34 residents in the facility from 10/22/18-10/28/18 which required 16 aide hours for second shift. -There were 12 hours of aide hours for second shift on 10/22/18, leaving the facility short 4 hours of aide hours. -There were 7 hours of aide hours for second shift on 10/23/18, leaving the facility short 9 hours of aide hours. -There were 14 hours of aide hours for second shift on 10/24/18, leaving the facility short 2 hours of aide hours. -There were 14 hours of aide hours for second shift on 10/25/18, leaving the facility short 2 hours of aide hours. -There were 6 hours of aide hours for second shift on 10/26/18, leaving the facility short 10 hours of aide hours. -There were 7 hours of aide hours for second shift on 10/27/18, leaving the facility short 9 hours of aide hours. -There were 7 hours of aide hours for second shift on 10/28/18, leaving the facility short 9 hours of aide hours.	D 201		

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D 201	Continued From page 61 Review of third shift staff time sheets and the facility census records for 10/22/18-10/28/18 revealed: -There were 34 residents in the facility from 10/22/18-10/28/18 which required 16 aide hours for third shift. -There were 6 hours of aide hours for third shift on 10/22/18, leaving the facility short 12 hours of aide hours. -There were 14 hours of aide hours for third shift on 10/23/18, leaving the facility short 2 hours of aide hours. -There were 7 hours of aide hours for third shift on 10/24/18, leaving the facility short 8 hours of aide hours. -There were no hours of aide hours for third shift on 10/25/18, leaving the facility short 16 hours of aide hours. -There were 7 hours of aide hours for third shift on 10/26/18, leaving the facility short 9 hours of aide hours. -There were 7 hours of aide hours for third shift on 10/27/18, leaving the facility short 9 hours of aide hours. -There were 6.75 hours of aide hours for third shift on 10/28/18, leaving the facility short 8.25 hours of aide hours. Review of first shift staff time sheets and the facility census records for 10/29/18-11/04/18 revealed: -There were 33 residents in the facility from 10/29/18-11/04/18 which required 16 aide hours for first shift. -There were 14 hours of aide hours for first shift on 10/29/18, leaving the facility short 2 hours of aide hours. -There were 7.25 hours of aide hours for first shift on 10/30/18, leaving the facility short 8.25 hours of aide hours.	D 201		

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D 201	Continued From page 62 -There were 7 hours of aide hours for first shift on 10/31/18, leaving the facility short 9 hours of aide hours. -There were 7.5 hours of aide hours for first shift on 11/01/18, leaving the facility short 8.5 hours of aide hours. -There were 8.5 hours of aide hours for first shift on 11/02/18, leaving the facility short 7.5 hours of aide hours. -There was 1 hour of aide hours for first shift on 11/03/18, leaving the facility short 15 hours of aide hours. -There were 7.5 hours of aide hours for first shift on 11/04/18, leaving the facility short 8.5 hours of aide hours. Review of second shift staff time sheets and the facility census records for 10/29/18-11/04/18 revealed: -There were 33 residents in the facility from 10/29/18-11/04/18 which required 16 aide hours for second shift. -There were 7 hours of aide hours for each second shift on 10/29/18, 10/30/18, 10/31/18, 11/01/18, 11/02/18, and 11/03/18, leaving the facility short 9 hours of aide hours for each second shift for those dates. -There were 7.5 hours of aide hours for second shift on 11/04/18, leaving the facility short 8.5 hours of aide hours. Review of third shift staff time sheets and the facility census records for 10/29/18-11/04/18 revealed: -There were 33 residents in the facility from 10/29/18-11/04/18 which required 16 aide hours for third shift. -There were 7 hours of aide hours for third shift on 10/29/18, leaving the facility short 9 hours of aide hours.	D 201		

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D 201	Continued From page 63 -There were no hours of aide hours for third shift on 10/30/18, leaving the facility short 16 hours of aide hours. -There were 7 hours of aide hours for each third shift on 10/31/18, 11/01/18, 11/02/18, and 11/03/18, leaving the facility short 9 hours of aide hours for each third shift for those dates. Review of first shift staff time sheets and the facility census records for 11/05/18-11/11/18 revealed: -There were 33 residents in the facility from 11/05/18-11/11/18 which required 16 aide hours for first shift. -There were 6.5 hours of aide hours for first shift on 11/05/18, leaving the facility short 9.5 hours of aide hours. -There were 7.25 hours of aide hours for first shift on 11/06/18, leaving the facility short 8.75 hours of aide hours. -There were 7.5 hours of aide hours for first shift on 11/07/18, leaving the facility short 8.5 hours of aide hours. -There were 7.5 hours of aide hours for first shift on 11/08/18, leaving the facility short 8.5 hours of aide hours. -There were 8.75 hours of aide hours for first shift on 11/09/18, leaving the facility short 7.25 hours of aide hours. -There were 7.25 hours of aide hours for first shift on 11/10/18, leaving the facility short 8.75 hours of aide hours. -There were 7.5 hours of aide hours for first shift on 11/11/18, leaving the facility short 8.5 hours of aide hours. Review of second shift staff time sheets and the facility census records for 11/05/18-11/11/18 revealed: -There were 33 residents in the facility from	D 201		

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11/05/18-11/11/18 which required 16 aide hours for second shift.
-There were 7 hours of aide hours for each second shift on 11/05/18, 11/06/18, and 11/07/18, leaving the facility short 7 hours of aide hours for each shift.
-There were 7.5 hours of aide hours for second shift on 11/08/18, leaving the facility short 8.5 hours of aide hours.
-There were 13 hours of aide hours for second shift on 11/09/18, leaving the facility short 3 hours of aide hours.
-There were 7 hours of aide hours for each second shift on 11/10/18 and 11/11/18, leaving the facility short 7 hours of aide hours for each shift.

Review of third shift staff time sheets and the facility census records for 11/05/18-11/11/18 revealed:
-There were 33 residents in the facility from 11/05/18-11/11/18 which required 16 aide hours for third shift.
-There were 7 hours of aide hours for third shift on 11/05/18, leaving the facility short 9 hours of aide hours.
-There were 6 hours of aide hours for third shift on 11/06/18, leaving the facility short 9 hours of aide hours.
-There were 7 hours of aide hours for third shift on 11/07/18, 11/08/18, 11/09/18, 11/10/18, and 11/11/18, leaving the facility short 9 hours of aide hours.

Interview with Resident #9 on 11/08/18 at 9:22am revealed:
-He could not remember when he had last had a shower; it had been "a long time".
-He could wash himself once he was in the shower but needed assistance getting in and out

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of the shower.
-Staff shaved him when he got a shower.
-He could not remember the last time his bed linens had been changed.
-He had asked for staff assistance with a shower "1 or 2 weeks ago" but no staff had helped him.
-He could not remember which PCA he had asked for assistance with his shower.
-He did not want to get any staff in trouble but he would like to have a shower.

Review of the Resident #9's current FL-2 dated 08/14/18 revealed:
-Diagnosis included hypertension, history of bilateral above the knee amputation and chronic pain.
-The resident required a wheelchair for ambulation.

Review of Resident #9's current Care Plan dated 09/21/18 revealed:
-The resident was non-ambulatory without wheelchair.
-He required extensive assistance with showers which were ordered 3 times a week and sponge baths were ordered on non-shower days.
-The resident required extensive assistance with grooming which was ordered daily.
-His memory was documented as adequate.

Interview with a second resident on 11/09/18 at 10:00am revealed:
-He had to change his own bed linens.
-When he asked staff to change the linens, they would say "OK" but never do.
-There was not enough staff available to do the things the residents needed done like changing the bed linens.
-Most days, there was only one employee who administered medications and the other

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employee worked the floor.

Observation of the activity room on 11/09/18 from 12:25pm to 12:35pm revealed:
-Fifteen residents were eating lunch in the activity room and there was no staff present.
-One resident began coughing and gagging loudly while eating at 12:33pm.
-Another resident got up, walked over, and started patting the gagging resident in his back.
-At 12:35pm, a PCA came into the activity room, pushing covered food trays, and assisted the gagging resident to the bathroom.

Interview with a third resident on 11/09/18 at 12:35pm revealed:
-It was normal for there to be no staff present when the residents were eating.
-The other residents always had to help the resident who was gagging because he got choked easily.
-Residents at the facility had to do a lot of things for themselves like bathing, dressing, making beds, and looking out for each other because there was not enough staff.
-The MA gave the medicine and the PCA did the baths, showers, laundry, and some PCAs helped in the kitchen sometimes.
-The resident "made do" and the resident had not complained about there not being enough staff because the resident did not think it would do any good to complain.

Interview with a fourth resident on 11/09/18 at 12:41 pm revealed:
-He had to do a lot of stuff on his own most of the time because there was not enough staff.
-He had to do his own bath and he could not even get staff to bring him the pan for a sponge bath.
-Staff may assist him with getting a shower every

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two weeks.
-Sometimes, the resident got help from other residents with things the resident needed help with because there was no staff available.
-The resident was not sure how many staff members were present on each shift.
-Staff often did not return when they said they were coming back to help the resident when he did ask for assistance from staff.

Interview with a personal care aide (PCA) on 11/08/18 at 10:11am revealed:
-She and the medication aide (MA) were the only two staff who were working with the residents on all 3 three halls for the 7:00am to 3:00pm shift.
-She was responsible to give all of the assigned baths for all three halls.
-The MA helped whenever they could but it was hard since there were so many residents and only two staff members.
-She did the best she could to take care of the residents.
-It was hard trying to keep up with taking care of the residents when she is in the middle of giving a bath, another resident calls for help, she still had to get snacks out, and there were still two more residents who needed baths before lunch.

Interview with a medication aide (MA) on 11/08/18 at 5:45pm revealed:
-She normally worked second shift and occasionally worked on third shift.
-It was normal for staff to be only scheduled with one MA and one PCA to work each shift.
-It was hard for staff to take care of residents when there was only two staff scheduled.
-She administered the medications and the PCAs did most of the baths and helped the residents with getting dressed.
-The MAs helped the PCAs when they could with

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taking care of the residents.
-She had not complained about staff needing additional staff to help with resident care because she did not think anything else could be done.

Interview with a second MA on 11/09/18 at 10:55am revealed:
-She worked mostly first shift and filled in sometime on second shift.
-All shifts were scheduled with one MA and one PCA.
-The MA administered the medications and the PCA took care of all the residents on all three halls.
-The PCA had to do baths and showers sometimes and the MA would monitor the three halls while the PCA was busy doing the showers and baths.
-The PCA and MA both helped residents with going to the bathroom when it was needed.
-The PCA was also responsible to do the laundry for residents in the facility.
-The washing machine and dryer were located in another building next to the facility.
-When the PCA did the laundry, the MA was responsible for watching all resident three halls.
-She had complained to the manager 2 weeks ago that there was not enough staff to help with the number of residents.
-No additional staff had been hired for resident care until today (11/09/18) and they had a new PCA who was training.
-There was too many residents and not enough staff to get all this work done.
-Sometimes resident care, such as bathing, dressing, and nail care, were documented as completed by the staff in the resident care logs when the staff did not have the time to complete the tasks for the residents.

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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 201	Continued From page 69 Confidential interview with a previous employee revealed: -It was normal for the facility to only be staffed with one MA and one PCA for all three shifts. -This had been a normal schedule for over two years. -Staff was not able to help the residents like they should because they did not have enough help to do it. -Staff could not do all of the baths, help residents get dressed, assist residents to the bathroom, pass out snacks, and do the laundry for the facility when there was only two staff working in the facility. Confidential interview with a second previous employee revealed: -It was normal for the schedule for all shifts for there to be only one PCA and one MA who worked to provide resident care. -It was expected for the PCA to also do the facility laundry too. -It was not possible for the two staff to all of the expected work needed for resident care with an average resident census of 33 to 35. -"Things simply were not done" like bathing because there was not enough staff to give baths to residents more than once or twice a week. Telephone interview with a MA on 11/15/18 at 01:25pm revealed: -She usually works 3:00pm until 11:00pm (second shift). -On the second shift, the PCA and the MA gave baths, changed beds and did laundry. -Extra help was needed to provide appropriate care for the residents. -The staff was not able to do all of the residents' baths like they should because they were short staffed.	D 201		

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D 201	Continued From page 70 Interview with the Assistant Manager on 11/09/18 at 12:45pm revealed: -The Manager was responsible to make the schedule for the staff. -All three shifts were normally staffed with one MA and one PCA. -She did not know of any complaints from the residents or staff about concerns of not having enough staffing, residents not getting bathed, changed linens, or provided supervision due to lack of staffing. Interview with the Manager on 11/15/18 at 2:00pm revealed: -She had started working as the Manager at the facility on 09/21/18. -She was responsible for making the schedule for the facility. -She scheduled for one MA and one PCA to work on each shift. -She did not know there had to be a certain number of staff on duty based on the resident census. -Her overall scheduling authorization was still approved by the finance team. -She knew she needed more staff for all shifts but it had to be approved by the finance team. -The PCAs were responsible to do the laundry in the facility and the laundry machines were located in the building next door. -When the PCA did the laundry, the MA, the Manager, or the Assistant Manager would supervise the residents on the floor. -Laundry was done during the first and second shifts by the PCAs because she no longer had staff to do the laundry. -She answered resident call bells but she did not give baths or provide other major resident care. -Staff did not leave the residents unsupervised.	D 201		

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D 201	Continued From page 71 -She did not know if only having two staff member to provide personal care had caused any problems with residents being able to getting baths or other personal care needs. -No residents or staff had complained to her about not having enough staff. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -The current Manager started working at the facility at the end of September 2018 and was responsible to make the schedule. -The Manager at the facility was still new and there were still some issues that needed to be worked out regarding staffing. -She did know there had been some concerns with there not being enough staff to work all 3 shifts at the facility. -The Administrator would address staff issues immediately with her management team. _____ The facility failed to assure adequate staff were on duty to meet the needs of residents according to the census for 62 of 63 shifts sampled for the 7:00am - 3:00pm, 3:00 - 11:00pm, and 11:00pm - 7:00am shifts from 10/22/18-11/11/18. The facility's failure resulted in the residents not receiving assistance with bathing, clean linen, and lack of supervision was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 201		

