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TRANQUILITY CARE	**5100 LANSING DRIVE WINSTON SALEM, NC 27105**

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 10/12/21 through 10/13/21.	{D 000}		
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 observations and interviews, the facility failed to ensure the floors were kept clean related to hallway floors throughout the facility. The findings are: Observation of Hallway A floors on 10/12/21 from 8:45am to 5:00pm revealed: -There was a thick layer of a light colored and brownish to black colored build-up extending from the baseboards on each side of the hallway. -The build-up extended to 1 to 2 feet in the hallways in some areas. Observation of Hallway B floors on 10/12/21 from 8:45am to 5:30pm revealed: -There was a thick layer of a light colored and brownish to black colored build-up extending from the baseboards on each side of the hallway. -The build-up extended to 1 to 2 feet in the	D 074		

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hallways in some areas.
-There were two medication carts stationed outside of the dining hall on Hallway B.
-There was a brownish build-up and debris on the floor between the two medication carts.

Observation of Hallway C floors on 10/12/21 from 8:45am to 5:30pm revealed:
-There was a thick layer of a light colored and brownish to black colored build-up extending from the baseboards on each side of the hallway.
-There was a black grime build-up throughout the middle of the hallway floors on Hallway C.

Interview with a housekeeper on 10/12/21 at 12:00pm revealed:
-She was responsible for cleaning residents' rooms and bathrooms.
-She mopped the hallway floors if there was a spill, but she did not mop the hallway floors routinely.
-There was not a cleaning list that she followed.
-She thought second shift and third shift cleaned the floors by sweeping and mopping.
-She deep cleaned in residents' rooms once a month, but she did not think anyone deep cleaned the hallway floors.

Interview with the head housekeeper on 10/12/21 at 12:33pm revealed:
-The housekeepers were cleaning the hallway floors by dust mopping, mopping, and spray buffing the floor.
-The housekeepers stopped spray buffing the floor when the facility starting it's remodeling project; something happened to the buffer and he did not know if it had been fixed yet.
-The housekeepers were spray buffing the floors every other week.
-The grime on the floor on Hallway C was the

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result of someone spilling something sticky.
-He had tried cleaning the grime off the floor on Hallway C with his hands, but he could not get it up.
-The build-up on the floor along the halls of Hallways A, B, and C, would need spray buffing to get it up.
-There was no schedule for cleaning the hallway floors.

Interview with a resident on 10/13/2021 at 10:45am revealed:
-She noticed the sticky film on the hall floors after workers sanded the handrails down along the hallways.
-She thought the floors came clean when the staff swept and mopped them.

Interview with a resident on 10/13/2021 at 10:50am revealed:
-The film had been on the hallway floors for approximately one month.
-Staff cleaned the floors by sweeping and mopping but he had never seen them clean with a machine or scrub the floors.

Interview with the Administrator on 10/12/21 at 12:45pm revealed:
-The grime and build-up on the hallway floors would probably come up with buffing and scrubbing.
-Housekeeping had purchased a degreaser and tried to get the build-up up from the floor, but it did not work.
-The floors had not been buffed since 2019.
-Replacing the hallway floors was a part of the facility's remodeling project; she did not think about having the hallway floors deep cleaned because they would eventually be replaced, but she did not know when.

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D 074	Continued From page 3 Interview with the Administrator on 10/13/21 at 3:10pm revealed: -It was the housekeepers' responsibility to make sure the floors stayed clean. -She spoke to the owner of the building and the owner told her the floors of the facility were not supposed to be buffed or waxed. -If the housekeepers had been sweeping and mopping like they were supposed to, the hallway floors would not look the way they did. -The housekeepers were responsible for for sweeping and mopping daily to prevent the build-up from accumulating on the hallway floors.	D 074		
{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: Based on observations, interviews, and record reviews the facility failed to ensure personal care was provided to 1 of 6 sampled residents (#4), who required staff's assistance with bathing. The findings are: Review of Resident #4's current FL2 dated 06/10/21 revealed: -Diagnosed included diffuse traumatic brain	{D 269}		

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{D 269}	Continued From page 4	{D 269}		

injury, aphasia, apraxia, polyneuropathy, and chronic pain syndrome.
-He required assistance with bathing and dressing.

