STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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
C 000	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual survey from May 29, 2019 - May 31, 2019.	C 000		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. The findings are: Review of the facility's current license effective 01/01/19 revealed the facility was licensed for 6 total residents; with a maximum of 3 non-ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 05/29/2019.	C 022		

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C 022	Continued From page 1 Observation on 05/29/19 at 9:45am revealed: -One staff member, a live-in personal care aide (PCA) was on duty. -Resident #1 was standing outside at the entrance of the facility smoking a cigarette. -Resident #6 was sitting in a chair outside at the entrance of the facility. -Resident #2 was sitting in a geriatric chair in the living room next to Resident #4. -Resident #3 was sitting in a geriatric chair in the living room watching television. -Resident #4 was sitting in a geriatric chair watching television, in between Resident #2 and #4. 1. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses of leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncope. -Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented. Review of Resident #3's Care Plan dated 2/21/19 revealed: -Resident #3 required extensive assistance from staff with eating, toileting, ambulation, bathing, and transfers. -Resident #3 was totally dependent upon staff for ambulation. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 03/18/19 revealed the resident's LHPS tasks included assistance with ambulation and mechanical lift transfers. (A Mechanical lift is a device used to transfer individual's by placing a sling under the body and connecting the sling to the mechanical lift).	C 022		

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C 022	Continued From page 2 Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03 am revealed: -Resident #3 could not walk. -Resident #3 required extensive assistance from staff with bathing, dressing, and toileting. -Resident #3 required a one-person transfer using a mechanical lift. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). Interview with Resident #3 on 05/29/19 at 11:00am revealed: -Resident #3 had lived at the facility for a long time. -He liked living at the facility and watching television. Review of a court document dated 05/05/18 revealed Resident #3 was appointed a guardian of the person. Observations of Resident #3 intermittently on 05/29/19 from 9:45am - 11:33 am revealed: -The resident was talkative but could not stay focused in conversation and would divert to different off subject conversations. -The resident asked the same question repeatedly. -At 11:33 am on 05/29/19 the resident was checked out of the facility by his guardian who transferred the resident via personal vehicle and returned the resident to the facility on 05/30/19. Interview with Resident #3's hospice PCA on 05/30/19 at 9:21 am revealed the hospice PCA transferred Resident #3 with a mechanical lift with no assistance.	C 022		

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C 022	Continued From page 3 Interview with Resident #3's hospice nurse on 05/31/19 at 11:02am revealed: -The hospice nurse had worked with the resident quite a bit since being under hospice care. -The patient would need assistance in order to get out of the building in case of an emergency. Interview with a second live-in PCA on 05/31/19 at 10:56 am revealed she used the mechanical lift with no assistance to transfer Resident #3. Attempted telephone interview with Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38 pm. Refer to the telephone interview with Administrator on 05/31/19 at 3:06pm.	C 022		

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C 022	Continued From page 4 2. Review of Resident #1's current FL-2 dated 09/8/18 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, tobacco use, schizophrenia, and dementia. -There was documentation Resident #1 was intermittently disoriented. -There was documentation Resident #1 was ambulatory. Review of Resident #1's Care Plan dated 10/19/18 revealed Resident #1 required limited assistance from staff for bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. Interview with Resident #1 on 05/31/19 at 11:08am revealed: -He would get all the residents out of the facility including himself if there was a fire. -He had been through a fire drill at the facility. -The staff get the "senior citizens" out of the facility first during a fire drill. -The fire alarm sounding meant that there is a fire in the "house". Telephone interview with a family member of Resident #1 on 05/31/19 at 10:22am revealed: -She visits the resident every other day. -It depended on Resident #1's "state of mind" in regard to if he would know to exit the facility during a fire. Interview with Resident #1's primary care provider (PCP) on 05/30/19 at 5:06pm revealed she would be concerned that Resident #1 would not know when to return back into the building if a fire were to occur.	C 022		

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C 022	Continued From page 5 Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in personal care aide (PCA) on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 3. Review of Resident #4's current FL-2 dated 03/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety. -There was documentation Resident #4 was constantly disoriented. -There was documentation Resident #4 was semi-ambulatory and used a wheelchair to ambulate. -There was documentation Resident #4 required extensive care for bathing and dressing.	C 022		

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C 022	Continued From page 6 Review of Resident #4's Care Plan dated 12/11/18 revealed: -Resident #4 requires extensive assistance with eating, ambulation, bathing, dressing, and transfers. -Resident #4 was totally dependent upon staff for toileting and grooming. Observation of Resident #4 on 05/29/19 - 5/31/19 at varying times revealed: -The resident ambulated in a wheelchair which she propelled on her own. -Staff used a mechanical lift to assist Resident #4 with getting into and out of her bed. (A mechanical lift is a device used to transfer individuals by placing a sling under the body connecting the sling to the mechanical lift). Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am revealed: -Resident #4 used a mechanical lift for transfers and was not ambulatory but could propel her wheelchair in her bedroom. -Resident #4 was dependent on staff for her personal care needs but could independently eat meals without staff assistance. Telephone interview with Resident #4's guardian on 05/31/19 at 9:06am revealed: -The guardian visited two times a month. -Resident #4 might be able to get herself out of the facility in the event of a fire if she was in her wheelchair. -She believed the Resident #4 knew what the fire alarm was for. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	C 022		

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C 022	Continued From page 7 Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 4. Review of Resident #6's current FL-2 dated 10/01/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficit. -There was documentation Resident #6 was ambulatory. -There was documentation Resident #6 was constantly disoriented. -There was documentation Resident #6 was very hard of hearing. Review of Resident #6's Care Plan dated	C 022		

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09/28/18 revealed:
-Resident #6 was independent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferring.
-Resident #6 was receiving medications for mental illness.

Interview with Resident #6 on 5/31/19 at 11:02am revealed:
-If there was a fire in the facility he would first look for a fire extinguisher.
-He would get everyone out of the facility.
-It would be "up to" him to get all the residents out of the facility.
-He would tell the worker about the fire.
-He had not been through a fire drill at the facility.

Interview with a live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed Resident #6 had "short term memory loss".