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D 269	Continued From page 72	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews and record reviews the facility failed to assure that 3 of 3 sampled residents (#7,#8. #9) received personal care assistance such as bathing, skin care, nail care and linen changes in accordance with the care plans and assessed needs of the individual resident. The findings are: 1.Review of the Resident #9's current FL-2 dated 08/14/18 revealed: -Diagnoses included hypertension, history of bilateral above the knee amputation and chronic pain. -The resident required a wheelchair for ambulation. Review of Resident #9's Resident Register revealed: -The resident's date of admission was 08/31/18. -He was his own responsible party.	D 269		

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D 269	Continued From page 73 Review of Resident #9's current Care Plan dated 09/21/18 revealed: -The resident was non-ambulatory without wheelchair. -He required extensive assistance with showers which are ordered 3 times a week. -Sponge baths were ordered on non-shower days. -The resident required extensive assistance with grooming which was ordered daily. -His memory was "adequate" without forgetfulness. Review of Resident #9's Licensed Health Professional Support (LHPS) Review and Evaluation of Resident form completed by a RN dated 09/30/18 revealed: -The resident required assistance with transfers to and from wheelchair to chair. -There was a note that "per staff" resident gets assistance with activites of daily living (ADLs) [personal care tasks such as bathing, skin and nail care, and toileting] and transfers. -The LHPS recommended continuation of the current plan of care. Observation of Resident #9 on 11/08/18 at 9:20am revealed: -The resident's hair was greasy and unkempt. -He had a heavy growth, approxiMAtely ½ to ¾ inch, of beard. -His face appeared greasy. Observation of the resident's room on 11/08/18 at 9:20am revealed the sheets on the resident's bed were tangled and appeared dirt. Interview with Resident #9 on 11/08/18 at 9:22pm revealed:	D 269		

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-He could not remember when he had last had a shower; it had been "a long time."
-He could wash himself once he was in the shower but needed assistance getting in and out of the shower and assistance washing his washing his hair.
-He stated staff shaved him when he got a shower.
-He could not remember the last time his bed linens were changed.
-He had asked for assistance with a shower "1 or 2 weeks ago" without results.
-He could not remember which personal care aide (PCA) he had asked for assistance.
-He did not want to get anyone in trouble but he would like to have a shower.

Review of the Resident #9's Personal Care Logs on 11/08/18 at 11:53am revealed:
-The resident was scheduled to have a shower on the 3:00pm to 11:00pm shift.
-Documentation indicated that the resident received a shower daily requiring extensive assistance on 11/01/18 through 11/07/18.
-Documentation also indicated that the resident received extensive assistance with shampoo/hair care, skin care (washing face and hands) daily on second shift on 11/01/18 through 11/07/18.
-The only place to document linen changes was in the toileting/incontinence section if linens were changed due to incontinence; there was no documentation of a linen change due to incontinence.

Review of a facility Bath List revealed:
-Resident #9 along with 3 other residents were scheduled to get assisted baths 3 times a week on the 7:00am- 3:00pm shift.
-Four residents were scheduled to receive assisted baths 3 times a week on the 3:00pm to

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11:00pm shift.
-Three residents were scheduled to receive assisted baths daily on the 11:00am to 7:00am shift.
-There was no sponge baths scheduled for Resident #9 on days that he did not receive a bath.

A second interview with Resident #9 on 11/08/18 at 6:45pm revealed:
-He had not had a shower yet.
-He was told that he would receive a shower after supper this evening (11/08/18).

Observation of Resident #9 on 11/09/18 at 10:07am revealed he still had not had a shower.

Observation of Resident #9 on 11/09/18 at 11:35am revealed that he had showered and was freshly shaven.

Interview with a medication aide/personal aide (MA/PCA) on 11/08/18 at 4:50pm revealed:
-She usually worked the 3:00pm to 11:00pm shift.
-The second shift did not do baths.
-Three residents received baths on the 11:00pm to 7:00am shift.

Telephone interview with facility's medical provider's nurse on 11/15/18 at 9:15am revealed that she would expect that personal would be performed as ordered on the resident's care plan.

Interview with Manager and Assistant Manager on 11/13/18 at 9:40am revealed:
-Neither Manger or Assistant Manger knew that Resident #9 had not had a bath for an undeterminable length of time.
-Neither Manger or Assistant Manager had noticed that his hair was greasy and that he

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looked unkempt in general.
-The Manager and Assistant Managers were not aware that documentation indicated that Resident #9 had received a shower and other personal care daily.
-The Manager nor Assistant Managers could provide documentation of routine linen changes.
-The Manager stated staff would be instructed immediately that personal care must be provided as ordered by the care plan and that documentation must be correct.
-Staff would also be instructed that routine linen changes must be done at least weekly and as needed.
-Staff would be instructed to document linens changes on the personal care log.

2. Review of Resident #8's current FL-2 dated 10/09/18 revealed:
-Diagnoses included hypertension, diabetes mellitus (unspecified), depression and pain.
-Ambulatory status was listed as "semi."

Review of Resident #8's Resident Register revealed an admission date of 10/12/18.

Review of Resident #8's Post Discharge Plan of Care completed by a local home health agency on 11/12/18 revealed:
-Resident's surgical history included bilateral above the knee amputations.
-He required a wheelchair to ambulate.
-With the use of the wheelchair, he was able to complete "some" activities of daily living [eating, bathing, toileting and dressing].

Observation of Resident #8's room on 11/08/18 at 9:30am revealed:
-His bed was against the wall.
-Several dried smears of a brownish material

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were on the bottom sheet.

Interview with Resident # 8 on 11/08/18 at 9:30am revealed:
-He had soiled his bed with feces 5 days ago.
-The resident had asked one of the personal care aides (PCA) to change his bed 5 days ago.
-The PCA told him that the residents changed their beds themselves.
-The resident had told the PCA it was her job to change his sheets.
-The resident could not remember the shift or name of the PCA.

Review of Resident #8's personal care log for November 2018 revealed:
-There was no location to document routine linen changes.
-There was an area to record linen changes because of incontinence.
-There was no documentation of incontinent related linen changes on the resident's personal care log.

Observation of Resident #8's bed on 11/08/18 at 6:45pm revealed that the linens had been changed.

Interview with a resident on 11/09/18 at 10:00am revealed:
-He changed his own bed linens.
-When he asked staff to change, they say "OK" but never do.
-He was able to shower without assistance.

Interview with a second resident on 11/09/18 at 11:46am revealed:
-She had to ask to have her linens changed.
-She did not know when her bed linens were last changed.

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D 269	Continued From page 78 -She feels it's her fault that they are not changed because she "should ask more often." Interview with a third resident on 11/09/18 at 12:10pm revealed: -He made his own bed. -When he had asked in the past, he was told by staff that everyone changed their own linens. -He cannot remember which staff told him that everyone changed their own linens. Interviews with seven random residents who all stated that they change their own bed linens. Interview with a PCA on 11/09/18 at 10:30am revealed: -Staff changed residents bed linens. -Linens were changed on days that residents showered. Interview with a medication aide (MA) on 11/14/18 at 1:25pm revealed that sheets are normally changed every other day. Interview with Assistant Manager and Manager on 11/13/18 at 9:40am revealed: -Neither was aware that Resident #8's linens were soiled with feces for at least 5 days. -Neither was aware that residents were being told that they must change their own linens. -The MAnagers could not provide documentation of routine linen changes. -Staff would be instructed that routine linen changes must be done at least weekly and when soiled. -Job responsibilities would be reviewed with staff as soon as possible. -Staff would be instructed to document linens changes on personal care log by writing in comment section.	D 269		

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D 269	Continued From page 79 3. Review of Resident #7's current FL-2 dated 12/27/17 revealed: -Diagnoses included hydronephrosis with renal and ureteral calculus, chronic kidney disease, hyperlipidemia and heart disease. -There was no orientation status indicated. -The resident was incontinent of bowel and bladder. Review of Resident #7's Resident Register dated 12/29/17 revealed he required assistance which included dressing, bathing, nail care, grooming, skin care, mouth care and feeding. Review of Resident #7's care plan dated 12/31/17 revealed: -Resident #7 was assessed as requiring extensive assistance with bathing, dressing, and grooming/personal hygiene. -Resident #7's grooming/personal hygiene assessment included nail care. -Resident #7's bathing assessment specified showers daily. -Resident #7 was forgetful and needed reminders. Interview with Resident #7 on 11/08/18 at 4:05pm revealed: -He was not a diabetic. -He had trouble with his feet and his toe nails being so long and thick. -He had asked staff to cut his toe nails but none of the staff would cut them. -He had asked the former Administrator to make him an appointment to see a foot doctor so that someone would cut his toe nails. -He would wear sandals year round because of the problems he had with his feet. -He last asked for his toe nails to be cut was	D 269		

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about two weeks ago.
-The last time Resident #7 had a shower was over two weeks ago.
-He would wash up in the sink in his bedroom in the mornings.
-The staff did the best they could but they were always busy.

Observation of Resident #7's feet on 11/08/18 at 4:04pm revealed:
-His toenails were thick, brown and cracked; the toenail on right great toe was long, extending approximately 1/4 inch beyond his toe.
-His toenails on both feet extended up to ½ inch from the toes.
-His fingernails on both hands were long, approximately ½ inch beyond the fingertip.
-The skin were dry and had areas where his skin was dark and indented.

Interview with a personal care aide (PCA) on 11/08/18 at 4:10pm revealed:
-She gave Resident #7 his bath including foot care every day.
-She had not noticed his toe nails needed to be cut.
-She and document the task in the personal care log along with refusals.

Observation of Resident #7's feet on 11/09/18 at 10:01am revealed:
-His toenails were thick, brown and cracked; the toenail on right great toe was long, extending approximately 1/4 inch beyond his toe.
-His toenails on both feet extended up to ½ inch from the toes.
-His fingernails on both hands were long, approximately ½ inch beyond the fingertip.
-The skin were dry and had areas where his skin was dark and indented.

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D 269	Continued From page 81 Observation of Resident #7's feet on 11/13/18 at 10:57am revealed: -His toenails were thick, brown and cracked; the toenail on right great toe was long, extending approximately 1/4 inch beyond his toe. -His toenails on both feet extended up to ½ inch from the toes. -His fingernails on both hands were long, approximately ½ inch beyond the fingertip. -The skin were dry and had areas where his skin was dark and indented. Review of Resident #7's November 2018 Personal care record revealed: -No documentation of a personal care log with documented refusals of personal care, nail care or showers. -Nail care was performed with extensive assistance by staff on first shift on 11/01/18 through 11/12/18. Interview with the Assistant Manager on 11/13/18 at 11:45am revealed: -She did not know that Resident #7's toe nails needed cutting. -She did not know the last time Resident #7's toe nails had been cut. -She would try to find the nail care policy. -MAs and PCAs were to cut the residents toe nail and finger nails weekly on Saturdays. -There was no documentation of the residents who nails were being cut on Saturdays. Interview with the Manager on 11/13/18 at 11:50am revealed: -She did not know that Resident #7 toe nails need cutting. -She did not know the last time Resident #7's toe nails had been cut.	D 269		

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D 269	Continued From page 82 -She would try to find the nail care policy. -Staff were to cut the residents toe nail and finger nails weekly on Saturdays. -She had purchased nail cutting supplies for the staff to use about a month ago. The nail cutters were kept on the medication charts. -There was no documentation of the resident who nails were being cut on Saturdays. The facility failed to provide personal care assistance for 3 of 3 sampled residents, including Resident #7, who had long and thick fingernails that could result in the resident scratching himself or other residents; and all of the sampled residents requiring assistance. This failure was detrimental to the residents' health and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D 269		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure that monthly weights were obtained as ordered for 1of 5 (Resident #3) sampled residents.

The findings are:

Review of Resident #3's current FL2 dated 07/07/18 revealed diagnoses included dementia-Alzheimer's, hypertension, generalized weakness and osteoporosis.

Review of Resident #3's physician order dated 07/07/18 revealed weights were to be checked monthly.

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

Review of Resident #3's weights recorded in the facility's weight/vital signs book revealed:
-On 07/18/18 the resident's weight was recorded as 130 pounds.
-On 08/18/18 the resident's weight was recorded as 101 pounds.
-On 10/30/18 the resident's weight was recorded as 130 pounds.
-There was not weight recorded for September 2018.
-Staff did not initial or otherwise identify who recorded the weights.

Interview with a medication aide (MA) on 11/14/18 at 11:20am revealed:
-She used a regular bathroom type scale weigh

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residents.
-She does not weigh wheelchair bound residents.

Interview with the Assistant Manager on 11/14/18 at 11:30am revealed:
-The facility only has the "step-up" scales.
-The facility did not have a wheelchair scale or other methods that could be used to weigh wheelchair bound residents.
-She did not know how the weights recorded were obtained.
-She knew the facility's policy was to weigh residents at least monthly.
-She did not explain how the wheelchair residents were to be weighed.
-The Assistant Manager does not know who recorded the weights for Resident #3 in the weight book.

A second interview with the Assistant Manager on 11/14/18 at 11:45am revealed that the facility used the weight from a 10/30/18 physician's visit for the November 2018 reading Resident #3.

Telephone interview with the facility's medical provider's nurse on 11/15/18 at 9:15am revealed:
-The facility's medical provider last saw Resident #3's in his office on 10/11/17.
-The weight recorded for that visit was taken from information sent to his office by the facility.
-The medical provider would expect his order monthly weights for Resident #3 to be implemented as written.