Review of Resident #4's care plan dated 01/27/21 revealed:
-He was non-ambulatory and needed a wheelchair.
-He was totally dependent on staff to assist with bathing, grooming, and personal hygiene.

Review of Resident #4's Activities of Daily Living (ADL) log for October 2021 revealed:
-There was an entry for Shower/Bathing: skin care - including face, hands, and feet scheduled for between 7:00am and 2:59pm, between 3:00pm and 10:59pm, and between 11:pm and 6:59am.
-There was documentation Resident #4 was assisted with bathing - skin care including face, hands, and feet three times daily from 10/01/21 through 10/12/21.
-There was an entry for Shower/Bathing: lower body, assist Resident with washing lower part of body including legs and feet from 3:00pm to 10:59pm.
-There was documentation Resident #4 was assisted with washing the lower part of his body including his legs and feet on 10/01/21, 10/04/21, 10/06/21, 10/08/21, and 10/11/21.
-There was an entry for Shower/Bathing: sponge bath, provide sponge bath on non-shower days scheduled between 3:00pm and 10:59pm.
-There was documentation Resident #4 was provided a sponge bath on 10/02/21, 10/03/21, 10/05/21, 10/07/21, 10/09/21, 10/10/21, and 10/12/21.
-There was an entry for Shower/Bathing: either a shower or tub bath scheduled between 3:00pm

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{D 269}	Continued From page 5 and 10:59pm. -There was documentation Resident #4 was assisted with a shower or tub bath on 10/01/21, 10/04/21, 10/06/21, and 10/11/21. -There were no documented refusals of assistance with bathing. Review of the ADL Staff Assignment Logs for Resident #4 for October 2021 revealed: -There were daily logs which documented Resident #4 was to receive a bath on Tuesday, Thursday, and Saturday between 3:00pm and 11:00pm, but there was no documentation of the type of bath received (sponge bath, shower, tub bath). -When staff provided bathing assistance to Resident #4, staff initialed beside his name to document a bath was provided. -On 10/01/21 (Friday), there was no documentation Resident #4 received a sponge bath, shower or tub bath. -There was no ADL Staff Assignment Log present for 10/02/21 (Saturday) or 10/03/21 (Sunday) for Resident #4. -On 10/04/21 (Monday), there was no documentation Resident #4 received a sponge bath, shower or tub bath. -There was no ADL Staff Assignment Log present for 10/05/21 (Tuesday) or 10/06/21 (Wednesday) for Resident #4. -On 10/07/21 (Thursday), there was documentation Resident #4 received a bath. -On 10/08/21 (Friday), there was no documentation Resident #4 received a sponge bath, shower or tub bath -On 10/09/21 (Saturday), there was no documentation Resident #4 received a sponge bath, shower or tub bath. -On 10/10/21 (Sunday), there was documentation Resident #4 received a bath.	{D 269}		

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-On 10/11/21 (Monday), there was no documentation Resident #4 received a sponge bath, shower or tub bath.
-On 10/12/21 (Tuesday), there was documentation Resident #4 received a sponge bath, shower or tub bath.
-There was no documentation Resident #4 refused a bath on either date.

Observation of Resident #4 on 10/13/21 at 8:54am revealed:
-Resident #4 was sitting outside in the smoking area in his wheelchair.
-Resident #4 did not have any shoes or socks on his feet and his toes were soiled with a black substance.
-There was also a black substance between each of his toes, and in the areas between the toenails and the skin surrounding the nails.
-There was a black substance on the bottom of Resident #4's feet.
-Resident #4 had thick white flakes in his hair and beard.

Interview with Resident #4 on 10/13/21 at 8:55am revealed:
-His bath days were on Tuesdays, Thursdays, and Fridays and he required assistance from staff with his baths.
-During his baths, staff assisted him by washing his back.
-Sometimes he was able to wash his own feet and sometimes he was not.
-He had asked for help in the past with washing his feet, but he was told by staff he had to do it himself.
-He preferred to have a tub bath and he had never refused a tub bath or a shower.
-Staff poured shampoo in his hands and he washed his own hair.