Interview with Resident #6's guardian on 5/31/19 at 9:56am revealed:
-Resident #6 would know to evacuate the facility in case of a fire.
-The guardian was unsure if Resident #6 would know when it was safe to re-enter the facility.

Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm.

Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54".

Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm.

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C 022	Continued From page 9 Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 5. Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesphogeal reflux disease. -There was documentation the resident was constantly disoriented. -There was documentation the resident required total care for personal care assistance from staff. Review of Resident #2's Care Plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am revealed Resident #2 used a mechanical lift for transfers, was not able to ambulate and was totally dependent on staff for all of her needs. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift).	C 022		

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C 022	Continued From page 10 A second interview with the live-in PCA on 05/31/19 at 2:22pm revealed: -Resident #2 was completely dependent on staff to get her out of the facility in the event of a fire. -If a fire occurred while Resident #2 was in bed, she would drag the bed mattress with the resident on it out of the facility but Resident #2 was "heavy". Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm.	C 022		

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Review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm revealed:
-Staff included a live-in personal care aide (PCA) and the Business Office Manager (BOM).
-The total time for all residents to evacuate the facility was 5 minutes.
-The fire drill was completed at 1:35pm.
-The live-in PCA "pushed out Resident #2 first, then Resident #4 while the live-in PCA was telling everyone else to go out the front door, then the live-in PCA got Resident #3 out of the "house".

Review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54" revealed:
-Staff included a live-in PCA and the BOM.
-The total time for all residents to evacuate the facility was 9 minutes.
-The residents were in the living room during the drill.
-The live-in PCA told the residents to evacuate.
-The live-in PCA "got" the three non-ambulatory residents out of the facility one by one.

Interview with the BOM on 05/30/19 at 5:00pm revealed:
-She was responsible for performing unannounced fire drills for the facility every 3 months.
-During the fire drills, she pulled the fire alarm and observed the reactions of the live-in PCAs, resident reactions and timed how long it took to evacuate the residents.
-Staff had been trained in the event of a fire to always evacuate the residents at an exit away from the fire.
-If Resident #2 was in the bed, the live-in PCAs had been instructed to always get her out first followed by the other two residents (Resident #3

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and Resident #4).
-Staff had been instructed to always evacuate the resident that was located closet to the fire.
-Staff had been instructed to "holler" at Resident #1, Resident #5 and Resident #6 that there was a fire and to get out of the building.
-Resident #1, Resident #5 and Resident #6 could exit the building without any other prompting.

Observations on 05/31/19 from 2:00pm-3:00pm revealed:
-The facility was not equipped with a sprinkler system.
-The facility was ground level with no steps at the front door, a wheelchair ramp at both exit doors on each end of the facility, and an exit door in the dining room with one step that led to concrete at ground level.

Interview with a live-in PCA on 05/31/19 at 2:22pm revealed:
-She was always "scared to death" that she would not be able to get all of the residents out of the facility in time if there was a fire because she was the only staff person in the house.
-She was concerned because she would be responsible to get the 3 non-ambulatory residents out and make sure the other 3 residents residing in the facility were out safely.

Confidential staff interview revealed the staff thought it would be physically impossible to get all of the residents out of the facility if there was a fire because 3 of the residents were completely dependent on staff to exit the facility and then they would still have to make sure the other ambulatory residents responded to the fire alarm and exited the facility.

Telephone interview with the fire inspector

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C 022	Continued From page 13 (Assistant Fire Marshal) on 05/31/19 1:38pm revealed: -There was a major concern with one staff person getting three non-ambulatory residents out of the facility timely in the event there was a fire. -The staff person would have to physically move each non-ambulatory resident out which would take time. -He did not think that one staff person could move three non-ambulatory residents out of the facility and assure all of the other residents had evacuated in time in the event of an active fire. -If the facility had a sprinkler system it would greatly change the scenario and give one-person time to get each resident out of the facility. Interview with the Administrator on 05/31/19 at 3:06pm revealed: -The facility did not have a sprinkler system. -She did not have to have a sprinkler system. -In the day time there were staff within close proximity that could come to help the one staff working in the facility to get residents out of the facility in the event the fire alarm sounded. -She prayed to God there was never a fire in the facility. -She thought the other ambulatory residents residing in the home could evacuate the facility in the event of a fire independently without any staff assistance. -She was licensed for 3 nonambulatory residents but was not aware residents with cognitive impairments were "counted" as nonambulatory residents in the event of an emergency evacuation. _____ The facility failed to assure the building was equipped and maintained to allow the residents living in the facility who had physical and cognitive deficits to evacuate independently in case of an	C 022		

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C 022	Continued From page 14 emergency such as a fire. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019	C 022		
C 191	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the personal care and supervision needs for 4 of 6 sampled residents (Resident #1, #2, #3, #4 and #5). The findings are: Review of the facility's current license effective 01/01/19 revealed the facility was licensed for 6 total residents; with a maximum of 3 non-ambulatory residents.	C 191		

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C 191	Continued From page 15 Review of the daily census revealed 6 residents resided in the facility on 05/29/2019. Observation on 05/29/19 at 9:45am revealed one staff member, a live-in personal care aide (PCA) was on duty. Interview with a live-in PCA on 05/29/19 at 10:03am revealed: -She was the only staff currently present on duty. -She worked 48 hour shifts that started on Mondays at 2:00pm through Wednesday at 2:00pm, then reported back to work on Friday at 2:00pm and worked until Monday at 2:00pm. -She slept at night from 10:00pm to 6:00am in the live-in quarters of the facility. A second interview with the live-in PCA on 05/29/19 at 11:46am revealed: -The facility had an audible call alarm system that was activated when the residents pulled a "pullstring" that was located at the residents' bedside. -The call system's main unit hub was located in the live-in's sleeping quarters. -When the call system was activated by a resident an audible alarm was activated and an indicator light illuminated. 1. Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesphogeal reflux disease. -There was documentation the resident was constantly disoriented. -There was documentation the resident required total care for personal care assistance from staff.	C 191		