Interview with the facility Manager on 11/15/18 at 10:03am revealed:
-She had not thought about weighing wheelchair bound residents.
-She could understand the need for a chair scale to weigh wheelchair bound residents.

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D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to serve residents 8 ounces of milk or equivalent at least twice daily. The findings are: Review of the facility's census report dated 11/08/18 revealed the current census was 33 residents. Observation of food supplies on 11/08/18 at 10:55am revealed approximately two-thirds of a gallon of 2% milk with an expiration date of 11/14/18. Interview with the cook revealed: -Food is delivered by truck "once a month or every 2 weeks, I'm not sure." -If something was needed staff went to the grocery store. Interview with the Assistant Manager on 11/08/18 at 11:05am revealed:	D 299		

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D 299	Continued From page 86 -Food was delivered every Friday by an institutional vender. -If something was needed in addition, it was purchased at a local grocery store. Observation of snack service on 11/08/18 at 10:00am revealed: -Residents had a choice of tea or Kool Aid with their snack. -Milk was not on the food service cart. Review of the menu for 11/08/18 revealed: -Eight ounces of milk was included in the breakfast meal. -Eight ounces of milk was included in the dinner meal. Observation of dinner service on 11/08/18 at 6:05pm revealed that milk or an alternative was not served or offered to residents. Interview with a resident on 11/08/18 at 5:40pm revealed: -She liked milk. -Milk was served once a day at breakfast usually with cereal. -Milk was never offered at other meals. Interview with a resident on 11/08/18 at 5:43pm revealed: -She "loved milk." -Milk was served "about once a month" as a beverage (not in cereal). -She does not remember milk being offered at meals other than breakfast. Second observation of food supplies after food delivery on 11/09/18 at 1:20pm revealed 3 gallons of 2% milk with an expiration date of 11/20/18.	D 299		

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D 299	Continued From page 87 Review of the menu for 11/09/18 revealed: -Eight ounces of milk was included in the breakfast meal. -Eight ounces of milk was included in the dinner meal. Interview with the Assistant Manager on 11/08/18 at 6:35pm revealed she did not know that milk or an alternative must be offered to the residents at least twice a day. Interview with the facility Manager on 11/13/18 at 2:42pm revealed: -She did not know that milk or an alternative should be offered at least twice a day.- -She nor the Assistant Manager had completed any type of dietary training. -The Assistant Manager was the kitchen Manager.	D 299		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews the facility failed assure that water was served along with other beverages at each meal. The findings are: Observation of the breakfast meal during on	D 306		

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D 306	Continued From page 88 11/08/18 at 8:15am revealed that water was not served to any resident with the meal. Observation of the dinner meal service on 11/08/18 at 6:15pm revealed water was not served with meal in addition to resident's choice of tea or Kool Aid to any resident. Observation of the lunch meal service on 11/09/18 at 12:20pm revealed water was not served in addition to iced tea to any resident. Interview with a personal care aide (PCA) on 11/09/18 at 12:42pm revealed: -Water was served with the meals "sometimes." -Most residents do not want water because they drink water with their medications. Interview with the Assistant Manager on 11/08/18 at 6:35pm revealed she did not know water must be served to the residents at each meal. Observation of the lunch meal on 11/13/18 at 12:23pm revealed that residents were not served water with their meal. Observation of the dining room on 11/14/18 at 6:15pm revealed: -A cart near the door of the dining room with glasses of water. -A resident asked a PCA for water. -The PCA asked the resident why he wanted water. -The PCA instructed the resident to get his own water. Interview with the Assistant Manager on 11/13/18 at 2:20pm revealed: -She had instructed the kitchen staff on 11/09/18 that water must be served with each meal .	D 306		

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D 306	Continued From page 89 -She does not know why water was not served with the lunch meal. Interview with the facility Manager on 11/13/18 at 2:42pm revealed: -She was not aware that water should be served with each meal. -Neither she nor the Assistant Manager had completed any type of dietary training. -The Assistant Manager was the kitchen Manager.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure that nutritional supplements were served as ordered to 1 of 4 (Residents #3) residents sampled and 1 of 4 residents (Resident #3) was served chopped meats as ordered. The findings are: 1. Review of Resident #3's current FL-2 dated 07/07/18 revealed:	D 310		

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-Diagnoses included dementia, hypertension, generalized weakness and osteoporosis.
-The resident was to receive a regular diet with chopped meats.
-The resident was to receive a nutritional supplement shake 3 times a day with meals.

a. Review of Resident #3's medication administration (MAR) record for November 2018 revealed:
-There was an entry for a nutritional supplement shakes 3 times a day scheduled for 8:00am, 12:00pm and 6:00pm.
-There was documentation the nutritional supplement shakes had been administered as ordered from November 01, 2018 through November 13, 2018

Interview with a medication aide (MA) on 11/08/18 at 4:50pm revealed MAs gave the nutritional supplements to residents.

Observation of Resident #3's dinner meal on 11/08/18 at 6:15pm revealed she did not receive a nutritional supplement with her meal as ordered and documented.

Observation of Resident #3's lunch meal on 11/09/18 at 12:20pm revealed she did not receive a nutritional supplement with her meal as ordered and documented.

Telephone interview with a MA on 11/14/18 at 1:20pm revealed:
-The MAs gave the nutritional supplements to the residents.
-Once she gave the nutritional supplement to the resident, she signs off on the MAR.

Telephone with the facility's medical provider's

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nurse on 11/14/18 at 9:15am revealed that the medical provider would expect his orders for nutritional supplementation to be implemented.

Interview with Assistant Manager on 11/13/18 10:50am revealed:
-The kitchen staff or MAs gave the nutritional supplement to the residents.
-She did not know that Resident #3 was not getting her nutritional supplement as ordered.
-She stated that she would instruct the MAs to give the supplements as ordered and assure the residents had received the supplement before signing the MAR.

Interview with the facility Manager on 11/13/18 at 9:40am revealed:
-She was not aware that residents were not getting ordered nutritional supplements.
-She was not sure who was responsible for administering the supplements.

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

Observation of the facility's menu for the lunch meal on11/09/18 revealed:
- Salisbury steak, rice with gravy, garden peas, roll and tea would be served
-There were no alternative menu items listed.

(b) Observation of Resident #3's lunch meal tray on 11/09/18 at 12:20pm revealed:
-The resident was served Salisbury steak that had dark, hardened edges from over cooking.
-The Salisbury steak portion was sent to the dining room without mechanical atlerations.
-The PCA assisting Resident #3 with her meal was trying to chop the meat at the table.

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D 310	Continued From page 92 Interview with the Assistant Manager on 11/08/18 at 1:02pm revealed -She was not aware Resident #3's meat was not chopped before serving. -Kitchen staff was to follow the diet sheet posted in the kitchen. Interview with the facility Manager on 11/13/18 at 9:40am revealed: -She was not aware Resident #3's meats were not chopped in the kitchen as ordered. -The Manager had just completed a new diet list so that staff could easily read the ordered diets. Observation of Resident #3's dinner meal tray on 11/14/18 at 6:14pm revealed the resident had a piece of pizza that was not mechanicaly altered. Second interview with the Assistant Manager on 11/14/18 at 6:40pm revealed: -She was not aware that Resident #3 was served an un-chopped piece of pizza for dinner. -She had explained to kitchen staff that foods were to be chopped in the kitchen using the proper equipment before serving to residents.	D 310		
D 324	10A NCAC 13F .0906 (d) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (d) Telephone. (1) A telephone shall be available in a location providing privacy for residents to make and receive calls. (2) A pay station telephone is not acceptable for local calls; and	D 324		

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D 324	Continued From page 93 (3) It is not the home's obligation to pay for a resident's toll calls This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure resident care and services were provided regarding access to a telephone made available for residents to privately make and receive calls as evidenced by residents having to use the telephone in the activity room. The findings are: Observation on 11/08/18 at 11:00am in the activity room revealed: -A landline phone supplied for resident use was located on a table in the left corner of the room -One resident was using the phone and a second resident was in a chair seated adjacent to the first resident. -There were five other residents in the activity room who were talking loudly while the first resident was on the phone. Confidential interviews with two residents revealed: -They would like have to private areas to use the phone when they make phone calls. -There had never had a private area for the residents to make phone calls. -Some residents had their own private cell phone to make phone calls with. -They did not think that a resident should have an additional expense of a cell phone bill in order to have privacy when they made their phone calls. Interview with a medication aide (MA) on 11/09/18 at 10:55am revealed: -The phone in the activity room was the only	D 324		

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D 324	Continued From page 94 phone the residents had access to in the facility except for the residents who had cell phones. -There was no privacy for the residents when they made phone calls in the activity room because the phone was out in the open. Interview with the Manager on 11/15/18 at 10:40am revealed: -She did not know the facility had to provide a private area for the residents to use the phone. -The residents always used the phone in the activity room to make phone calls whenever they wanted. -No resident had complained about privacy when using the phone in the activity room.	D 324		
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: TYPE A2 VIOLATION Based on interviews, observations, and record reviews, the facility failed to assure 4 of 6 sampled residents were treated with dignity and respect and received adequate care and services as evidenced by two residents (#5 and #10) being transported out of the facility by a non-staff	D 338		

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person and being left without a means of return transportation to the facility for least 3 hours with exposure to weather and one resident (#10) without access to an adequate oxygen supply resulting in the need for emergency medical services (EMS); one resident (#3), with a history of osteoporosis and decubiti, who was handled roughly by staff during personal care; and one resident (#1), with a history of mental illness, to verbally threaten and intimidate the residents and staff at the facility.

The findings are:

1. Review of Resident #3's current FL2 dated 07/07/18 revealed:
-Diagnoses included dementia-Alzheimer's, hypertension, generalized weakness and osteoporosis.
-Resident #3 was incontinent of bowel and bladder.
-Resident #3 was constantly disoriented and was non-ambulatory.

Review of Resident #3's Plan of Care dated 07/12/18 revealed:
-Resident #3 had a history of Alzheimer's and generalized weakness.
-Resident #3 had daily incontinence of both bowel and bladder.
-Resident #3 was totally dependent with toileting and used incontinence briefs and was to be checked and changed.

Review of a Licensed Health Professional Support (LHPS) evaluation dated 09/30/18 revealed:
-Resident #3 had a diagnosis of dementia and osteoporosis.
-Resident #3 required total care from staff.

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-Resident #3 was inconstant of bowel and bladder and used incontinence briefs.
-Resident #3 was to get assistance with all activities of daily living.

Review of Resident #3's Personal Care Record for 11/01/18 through 11/8/18 revealed:
-There were documented entries for toileting / incontinence on first and second shifts, assistance codes were entered as independent (the resident can perform activity without help or with only occasional help).
-There were documented entries for toileting / incontinence on third shift, assistance codes were entered as totally dependent (someone must complete the task for the resident at all times).
-There were documented entries for toileting / incontinence on all three shifts totaling thirty-four events that required toileting changes.

Observation of Resident #3 receiving incontinent care on 11/08/18 at 4:30pm revealed:
-The personal care aide (PCA) was changing Resident #3's incontinence briefs.
-Resident #3 was lying flat on her back in her bed.
-The PCA grabbed the resident by both legs (mid-calf level).
-The PCA lifted the entire lower half of Resident #3's body, pushing the resident's knees to the resident's forehead repeatedly during the incontinence care.
-Another PCA entered the resident's room to assist the first PCA.
-The second PCA assisted by applying a clean incontinence brief to Resident #3 while the first PCA continued to hold Resident #3 by lifting the lower half of the resident's body to the point Resident #3's knees were touching her forehead repeatedly.

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D 338	Continued From page 97 Interview with the first PCA on 11/08/18 at 4:30 pm revealed: -Lifting Resident #3 this way was easier than rolling the resident from side to side to change her and sometimes Resident #3 would fight when staff rolled her. -She did not need help to change Resident #3 because Resident #3 was so small and she could just lift her bottom up and change her. -This was the way she always changed Resident #3's incontinence briefs and dressed and undressed her. Interview with the second PCA on 11/08/18 at 4:38 pm revealed Resident #3 should have been rolled from side to side if possible during incontinence brief changes. Attemped interview with Resident #3 on 11/08/18 at 4:40pm Resident #3 was not interviewable. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -The PCAs were responsible for providing toileting care. -She did know the PCA lifted the entire lower half of Resident #3's body, pushing the resident's knees to the resident's forehead repeatedly during the incontinence brief change. -She expected staff to roll Resident #3 when performing toileting, dressing or repositioning. Interview with the Manager on 11/14/18 at 4:55pm revealed: -The PCAs were responsible for providing toileting assistance. -She did not know the PCA lifted the entire lower half of Resident #3's body, pushing the resident's knees to the resident's forehead repeatedly	D 338		

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during the incontinence briefs change.
-She expected staff to roll Resident #3 when performing toileting, dressing or repositioning.

2. Confidential interview with a previous staff member revealed:
-Two residents were driven to court by the facility's Assistant Manager's companion (non-staff) in a town located an hour away from the facility on the morning of 11/09/18.
-The companion left the residents at the courthouse and the Assistant Manager went to pick up the residents around 5:30pm on 11/09/18.
-The previous staff was not sure when the companion picked up the residents or when he had left the two residents at the courthouse.
-The Assistant Manager was not able to locate either resident at the courthouse sometimes after 6:00pm and the Assistant Manager returned home (time not specified for return Assistant Manager's return home)
-Someone from the sheriff's department had to keep calling the facility about who was going to pick up the residents.
-The residents finally got back to the facility in a cab sometime after 9:30pm on 11/09/18 and the staff paid for the cab ride for the residents.

Review of weather condition at the location of the courthouse on 11/09/18 from 5:45pm to 8:30pm revealed the weather was overcast with passing clouds and the outside temperature varied between 59°Fahrenheit and 61°Fahrenheit.

a. Review of Resident #10's current FL-2 dated 10/31/18 revealed:
-Diagnosis included chronic obstructive pulmonary disease (COPD), acute respiratory failure, coronary artery disease, and tobacco use.
-There was an order for oxygen at 3 liters (L) per

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minute as needed for shortness of breath.