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{D 269}	Continued From page 7 -He last washed his hair and bathed last Thursday, 10/07/21. -Last Sunday, 10/10/21, staff asked him if he wanted a bath and he said yes, but the staff never came back to assist him to the bathroom for a bath. -He was not asked if he wanted a bath on yesterday, 10/12/21, which was his bath day (Tuesday). -No staff offered to assist him with washing his feet today, 10/13/21, and he did not ask for assistance. -He went barefoot a lot. -He had shoes and socks, but it was hard for him to put his shoes and socks on by himself. -Staff had to assist him putting his socks and shoes on. Telephone interview with a personal care aide (PCA) on 10/13/21 at 10:48am revealed: -Resident #4 needed staff assistance with bathing. -She last assisted him with a bath on Monday, 10/11/21. -Resident #4 did not want her assisting him much with his bath and he washed his own feet and hair. -She assisted him by washing his back and back side. -Resident #4 did not bathe regularly, he got a good bath on 10/11/21 because the sides of the tub were gray. Telephone interview with a second PCA on 10/13/21 at 12:44pm revealed: -Resident #4 liked to take a tub bath. -Resident #4 refused baths at times, but he would take them. -Resident #4 required assistance with his baths, and staff assisted him with getting in and out of	{D 269}		

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the tub, washing his back and bottom and with drying off.
-Resident #4 washed his own feet.
-Resident #4's feet were dirty because he did not like to wear socks and used his feet to scoot around in his wheelchair.
-Resident #4 washed his own hair.
-Resident #4 had flakes in his hair and beard because he liked to stay outside smoking and got sunburned from being outside.
-Resident #4 received baths on Tuesdays, Thursdays, and Saturdays.
-She had not offered to wash Resident #4's feet or assist with washing his hair on non-bath days and did not know if other PCAs offered.
-Resident #4 should have received a bath on 10/12/21.

Telephone interview with a third PCA on 10/13/21 at 12:57pm revealed:
-She assisted Resident #4 with baths during her shift, but she did not provide a bath for Resident #4 on 10/12/21 because he did not want one.
-She told the MA who worked during her shift on 10/12/21 that Resident #4 refused a bath.
-Resident #4 last received a shower last week with the assistance of another PCA, but she did not remember which day.
-She noticed Resident #4's feet were dirty sometimes, and she tried to get him to take a tub bath.
-She told Resident #4 he needed to wear socks to keep his feet from getting dirty.
-She had not noticed any flakes in Resident #4's hair or beard.

Interview with the Resident Care Coordinator (RCC) on 10/13/21 at 1:22pm revealed:
-Resident #4 liked to take tub baths.
-Resident #4 sometimes refused baths, but not

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{D 269}	Continued From page 9 often. -She was not sure if staff assisted Resident #4 with his baths or with washing his feet. -He used a wheelchair to ambulate and did not like to wear shoes or socks. -He sat in his wheelchair sometimes with his feet curled underneath the wheelchair and the top of his feet touched the ground. -She would expect for staff to assist with baths or with washing Resident #4's feet if they saw his skin was dirty even if it was not his bath day. Interview with Resident #4's primary care provider (PCP) on 10/13/21 at 11:03am revealed: -Staff reported to her Resident #4 refused to wear shoes and refused showers. -Resident #4's feet were always dirty because he would not wear socks. -She expected staff to assist Resident #4 with washing his feet on non-bath days if he would let them. Interview with the Administrator on 10/13/21 at 2:16pm revealed: -Staff assisted Resident #4 with tub baths. -Resident #4 used to refuse baths, but she was not aware of any current refusals. -Staff assisted Resident #4 with his baths and should have assisted Resident #4 if he needed a bath on non-bath days. -She saw Resident #4's feet were dirty yesterday on 10/12/21, but she thought a second shift PCA would have assisted him with a bath or washed his feet.	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	{D 273}		

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{D 273}	Continued From page 10 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure an outside provider referral for 1 of 5 sampled residents (#2) who had a referral for a nail consult from the primary care provider (PCP) due to skin overgrowth under his fingernails and his fingernails needed to be trimmed. The findings are: Review of Resident #2's current FL2 dated 02/03/21 revealed diagnoses included closed head injury, abdominal distention, partial bowel obstruction, neuropathy, overactive bladder, cholecystitis, and osteoporosis. Review of Resident #2's care plan dated 02/04/21 revealed: -Resident #2 was non-ambulatory and needed a wheelchair. -Resident #2 was totally dependent on staff for grooming and personal hygiene. Observation of Resident #2 on 10/12/21 at 12:11pm revealed: -The right hand, thumb fingernail and index fingernail were one-half inch beyond Resident #2's fingertips. -The fingernails on the other fingers of the right hand were one-fourth inch beyond Resident #2's fingertips. -The left hand, thumb fingernail and little finger, fingernails were one-half inch beyond Resident #2's fingertips. -The fingernails of the other fingers of the right	{D 273}		

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{D 273}	Continued From page 11	{D 273}		

hand were one-fourth inch beyond Resident #2's fingertips.