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C 191	Continued From page 16 Review of Resident #2's Care Plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm revealed: -Resident #2 used a mechanical lift for transfers, was not able to ambulate and was totally dependent upon staff for all of her needs. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). -Resident #2 could not activate the call system for staff help when the resident was in the bed. -She thought Resident #2 could not "comprehend" or know how or when to pull the string if she needed help. -Before she went to sleep at night she always made the sure the call system pull string was not in Resident #2's reach because she was afraid the resident would get tangled in the cord. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed Resident #2 was not physically or mentally able to call for help using the call system but when she heard her make any noises she would get up and check on her. Telephone interview with Resident #2's family member on 05/31/19 at 4:40pm revealed: -Resident #2 had dementia and was completely dependent on staff for all of her needs. -She was aware staff slept in the facility at night. Telephone interview with Resident #2's primary care provider (PCP) on 05/30/19 at 5:22pm revealed:	C 191		

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C 191	Continued From page 17 -Resident #2 should have 24-hour care and supervision and would expect staff to be awake in the facility at all times. -The PCP was unaware the facility had no awake 24-hour staff. -She had safety concerns because some of the residents could not communicate the need for help when the resident needed it. -She expected staff to be awake at all times for the care of the residents. Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Resident #2. Based on interviews, and record review, it was determined Resident #2 was not interviewable. Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with the Administrator on 05/31/19 at 3:19pm. 2. Review of Resident #4's current FL-2 dated 3/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety. -There was documentation the resident was semi ambulatory with a wheelchair. -The was documentation the resident was constantly disoriented. Review of Resident #4's Resident Register	C 191		

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C 191	Continued From page 18 revealed an admission date of 12/17/2003. Review of a court document revealed Resident #4 was adjudicated incompetent and appointed a guardian on 06/12/18. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm revealed: -Resident #4 used a mechanical lift for transfers, was not able to ambulate and was totally dependent on staff for all of her needs. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). -Resident #4 could not tell staff what she needed. -Resident #4 was confused at night. -Resident #4 could not activate the call system when she was in her bed. -She thought Resident #4 could not "comprehend" or know how or when to pull the string if she needed help. -Before she went to sleep at night she always made the sure the call system pull string was not in Resident #4's reach because she was afraid the resident would get tangled in the cord. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed Resident #4 could not remember how to call for help using the call system but when she heard her make any noises she would get up and check on her. Telephone interview with Resident #4's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -Resident #4 should have 24-hour care and supervision and would expect staff to be awake in the facility at all times. -The PCP was unaware the facility had no awake	C 191		

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24-hour staff.
-She had safety concerns because some of the residents could not communicate the need for help when the resident needed it.
-She expected staff to be awake at all times for the care of the residents.

Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Resident #4.

Based on interviews, and record review, it was determined Resident #4 was not interviewable.

Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm.

Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm.

Refer to the interview with the Administrator on 05/31/19 at 3:19pm.

3. Review of Resident #3's current FL-2 dated 09/15/18 revealed:
-Diagnoses included leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncope.
-There was documentation Resident #3 was non-ambulatory
-There was documentation Resident #3 was intermittently disoriented.

Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:22pm revealed:
-Resident #3 could not walk.
-Resident #3 wore 2 liters of oxygen at night.
-Resident #3 removed the nasal cannula

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throughout the night.
-Resident #3 did not like to wear his oxygen at night.
-Resident #3 required extensive assistance from staff with bathing, dressing, and toileting.
-Resident #3 required a one-person transfer using a mechanical lift transfer (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift).
-She told Resident #3 every night to keep his oxygen in his nose and the resident had his oxygen in his nose the "majority of the time" when she got up at night.

Interview with a second live-in PCA 05/30/19 at 3:12pm revealed at one time Resident #3 would not pull his call string to alert staff for help but when Resident #3 needed help he knew to pull his call string cord in his room.

Observations of Resident #3 intermittently on 05/29/19 from 9:45am - 11:33am revealed:
-The resident was talkative but could not stay focused in conversation and would divert to different off subject conversations.
-The resident asked the same question repeatedly.

Review of court document dated 05/05/18 revealed Resident #3 was appointed a guardian of the person.

Interview with the hospice nurse on 05/31/19 at 11:02am revealed:
-The hospice nurse had worked with the resident quite a bit since being under hospice care.
-Resident #3 was ordered to wear his oxygen at night that treated multiple diagnoses.
-Staff should monitor Resident #3 to make sure

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his nasal cannula was worn at night.
-Oxygen would help Resident #3 rest better at night.
-Supplemental oxygen would help keep Resident #3's oxygen saturations up at night when he was sleeping and lying flat in the bed.
-Resident #4's oxygen levels had been in normal range when checked.

Telephone interview with Resident #3's primary care provider (PCP) on 05/30/19 at 5:22pm revealed:
-Resident #3 should have 24-hour care and supervision and would expect staff to be awake in the facility at all times.
-The PCP was unaware the facility had no awake 24-hour staff.
-She had safety concerns because some of the residents could not communicate the need for help when the resident needed it.
-She expected staff to be awake at all times for the care of the residents.

Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Residents #3.

Attempted telephone interview with Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am.

Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm.

Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm.

Refer to the interview with the Administrator on 05/31/19 at 3:19pm.

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C 191	Continued From page 22 4. Review of Resident #6's current FL-2 dated 10/01/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficit. -There was documentation the resident #6 was ambulatory, constantly disoriented and was very hard of hearing. Review of Resident #6's Care Plan dated 09/28/18 revealed: -Resident #6 was independent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferring. -Resident #6 was receiving medications for mental illness. Interview with Resident #6 on 05/29/19 at 11:12am revealed: -He was very hard of hearing and could not hear anything out of his right ear. -He did not sleep well at night and had spoken with his primary care provider (PCP) about that. -He had a past history of a head injury, "I don't have a brain that works right". A second interview with Resident #6 on 05/31/19 at 11:02am revealed: -He had seen a string in his room (call string) but did not know what it was for. -When he got up at night he didn't need anything from staff and stayed in his room. Interview with a second live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed: -Resident #6 had told her he was not sleeping at night and when she did get up at night to check on the residents', Resident #6 was always up in	C 191		

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his room or in the shared bathroom.
-Resident #6 had "short term memory loss" but did not come out of his room at night.
-Resident #6 shared a bathroom with Resident #4.
-She always locked Resident #4's bathroom at night to keep Resident #6 from entering into Resident #4's room because she did not know Resident #6 that well since he had only lived at the facility a short time.
-She never saw Resident #6 anywhere in the facility at night except his bedroom or his bathroom when she got up to check on the residents.
-Resident #6 had "agitation" at times with staff but she was not aware of Resident #6 having agitation with other residents.
-Resident #6 would pace and become verbally loud if staff told him a specific time for something to be done and it was done at the specific time he was told and he would become agitated when he was out of cigarettes.