Review of Resident #10's Resident Register revealed:
-He was admitted on 10/03/18.
-His memory was adequate and he required assistance with getting in and out of bed.
-He required staff assistance with the use of his wheelchair and with transfers.

Review of Resident #10's care plan dated 10/17/18 revealed Resident #10 required extensive assistance with toileting, ambulation, bathing, toileting, dressing, grooming, and transferring.

Interview with Resident #10 on 11/08/18 at 1:30pm revealed:
-He was admitted to the facility "about a month ago" from a local hospital.
-He had been taken to the hospital because of some breathing difficulty he had while in a hurricane shelter.
-He used a wheelchair for ambulation "except for short distances" and he used oxygen via nasal cannula "whenever he got short of breath".

Attempted telephone interview with Resident #10's physician on 11/14/18 at 4:43pm was unsuccessful.

Interview with Resident #10 on 11/14/18 at 1:45pm revealed:
-He had a court appearance in a nearby city on 11/09/18.
-He and another resident were driven to the courthouse by the Assistant Manager's companion (who did not work at the facility) who used the facility's manager's car to drive them.
-The other resident came along to "help him in

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and out of the car".
-He did not know their departure time from the facility, but "it was early before breakfast" (breakfast was usually served at 8:00am).
-He was not given breakfast or his morning medication before he left the facility on 11/09/18.
-He arrived late for his court date and had to wait until the end of the day to be seen.
-The Assistant Manager's companion had to leave about 5:30pm "because he had to be back home by 7:00pm".
-He was finished with his court appearance around 6:00pm.
-The courthouse was closed so he and other resident had to wait out on the street and they did not have a cellphone or other means to contact the facility.
-He was dressed in a short sleeve shirt and wore only socks without shoes because he had lost one shoe.
-Neither he nor the other resident had a coat or jacket and "it had started to feel very cool outside".
-"We went about 4 blocks from courthouse before they found someone who let them use a cellphone to call the facility to ask for someone to come get them".
-He was told someone from the facility was on the way to pick them up and they returned to wait outside the locked courthouse.
-He did not specify who spoke to him from the facility.
-Around 7:00pm, someone who worked inside the courthouse let them inside so he could use the restroom.
-The courthouse staff allowed them to wait inside the courthouse since it was cold and dark outside.
-"I had ran out of oxygen and was feeling short of breath."

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D 338	Continued From page 101 -He had extra oxygen tanks in the car but when the assistant manager's companion left, he did not leave the extra oxygen. -The courthouse staff called the local emergency medical service (EMS) and they provided the resident with an oxygen cylinder. -The courthouse staff called the facility to ask how the residents were getting back to the facility. -They were told a cab was on the way to pick them up. -After about an hour, the courthouse staff placed a second call to the facility because no one had picked them up yet. -The courthouse staff finally called a cab for the residents and the cab took them back to the facility. -It was "about 10:20pm" when the two residents returned to the facility. -There was just the "usual" night staff working when he returned to the facility. -The Manager nor the Assistant Manager were at the facility when he returned. -He was not given any dinner or offered anything to eat when he returned to the facility. Attempted telephone interview with the assistant manager's companion on 11/15/18 at 5:30pm and on 11/16/18 at 8:30am were unsuccessful. Refer to telephone interview with a sheriff's department call center employee on 11/15/18 at 2:00pm. Refer to telephone interview with a second sheriff's department call center employee on 11/15/18 at 7:59pm. Refer to interview with the Assistant Manager on 11/14/18 at 6:05pm.	D 338		

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Refer to interview with the Manager on 11/15/18 at 10:40am.

Refer to telephone interview with a medication aide on 11/16/18 at 8:53am.

Refer to interview with the Administrator on 11/16/18 at 3:22pm

b. Review of Resident #5's current FL-2 dated 03/07/18 revealed:
-Diagnoses included atherosclerosis, hyperlipidemia, articular gout, autoimmune disorder, pre-diabetes, continued illicit drug use, and dental caries.
-He was ambulatory and intermittently disoriented.

Review of Resident #5's care plan dated 04/25/18 revealed:
-Resident #5 had no problems with ambulation and was oriented with adequate memory.
-Resident #5 required extensive assistance with bathing, dressing and grooming.
-Resident #5 required supervision with meals and was independent with toileting, ambulation, and transferring.

Review of psychiatric notes for Resident #5 dated 09/08/18 revealed:
-Resident #5 had a history of major depressive disorder, anxiety, and insomnia.
-Resident #5 was distracted but cooperative.
-His thought process was disorganized and illogically but he was alert and oriented.
-Resident #5's insight, judgment, and concentration were impaired and he had below average intellectual functioning.

Attempted telephone interview with Resident #5's

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D 338	Continued From page 103 physician on 11/14/18 at 4:43pm was unsuccessful. Interview with Resident #5 on 11/14/18 at 1:24pm revealed: -He went to court with another resident to be supportive on 11/09/18. -He and the other resident were taken to court by the Assistant Manager's companion who used the facility Manager's car to drive them to court. -They left the facility at approximately 8:30am. -He did not get any of his medications or breakfast before he left for court. -He and the other resident were supposed to leave earlier and he guessed there was not time for him to get his medications or breakfast and still leave for court on time. -The Assistant Manager's companion dropped him and the other resident off at the courthouse at approximately 9:30am. -He had to push the other resident's wheelchair and help to maneuver his oxygen tank when they went inside the courthouse. -They had stayed in court most of the day and had lunch at a fast food restaurant. -The Assistant Manager's companion left them at the courthouse around 5:30pm because the companion had a 7:00pm curfew and was on probation. -He did not know how they were going to get back to the facility after court was over. -He and the resident had to wait outside the courthouse because it was closed. -He used a stranger's phone, called the facility, and spoke with the Assistant Manager. -He was not sure what time he called and spoke with the Assistant Manager; but it had started turning dark outside. -The Assistant Manager said someone would be on the way to pick them up.	D 338		

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D 338	Continued From page 104 -He called the facility at least 4 times trying to find out who was going to pick him and the other resident up from the courthouse. -Two court employees saw them waiting outside and let them back inside the courthouse. -The female court employee called the facility 3 to 4 times about picking them up. -The other resident ran out of oxygen and became short of breath. -One of the court employees called 911 and the rescue squad was able to bring the other resident some oxygen when they came. -The other resident's "spare oxygen tanks were in the Manager's car, but the Assistant Manager's companion had left with the car". -Somebody finally called a cab for them to go back to the facility. -He was just tired of waiting and he wanted to get inside because it was damp outside. -"It was a headache because if I had known we didn't have a ride, I would have made other arrangements." -"We had to keep calling the facility and then the 'court people' had to keep calling facility to find out who was coming to pick us up; it didn't make any sense." -"I bet they would not like it if someone just dropped them off somewhere and then they did not know how they were going to get back home." -They did not return back to the facility until after 10:00pm and the staff paid for the cab. -He did not eat anything when he returned to the facility. -"I would not have eaten the food anyway; I was too tired and I just went straight to bed." Attempted telephone interview with the assistant manager's companion on 11/15/18 at 5:30pm and on 11/16/18 at 8:30am were unsuccessful.	D 338		

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D 338	Continued From page 105 Refer to telephone interview with a sheriff's department call center employee on 11/15/18 at 2:00pm. Refer to telephone interview with a second sheriff's department call center employee on 11/15/18 at 7:59pm. Refer to interview with the Assistant Manager on 11/14/18 at 6:05pm. Refer to interview with the Manager on 11/15/18 at 10:40am. Refer to telephone interview with a medication aide on 11/16/18 at 8:53am. Refer to interview with the Administrator on 11/16/18 at 3:22pm _____ Telephone interview with a sheriff's department call center employee on 11/15/18 at 2:00pm revealed: -He was working inside the courthouse on 11/09/18 when the housekeeper came inside the call center where he worked and told him there were 2 men waiting outside the courthouse in the dark and one was in a wheelchair. -He thought it must have been around 6:45 pm - 7:00 pm because his shift started at 6:00 pm and he hadn't been there long. -He and another call center employee both went outside to see what was going on. -He found two men; one man was sitting in a wheelchair wearing a thin shirt, socks with no shoes and had a portable oxygen tank. -He was unsure by talking with the two men that they were both residents in an assisted living facility. -He knew the man in the wheelchair was a	D 338		

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resident but thought the other man was his caretaker.
-He determined by talking with them both men had come for court and had been at the courthouse since that morning.
-The wheelchair bound man said he had to use the restroom and did not have anywhere to go because the courthouse was locked; he had been holding his urine for about an hour.
-The employee unlocked the courthouse and assisted the two men inside because it was cold and the wheelchair bound man needed to use the bathroom.
-The other man, whom the sheriff employee assumed to be the caretaker, assisted the wheelchair bound man to use the restroom.
-The wheelchair bound man was out of oxygen and reported he had been out of oxygen for about 30 minutes, but said he could go an hour without it.
-The wheelchair bound man did not appear to be in distress but the sheriff's employee called the local EMS.
-EMS arrived and brought a new oxygen tank for the wheelchair bound man and he quickly put on the oxygen.
-The employee's coworker called the facility and tried to find out where the two men needed to go so they would not be left outside in the cold.

Telephone interview with a second sheriff's department call center employee on 11/15/18 at 7:59pm revealed:
-She was at work at the courthouse on 11/09/18 when a courthouse housekeeper came into the office where she and the other employee were and told her there were two men outside the courthouse and one man was in a wheelchair.
-She thought it was around 6:45pm when the housekeeper came in the office and told them

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about the two men outside.
-She and her coworker went outside and found two men, one man was in a wheelchair had on a t-shirt, wore socks, but no shoes, and had an empty portable oxygen tank.
-The wheelchair bound man told her that he lived in a nearby city in a nursing home and came for court that morning.
-She was not sure where the other man was from but they appeared to be friends.
-Her coworker called EMS to get the wheelchair bound man an oxygen tank because he did not have oxygen.
-It was cold and dark outside that night so she and her coworker assisted the two men inside the locked courthouse to stay warm until it could be determined where they needed to go since the wheelchair bound man did not have a coat.
-She was unsure if either resident had a phone.
-The facility's staff member's companion had brought them and dropped them off this morning but there had been no one there to pick the up and they had been waiting outside since court ended.
-She called the facility, spoke with staff and it was determined a cab was on the way to pick up the two men.
-Approximately thirty to forty minutes passed and there was no cab to pick up the two men.
-She called back to the facility and the same staff told her that she talked to her Manager and asked the sheriff's employee to call a cab because she did not know any cab services in the town where the two men were.
-The sheriff's employee said no and told the staff member to look it up on the internet.
-The facility staff asked the sheriff's employee to call back in ten minutes.
-The sheriff's employee called the same staff member back ten minutes later and the staff said

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a cab was coming but asked the sheriff employee to call the cab company and give them the address of the courthouse.
-The sheriff's employee called the cab company and the cab arrived and picked up both men.
-She was not sure of what time this was when the two men were picked up.
-She had to call the facility 3 times over 30-45 time minute span to determine who was going to pick them up.
-She was told by the same staff member that someone came to pick the men up at 5:00pm but the two men were not outside the courthouse so the staff left.

Interview with the Assistant Manager on 11/14/18 at 6:05pm revealed:
-Resident #10 had a court appearance scheduled on 11/09/18 and he had arranged for her companion to drive him to the courthouse.
-The facility Manager provided her car to transport the resident to the courthouse because the Assistant Manger's car had a bad tire.
-Resident #10 had arranged for Resident #5 to go with him "to help him out" with his wheelchair and getting around the courthouse.
-She gave Resident #5 and Resident #10 their morning medications but could not remember if they had eaten breakfast before they left for court.
-She could not remember the exact time the two residents left the facility with her companion.
-Her companion stayed with the two residents until 5:30pm when he had to leave because he "wore an ankle monitor and he had to be back home by 7:00pm".
-Her companion called her and told her that he had to leave the two residents at the courthouse and return home.
-The Assistant Manager waited until she got off at

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6:00pm and then drove to the courthouse to get the two residents.
-When she arrived at the courthouse she could not locate the two residents outside so she went inside the courthouse and asked an unidentified employee if they knew where the two residents were.
-She still could not find the two residents so she walked around inside the courthouse for 5-7 minutes and then went back outside.
-The Assistant Manager drove around the courthouse about "4 times" but still did not see the two residents so she returned to the facility.
-She looked for the two residents for approximately 20 minutes before she returned back to the facility.
-She did not seek any assistance from law enforcement to help find the two residents and she did not call the facility to see if the residents had returned before she left the courthouse.
-When she returned to the facility she told the MA if the residents telephoned, to have them call a cab, and return to the facility
-The facility would pay for the cab fare for the residents' return.
-The Assistant Manager left the facility after 8:00pm to get money to pay for the cab and returned with it shortly (time unspecified).
-The Assistant Manager then left the facility again "to run errands "and did not return to the facility that night.
-The MA called her around 10:00pm to let her know that the two residents had returned.

Interview with the Manager on 11/15/18 at 10:40am revealed:
-Resident #10 was supposed to be transported to court by their facility transporter, but the transporter had a doctor's appointment on the same day.