Interview with Resident #2 on 10/12/21 at 12:12pm revealed:
-The PCP told him he had some type of skin growth under his fingernails.
-The facility staff did not cut his fingernails.
-The PCP had cut his fingernails before, but it had been 3 or 4 months since his fingernails were last cut.
-He had to bite his nails to reduce the length of them.

Interview with a personal care aide (PCA) on 10/13/21 at 10:48am revealed:
-All PCAs were responsible for providing nail care as needed for residents.
-She noticed Resident #2's fingernails needed to be clipped about 2 weeks ago; she and the medication aide (MA) on duty at that time went to search for fingernail clippers, but they were broken.
-She did not know if there had been any follow-up with nail care for Resident #2.

Interview with Resident #2's PCP on 10/13/21 at 11:03am revealed:
-She did not expect for staff to clip Resident #2's fingernails.
-Resident #2 had a condition where the skin grew and attached to the underside of the fingernail as it grew.
-The condition caused it to be painful for Resident #2 to get his fingernails clipped.
-She wrote an order for Resident #2 to have his fingernails clipped by an outside provider towards the beginning of the pandemic, but she did not remember when.
-She did not know if the facility scheduled

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{D 273}	Continued From page 12 Resident #2 to be seen by an outside provider, but she knew everyone was far behind due to the pandemic. Interview with another PCA on 10/13/21 at 12:57pm revealed: -She knew Resident #2's fingernails were long. -She had tried to trim Resident #2's fingernails before, but he had skin under his fingernails, and it hurt him when she tried to trim them. -She had not talked to anyone about the skin under Resident #2's fingernails and that it was painful to trim. Interview with the Resident Care Coordinator (RCC) on 10/13/21 at 1:22pm revealed: -Resident #2's PCP mentioned to her that Resident #2 had some type of skin growth under his fingernails and the PCP told her to make an appointment for Resident #2 to get his fingernails clipped by an outside provider. -She did not remember when the PCP told her to make an appointment for Resident #2, but she thought it was in 2021. -She did not know whether or not there was an actual order to get Resident #2's fingernails clipped. -Sometimes, Resident #2's PCP came to the facility to see residents and told her to schedule appointments for residents, but sometimes, she did not write an order. -She was responsible for making appointments for residents to be seen by outside providers. -She did not remember if she made an appointment for Resident #2 to be seen by a provider to get his fingernails clipped. -Resident #2 had not been seen by a provider to have his fingernails clipped. A second interview with the RCC on 10/13/21 at	{D 273}		

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{D 273}	Continued From page 13 3:12pm revealed: -The RCC received a return text from Resident #2's PCP after the RCC sent an initial text Resident #2 being seen by an outside provider regarding his fingernails. -The PCP texted the RCC that there was an order written for a nail consultation in July 2020 and she had found the order in Resident #2's chart. -The PCP documented in the text that right after she wrote the order for the nail consultation, Resident #2 had a kidney stone and "all that mess" with his bladder and she thought it just got delayed. -She had not followed back up with Resident #2's PCP regarding Resident #2's fingernails since the PCP told her to schedule an appointment for a nail consultation in July 2020. -She just did not think about Resident #2's fingernails after speaking with the PCP in July 2020. Interview with the Administrator on 10/13/21 at 2:16pm revealed: -She was not aware of the skin growth condition with Resident #2's fingernails or that the PCP spoke to the RCC regarding making an appointment for a nail consult. -The RCC was responsible for making appointments for residents when the PCP made referrals or wrote orders for residents to be seen by outside providers. -There had been an issue with the PCP making referrals, but not putting the referrals or orders in writing.	{D 273}		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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(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 observations, record reviews and interviews the facility failed to administer treatments as ordered by a licensed prescribing practitioner for 1 of 6 sampled residents (Resident #3) related to oxygen.