Telephone interview with Resident #6's primary care provider (PCP) on 05/30/19 at 5:22pm revealed:
-The PCP was unaware the facility had no awake 24-hour staff.
-She expected staff to be awake at all times for the care and supervision of the residents but was not concerned for the ambulatory residents needing staff assistance in the facility at night.

Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm.

Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm.

Refer to the interview with Administrator on

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C 191	Continued From page 24 05/31/19 at 3:19pm. 5. Review of Resident #1's current FL-2 dated 09/8/18 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, tobacco use, schizophrenia, and dementia. -There was documentation Resident #1 was intermittently disoriented and was ambulatory. Review of Resident #1's Care Plan dated 10/19/18 revealed: -Resident #1 required limited assistance from staff with bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. -Resident #1 was receiving mental health medication. Interview with Resident #1 on 05/31/19 at 11:08am revealed he knew there was a string to pull to call staff in his room but he had never used it. Interview with a live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed: -Resident #1 did not wander inside the facility or try to go outside at night after the door alarms were activated. -Resident #1 did not need staff assistance at night and was able to do all of his care independently. Telephone interview with Resident #1's primary care provider (PCP) on 05/30/19 revealed: -The PCP was unaware the facility had no awake 24-hour staff. -She expected staff to be awake at all times for the care and supervision of the residents but was not concerned for the ambulatory residents	C 191		

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C 191	Continued From page 25 needing staff assistance in the facility at night. Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with Administrator on 05/31/19 at 3:19pm. _____ Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm -She was a "light sleeper" and did not sleep all night. -She always slept with her door opened at night. -She would get up if she heard a "cough or something" but sometimes she did not get up at all to check on the residents. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed: -She did not sleep well at night and always got up at least twice during the night to check on the residents. -She typically activated the door alarms around 9:50pm, went to bed around 10:00pm and got up around 6:00am the next morning. Interview with the Administrator on 05/31/19 at 3:19pm revealed she was not aware awake staff were required 24 hours a day for the supervision of residents with physical or cognitive limitations, "that's new to me". _____ The facility failed to have awake staff on duty and awake at all times to meet the supervision and personal care needs for 4 of 6 sampled residents assessed as intermittently and/or disoriented. The	C 191		

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C 191	Continued From page 26 facility's failure was detrimental to health, safety, and welfare of the residents and constitutes a Type B Violation. _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019.	C 191		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up with the primary care provider for 1 of 4 sampled residents related to a resident having trouble swallowing her food for at least a week (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 3/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety. -There was documentation that the resident was semi ambulatory with a wheelchair. -There was documentation that the resident was	C 246		

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DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

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constantly disoriented.
-There was an order for no added salt diet.

Review of Resident #4's resident register revealed an admission date of 12/17/03.

Review of a court document revealed Resident #4 was adjudicated incompetent and appointed a guardian of the person on 06/12/18.

Review of Resident #4's Care Plan dated 12/11/18 revealed the resident requires extensive assistance with eating.

Observation Resident #4's lunch meal on 5/29/19 from 12:30 - 12:45pm revealed:
-The resident fed herself.
-The resident coughed constantly while eating.
-The resident made a constant gurgling sound while eating.
- The resident gagged while eating.

Observation of Resident #4's dinner meal on 5/29/19 at 5:00pm - 5:15pm revealed:
-The resident fed herself.
-Resident #4 begun coughing after her first bite of food.
-Resident #4 coughed constantly while eating.
-Resident #4 made a constant gurgling sound while eating.
-Resident #4 gagged while eating.
-The live-in personal care aide (PCA) was in the room during this time.
-The live-in PCA was providing feeding assistance to another resident.
-The live-in PCA observed Resident #4 had trouble swallowing her food.
-The live-in PCA asked Resident #4 if she was "alright".
-The live-in PCA encouraged Resident #4 to drink

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her beverage when coughing.

Interview with the live-in PCA on 5/30/19 at 9:20am revealed:
-She had noticed Resident #4 having trouble swallowing last week.
-She felt that Resident #4 needed a "swallowing test".
-Resident #4 "chewed her food she then pushed the food down with her tongue instead of being able to swallow it normally".
-She had noticed Resident #4 no longer ate all her food as she used too due to trouble swallowing.
-She had not reported Resident #4's swallowing issue to anyone.
-She did not document any of her observations or concerns because she did not have a notebook.
-There was no system in place of documenting concerns.
-Typically, she notified the medication aide/supervisor in charge (MA/SIC) of concerns during his medication pass.
-At times she forgot to tell the MA/SIC because she was "too busy".

Interview with the MA/SIC on 5/31/19 at 4:02pm revealed:
-He had not noticed Resident #4 having trouble swallowing.
-The live-in staff had not made him aware.
-Had he known of the swallowing difficulty he would have made Resident #4's primary care provider (PCP) aware.

Interview with the Administrator on 5/30/19 at 3:46pm revealed:
-She was not aware of Resident #4 had trouble swallowing food.
-She or MA/SIC would talk with Resident #4's

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C 246	Continued From page 29 PCP had she been made aware. -She would ask staff to chop Resident #4's food until the PCP addressed the swallowing concern. -She expected the live-in PCA to make management staff aware that Resident #4 had trouble swallowing which was the normal process of reporting. -The MA/SIC was responsible for healthcare referral and follow-up incidences. Review of a diet order signed by Resident #4's PCP on 5/30/19 for Resident #4 revealed a diet order for chopped foods. Observation of Resident #4's breakfast meal on 5/31/19 at 8:03am revealed: -Resident 4's breakfast meal was chopped. -Resident had trouble swallowing her food. -The live-in PCA asked Resident #4 if she was "alright". -The live-in PCA encouraged Resident #4 to drink her beverage. Interview with Resident #4's PCP 5/30/19 at 5:06pm revealed: -No one made her aware that Resident #4 had trouble swallowing for a week. -She expected the facility to make her aware that Resident #4 had trouble swallowing as soon as they noticed the problem or change. -She would order a modified barium swallow test for further evaluation. Based on observations, interviews, and record reviews, it was determined Resident #4 is not interviewable. _____ The facility failed to notify Resident #4's primary care provider of the resident's swallowing difficulties during meals which delayed	C 246		

