Received via electronic mail 3/25/24.

**D087**

**10A NCAC 13F .0306(b) (1) Housekeeping and Furnishings**

The facility will ensure that each residents bedroom is clean and has furnishings in good repair. Each bed will have the following: mattress and boxspring, at least one pillow with clean pillowcase, clean fitted and top sheets, and clean bedspread. All beds will be changed as often as necessary, but at least once a week. The facility has increased their linen supply to ensure that there is always an adequate supply. Housekeeping staff will inspect and count linen supply once quarterly and report findings to the Operational Manager. The Operational Manager will order linens, when necessary, based on the quarterly report to ensure an adequate supply is maintained.

Completion date: 3/13/2024

**D255**

**10A NCAC 13F .0801(c) (1) Resident Assessment**

The facility will ensure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph(b) of this Rule. Resident #2 care plan was immediately corrected. All resident care plans were immediately reviewed for compliance. When a resident is identified to have had a significant change the facility will have an assessment and new care plan within 10 days following the identification of the change.

The Resident Care Coordinator will conduct Collaborative Care Assessments on each resident every thirty days. All medication orders, current orders, chart notes, vitals, increased supervision checks (if necessary), accident/incident reports (if necessary), and visual observation will be included in this review.

The Operational Manager will review all care plans monthly to ensure they match the current level of care.

Completion date: 2/20/2024

**D270**

**10A NCAC 13F .0901(b) Personal Care and Supervision**

The facility will ensure that staff provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Staff will be re-trained in the following areas related to personal care and supervision:

1. When a resident falls guideline – February 19, 2024
2. Personal Care & Supervision – March 26, 2024
3. Accident/Incident Reporting – March 27, 2024
4. Documentation Training – March 19, 2024, March 20, 2024, March 27, 2024
5. De-escalation and Disengagement – March 13, 2024, March 20, 2024, March 27, 2024, and April 3, 2024

All staff have also attended Mindset training twice weekly from 1/31/2024 through 3/14/2024.

All residents assessed with fall risk will be provided with an assistant bell for their room to ring for staff to assist them with transfers and ambulation.
Resident Care Coordinator will conduct Collaborative Care review on each resident every thirty days to assess their needs, along with any new or current symptoms.

The Operational Manager will review all Collaborative Care assessments after the competition, once monthly, to reassure that all residents are receiving the care and supervision that they are assessed to need.

Completion Date: 3/27/2024

**D273**

**10A NCAC 13F .0902(b) Health Care**

The facility will ensure that referrals and follow-ups will meet the routine and acute health care needs of residents.

The Resident Care Coordinator will continue to utilize the "Order Log" to track all referrals from start to competition. All transmissions between the facility and Teli-Meds in reference to referrals will be printed and logged daily for review.

The Operational Manager will review all referrals weekly to ensure competition.

Completion date: 2/20/2024

**D310**

**10A NCAC 13F .0904(e) (4) Nutrition and Food Services**

The facility will ensure that all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

Facility Management relayed to Dietitian all concerns raised by the state. The dietitian reviewed the current diet menu and found one typing error that was corrected, but otherwise she stated "The menus were written based on The International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines, and she would not change how it is written. Dietary staff and Clinical staff were re-trained on procedures for following diet orders and on the Nutrition and Food Serv ice Rule on February 19, 2024. When diet orders change, the Resident Care Coordinator will see that Dietary Manager receives new diet and that paperwork is changed to reflect the new orders. The Resident Care Coordinator will inform Clinical Staff of these changes in daily stand-up.

The Operational Manager will check twice monthly all diet orders to assure that they match their current order and that they are being prepared as ordered.

Completion Date: 2/19/2024

Reviewed and acknowledged 3/15/24. SG

Received via electronic mail 3/25/24



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______<br>B. WING ______ | R-C<br>02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE<br>YADKINVILLE, NC 27055 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey from 02/14/24 to 02/15/24. | {D 000} | | |
| D 087 | 10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:<br>(1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following:<br>(A) at least one pillow with clean pillow case;<br>(B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and<br>(C) clean bedspread and other clean coverings as needed;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to provide a clean top and bottom sheet for 1 of 5 sampled residents (#3) with bed changed as often as necessary, but at least once a week.<br><br>The findings are:<br><br>Review of Resident #3's current FL2 dated 10/17/23 revealed diagnoses included cerebral | D 087 | | |



Reviewed and acknowledged 3/25/24. SG

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

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| D 087 | Continued From page 1<br><br>infarction, hemiplegia following cerebral infarction, left non dominant side, contracture of muscle, and essential hypertension.<br><br>Review of Resident 3's care plan dated 10/13/23 revealed:<br>-Resident #3 had limited range of motion of his left upper extremities.<br>-Resident #3 needed limited assistance with grooming/personal hygiene and extensive assistance with bathing.<br>-Staff completed his daily housekeeping tasks.<br><br>Review of Resident #3's Activities of Daily Living (ADL) Log for November 2023 revealed:<br>-There was an entry for bathing/personal hygiene: linen change Monday, Wednesday, and Friday on first shift scheduled for between 7:00am and 6:59pm.<br>-There was an entry for bathing/personal hygiene: linen change as needed.<br>-There was documentation Resident#3 linen was changed 12 of 13 opportunities between 11/01/23 and 11/30/23.<br>-There was documentation Resident #3's linen was not changed on 11/13/23 due to Resident #3 refused.<br>-There was no documentation Resident #3's linen was changed as needed.<br><br>Review of Resident #3's ADL Log for December 2023 revealed:<br>-There was an entry for bathing/personal hygiene: linen change Monday, Wednesday, and Friday on first shift scheduled for between 7:00am and 6:59pm.<br>-There was an entry for bathing/personal hygiene: linen change as needed.<br>-There was documentation Resident#3 linen was changed 9 of 13 opportunities between 12/01/23 | D 087 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: ______<br>B. WING ______ | R-C<br>02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE<br>YADKINVILLE, NC 27055 |