Findings are:

Review of Resident #3's current FL2 dated 08/04/21 revealed:
-Diagnoses included chronic obstructive pulmonary disease with hypoxia, schizoaffective bipolar disorder and nicotine dependence.
-There was an order for continuous oxygen at 3 liters (L) per minute via nasal cannula, Resident may go out to smoke periodically .

Review of Resident #3's electronic Medication Administration Records (eMAR) for August 2021, September 2021 and October 2021 revealed:
-There was an entry for oxygen to be worn continuously at 3L via cannula, Resident may go out to smoke periodically.
-There was entry for oxygen 3L continuously and documentation oxygen 3L was administered continuously for each shift, from 7:00am to 3:00pm, from 3:00pm to 11:00pm and from 11:00pm to 7:00am.
-There were no refusals documented.

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D 358	Continued From page 15 Observation of Resident #3 at various times on 10/12/21 through 10/13/21 revealed: -Resident #3 was walking in the hallway without oxygen. -Resident #3 was in the dining hall without oxygen. -Resident #3 was smoking cigarettes on the patio without oxygen. -Resident #3 sat in a chair in the hallway by the medication cart waiting for staff to give his medications without oxygen. Observation of Resident #3's room on 10/12/21 at 11:44am revealed: -There was an oxygen concentrator beside Resident #3's bed. -Resident #3 was laying on the bed and appeared short of breath but was able to speak full sentences. -He did not have his oxygen on, he was holding the nasal cannula in his hand. -Resident #3's oxygen was set at 6L. -There were 2 large oxygen tanks available in Resident #3's room, both meters were empty in the red area. -There were no other portable oxygen tanks in the facility. Interview with Resident #3 on 10/12/21 at 11:45am revealed: -His oxygen was supposed to be set at 3-4L. -The large oxygen tanks in his room were for power outages. -He did not know his oxygen was currently set at 6L or how long it had been set at 6L, he kept it between 3-4L. -He wore oxygen when he felt short of breath, not all the time. -His doctor knew he only wore his oxygen when he thought he needed to.	D 358		

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D 358	Continued From page 16 -He had portable oxygen tanks and another machine that sat on top of his concentrator, but it was too noisy, and his insurance did not pay for it so he told staff to remove it. -He did not wear oxygen when he walked in the hallways or when he went to the dining hall because he did not need it. -He went on weekend outings with his family without his oxygen because he did not need it. -He took his concentrator if he went to his family member's home for long holidays. -He was not having any difficulty breathing or shortness of breath. -He wanted the small tanks he could carry on his shoulder when he went to visit his family member. Interview with a medication aide (MA) on 10/12/21 at 12:00pm revealed: -She did not know Resident #3's oxygen order was to wear continuously except to smoke. -She thought his oxygen order was only when he was in his room. -She read Resident #3's oxygen order from the eMAR. -MAs were responsible for making sure oxygen was on Resident #3 when he was in his room. -She did not check or adjust his oxygen liters because the oxygen provider sat it when the concentrator was delivered. -When MAs documented on the eMAR, they were documenting that they walked to his room and saw he had his oxygen on, not the liters he received. -She has not known Resident #3 to ever change the oxygen level himself from 3L to 6L. -The large oxygen tanks in his room were for power outages. -She knew the 2 tanks in his room were empty and she and the Resident Care Coordinator(RCC) had called the oxygen provider	D 358		

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multiple times to replace them but she did not know when the oxygen provider was called.
-He had an oxygen refill machine and portable tanks before, she did not remember the date, but he asked for it to be taken out because it was noisy.
-She was unsure of the date he last had the oxygen refill machine and portable tanks.
-She did not know who took the oxygen refill machine out of his room nor where they took the machine.
-The facility had portable oxygen tanks on rolling holders in storage for residents, but he would not use the portable tanks when staff offered them to him, only his concentrator when in his room.
-He said repeatedly that he did not need oxygen all the time even though the provider told him he needed it.
-He told the PCP he did not need oxygen all the time and the PCP had seen him many time out of his room without his oxygen.