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C 246	Continued From page 30 modifications made to her ordered diet and delayed diagnostic testing to assess and treat the resident's swallowing difficulties. This failure was detrimental to the health, welfare and safety of the resident which constitutes a Type B Violation. _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D - 34 on 5/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019.	C 246		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident who was diagnosed with advanced dementia and had an order for a pureed diet (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 03/07/19 revealed:	C 284		

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-Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesophageal reflux disease.
-There was an order for a no concentrated sweet (NCS) pureed diet.
-There was documentation the resident was constantly disoriented.
-There was documentation the resident required "total care" for personal care assistance from staff.

Review of Resident #2's Assessment and Care Plan dated 03/07/19 revealed:
-There was documentation the resident was always disoriented and had a significant memory loss and required direction.
-There was documentation the resident required extensive assistance from staff with eating.

Review of the facility's diet list posted on the refrigerator in the facility's kitchen on 05/29/19 at 12:05pm revealed Resident #2 was on a NCS, pureed diet.

Interview with a live-in personal care aide (PCA) on 05/29/19 at 12:06pm revealed:
-She made sure Resident #2's foods were cut into "smaller pieces" and she had been doing that for "years".
-She thought Resident #2 was on a pureed diet at one time because the resident could not swallow.
-She was aware the facility's diet list posted in the kitchen indicated that Resident #2's current diet order was for a pureed, no concentrated sweet diet.
-She was told by the Business Office Manager (BOM) that Resident #2's food did not have to be pureed unless "I wanted" to puree the resident's

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foods.
-She usually did not puree Resident #2's foods because the resident would not eat it and would spit the food back out if pureed.

Observation of Resident #2 during the lunch meal on 5/29/19 at 12:07pm revealed:
-Resident #2's food was prepared by the live-in personal care aide (PCA).
-Resident #2's food was not pureed.
-Resident #2 was served turkey, gravy, bow tie noodles, mashed potatoes, green beans, roll and mandarin oranges.
-The live-in PCA sat beside Resident #2 and assisted the resident to eat the meal.
-The live-in PCA used a spoon to cut the food up in small pieces before placing the food on the spoon and fed Resident #2 the foods cut into small pieces.
-Resident #2 made movements with her bottom jaw then swallowed the food without any observed difficulty.
-Resident #2 ate 100% of the plated food.

Observation of a second live-in PCA on 05/29/19 at 4:27pm revealed:
-The live-in PCA aide placed a cooked hamburger that was broken into pieces, bread and water in a blender.
-The live-in PCA left the blender running to puree the foods while she assembled the food on plates for the other residents.
-The live-in PCA stopped the blender and stirred the food and added more water and mayonnaise to the food and started the blender again to puree the food.
-After approximately 2 minutes, the live-in PCA stopped the blender and plated the pureed hamburger, bread and mayonnaise.
-The food was in a pureed consistency.

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C 284	Continued From page 33 -The live-in PCA pureed cooked French fries and water in the blender and stopped the blender at intervals and would shake the blender's glass canister and restart the blender until the food was in a mashed potato consistency, then plated the pureed French fries and used a fork to mash through the French fries. Observation of Resident #2 during the dinner meal on 5/29/19 at 5:00pm revealed: -The resident was served pureed hamburger/bun with mayonnaise, French fries, and apple sauce. -The second live-in PCA sat beside Resident #2 and assisted the resident to eat the meal. -Resident #2 swallowed the food without any observed difficulty. Interview with the second live-in PCA on 05/29/19 at 5:30pm revealed: -Resident #2 was on a pureed diet. -She always pureed all of Resident #2's foods before serving and feeding the resident. -She thought it was important for the foods to be in a "smooth", "pudding like" consistency with "no chunks" of food, so the resident could swallow the foods easily. -She had received training from "a lady" a few years ago (unable to recall the exact time) and had to demonstrate to the "lady" how to puree foods. -She knew what ordered diet each resident was on by referring to the diet list posted on the refrigerator. -She never saw any of the residents' diet orders but the BOM was responsible for updating the residents' diet order on to the posted diet list. -She occasionally would shake the blender's canister to make sure the foods were not on the side of the canister and to make sure the foods were in direct contact with the blades to remove	C 284		

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C 284	Continued From page 34	C 284		

any food chunks and pieces.

Telephone interview with Resident #2's guardian on 05/31/19 at 4:40pm revealed:
-Resident #2 had suffered a stroke and since then had been on a pureed diet and her speech was also effected by the stroke.
-There was one of the live-in PCAs (named as the live-in PCA that was observed on 05/29/19 that pureed the dinner meal for Resident #2) who was "a little more afraid" when she assisted Resident #2 with eating than the other live-in PCA that worked in the facility.
-She had visited when the other live-in PCA did not puree Resident #2's food and chopped "the food up good" instead of serving the food to the resident in a pureed consistency.
-The guardian had not observed Resident #2 having any difficulty swallowing food that was not in a pureed consistency, no observations of the resident coughing during a meal.

Interview with the BOM on 05/30/19 at 5:00pm revealed:
-She was responsible for updating the diet list for the facility which showed the latest diet ordered by the residents' primary care provider (PCP).
-The live-in PCAs were responsible for preparing the residents' meals according to the diet list.
-She had not instructed the live-in PCAs not to puree Resident #2's food.
-It was very important for Resident #2 to have her foods pureed so the resident would not choke.
-She did not physically monitor the meals served to the residents unless she was in the facility during the residents' meals.
-She had not observed staff serving foods that were not pureed.