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D 338	Continued From page 110 -She and the Assistant Manager asked the Assistant Manager's companion to take Resident #10 to court on 11/09/18 and she let the assistant manager's companion use her car. -She had let the companion use her car because the Assistant Manager's car had a bad tire. -Resident #5 went along with Resident #10 to help with getting Resident #10 around the courthouse with his oxygen and wheelchair. -She was not sure what time the two residents left the facility with the Assistant Manager's companion. -The Manager did not know the companion wore an ankle monitor and had to be home by 7:00pm. -She believed the assistant manager's companion stayed with the 2 residents at the courthouse until about 5:30pm on 11/09/18. -The Manager had left the facility at 5:00pm and no staff called to say the two residents had been left at the courthouse by the assistant manager's companion. -The Assistant Manager did not call her when she could not locate the two residents at the courthouse. -She did not know about the incident until the next day when the Assistant Manager told her about it. -"It was not good judgment to send those residents out like that." -She did not know 911 had to be called for Resident #10 because he ran out oxygen and the assistant manager's companion had left with all the spare oxygen tanks. -Her expectations were the residents would not be left unattended. Telephone interview with a MA on 11/16/18 at 8:53am revealed: -She worked as the MA for the 3:00pm to 11:00pm shift on 11/09/18. -Resident #10 and Resident #5 were already out	D 338		

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D 338	Continued From page 111 of the facility when she arrived. -She got the first phone call from the courthouse employee sometime around 5:00pm on 11/09/18 about who was coming to pick up the two residents. -She advised the employee that someone was on the way to pick the residents. -The Assistant Manager had left at 4:45pm to go pick Resident #5 and Resident #10 and had to drive for about an hour. -The Assistant Manager called the facility at approximately 5:45pm and wanted to know where the two residents were located. -The MA did not know where the residents were and the Assistant Manager was supposed to be looking for them. -"A lady from the sheriff's department called the facility at least 3 times between 6:00pm and 7:55pm." -"The lady from the sheriff's department wanted to know if someone was coming to pick up the 2 residents at the courthouse because the residents had been standing outside the courthouse for almost an hour and she had brought them inside because it was getting dark and cold outside." -The MA called the Assistant Manager and the Assistant Manager reported the residents could not be found at the courthouse and the Assistant Manager had left. -She did not call the Manager or the Administrator. -The Assistant Manager instructed the MA to do an internet search to a find a cab service that would bring the residents back to the facility. -The MA did not know what address to use for the residents' location. -The Assistant Manager told the MA to have the sheriff's department to call the cab for the residents since they knew the address.	D 338		

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-The MA received another call from the lady at the sheriff's department and told the lady to call back in 15 minutes with the department's address where the residents were located.
-The lady at the sheriff department called her back at 8:30pm and the two residents were supposed to be in the cab headed back to the facility at 8:40pm.
-The Assistant Manager did not come back to the facility until almost 9:00pm but she left the facility again.
-The Assistant Manager returned to the facility at 9:45pm with money for the cab and she left again.
-Resident #5 and Resident #10 returned to the facility around 10:20pm and the MA called the Assistant Manager to let her know the two residents were back.
-Both residents were dressed in short sleeve shirts and they did not have any coats or jackets.
-Both residents work long pants.
-Resident #10 was wearing only socks and no shoes because sometimes Resident #10 had problems with his feet swelling.

Interview with the Administrator on 11/16/18 at 3:22pm revealed:
-She did not know about the two residents were left at the courthouse on 11/09/18 until the morning of 11/16/18 when the Manager told her about it.
-She did not know the two residents were transported by the assistant Manager's companion using the manager's car and not a staff member.
-The residents should not have been transported by non-staff and they should not have been left to wait for a ride outside the courthouse.
-She did not know one resident had to attend to the needs of the other resident who was in the

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wheelchair.
-She did not know 911 had to be called because one of the residents had run out of his oxygen while waiting for his ride outside the courthouse on 11/09/18.
-It was her expectation for the residents' safety to be a priority and leaving the two residents outside the courthouse without a ride back to the facility was "poor judgment".

3. Review of Resident #1 current FL-2 revealed diagnoses of schizoaffective disorder-bipolar type, hypertension and gastroesophageal reflux disease (GERD).

Observation on 11/08/18 at 8:50 am on the hall near the temporary dining room/activity room revealed:
-Resident #1 was in the restroom speaking loudly.
-The language used by Resident #1 was at times vulgar, racist and sociably unacceptable.
-The conversation continued for at least 30 minutes.
-Two staff passed by without acknowledging Resident #1's outburst.

Interview with a personal care aide (PCA) on 11/08/18 at 8:40am revealed:
-Resident #1 was in the restroom alone talking to himself.
-It was normal for the resident to stay in the bathroom for an hour or more talking, screaming, yelling and arguing to himself.
-Resident #1 would come out when he was done.
-Management knew about Resident #1's behavior.

Interview with a housekeeper on 11/08/18 at 8:42am revealed:

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D 338	Continued From page 114 -"Oh that's just Mr. [Resident #1 name], he does this all the time-he's OK". -"He goes into the bathroom rid himself of demons and is fine when he comes out". Interview with a resident on 11/08/18 at 9:50am revealed she left the dining room and went to her room after she heard all that yelling and was scared. Observation of Resident #1 in the dining room at 5:40pm on 11/08/18 revealed: -The resident was sitting by himself talking to himself. -The resident became very loud at times and cursed. -He continued the conversation until food was placed before him at 6:07pm. -The resident became very loud when addressing a PCA when she attempted to remove his empty plate from the dining table; he stood up and was inches from her face during the outburst. -The PCA left his plate on the table and walked away. Interview with a PCA on 11/08/18 at 6:55pm revealed: -She was not "bothered" by Resident #1's verbal outburst aimed at her. -Such things happen often. -To her knowledge, Resident #1 had never become physical with any residents.. Interview with a second resident at 5:50pm on 11/08/18 revealed: -Resident #1 had loud outbursts often, usually daily. -It bothered her because she could not hear the television when Resident #1 became loud.	D 338		

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D 338	Continued From page 115 Interview with a third resident on 11/09/18 at 9:35am revealed: -Resident #1 woke "everyone" up this morning at 4:30am. -Resident #1 was walking in the hallways yelling curse words. -About 3 months ago, Resident #1 came to her room at 1:30am and knocked on her door; she yelled at him to go away and he did. -The resident was afraid of Resident #1. -Resident #1 "gets in people's faces but never becomes physical with anyone". -The resident had not reported the incident. Interview with a fourth resident on 11/09/18 at 9:40am revealed: -In the smoking area, he observed Resident #1 accused another resident of hitting his foot. -The accused resident was not sitting close enough to Resident #1 to have contact with his foot. -The resident denied hitting Resident #1's foot and left the smoking area. -There was no physical contact between the 2 residents. Interview with a medication aide (MA) on 11/14/18 at 12:15pm revealed: -The only way Resident #1 would take his medications, other than ordered laxatives, was if they were crushed and put in his food. -To her knowledge, all MAs gave Resident #10 his medications in this manner. -The last time Resident #1 was seen in the facility by his psychiatrist, Resident #1 cursed at the psychiatrist. -The psychiatrist ordered a medication to be given as needed (prn) when Resident #1 became agitated. -When Resident #1 was agitated, he would not	D 338		

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take medication in any manner offered.
-If he was offered medications crushed in a beverage at times other than with meals or scheduled snacks, he would refuse to drink it.

Telephone interview with PCA/MA on 11/14/18 at 1:25pm revealed:
-Resident #1 would often scream and talk loudly.
-The only way Resident #1 would take his medication was if crushed and put in food or drink.
-She would put Resident #1's bedtime medications in whatever drink he would have at 8:00pm snack.
-She thought she had given the prn medication once.

Telephone interview with Resident #1's psychiatric provider on 11/15/18 at 2:25pm revealed:
-The provider had seen the resident on 10/29/18.
-She had observed the resident yelling and cursing at the Manager.
-The resident later became belligerent with the provider yelling and cursing at her.
-The resident had 2 different internal persons he spoke with frequently.
-The resident would become loud and verbally abusive during these conversations.
-She was aware staff crushed Resident #1's medication and concealed it in food or drink.
-The resident was not capable of making medical decisions without assistance.
-The staff knew how to ignore him.
-The behaviors were disruptive.
-She had spoken with previous Managers several times about seeking legal guardianship for the resident.
-She had spoken with the new Manager about guardianship during the 10/29/18 facility visit.

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D 338	Continued From page 117 Interview with the facility Manager on 11/15/18 at 11:15am revealed: -Resident #1 was doing "much better" since the timing of his medication had been adjusted. -She felt the staff "knew how to deal with him". A second interview with the facility manger on 11/16/18 at 12:10pm revealed: -She did not remember Resident#1's psychiatric provider discussing legal guardianship for him. -She would begin the process when she returned to the facility on 11/19/18. _____ The facility failed to maintain the rights of the residents by not assuring the safety and well-being of Resident #10 and Resident #5 when the residents were left stranded without return transportation to the facility for at least 3 hours, with exposure to cool temperatures and inadequate clothing, and Resident #10 not having access to supplemental oxygen resulting in the need for emergency services due to Resident #10's shortness of breath; staff being aggressive and unprofessional to Resident #3 during personal care by grabbing her legs and folding them forward touching her face during incontinence care and dressing; and to protect other residents from verbal and mental intimidation from Resident #1 who exhibited agitated behaviors of yelling and screaming. The facility's failure placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/18 for this violation.	D 338		

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D 338	Continued From page 118 THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 16, 2018.	D 338		
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: Based on observation, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 6 residents sampled (#5 and #10). The findings are: Review of Resident #10's current FL-2 dated 10/31/18 revealed diagnosis included chronic obstructive pulmonary disease (COPD), acute respiratory failure, and coronary artery disease and tobacco use. a. Review of Resident #10's hospital discharge	D 358		

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medication orders dated 10/03/18 revealed there was an order Spiriva 18 micrograms to be inhaled once daily for COPD.

Review of Resident #10's November 2018 Medical Administration Record (MAR) revealed:
-There was an entry for Spiriva 18mcg to be administered at 8:00am daily.
-Spiriva was documented as administered at 8:00am on 11/09/18.

b. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Flomax 0.4 mg daily for enlarged prostate.

Review of Resident #10's November 2018 for revealed:
-There was an entry for Flomax 0.4mg to be administered at 8:00am daily.
-Flomax was documented as administered at 8:00am on 11/09/18

c. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Altace 1.25 mg once daily for high blood pressure.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Altace 1.25mg to be administered at 8:00am daily.
-Altace was documented as administered at 8:00am on 11/09/18.

d. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Hydrochlorothiazide 12.5 once daily for high blood pressure.

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Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Hydrochlorothiazide (HCTZ) 12.5mg to be administered at 8:00am daily.
-HCTZ was documented as administered at 8:00am on 11/09/18.

e. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Prozac 20 mg daily for depression.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Prozac 20mg to be given at 8:00am daily.
-Prozac was documented as given on 11/09/18.

f. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Aspirin 325 mg daily for heart health.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Aspirin 325mg to be administered at 8:00am daily.
-Aspirin was documented as administered at 8:00am on 11/09/18.

g. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Norvasc 2.5mg once daily for high blood pressure.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Norvasc to be administered at 8:00am daily.

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D 358	Continued From page 121 -Norvasc was documented as administered at 8:00am on 11/09/18. h. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Advair 250-50 Diskus 1 puff twice daily for COPD Review of Resident #10's November 2018 MAR revealed: -There was an entry for Advair 250-50mcg to be administered at 8:00am and 8:00pm daily. -Advair was documented as administered at 8:00am and 8:00pm on 11/09/18. i. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Lopressor 12.5 mg twice daily high blood pressure. Review of Resident #10's November 2018 MAR revealed: -There was an entry for Lopressor 12.5mg to be administered at 8:00am and 8:00pm daily. -Lopressor was documented as administered at 8:00am and 8:00pm on 11/09/18. j. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Protonix DR 4 once daily for gastroesophageal reflux. Review of Resident #10's November 2018 MAR revealed: -There was an entry for Protonix 40mg Extended Release (ER) to be administered at 8:00am daily. -Protonix was documented as administered at 8:00am on 11/09/18. k. Review of Resident #10's hospital discharge	D 358		

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medication orders dated 10/03/18 revealed there was an order for Neurontin 300 mg 3 times daily for nerve pain.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Neurontin 300mg to be administered at 8:00am, 2:00pm and 8:00pm daily.
-Neurontin was documented as administered at 8:00am, 2:00pm, and 8:00pm on 11/09/18.

l. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Lipitor 40mg once daily for elevated cholesterol.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Lipitor 40mg to be administered at 8:00pm daily.
-Lipitor was documented as administered at 8:00pm on 11/09/18.

m. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Metformin 50 mg twice daily for diabetes mellitus type II.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Metformin 50mg to be administered at 8:00am and 8:00pm daily.
-Metformin was documented as administered at 8:00am and 8:00pm on 11/09/18.

n. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Remeron 15 mg once daily.

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Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Remeron 15mg to be administered at 8:00pm.
-Remeron was documented as administered at 8:00pm on 11/09/18.

o. Review of Resident #10's hospital discharge medication orders dated 10/03/18 revealed there was an order for Elavil 50 mg once daily for depression.

Review of Resident #10's November 2018 MAR revealed:
-There was an entry for Elavil 50mg to be administered 8:00pm daily.
-Elavil was documented as administered at 8:00pm on 11/09/18.