Interview with a personal care aide (PCA) on 10/12/21 at 12:30pm revealed:
-Resident #3 wore his oxygen in his room, but he did not wear oxygen outside of his room.
-She did not know Resident #3 was always supposed to have his oxygen on except to smoke.
-She had seen Resident #3 with portable oxygen tanks in his room months ago, she did not remember the date, but he still did not use them when staff reminded him at that time.
-She did not know what happened to the other machine that was on top of his oxygen concentrator or small oxygen tanks.
-The MAs or the Resident Care Coordinator (RCC) were responsible to monitor residents' oxygen.

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Interview with a second MA on 10/12/21 at 3:35pm revealed:
-She did not know Resident #3's oxygen order was supposed to be to wear continuously except to smoke.
-She thought his oxygen order was 2L as needed.
-MAs were responsible for making sure oxygen was on as ordered for Resident #3.
-She did not check or adjust his oxygen liters.
-The large oxygen tanks in his room were for power outages.
-She knew the 2 tanks in his room were empty and she and home health had been called to replace them, but she did not know the date home health were called.
-When MAs documented on the eMAR, they were documenting that they walked to his room and saw he had his oxygen on.
-He had an oxygen refill machine and portable tanks before, but she was unsure of the date he last had the oxygen refill machine and portable tanks in his room.
-She did not know who took the oxygen refill machine out of his room.
-He had refused to use the small portable oxygen tanks every time she worked when he had the small portable tanks in his room and said that he did not need oxygen all the time.

Telephone interview with a representative from the oxygen provider on 10/12/2021 at 4:15pm revealed:
-There was a current order dated 9/26/2021 for Resident #3 a home fill system and tanks that was faxed to the company on 10/11/2021 and an employee would deliver the order that day, 10/12/2021.
-There was no record of the order received before 9/28/2021.
-The previous order for the same equipment was

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dated 1/08/202,1 but there was no record of that equipment being returned to the company.

Observation on 9/12/2021 at 4:30pm revealed there was an piece of equipment in the medication cart storage room labeled "HomeFill" sitting on top of other equipment and boxes by the drink machine. There was no resident name on the equipment.

Observation on 9/12/2021 at 4:40pm revealed the Administrator entered the medication cart storage room , talking on her cell phone and said "Here it is. I can take it to the room and hook it up and let you here the sound it makes. "and she removed the "HomeFill" equipment from the stack of equipment and carried it out of the room.

Observation of Resident #3's room on 10/13/2021 at 8:10am revealed:
-There was an oxygen concentrator set at 3L with a home fill system attached to the top.
-There were 4 small portable oxygen tanks without gauges in a storage rack, 1 with a gauge in red in a black cloth carrier and 1 large oxygen tank in a rack by the closet door.

Observation of Resident #3 on 10/13/2021 at 8:14am revealed him sitting in a chair in the hall outside of the dining room without oxygen.

Interview with Resident #3 on 10/13/2021 at 8:15am revealed:
-A refill system and 5 tanks were delivered late yesterday, 10/12/2021.
-He knew how to refill the tanks from the refill system.
-He was not wearing his portable tank because he was going to smoke.

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Interview with the Resident Care Coordinator (RCC) on 10/13/21 at 9:10am revealed:
-She was responsible to ensure oxygen treatment orders were followed by the staff.
-Resident #3 had an order for oxygen 3L continuously, he can take it off to smoke.
-She did not know Resident #3's oxygen concentrator was set to deliver 6L.
-Resident #3 had refused to wear his oxygen for months even after the primary care provider (PCP) told him he needed his oxygen all the time.
-He agreed to use the oxygen concentrator but still refused to use the portable tanks outside of his room when he had them.
-He had a refill system on his concentrator and small portable tanks once, she was unsure of the date, but he sent it back because he had to pay for it.
-The facility had all the extra oxygen tanks picked up by the oxygen provider after the last survey she believed in early July 2021.
-There were oxygen tanks of all sizes including small portable ones that were returned but she did not know if any of them belonged to Resident #3.
-There were no extra portable oxygen tanks in facility storage for Resident #3 to use.
-She knew the 2 large oxygen tanks in his room were empty and she had called the oxygen provider numerous times to replace the tanks.
-She faxed the PCPs order for his home fill oxygen system 2 times on September 28, 2021 and October 11, 2021