A second interview with the live-in PCA that

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served Resident #2 food on 05/29/19 that was not pureed on 05/31/19 at 2:22pm revealed:
-Resident #2 could eat anything and ate better when she did not puree the resident's food.
-She would not give Resident #2 anything to eat that she thought would hurt her.
-She was not aware that a PCP's order was needed to serve Resident #2's a chopped diet instead of a pureed diet.
-Resident #2 never coughed, choked or seemed to have any problems when eating chopped food.
-The Administrator, medication aide/supervisor-in -charge (MA/SIC) and the BOM did not monitor the residents' meals or the preparation of the residents meal unless they just "pop in" when she was preparing or serving the residents' meals.

Interview with the MA/SIC on 5/31/19 at 4:06pm revealed:
-It was the responsibility of the office staff which includes the Administrator and BOM to ensure diet orders were being followed as ordered.
-He was not aware that Resident #2's meals were not always being served pureed.
-The live-in staff were aware that they were supposed to puree Resident #2's foods.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Interview with the Administrator on 5/31/19 at 3:06pm revealed:
-She never provided instruction concerning pureed diets.
-Puree was the easiest diet order to follow.
-There was no training provided to staff on the preparation of therapeutic diets.
-Office staff posted the diet orders in the kitchen for live-in PCAs to follow.

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C 284	Continued From page 36 -When a residents' diet order changed it was updated on the diet list, posted in the kitchen and verbally given to live-in staff by the BOM and administrative staff. -She was not aware that the live-in PCA aide was not following Resident #2's therapeutic diet order. -Her expectation was that Resident #2's food be prepared as directed by the diet order. Telephone interview with Resident #2's PCP on 05/30/19 at 5:22pm revealed: -Resident #2 was placed on a pureed diet for aspiration precautions because of advanced Alzheimer's disease. (Aspiration is when foods or fluids get into a persons airway which could lead to trouble breathing, lung infections and pneumonia. Aspiration precautions are practices which that help prevent foods or fluids from getting into a persons airway). -She expected staff to follow the residents' diet orders that had been given. _____ The facility failed to assure therapeutic diets were served as ordered for Resident #2 who was ordered to receive pureed foods for aspiration precautions and was observed receiving chopped foods during a meal observation. The facility's failure to assure Resident #2 received pureed foods was detrimental to the health and safety of the resident, which constitutes a Type B Violation. _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/30/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019	C 284		

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C 311	Continued From page 37	C 311		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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 A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by failing to stabilize the lift when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly. The findings are: Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesphogeal reflux disease. -There was documentation the resident was constantly disoriented. -There was documentation the resident required "total care" for personal care assistance from staff. Review of Resident #2's Resident Register revealed an admission date of 04/07/11.	C 311		

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Review of Resident #2's assessment and care plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring.

Review of Resident #2's Licensed Health Professional Support (LHPS) evaluations revealed:
-The resident's LHPS tasks included mechanical lift transfers. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift).
-There was documentation staff were competency validated for the quarterly reviews dated 04/08/19, 01/07/19,12/06/18, 09/05/18, and 06/08/18 for mechanical lift transfers.

Review of an "Accident/Incident Report" for Resident #2 dated 02/27/19 revealed:
-The resident was assisted to her room by staff around 8:00pm on 02/17/19.
-The staff "hooked up net to place the resident in bed" and realized there was one "hook" the staff forgot to "hook" and the resident fell to the floor.
-The staff contacted the Administrator and then called 911.
-The Administrator contacted Resident #2's family member.
-The resident was admitted to the hospital with a right hip fracture.
-There was documentation the Administrator completed and signed the form.

Review of Resident #2's hospital Inpatient Discharge Summary revealed:
-The resident was admitted on 02/27/19 and discharged on 03/06/19.
-There was documentation the resident's discharge diagnosis was a right hip fracture

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secondary to a mechanical fall.
-In the hospital course section of the Summary there was an entry on 02/27/19, the resident was placed in a mechanical lift and moved off her bed in order to be cleaned. The resident was not well secured "within the left" and the resident tumbled to the floor.
-On 02/24/19 an x-ray of the resident's hip and pelvis showed a minimally displaced fracture of the right hip.
-The resident underwent a surgical procedure for a intrameduallary nail fixation of the right hip (a metal rod forced into the cavity of the bone to treat the fracture).

Observation of the live-in personal care aide (PCA) assisting Resident #2 with transferring using a mechanical lift on 05/29/19 at 9:34am revealed:
-Resident #2 was pushed in a Geri-chair to her bedroom by the live-in PCA.
-Resident #2's bed was against the left long wall of the room.
-The live-in PCA positioned Resident #2's Geri-Chair beyond the bed and turned the Geri-chair sideways passed the end of the resident's bed. The live-in PCA pushed the wheels of the Geri chair in alignment with the chair and locked the wheels.
-The live-in PCA rolled a white colored mechanical lift base underneath the Geri-chair, then stopped.

Interview with the live-in PCA on 05/29/19 at 9:37pm revealed:
-The white colored mechanical lift belonged to Resident #2.
-She did not like this mechanical lift because it did not have clips and she "was not comfortable" using it but was more comfortable using the blue

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colored lift.
-She thought she had to use Resident #2's white colored mechanical lift today (05/30/19) during the observation of Resident #2's transfer but never used Resident #2's lift and always used the blue colored mechanical lift that belonged to another resident in the facility to transfer Resident #2.

A second observation of the live-in PCA assisting Resident #2 with transferring using the blue colored mechanical lift belonging to another resident on 05/29/19 at 9:38am revealed:
-The live-in PCA removed the white colored mechanical lift from Resident #2's room and brought in a blue colored mechanical lift.
-The live-in PCA told Resident #2 she was going to transfer her from the Geri-chair to the bed.
-Resident #2's transfer mesh sling was positioned underneath the resident in the Geri-chair.
-The live-in PCA straightened the sides and corners of the meshed sling positioned underneath Resident #2 and checked the positioning of the sling underneath the resident's upper back, sides and knees.
-The live-in PCA rolled the base of the mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift legs were not in an opened position.
-The live-in PCA hooked the color-coded sling loops onto the spreader bar with the red colored loops to support the top portion of the resident and the black colored loops to support the resident's lower portion, then checked each sling loop on the hook with the clips by walking on both sides of the chair checking each loop.
-The live-in PCA checked the pressure knob, slowly used the hand crank to the mechanical lift

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to raise Resident #2 from the Geri-chair and once cleared checked the pressure knob again to assure it was secure and in position, then moved the mechanical lift away from the Geri-chair and slowly positioned the mechanical lift toward the bed while guiding the resident's movement in the suspended sling until the resident was positioned in the sling over the bed.
-The live-in PCA centered Resident #2 over the bed and rotated the resident to face the foot section of the bed then slowly released the pressure knob and guided the resident onto the bed.
-During the transfer the live-in PCA did not widen the base of the mechanical lift legs to the maximum opened position.