Interview with Resident #10 on 11/14/18 at 1:45pm revealed:
-He had a court appearance in a nearby city scheduled on 11/09/18
-He could not state the time of departure but said "it was early-before breakfast".
-He was not administered any medications before he departed the facility.
-He was late for the court appointment and had to wait until the end of the day to be seen.
-The person providing transportation to and from the court appearance had to leave at 5:30pm.
-It was 6:00pm when he finished his court appearance.
-He did not return to the facility until "after 10:00pm" because of transportation issues.
-He was not administered any medications after he returned to the facility

Telephone interview with a medication aide (MA) on 11/14/18 at 1:25pm revealed:

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D 358	Continued From page 124 -She had worked 3:00pm until 11:00pm on 11/09/18. -Resident #10 returned to the facility at "10:05pm". -The MA had "popped" Resident #10's 8:00pm medication at 9:00pm because she knew he was on the way back. -The MA thought that having the medications ready for Resident #10 to take as soon as he "walked in the door" was a good idea. -The MA then "disregarded" the medications around 9:30pm because "it was too late to give the 8:00pm medications". -The facility's policy was to draw a circle around the MA's initials and document the reason not administered. -She had forgot to draw a circle around her initials and document the medications were not administered. -She had put the medications in the sharps container without anyone observing her. -The MA had not notify Resident #10's physician of missed medication doses. -The MA had not complete an incident report or any other type of documentation regarding the missed medications. Interview with the Assistant Manager on 11/14/18 at 6:05pm revealed: -She had administered Resident #10 his morning medications. -She had not known Resident #10's bedtime medications were not administered. -She had not known if an incident report was completed. -She had not known if Resident #10's physician had been notified about the missed medications. Interview with the Manager on 11/15/18 at 12:10pm:	D 358		

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-The Manager had left for the day around 5:00pm on 11/09/18 and did not receive any phone calls from staff members.
-She was told about the incident the next morning by the Assistant Manager.
-She assumed the residents received their bedtime medications once they returned to the facility.
-She did not know if an incident report was completed about the events.
-She did not know if Resident #10's physician was notified about the missed medications.

Telephone interview with Resident #10's physician's nurse on 11/15/18 at 9:15am revealed:
-The physician was out at another facility.
-To her knowledge, the physician had not received notification that the resident had not received medications.
-She would expect that all medications would be administered as ordered.
-She could not state the results of the residents missed medications.

2. Review of Resident #5's current FL-2 dated 03/07/18 revealed:
-Diagnoses included atherosclerosis, hyperlipidemia, articular gout, autoimmune disorder, pre-diabetes, continued illicit drug use, and dental caries.
-He was ambulatory and intermittently disoriented.

Interview with Resident #5 on 11/14/18 at 1:24pm revealed:
-He left the facility at approximately 8:30am on 11/09/18 to attend court in nearby city located an hour away from the facility.
-He did not return back to the facility until after

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10pm and he did not get his afternoon or his evening medications on 11/09/18.

a. Review of physician's orders for Resident #5 revealed there was a medication order dated 06/25/18 for Lorazepam 0.5mg take one tablet twice daily at 8:00am and 4:00pm for anxiety (Lorazepam is used to treat anxiety).

Review of Resident #5's November 2018 medication administration record (MAR) revealed:
-There was a computer generated entry for Lorazepam 0.5mg take one tablet twice daily, scheduled to be administered at 8:00am and 4:00pm
-There was documentation the medication was administered twice daily from 11/01/18 starting at 8:00am through 11/14/18 at 8:00am.
-There was no documentation of the omission of the 4:00pm dose of Lorazepam when Resident #5 was not at the facility.

Review of facility pharmacy dispensing records revealed sixty tablets of Lorazepam 0.5mg were dispensed for Resident #5 on 11/07/18.

Observation of Resident #5's medications on hand on 11/14/18 revealed:
-All of Resident 5's medications were dispensed in medication bottles.
-There were forty-five tablets of Lorazepam 0.5mg remaining for Resident #5, which was incorrect per the last dispensing records for Resident #5.
-The remaining tablets did not account for the one dose omitted of Lorazepam for Resident #5 on 11/09/18 at 4:00pm.

Telephone interview with a medication aide (MA) on 11/15/18 at 1:25pm revealed:

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D 358	Continued From page 127 -She was the MA who worked second shift on 11/09/18. -Resident #5 was not in the facility when she reported to work at 3:00pm. -She documented on Resident #5's MAR she administered Lorazepam to Resident #5 on 11/09/18 at 4:00pm but it was a mistake. -She never removed the Lorazepam for Resident #5 because he was not in the facility. -She did not know why she did not document Resident #5 was not in the facility for this 4:00pm dose of Lorazepam 0.5mg on Resident #5's MAR on 11/09/18. -She forgot and initialed the block of Resident #5's as if she administered his Lorazepam but Resident #5 was not in the facility at 4:00pm. Second telephone interview with the same MA on 11/16/18 at 8:53am revealed: -She prepared Resident #5's 4:00pm dose of Lorazepam on 11/09/18 but she did not administer it. -She wasted Resident #5's Lorazepam in the sharp containers because Resident #5 was not in the facility. -No one witnessed when she wasted Resident #5's Lorazepam in the sharps container. -She did know Resident #5's Lorazepam tablets were dispensed from the pharmacy in a medication bottle but she wasted the Lorazepam in the sharps container so the medication count would not be wrong. -She did not notify the Resident #5's physician regarding the missed Lorazepam on 11/09/18. -She did document she administered Resident #5's Lorazepam at 4:00pm on 11/09/18 on his MAR, but it was mistake. Review of the facility's medication policies and procedures revealed:	D 358		

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-Omissions and refusal of medications and the reason for omissions will be documented on the MAR.
-Any medication destroyed at the facility will be destroyed by the administrator or the administrator's designee.
-A pharmacist, dispensing practitioner or their designee will witness the destruction of the medications.
-The destruction will be conducted so that no person can use, administer, sell, or give away the medication.
-A record of the medication destroyed or returned to a pharmacy for destruction will be maintained for a minimum of five years.
-Any medication contaminated or not administered may be destroyed in the facility by flushing the medication in the toilet.
-The facility's medication policies and procedures was last updated 10/29/04.

b. Review of physician's orders for Resident #5 revealed there was a medication order dated 06/25/18 for Mirtazapine 15mg take a one and half tablets at bedtime for insomnia and anxiety (Mirtazapine is used to treat insomnia and anxiety).

Review of Resident #5's November 2018 MAR revealed:
-There was a computer generated entry for Mirtazapine 15mg take one and half tablets at bedtime scheduled to be administered at 8:00pm.
-There was documentation the medication was administered once daily from 11/01/18 starting at 8:00pm through 11/13/18 at 8:00pm.
-There was no documentation of the omission of the 8:00pm dose of Mirtazapine when Resident #5 was away from the facility.

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D 358	Continued From page 129 Telephone interview with a MA on 11/15/18 at 1:25pm revealed: -Resident #5 was not in the facility when she arrived for work for second shift on 11/09/18. -She administered Resident #5's ordered dosage of Mirtazapine 15mg when he returned to the facility sometime after 10:00pm on 11/09/18. -She knew it was outside the scheduled time for the administration of Mirtazapine according to the facility medication policy but Resident #5 needed his medicine. Second telephone interview with the same MA on 11/16/18 at 8:53am revealed: -She prepared Resident #5's 8:00pm dose of Mirtazapine on 11/09/18 sometime after 9:00pm but she did not administer it. -She wasted Resident #5's Mirtazapine in the sharp containers because Resident #5 was not back in the facility by 9:45pm. -She did not notify the Resident #5's physician regarding the missed Mirtazapine on 11/09/18. -She did document she administered Resident #5's Mirtazapine at 8:00pm on 11/09/18 on his MAR, but it was a mistake. Interview with the Assistant Manager on 11/14/18 at 6:05pm revealed: -Resident #5 was not in the facility from about 8:00am until after 10:00pm on 11/09/18. -She did not know it was documented Resident #5 had received his scheduled doses of Lorazepam at 4:00pm and Mirtazapine at 8:00pm on 11/09/18 by the MA. -She did not know what happened to the dose of Lorazepam that was documented as given by staff. -It was the facility's medication policy when a resident was away from the facility, the MA was supposed to circle and initial to document the	D 358		

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D 358	Continued From page 130 omitted medication dose and an explanation was written on the back of the resident's MAR. -She did not know why this did not happen with Resident #5's medications on the afternoon and evening of 11/09/18. Interview with the Manager on 11/15/18 at 10:40am revealed: -She did not know anything about the MA documenting that she had administered medications to Resident #5 when he was out of the facility on 11/09/18. -She did not expect staff to document any tasks the staff had not done when the residents were not in the facility. -She did not have a response about the missing Lorazepam tablet from the 11/09/18 4:00pm dosage. Telephone interview with Resident #5's mental health provider on 11/15/18 at 2:25pm revealed: -She did not know Resident #5 missed any doses of his Lorazepam or Mirtazapine. -She did not think there was any outcome for Resident #5 missing one dose of Lorazepam or Mirtazapine. -She did expect for all medications to be administered as ordered for Resident #5.	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	D 367		

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D 367	Continued From page 131 administered; (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 interviews and record reviews, the facility failed to assure the medication administration records were accurate for 1 of 6 residents sampled (#3) including documentation of sliding scale insulin. The findings are: Review of Resident #11's current FL-2 dated 02/12/18 revealed: -Diagnoses included diabetes, hypertension, schizophrenia and history of left breast cancer with lumpectomy. -Finger stick blood sugars checked daily before meals. Review of Resident #11's Resident Register revealed Resident #11 was admitted to the facility on 12/22/17.	D 367		

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D 367	Continued From page 132 Review of physician's orders for Resident #11 revealed: -There was a medication order dated 07/07/18 for finger stick blood sugar (FSBS) testing daily before breakfast with Humalog 100 units/ml sliding scale (SSI) according to the following scale: for FSBS result of 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units (Humalog is a rapid acting insulin used to lower blood sugar). -There was documentation of "order rewritten" hand written on the computer generated entry. -There was documentation of a sliding scale (SSI): 301-350 = 15 units and 351- above = 20 units to be administered at 7am, which was hand written on an additional MAR. Review of Resident #11's November 2018 medication administration record (MAR) revealed: - There was a computer generated entry for finger stick blood sugar (FSBS) testing daily before breakfast with Humalog 100units/ml sliding scale (SSI) according to the following scale: for FSBS result of 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units. -There was documentation of "order rewritten" hand written on the computer generated entry. -There was documentation of a sliding scale (SSI): 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units to be administered at 7am, which was hand written on an additional MAR. -There was documentation the resident's FSBS was 233mg/dl on 11/10/18 at 7:30am and there was no documentation for the quantity of Humalog given and no entry documented in the exception section of the MAR. -There was documentation the resident's FSBS was 233mg/dl on 11/11/18 at 7:30am and there	D 367		

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was no documentation for the quantity of Humalog given and no entry documented in the exception section of the MAR.
-There was documentation the resident's FSBS was 317mg/dl on 11/12/18 at 7:30am and there was no documentation for the quantity of Humalog given and no entry documented in the exception section of the MAR.

Telephone interview with a medication aide (MA) on 11/14/18 at 5:10pm revealed:
-Resident #11 was one of the residents that she checked FSBS and administered insulin.
-Resident #11 was on a SSI but she could not remember the ranges.

Telephone interview with a nurse from Resident #11's physician's office on 11/15/18 at 9:10am revealed:
-Resident #11's finger stick blood sugar (FSBS) testing daily before breakfast with Humalog 100units/ml sliding scale (SSI) according to the following scale: for FSBS result of 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units.
-All orders given by the provider were expected to be followed.

Interview with the Assistant Manager on 11/15/18 at 2:30pm revealed:
-Resident #11's finger stick blood sugar (FSBS) testing daily before breakfast with Humalog 100units/ml sliding scale (SSI) according to the following scale: for FSBS result of 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units.
-Resident #11 had been receiving insulin according to the correct SSI.
-She did not know the MAR for November 2018 and the physician order dated 07/07/18 did not

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D 367	Continued From page 134 match. -She was responsible for checking the MARs monthly for accuracy. -The computer generated entry on the physician order was correct, it was written over to give room to document the units of insulin administered. -The complete SSI order was hand written in on the MAR. -The SSI that was hand written on the physician's order had the first half of the SSI order omitted by accident. Interview with the Manager on 11/15/18 at 2:40 pm revealed: -Resident #11's finger stick blood sugar (FSBS) testing daily before breakfast with Humalog 100units/ml sliding scale (SSI) according to the following scale: for FSBS result of 200-250= 5 units; 251-300= 10 units; 301-350 = 15 units; 351 and above = 20 units. -She did not know the MAR for November 2018 and the physician order dated 07/07/18 did not match. -The Assistant Manager was responsible for checking the MARs monthly for accuracy. Review of the facility's medication policies and procedures revealed the MAR will be updated and changed when medication or treatment orders from the prescribing practitioner changes.	D 367		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when	D 378		

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D 378	Continued From page 135 under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. The findings are: Observation of a medication cart located in the hallway on the left side of the manager's office door on 11/08/18 from 8:25am to 8:40am revealed: -There was a box that contained Fluticasone Propionate nasal spray on a ledge on the top right side of the medication cart at 8:25am and no medication aide (MA) or other staff were present to monitor or the medication left on top of the medication cart (Fluticasone is a medication used to treat seasonal allergies). -Three residents walked past the medication on the medication cart in the hallway at 8:29am. -The MA came and started working from another medication cart next to the door way of the dining room at 8:30am. -The Manager walked past the medication left on the medication cart and went inside of her office at 8:35am. -The MA noticed the medication that was left on top of the medication cart, removed it from the top of the cart, and secured it inside the medication cart at 8:40am. Interview with the MA on 11/08/18 at 8:40am revealed:	D 378		

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D 378	Continued From page 136 -She forgot and left the medication on top of the medication cart after she administered medication to a resident on the morning of 11/09/18. -She knew all medication was supposed to be secured in the medication cart. -She thought the medication may have been left unsecured on top of the medication for about 20 to 30 minutes before she locked the medication back in the medication cart. Interview with the Assistant Manager on 11/08/18 at 9:10am revealed: -The Assistant Manager was made aware the MA had left the nasal spray on the top of the medication cart unsupervised on 11/08/18 at 8:45am. -The MA should not have left medication on the medication cart unsupervised. -The facility did not have any type of monitoring system in place to check to be sure the MAs were storing residents' medications properly. Interview with the Manager on 11/08/18 at 9:20am revealed: -She was made aware the MA left the nasal spray on top of the medication cart unsupervised. -All residents' medications should be locked up after medication administration. -She did not notice the nasal spray when it was sitting out on top of the medication cart. Review of the facility's medication policies and procedures revealed: -All medications administered by facility staff will be kept locked except when staff responsible for medication administration was in close proximity and can see the medication. -The facility's medication policies and procedures was last updated on 10/29/04.	D 378		

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D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure each resident was treated with dignity as related to resident rights. The findings are: 1. Based on interviews, observations, and record reviews, the facility failed to assure 4 of 6 sampled residents were treated with dignity and respect and received adequate care and services as evidenced by two residents (#5 and #10) being transported out of the facility by a non-staff person and being left without a means of return transportation to the facility for least 3 hours with exposure to weather and one resident (#10) without access to an adequate oxygen supply resulting in the need for emergency medical services (EMS); one resident (#3), with a history of osteoporosis and decubiti, who was handled roughly by staff during personal care; and one resident (#1), with a history of mental illness, to verbally threaten and intimidate the residents and staff at the facility [Refer to Tag 0311 10A NCAC 13F .0909 Residents Rignts (Type A2 Violation)].	D911		
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:	D912		

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D912	Continued From page 138 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 each resident received care and services which were adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to medication aide competency, staff qualifications, exit door alarms, personal care, kitchen sanitation, staffing, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure there was enough staff on duty to meet and assist with the needs of the residents according to the facility's census for 62 of 63 shifts sampled from 10/22/18-11/11/18 [Refer to Tag 201 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing (Type B Violation)]. 2. Based on observation, interviews and record reviews the facility failed to assure that 3 of 3 sampled residents (#7, #8, #9) received personal care assistance such as bathing, skin care, nail care and linen changes in accordance with the care plans and assessed needs of the individual resident [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on interviews and record reviews, the	D912		

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facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 5 of 6 staff sampled (Staff A, B, C, D and F) sampled who were hired after 10/01/13 [Refer to Tag 992 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (Staff A, D, and C) who administered medications had employment verification or completed the 5, 10 or 15 hour state approved medication administration training courses as required, or had a Medication Clinical Skills Competency checklist completed or had passed the medication examination prior to administering medications [Refer to Tag 935 G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)].

5. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 2 of 6 sampled staff (Staff A, and B) [Refer to Tag 167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].

6. Based on record reviews and interviews, the facility failed to assure 3 of 6 sampled staff (Staff A, B, and D) had a criminal background check completed in accordance with G.S. 114-19.10 and D-40 upon hire [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)].

7. Based on interviews and record reviews, the

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D912	Continued From page 140 facility failed to assure 3 of 6 sampled staff (staff A, B and D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256 upon hire [Refer to Tag 137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)]. 8. Based on interviews, record reviews, and observations, the facility failed to assure 7 of 7 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 1 sampled residents (Resident #5) who was intermittently disoriented [Refer to Tag 067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 9. Based on observations, interviews and record reviews the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above in the kitchen at all times [Refer to Tag 077 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings (Type B Violation)]. 10. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with rules and statutes related to the sanitation grade of the kitchen, exit door alarms, personal care and other staffing, personal care and supervision, ACH medication aide training and competency, health care personnel registry checks, criminal background checks, cardiopulmonary resuscitation training, controlled substances training, and residents' rights [Refer to Tag 980 G.S. 131D-25 Implementation (Type A2 Violation)].	D912		

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D935	Continued From page 141	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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D935	Continued From page 142 exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (Staff A, D, and C) who administered medications had employment verification or completed the 5, 10 or 15 hour state approved medication administration training courses as required, or had a Medication Clinical Skills Competency checklist completed or had passed the medication examination prior to administering medications. The findings are: 1. Review of Staff A's personnel record revealed: -The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA). -There was no documentation Staff A had completed the 5, 10 or 15 hour medication aide training. -There was documentation Staff A had a Medication Clinical Skills Competency checklist dated 09/26/18 that was not completed and had missing completed dates on skills. -There was no documentation Staff A had passed the written medication aide exam. -There was no documentation of employment	D935		

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verification showing Staff A worked as a medication aide within the past 24 months.
-Staff A's 60 day time period to pass the written medication aide exam from the documented hire date as a MA would have ended 11/11/18.

Review of a resident's November 2018 medication administration record (MAR) revealed Staff A documented administration of medications on 11/12/18 and 11/13/18.

Telephone interview with Staff A on 11/15/18 at 1:30pm revealed:
-She had been working at the facility as a PCA for three years, but had left and came back to work at the end of August 2018.
-She had worked as a MA for the last 6 months on second shift (3pm to 11pm).
-Her responsibilities were to administer medications to the residents including insulin and finger stick blood sugars.
-She had not worked at any other facility as a MA.
-She received all her training for MA in two weeks from the facility's former manager, who was also a MA.
-Her training consisted of observing another MA administer medication for two days, administer insulin and obtaining FSBS for two days.
-Her medication clinical skills checklist was conducted by a former facility manager who was a MA.
-She had not completed the 5, 10 or 15 hour medication aide training or the diabetic care training.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:
-Staff A was hired as a MA.
-She was expected to perform all the duties of a MA including administering insulin injections and

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diabetic care.
-She did not know Staff A had not completed the 5, 10 or 15 hour medication aide training.
-She did not know Staff A's Medication Clinical Skills Competency checklist was not completed or conducted by a register nurse (RN).
-She did not know Staff A had not passed the written medication administration aide exam.

Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm

Interview with the Manager on 11/14/18 at 4:55pm revealed:
-She did not know Staff A had not completed the 5, 10 or 15 hour medication aide training.
-She did not know Staff A's Medication Clinical Skills Competency checklist was not completed or conducted by a RN.
-She did not know Staff A had not passed the written medication administration aide exam.

Refer to the interview with the Manager on 11/14/18 at 4:55pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

2. Review of Staff B's personnel record revealed:
-The date of hire was documented as 10/01/18 as a medication aide (MA).
-There was documentation Staff B had a Medication Clinical Skills Competency checklist that did not have any of the dates completed for all the competency skills.

Review of a resident's October 2018 medication administration records revealed Staff B documented administration of medications on 10/08/18, 10/12/18, 10/14/18, 10/20/18, 10/21/18

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D935	Continued From page 145 and 10/31/18. Review of a resident's November 2018 medication administration records revealed: -Staff B documented administration of medications on 11/03/18, 11/08/18, 11/11/18 and 11/14/18. -Staff B documented administering insulin injections on 11/02/18, 11/04/18, 11/07/18, 11/08/18, 11/09/18 and 11/14/18. Telephone interview with Staff B on 11/14/18 at 5:10pm revealed: -She had been working at the facility as a MA since October 2018. -Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars. -She had not worked at any other facility as a MA. -She received all her training for MA in three days from the facility's former manager, who was also a MA and a current MA. -Her training consisted of having observing another MA administer medications for 2 days, administering insulin injections for and obtaining finger stick blood sugars (FSBS) on the 3rd day. -After her three days of training she was put on the medication cart alone. -She had not trained with or had any medication competency validation with a registered nurse (RN). -She had not signed any paper work regarding any kind of medication training or skills check off list. -She had not completed any of the 5, 10 or 15 hour medication aide training or the diabetic care training. -It was not her signature on the Medication Clinical Skills Competency checklist in her	D935		

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personal record.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:
-Staff B was hired as a MA.
-Staff B was expected to perform all the duties of a MA including administering insulin injections and FSBS.
-She did not know Staff B had not completed the 5, 10 or 15 hour medication aide training.
-She did not know Staff B's Medication Clinical Skills Competency checklist was not completed and was conducted by a manager and not a RN.
-She did not know Staff B only had 3 days of medication aide training that was given by the former Manager and a current MA.

Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm.

Interview with the Manager on 11/14/18 at 4:55pm revealed:
-She did not know Staff B had not completed the 5, 10 or 15 hour medication aide training.
-She did not know Staff B's Medication Clinical Skills Competency checklist was not completed and was conducted by a manager and not a RN.

Refer to the interview with the Manager on 11/14/18 at 4:55pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

3. Review of the Manager's personnel record revealed:
-The date of hire was documented as 08/02/18 as a medication aide (MA).
-There was no documentation of employment verification showing she worked as a medication

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aide within the past 24 months.
-There was no documentation the Manager had completed the Medication Clinical Skills Competency checklist.
-There was no documentation the Manager had passed the written medication aide exam.
-The 60 days to complete the written medication aide exam from the documented hire date as a MA would have been 10/01/18.

Interview with the Manager on 11/14/18 at 4:55pm revealed:
-She was hired on 08/02/18 as a MA.
-She had worked as a MA until the end of September, 2018 when she became the Manager.
-She was a physician up until she relinquished her license in February 2018 after which she started working at the facility as a MA.
-She did not know that she had to take the Medication Clinical Skills Competency checklist.
-She did not know that she had to take the written medication aide exam.
-She thought being a retired physician she did not have to take the training.
-Her responsibilities were to administer medications to the residents including administering insulin and checking finger stick blood sugars while she was the MA.
-She had not worked at any other facility as a MA.
-She had not worked as a MA since becoming the Manager.

Review of a resident's September 2018 medication administration records revealed the Manager documented administration of medications on 09/01/18, 09/02/18, 09/05/18, 09/06/18, 09/08/18, 09/09/18, 09/12/18, 09/14/18, 09/15/18, 09/16/18, 09/17/18 and 09/19/18.

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D935	Continued From page 148 Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: - The manager was hired as a MA. -The Manager no longer worked as a MA. -She knew the Manager had relinquished her license in February 2018 -She did not know the Manager had not completed the Medication Clinical Skills Competency checklist. -She did not know the Manager had not had passed the written medication administration exam. Refer to the interview with the Assistant Manager on 11/14/718 at 4:50pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. _____ Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff hired as a MA were expected to perform all the duties of a MA including administering insulin injections and FSBS when in the role of MA. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assist Manager. -There was no scheduled or allotted time for the staff records to be audited by her or the Manager. Interview with the Manager on 11/14/18 at 4:55pm revealed: -She thought all the staff records were complete and included all the required documentation.	D935		

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D935	Continued From page 149 -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Manager had all the required documentation. -She and the Assistant Manager were responsible for auditing staff records. -She had not audited any staff records since being the Manager. -Staff from a sister facility had come in this week and audited all the staff records. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there were any problems with the staff records and completion of medication aide training for staff. -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records. _____ The facility failed to assure 3 of 4 staff had received employment verification or completed the 5, 10 or 15 hour state approved medication administration training courses, or completed a Medication Clinical Skills Competency checklist or passed the written medication administration examination prior to performing unsupervised medication aide duties. The failure placed all residents at risk for medication errors and was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/18 for this violation.	D935		

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D935	Continued From page 150 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D935		
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 A2 VIOLATION Based on interviews, and record reviews, the Administrator failed to assure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' right which resulted in significant noncompliance with rules and statutes related to the sanitation grade of the kitchen, exit door alarms, personal care and other staffing, personal care and supervision, ACH medication aide training and competency, health care personnel registry checks, criminal background checks, cardiopulmonary resuscitation training, controlled substances training, and residents' rights. The findings are: Interview with the Administrator on 11/16/18 at 3:22pm revealed: -She resumed at the Administrator in late September 2018 when the previous Administrator left.	D980		

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D980	Continued From page 151 -She did not realize there were so many issues that need to be addressed since she had taken over as the Administrator. -The daily operation of the facility were the responsibility of the Manager. -If there were any problems, the Manager could call her at any time. -She had not visited the facility in recent weeks but she was available by phone. -The frequency of her visits to the facility had varied in recent months due to the hurricane and personal issues. -She was trying to complete the repairs to the wall and ceilings in the facility first before she started anything else. 1. Based on observations, interviews, and record reviews, the facility failed to assure there was enough staff on duty to meet and assist with the needs of the residents according to the facility's census for 62 of 63 shifts sampled from 10/22/18-11/11/18 [Refer to Tag 201 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing (Type B Violation)]. 2. Based on observation, interviews and record reviews the facility failed to assure that 3 of 3 sampled residents (#7, #8, #9) received personal care assistance such as bathing, skin care, nail care and linen changes in accordance with the care plans and assessed needs of the individual resident [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on interviews, observations, and record reviews, the facility failed to assure 4 of 6 sampled residents were treated with dignity and respect and received adequate care and services as evidenced by two residents (#5 and #10) being	D980		

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D980	Continued From page 152 transported out of the facility by a non-staff person and being left without a means of return transportation to the facility for least 3 hours with exposure to weather and one resident (#10) without access to an adequate oxygen supply resulting in the need for emergency medical services (EMS); one resident (#3), with a history of osteoporosis and decubiti, who was handled roughly by staff during personal care; and one resident (#1), with a history of mental illness, to verbally threaten and intimidate the residents and staff at the facility [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 4. Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 5 of 6 staff sampled (Staff A, B, C, D and F) sampled who were hired after 10/01/13 [Refer to Tag 992 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure 3 of 4 staff sampled (Staff A, D, and C) who administered medications had employment verification or completed the 5, 10 or 15 hour state approved medication administration training courses as required, or had a Medication Clinical Skills Competency checklist completed or had passed the medication examination prior to administering medications [Refer to Tag 935 G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency Evaluation Requirements (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training	D980		

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D980	Continued From page 153 within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 2 of 6 sampled staff (Staff A, and B) [Refer to Tag 167 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 7. Based on record reviews and interviews, the facility failed to assure 3 of 6 sampled staff (Staff A, B, and D) had a criminal background check completed in accordance with G.S. 114-19.10 and D-40 upon hire [Refer to Tag 139 10A NCAC 13F .0407(a)(7) Other Staff Qualifications (Type B Violation)]. 8. Based on interviews and record reviews, the facility failed to assure 3 of 6 sampled staff (staff A, B and D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256 upon hire [Refer to Tag 137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation)]. 9. Based on interviews, record reviews, and observations, the facility failed to assure 7 of 7 exit doors accessible for residents' use had an alarm that activated for the safety for 1 of 1 sampled residents (Resident #5) who was intermittently disoriented [Refer to Tag 067 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)]. 10. Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health sanitation score of 85 or above in the kitchen at all times [Refer to Tag 077 10A NCAC 13F .0306(a)(4) Housekeeping and Furnishings (Type B Violation)]. 11. Based on observation and interviews, the	D980		

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D980	Continued From page 154 facility failed to assure that bleach, glass cleaner, oven cleaner, furniture polish, floor clean, scouring cleanser, dishwashing liquid, and multipurpose liquid cleaners were stored in locked areas of the facility resulting in hazardous chemicals being unattended and accessible to residents [Refer to Tag 056 10A NCAC 13F .0305(f)(4) Physical Environment]. 12. Based on observation and interviews, the facility failed to assure that walls, ceilings and floors were kept in good repair as evidenced by a weak area of the floor and a faucet on a piece of pipe protruding from the wall in a common bathroom near resident room #20, weak flooring by an exit door by resident room #5, cracked walls and peeling paint in resident room #15, and bubbled drywall with flaking white paint in resident room #19 [Refer to Tag 074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings]. 13. Based on observation, interviews and record reviews, the facility failed to assure the facility was free of hazards as evidenced by flies and live roaches observed in the kitchen, dining room, one resident room, and two common resident bathrooms [Refer to Tag 074 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings]. 14. Based on interviews and record reviews, the facility failed to assure 2 of 6 staff sampled (Staff A and E) were tested upon hire for tuberculosis (TB) disease with the two-step TB skin test in compliance with control measures adopted by the Commission for Health Services [Refer to Tag 131 10A NCAC 13F .0406(a) Test for Tuberculosis]. 15. Based on observation, interviews and record reviews, the facility failed to assure 2 of 3	D980		

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D980	Continued From page 155	D980		

sampled staff (staff D and F) who provided personal care to residents, had successfully completed an 80 hour personal care training and competency evaluation program, within 6 months after hire [Refer to Tag 150 10A NCAC 13F .0501 Personal Care Training and Competency].