Telephone interview with Resident #3's PCP on 10/12/21 at 15:20pm revealed:
-Resident #3 had an order for oxygen at 3L continuous, he could take it off to go smoke.
-She expected the staff to encourage him to wear

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D 358	Continued From page 21 his oxygen continuously at 3L except when smoking. -She had to convince him to wear the concentrator in his room when it was ordered. -He had an oxygen refill system and tanks but continued to refuse to wear the portable oxygen outside of his room. -She did not know Resident #3's oxygen was currently set at 6L. -Staff reported to her during every visit that Resident #3 would not where his oxygen continuously. -She last saw Resident #3 on 9/23/21 and he was having shortness of breath and oxygen saturation of 86%. -The order was faxed 2 times to the oxygen provider. She could not remember the first date, but the second date was 10/11/21. -She followed up herself on 10/12/2021 with an employee at the oxygen provider, but normally she would expect the RCC at the facility to follow up on her orders. -Resident #3 had a home fill system before but it made too much noise, so she ordered from another oxygen provider, then the company was bought out and she guessed his order was lost in the buyout. -She thought he had extra portable tanks to use at the facility. Interview with the Administrator on 10/13/21 at 9:40am revealed: -She and the RCC were responsible to ensure the providers treatment orders were carried out including Resident #3's oxygen orders. -Resident #3 repeatedly refused to wear his oxygen, even when he had small portable tanks even though the PCP had spoken told him that he needed to where his oxygen all the time. -The refill system in the facility 10/12/2021 was	D 358		

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D 358	Continued From page 22 from his room but she could not remember the date it was taken out of his room. -The oxygen provider never brought any small portable tanks, they only left the 2 large tanks that were sitting in his room. -Resident #3's PCP told her the home fill system made too much noise and to remove it and she would call an oxygen provider she knew, and have it replaced. -The second oxygen provider delivered another oxygen refill system, she did not know the date, but came back to pick it up the next month because the insurance would not pay due to double billing. -There were no portable oxygen tanks available for residents ordered oxygen except the ones in their rooms. -She knew the 2 tanks in Resident #3's room were empty, and the oxygen provider had been called to replace them, she was unsure of the date.	D 358		
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 ensure all residents were treated with respect, consideration, and dignity related to a resident (#2) only being offered a sponge bath. The findings are:	D911		

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Review of Resident #2's current FL2 dated 02/03/21 revealed:
-Diagnoses included closed head injury, abdominal distention, partial bowel obstruction, neuropathy, overactive bladder, cholecystitis, and osteoporosis.
-Resident #2 was non-ambulatory and used a wheelchair.
-Resident #2 required assistance with bathing and was incontinent of bladder and bowel.

Review of Resident #2's care plan dated 02/04/21 revealed:
-Resident #2 was non-ambulatory and needed a wheelchair.
-Resident #2 was totally dependent on staff for bathing.

Review of Resident #2's Activities of Daily Living (ADL) Log for September 2021 revealed:
-There was an entry for Shower/Bathing: sponge bath scheduled for 3:00pm to 10:59pm.
-There was documentation a sponge bath was given on 09/02/21, 09/04/21, 09/07/21, 09/09/21, 09/11/21, 09/14/21, 09/16/21, 09/18/21, 09/21/21, 09/23/21, 09/25/21, 09/28/29 and 09/30/21.
-There was an entry for Shower/Bathing: tub/shower scheduled for 3:00pm to 10:59pm.
-There was documentation a tub bath/shower was given on the same dates as the sponge bath.

Review of Resident #2's ADL Log for October 2021 revealed:
-There was an entry for Shower/Bathing: sponge bath scheduled for 3:00pm to 10:59pm.
-There was documentation a sponge bath was given on 10/02/21, 10/05/21, 10/07/21, and 10/09/21.
-There was an entry for Shower/Bathing:

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D911	Continued From page 24 tub/shower scheduled for 3:00pm to 10:59pm. -There was documentation a tub bath/shower was given on the same dates as the sponge bath. Observation of Resident #2 on 10/12/21 at 9:02 revealed: -Resident #2 was in his room sitting in his electric wheelchair. -Resident #2's clothes and skin appeared clean. -There were no odors observed. Interview with Resident #2 on 10/12/21 at 9:03am revealed: -"I can't get a bath (shower or tub bath)." -Staff said he was too big to get a bath. -He only received sponge baths and did not feel sponge baths were enough for him because he felt dirt on his hands and arms. -Staff provided him with a sponge bath before he got out of bed in the mornings. -During a sponge bath, staff washed his whole body. -His last sponge bath was this morning, but he would like to have a shower or tub bath. A second interview with Resident #2 on 10/12/21 at 12:11pm revealed: -Staff had given him a shower in the past, but the last time he received a shower was prior to the pandemic. -When he received his shower in the past, he sat in a manual wheelchair to take the shower and staff did not put him in a shower chair. "They say I'm too heavy or too big." -He had not recently asked the staff to assist him with a shower or tub bath because of staff previously saying he was too big. -Staff had not asked him if he wanted to take a shower or tub bath since prior to the pandemic.	D911		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY CARE	**5100 LANSING DRIVE WINSTON SALEM, NC 27105**

(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
D911	Continued From page 25	D911		

Interview with a medication aide (MA) 10/12/21 at 4:25pm revealed:
-Resident #2 received sponge baths on second shift.
-Resident #2 was scheduled for a sponge bath on Tuesdays, Thursdays, and Saturdays, but he received a sponge bath almost every day.
-Resident #2 required a 2 person assist for showers or tub baths.
-He never asked for a shower or bath.
-She did not know if the personal care aides (PCA) asked Resident #2 if he wanted a shower or tub bath on his shower/bath days.

Interview with a PCA on 10/12/21 at 4:31pm revealed:
-Resident #2 received sponge baths only and was scheduled for baths on second shift.
-She sometimes did not give Resident #2 a full bath because he was not ready to go to bed during her shift.
-Resident #2 sometimes received his sponge bath during third shift.
-Resident #2 required 2 staff to assist with transferring and incontinence care.
-She had never provided Resident #2 with a shower or tub bath and he had not asked for a shower or tub bath.
-She was talking to Resident #2 on yesterday and he told her he had not been getting showers.
-She told Resident #2 he was supposed to be getting a sponge bath, but to let the staff caring for him know he wanted a shower in the future.

Telephone interview with a PCA on 10/13/21 at 10:48am revealed:
-She gave Resident #2 sponge baths during her shift.
-Resident #2 had not requested a shower or a tub bath and she had never offered to give Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: ______ B. WING ______	R-C 10/13/2021

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#2 a shower or a tub bath.
-She had always been told by other staff Resident #2 only received sponge baths.
-Staff could shower Resident #2 if he asked for a shower; there just needed to be 2 people available to assist.

Telephone interview with a second PCA on 10/13/21 at 12:44pm revealed:
-Resident #2 was a 2 person assist from his bed to his electric wheelchair and from his electric wheelchair to bed.
-The person who trained her told her that Resident #2 only got sponge baths.
-She had never offered Resident #2 a shower or a tub bath.

Interview with the Resident Care Coordinator (RCC) on 10/13/21 at 1:22pm revealed:
-Resident #2 did not trust getting in the shower without falling so PCAs gave him a sponge bath.
-She did not know if the PCAs asked Resident #2 if he would like to have a shower or tub bath on his shower/bath days.
-PCAs were giving Resident #2 a shower and he was able to sit in the shower chair.
-Resident #2 had his electronic wheelchair repaired in the past, but she did not remember when.
-Resident #2 requested to stay in bed and to have a sponge bath while his wheelchair was being repaired.
-She did not think staff thought to ask Resident #2 if he wanted to continue getting a shower after he had requested sponge baths.

Telephone interview with Resident #2's PCP on 10/12/21 at 3:14pm revealed:
-Resident #2 never voiced to her that he wanted a tub bath or shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034104	A. BUILDING: ______ B. WING ______	R-C **10/13/2021**

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D911	Continued From page 27	D911		

-Staff should be able to assist Resident #2 with a tub bath or shower if they had a shower chair.
-Resident #2 required a 2 person assist and was able to stand and pivot.

Interview with the Administrator on 10/12/21 at 3:28pm revealed:
-Resident #2 received a shower on Tuesdays, Thursdays, and Saturdays and a sponge bath on Mondays, Wednesdays, and Fridays.
-It was her understanding Resident #2 received his shower while sitting on a shower chair or in his manual wheelchair.
-She did not know Resident #2 was not being offered a shower or bath.