A second interview with the live-in PCA on 05/30/19 at 9:41am revealed:
-She stopped using Resident #2's white colored mechanical lift in February 2019 after the resident fell from the lift.
-She was assisting Resident #2 back to the bed from the Geri-chair and became distracted by another resident that came to Resident #2's door asking her for a glass of milk as she was securing the resident's sling loops to lift and transfer the resident.
-She remembered as she turned around to tell the other resident she would be right there, she then noticed she had not placed any incontinent linen savers on Resident #2's bed and stopped in the process of securing the sling loops to place the incontinent linen savers on the bed.
-When she went back to complete Resident #2's transfer using the mechanical lift, she did not double check to assure all of the loops were secured and did not realize one of the bottom straps was not fastened.
-Resident #2 was lifted in the sling using the

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mechanical lift and when she pulled the lift away from the chair, Resident #2 fell out of the sling and onto the floor.
-Since Resident #2 fell from the lift she now always physically walks around the chair or bed to make sure all of the sling loops were hooked and secured instead of just leaning over to check the hooks.
-She had not used Resident #2's white colored mechanical lift since the incident in February 2019.
-She had never felt comfortable using Resident #2's mechanical lift "anyway" because it did not hook the sling loops like the other residents' lifts.
-She had never mentioned to the Administrator or to the medication aide/supervisor-in -charge (MA/SIC) that she was uncomfortable using Resident #2's mechanical lift.
-She had worked for the facility since 2007.
-She did not have any prior PCA experience and no previous experience operating a mechanical lift when she was initially hired.
-She received on the job training from a co-worker for the use of the residents' mechanical lifts.
-She thought years ago she had to do a return demonstration using a residents' mechanical lift for someone but was not sure if she was observed or passed off by a nurse or medical professional.
-She "seldom" widened the lift's base to the maximum opened position when transferring residents' in the mechanical lifts.
-She had to narrow the mechanical leg base to fit the lift under the Geri-chair.
-She did not know that widening the base of mechanical leg lifts stabilized the lift to prevent the lift from falling over.
-She could not remember a time that the Administrator nor the MA/SIC had observed her

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during the entire process of transferring a resident using a mechanical lift from start to finish.

A third observation of the live-in PCA on 05/30/19 at 2:04pm revealed:
-The live-in PCA assisted another resident sitting in a wheelchair to her room.
The live-in PCA locked the wheels of the wheelchair and explained to the other resident that she was going to transfer her from the wheelchair to the bed.
-The live-in PCA widened the base of the mechanical lift legs as she positioned the lift around the front of the resident's wheelchair and kept the lift legs in the maximum opened position during the resident's complete transfer from the wheelchair to the bed.

A third interview with the live-in PCA on 05/30/19 at 2:10pm revealed:
-Since the incident occurred in February 2019 with Resident #2 falling out of the mechanical lift she was not in a "hurry anymore" when she transferred residents using mechanical lifts and had started practicing safety checks to make sure everything was secure and in position before transferring and moving residents in mechanical lifts.
-She did not know if there was an owner's manual available for instructions on the use of Resident #2's mechanical lift or an owner's manual for use instructions for the other two mechanical lifts in the home that belonged to the other residents.
-No one had ever reviewed step by step instructions with her on the use and safety precautions that should be used when operating and transferring a resident using a mechanical lift.
-She had spoken with Resident #2's hospice

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provider today (05/30/19) to see if the resident could qualify for a new mechanical lift because the resident had this same mechanical lift for years.

Observation of Resident #2's mechanical Lift on 05/30/19 at 10:05am revealed:
-There was sticker on the center bar of the mechanical lift that provided a number for service of the lift and the name of the durable medical equipment provider (DME).
-There was a suspended spreader bar with six-point curved hooks to attach the patient lift sling that was not equipped with clips at the end however the bar hooks were curved and elongated.
-The serial number sticker was worn and unreadable.

Attempted telephone interview with the DME company for Resident #2's mechanical lift on 05/30/19 at 7:00pm and on 05/31/19 at 2:08pm was unsuccessful.

A second observation of Resident #2's mechanical Lift on 05/31/19 at 3:12pm revealed:
-There was a labeled "Caution" sticker with instructions printed in red font.
-There were instructions trained caregivers only should operate the equipment.
-Whenever possible two caregivers should be present during lifting and transferring.
-To ensure safety, frequent inspections of this equipment and its accessories should be performed by a qualified maintenance staff to detect wears and tears and worn parts replaced.
-Operating details were referred to the Owner's manual.

Observation of the mechanical lift used to transfer

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C 311	Continued From page 45 Resident #2 on 05/30/19 revealed a 6-point hooks with movable clips at the ends on the suspended spreader bar. Review of an online Owner's manual for the mechanical lift used to transfer Resident #2 on 05/30/19 revealed: -Before using the lift, please read and adhere to the safety precautions and warnings. Failing to do so could result in serious personal injury or damage to your personal lift. -Protect yourself, your attendant and the patient lift by having it serviced regularly. -There was an entry labeled "WARNING" patient lifts may tip over if used incorrectly. Read and adhere to the operating instructions prior to lifting anyone. There was a second entry labeled "WARNING" that it was strongly recommended that two caregivers take part in the lifting process. -There was a third entry labeled "WARNING" to ensure stability while lifting and transferring a patient, the patient lift legs must be locked in the maximum open position. -There was a fourth entry labeled "WARNING" to ensure the lifting sling loops were correctly attached to the hooks to prevent the patient from sliding or falling out of the sling, which could result in personal injury. Interview with the Administrator on 05/30/19 at 3:50pm revealed: -The facility did not have a written policy and procedure for the use of the residents' mechanical lifts and "they" just had the staff checked off on the use of the mechanical lifts before the staff used the lifts. -She was not aware that the live-in PCA was not comfortable using Resident #2's mechanical lift and did not know she was not using it.	C 311		