16. Based on observations, record reviews, and interviews, the facility failed to assure 4 of 6 sampled staff (Staff A, B, C and D) personal care aide (PCA) Staff D and medication aide (MA) Staff A, B and C were competency validated for Licensed Health Professional Support (LHPS) tasks related to blood glucose monitoring, insulin injections, and providing personal care services [Refer to Tag 161 10A NCAC 13F .0504(a) Competency Validation for LHPS Tasks].

17. Based on record review and interviews, the facility failed to assure 2 of 4 medication aides (Staff A and B) received diabetic training prior to the administration of insulin [Refer to Tag 164 10A NCAC 13F .0505 Training on Care of Diabetic Resident].

18. Based on observations, interviews and record reviews, the facility failed to assure that monthly weights were obtained as ordered for 1of 5 (Resident #3) sampled residents [Refer to Tag 276 10A NCAC 13F .0902(c)(4) Health Care].

19. Based on observations and interviews, the facility failed to serve residents 8 ounces of milk or equivalent at least twice daily [Refer to Tag 299 10A NCAC 13F .0904d (3)(A) Nutrition and Food Service].

20. Based on observations and interviews the facility failed assure that water was served along with other beverages at each meal [Refer to Tag

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D980	Continued From page 156 306 10A NCAC 13F .0904d (3)(B) Nutrition and Food Service]. 21. Based on observations, interviews and record reviews the facility failed to assure that nutritional supplements were served as ordered to 2 of 4 (Residents #3 & #9) residents surveyed and 1 of 4 residents (Resident #3) was served chopped meats as ordered [Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service]. 22. Based on observation and interviews, the facility failed to assure resident care and services were provided regarding access to a telephone made available for residents to privately make and receive calls as evidenced by residents having to use the telephone in the activity room [Refer to Tag 324 10A NCAC 13F .0906(d) Other Resident Care and Services]. 23. Based on observation, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 6 residents sampled (#5 and #10) to including a narcotic (#10) and a nerve medication (#5) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration]. 24. Based on interviews and record reviews, the facility failed to assure the medication administration records were accurate for 1 of 6 residents sampled (#3) including documentation of sliding scale insulin [Refer to Tag 367 10A NCAC 13F .1004(j) Medication Administration]. 25. Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration [Refer to Tag	D980		

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D980	Continued From page 157 378 10A NCAC 13F .1005(b) Medication Storage]. _____ The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations of the facility; failed to assure hazardous chemicals were safely stored and not accessible to residents; failed to assure that walls, ceilings and floors were kept in good repair as evidenced by a weak flooring in a common bathroom and resident, cracked walls, bubbled drywall, and peeling and flaking paint in 2 resident rooms; failed to assure the facility was free of flies and live roaches in the kitchen, dining room, one resident room, and two common resident bathrooms; failed to assure 2 of 6 staff sampled were compliant with the two-step TB skin test process; failed to assure 2 of 3 sampled staff had completed the required 80 hour personal care training and competency evaluation within 6 months of hire; failed to assure 4 of 6 sampled staff were competency validated for Licensed Health Professional Support (LHPS) tasks; failed to assure 2 of 4 medication aides received diabetic training prior to the administration of insulin; failed to assure that monthly weights were obtained as ordered for 1 resident; failed to assure 8 ounces of milk was served at least twice daily to the residents; failed to assure water was offered at each meal; failed to assure nutritional supplements and diet were served as ordered by the physician; failed to medications were administered by staff as ordered for two residents; failed to assure staff was accurately documenting insulin administration on the MAR for one resident; failed to assure staff stored medications safely; failed to assure 7 of 7 exit doors were equipped with a sounding device that activated when doors were opened with at least	D980		

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D980	Continued From page 158 one resident living in the facility who was intermittently disoriented; failed to maintain a sanitation score of 85 or above in the kitchen including no hand soap in the kitchen for hand washing and live roaches in the kitchen and the dining room; failed to assure 3 of 6 sampled staff had a North Carolina Health Care Personnel Registry or criminal background check upon hire which put the health, safety, and welfare of all the residents at risk for abuse and/or neglect; failed to assure there was at least one staff person on duty for 17 of 23 shifts from 10/22/18-11/15/18 who was CPR certified; failed to assure adequate staffing for 62 of 63 shifts sampled for the 7:00am - 3:00pm, 3:00 - 11:00pm, and 11:00pm - 7:00am shifts from 10/22/18-11/11/18 resulting in the residents not receiving assistance with bathing, assistance with changing linen, and other personal care needs; failed to assure screening for the presence of controlled substances prior to hire for 5 of 6 sampled staff who provided direct care to residents which included 3 medication aides who administered medications including controlled substances; failed to assure staff provided personal care assistance to residents including bathing, changing linen, and nail care; failed to assure 3 of 4 staff had received employment verification or completed requirements for medication aide training, including the 5, 10 or 15 hour state approved medication administration training courses, or completed a Medication Clinical Skills Competency checklist, or passed the written medication administration examination prior to performing unsupervised medication aide duties; failed to maintain the rights of the residents by not assuring the safety and well-being of two residents who were left stranded without return transportation to the facility for at least 3 hours who were inadequately clothed and exposed to	D980		

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D980	Continued From page 159 cool temperatures, and one resident not having access to supplemental oxygen and consequentially having to access emergency services due to shortness of breath; staff being aggressive and unprofessional to a resident by grabbing her legs and folding them forward touching the resident's face with the resident's legs during incontinence care and dressing; and to failed protect other residents from verbal and mental intimidation from a resident who exhibited agitated behaviors of yelling and screaming. The Administrator's failure placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening	D992		

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D992	Continued From page 160 of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure examination and screening for the presence of controlled substances was completed upon hire for 5 of 6 staff sampled (Staff A, B, C, D and F) sampled who were hired after 10/01/13. The findings are: 1. Review of Staff A's personnel record revealed: -The date of hire was documented as 09/12/18 as a personal care aide (PCA) / medication aide (MA).	D992		

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D992	Continued From page 161 -There was no documentation of a controlled substance screening prior to hire. -There was no signed consent for a controlled substance screening prior to hire. Telephone interview with Staff A on 11/15/18 at 1:30pm revealed: -She had worked as a MA for the last 6 months. -She had not taken a controlled substance screening prior to her being hired. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff A was hired as a medication aide (MA). -She did not know that Staff A had not completed a controlled substance screening prior to being hired. Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -Staff A was hired as a medication aide (MA). -She did not know that Staff A had not completed a controlled substance screening prior to her being hired. Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 2. Review of Staff B's personnel record revealed: -The date of hire was documented as 10/01/18 as a medication aide (MA). -There were results of a controlled substance screening dated 01/19/18. -There was no documentation of a controlled	D992		

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D992	Continued From page 162	D992		

substance screening prior to hire.
-There was no signed consent for a controlled substance screening prior to hire.

Telephone interview with Staff B on 11/14/18 at 5:10pm revealed:
-She had been working at the facility as a medication aide (MA) since October, 2018.
-She had left and came back as a rehire in October 2018.
-She had not been asked to take a controlled substance screening prior to rehire.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:
-Staff B was hired as a MA.
-She did not know Staff B had not completed a controlled substance screening prior to her being hired on 10/01/18

Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm.

Interview with the Manager on 11/14/18 at 4:55pm revealed:
-Staff B was hired as a MA.
-Staff B was a rehired in October 2018.
-She did not know Staff B had not completed a controlled substance screening prior to her being hired.

Refer to the interview with the Manager on 11/14/18 at 4:50 pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

3. Review of the Manager's personnel record revealed:
-The date of hire was documented as 08/02/18 as

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	HAL025023	A. BUILDING: _____ B. WING _____	11/16/2018

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GOOD SHEPHERD HOME FOR THE AGED	603 WEST STREET NEW BERN, NC 28560

(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
D992	Continued From page 163	D992		

a medication aide (MA).
-There were results of a negative controlled substance screening dated 08/02/18, but no documentation of what type of controlled substance were screened for.
-There was no signed consent for controlled substance screening to be performed.

Interview with the Manager on 11/14/18 at 4:55pm revealed:
-She was hired on 08/02/18 as a MA.
-She had worked as a MA until the end of September 2018 when she became the manager.

Refer to the interview with the Manager on 11/14/18 at 4:55pm.

Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed:
-The Manager was hired as a MA.
-She did not know the Manager had not taken a controlled substance screening prior to her being hired.

Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm.

Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm.

4. Review of Staff D's personnel record revealed:
-The date of hire was documented as 10/24/17 as a personal care aide (PCA).
-There was no documentation of a controlled substance screening prior to hire on 10/24/17.
-There was no documentation of a signed consent for controlled substance screening to be performed.

Attempted interview with Staff D on 11/15/18 at

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	HAL025023	A. BUILDING: _____ B. WING _____	11/16/2018

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D992	Continued From page 164 5:20pm was unsuccessful. Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff D was hired as a PCA. -She did not know Staff D had not completed a controlled substance screening prior to her being hired. Refer to interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -Staff D was hired as a PCA. -Staff D was a rehired in October 2018. -She did not know Staff D had not completed a controlled substance screening prior to her being hired. Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. 5. Review of the Staff F's personnel record revealed: -The date of hire was documented as 12/22/17 as a Personal Care Aide (PCA). -There was documentation that a controlled substance screening dated 12/22/17 had been performed. -There was no documentation of what type of controlled substance were screened for. -There was no signed consent for controlled substance screening to be performed. Attempted interview with Staff F on 11/16/18 at 8:12am was unsuccessful.	D992		

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D992	Continued From page 165 Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -Staff F was hired as a PCA. -She did not know Staff F had not completed a controlled substance screening prior to her being hired. Refer to the interview with the Assistant Manager on 11/14/18 at 4:50pm. Interview with the Manager on 11/14/18 at 4:55pm revealed: -Staff F was hired as a PCA. -She did not know Staff F had not completed a controlled substance screening prior to her being hired. Refer to the interview with the Manager on 11/14/18 at 4:55pm. Refer to telephone interview with the Administrator on 11/16/18 at 3:22pm. _____ Interview with the Assistant Manager on 11/14/18 at 4:50pm revealed: -She and the Manager had collected urine for a controlled substance screening on all employees on 10/26/18. -The results were kept in the Manager's office. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Assistant Manager had all the required documentation. -She and the Manager were responsible for auditing staff records. -She had not audited any staff records since being the Assistant Manager. -There was no scheduled or allotted time for the	D992		

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D992	Continued From page 166 staff records to be audited by her or the Manager. Interview with the Manager on 11/14/18 at 4:55pm revealed: -She and the Assistant Manager collected urine for a controlled substance screening on all employees on 10/26/18. -The results were kept in her office. -She did not have staff sign a consent form prior to taking the urine controlled substance screening. -She did not know what substances the controlled substance screening tested for. -She could not provide documentation of what type of controlled substance screening was used. -She had a list of staff names that had taken the controlled substance screening on 10/26/18. -She could not provide documented results of controlled substance screening any staff. -She thought all the staff records were complete and included all the required documentation. -She thought all the staff that were hired prior to her becoming the Manager had all the required documentation. -She and the Assistant Manager were responsible for auditing staff records. -She had not audited any staff records since being the Manager. -Staff from a sister facility had come in this week and audited all the staff records. -There was no scheduled or allotted time for the staff records to be audited by her or the Assistant Manager. Telephone interview with the Administrator on 11/16/18 at 3:22pm revealed: -She did not know there any problems with the staff records and the completion of screening for controlled substances prior to employment for staff.	D992		

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D992	Continued From page 167 -The facility had recently changed management and they were in the process of reviewing staff records. -She had a management team who was coming to the facility to help the current Manager update any needed records. _____ The facility failed to assure examination and screening for the presence of controlled substances for 5 of 6 sampled staff who were hired after 10/01/13 who provided direct care to residents; 3 of the 5 staff were medication aides and administered medications including controlled substances to residents. This failure was detrimental to the 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 11/15/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 31, 2018.	D992		