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C 311	Continued From page 46 -She thought the live-in PCA observed transferring Resident #2 today (05/30/19) had received training and was passed off to use a mechanical lift when she first began her employment at the facility. -She had observed the live-in PCA transfer a resident in a mechanical lift in the past but could not provide a date. -She thought additional training would be needed and that "maybe it was her fault" that she had not provided any additional training for staff after the incident occurred when Resident #2 fell out of the mechanical lift in February 2019. -She would have expected for staff to inform her immediately if they were not comfortable using any equipment including mechanical lifts. -She did not know that the live-in PCA was not routinely widening the base of the lift when transferring residents. Interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm revealed: -She was not aware of a process or procedure the facility had to ensure all resident equipment including mechanical lifts had been serviced or working properly. -She thought "we" needed to put something into place to have the equipment suppliers come to the facility to make sure the mechanical lifts were serviced and working properly. -She was not aware that any of the staff in the facility did not feel comfortable with Resident #2's mechanical lift. Interview with Resident #2's hospice nurse on 05/31/19 at 10:57am revealed: -She never saw staff at the facility use Resident #2's mechanical lift because the resident was always up in the Geri-chair when she visited. -It would be very important for the residents'	C 311		

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safety for staff to report if they were not comfortable using Resident #2's mechanical lift.

Telephone interview with the facility's contracted LHPS nurse on 05/31/19 at 1:58pm and at 4:02pm revealed:
-She recently started providing LHPS quarterly reviews for the facility around the Fall of 2018.
-She had not "signed off" on the staffs' skills to perform mechanical lift transfers.
-The facility should have a system in place to monitor staff using mechanical lifts to make sure the proper techniques and safety steps were followed by staff to protect the residents' safety.
-All mechanical lifts came with an instruction manual but most of the mechanical lifts were the same.

Interview with the MA/SIC on 05/31/19 at 4:09pm revealed:
-The facility did not have a policy for the use of the residents' mechanical lifts used for transferring.
-There were no manuals available for the residents' mechanical lifts.
-The previous nurse that done training for staff and the facility's LHPS quarterly reviews had passed away.
-The residents' mechanical lifts were not on a scheduled service plan.
-Typically, he would ask the DME supplier to look at the lifts when they made visits to the facility to bring other DME equipment.
-He remembered a DME staff person did look at Resident #2's mechanical lift about 2 months ago.
-The staff using the mechanical lifts in the facility would be responsible to report if a mechanical lift was not working properly.
-The live-in PCA had not made him aware that she was uncomfortable and not using Resident

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C 311	Continued From page 48 #2's mechanical lift for transfers. -He just had a meeting the first of May 2019 and asked the live-in staff if they had any concerns with any resident equipment and no one mentioned any concerns. -A registered nurse (RN) had been contacted today (05/31/19) to pass off and train staff in the use of the mechanical lifts used to transfer the residents. The RN was scheduled to come Monday 06/03/19. -If he had known the live-in PCA was not comfortable using Resident #2's mechanical lift then he could have had a refresher course set-up for the staff. Interview with a second live-in PCA on 05/31/19 at 2:22pm revealed: -She used Resident #2's mechanical lift and did not have any problems using it. -If she saw a problem with any residents' equipment then she would not use it and report it immediately to the MA/SIC or the Administrator. -Resident #2's mechanical lift was "old" and never had any clips on the end of the hooks. -She was not aware of a owner's manual for Resident #2's mechanical lift. -The hook bars on Resident #2's mechanical lift were designed longer to connect the sling and secure the sling into place. -She always "tugged" down on the loops to make sure the loops were secure and against the hooks bar before lifting Resident #2 with the mechanical lift. -She was trained and had to give a returned demonstration how to use a mechanical lift to transfer a resident when she started back in 2017. -She did not know that widening the base of the mechanical lift ensured the stability of the lift during transfers and could have been told that in	C 311		

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C 311	Continued From page 49 training, but was not sure. Interview with the Administrator on 05/31/19 at 3:22pm revealed: -She did not monitor the mechanical lifts to assure the lifts were working properly because the live-in PCAs working with the lifts would know if the lift was working properly or not. -She had seen one of the live-in PCAs use a mechanical lift to transfer a resident in the last 2 weeks and the base of the mechanical lift was widened. Telephone interview with Resident #2's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -She expected staff to always assure the transfer sling to a mechanical lift was well secured prior to transferring a resident. -If a staff person felt uncomfortable using Resident #2's mechanical lift then that should have been reported immediately to the Administrator for the safety of the resident. -It was important for all staff to be trained on the use of any equipment prior to use. _____ The facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by not following safety steps when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly. The facility's failure which resulted in Resident #2 being dropped while being transferred by a staff who did not follow safety protocol. The facility's failure resulted in Resident #2 sustaining a hip fracture and constitutes a Type A1 Violation for serious	C 311		

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C 311	Continued From page 50 physical harm and neglect, _____ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 30, 2019	C 311		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to management and other staff, healthcare referral and follow up, nutrition and food service and design and construction. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident who was diagnosed with advanced dementia and had an order for a pureed diet (Resident #2). [Refer to Tag 284 10A NCAC 13G .0904(e)(4) Nutrition and Food Service (Type B Violation)].	C 912		

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C 912	Continued From page 51 2. Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. [Refer to Tag 0022 10A NCAC .0302(b) Design and Construction (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up with the primary care provider for 1 of 4 sampled residents related to a resident having trouble swallowing her food for at least a week (Resident #4). [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the personal care and supervision needs for 4 of 6 sampled residents (Resident #1, #2, #3, #4 and #5). [Refer to Tag 0191 10A NCAC 13G .0601(d) Management and Other Staff (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to Residents' Rights. The findings are:	C 914		

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C 914	Continued From page 52 Based on observations, interviews and record reviews, the facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by failing to stabilize the lift when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly. [Refer to Tag 311 10A NCAC 13G .0909 Residents' Rights (Type A1 Violation)].	C 914		