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|---|---|---|---|---|
| D 087 | Continued From page 2 | D 087 | | |

and 12/31/23.
-There was documentation Resident #3's linen was not changed on 12/13/23, 12/25/23, 12/27/23, and 12/29/23 due to Resident #3 refused.
-There was no documentation Resident #3's linen was changed as needed.

Review of Resident #3's ADL Log for January 2024 revealed:
-There was an entry for bathing/personal hygiene: linen change Monday, Wednesday, and Friday on first shift scheduled for between 7:00am and 6:59pm.
-There was an entry for bathing/personal hygiene: linen change as needed.
-There was documentation Resident #3 linen was changed 14 of 14 opportunities between 12/01/23 and 12/31/23.
-There was no documentation Resident #3's linen was changed as needed.

Review of Resident #3's ADL Log for 02/01/24 through 02/14/24 revealed:
-There was an entry for bathing/personal hygiene: linen change Monday, Wednesday, and Friday on first shift scheduled for between 7:00am and 6:59pm.
-There was an entry for bathing/personal hygiene: linen change as needed.
-There was documentation Resident#3 linen was changed 6 of 6 opportunities between 02/01/24 and 02/14/24.
-There was no documentation Resident #3's linen was changed as needed.

Observation of Resident #3's room on 02/14/24 at 9:15am revealed:
-Resident #3 was sitting in his wheelchair in his room in front of his bed.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| D 087 | Continued From page 3<br>-Resident #3's left arm was propped on the arm of his wheelchair and he used his right hand to assist with moving his left arm.<br>-His bed was disheveled and had balled-up blankets and clothes at the foot and on the side of the bed along the wall.<br>-There was not a top sheet present on the bed.<br>-Resident #3's bottom fitted sheet was soiled throughout with larger brown stains towards the head of the bed and the black streaks at the foot of the bed.<br>-There were two pillows on the bed; one was covered by a pillow case and the other was not.<br><br>A second observation of Resident #3's room on 02/15/24 at 9:03am revealed:<br>-Resident #3 was sitting in his wheelchair in his room in front of his bed.<br>-Resident #3's sheets had not been changed and there were no clean sheets present in his room.<br><br>Observation of the linen supply closet on 02/15/24 at 9:28am revealed there was an ample supply of clean linen including top and bottom bed sheets.<br><br>Interview with Resident #3 on 02/14/24 at 9:15am revealed:<br>-Staff had not changed his bed sheets since he had been in the facility; he was admitted to the facility in October 2023.<br>-He had an incontinence episode on his bed sheets, and he had to clean it up himself.<br>-The personal care aides (PCA) walked by his room daily and did not offer to change his bed sheets.<br>-He asked a PCA to change his bed sheets after he had the incontinence episode, but she did not want to change the sheets.<br>-He had limited use of his left arm. | D 087 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______<br>B. WING ______ | R-C<br>02/15/2024 |

NAME OF PROVIDER OR SUPPLIER: PATRIOT LIVING OF YADKINVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 409 HARRISON AVENUE, YADKINVILLE, NC 27055

| (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 |
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| D 087 | Continued From page 4<br>-He liked to do things for himself including transferring to and from his wheelchair, taking his own bed baths, and washing his clothes in his bathroom sink, but he was not able to change his bed sheets or make his bed.<br><br>A second interview with Resident #3 on 02/15/24 at 3:24pm revealed he used to sleep in his wheelchair, but he had been sleeping in his bed every night for a few months.<br><br>Telephone interview with a PCA on 01/15/24 at 9:52am revealed:<br>-She documented ADLs including linen changes on the residents' ADL log.<br>-Every time PCAs assisted residents with showers, they were to change their linen.<br>-She worked on 01/14/24, but she did not change Resident #4's bed linen.<br>-She asked Resident #4 if he wanted his bed linen changed and he said that he did not.<br>-She documented she changed Resident #4's linen on 02/14/24, but she did not because she had gotten busy assisting another resident.<br>-She tried to get Resident #4 to allow her to change his bed sheets every day, but he liked to do things on his own and would not allow staff to change his bed sheets regularly.<br>-She did not think he was able to change his own bed sheets.<br>-If Resident #4 refused to have his sheets changed, she typically documented on the ADL log that he refused and there would be a circle around her initials indicating that the sheets were not changed.<br><br>Interview with a second PCA on 02/15/24 at 10:37am revealed:<br>-PCAs were responsible for changing residents' linen and documenting the changes or refusals | D 087 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

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| D 087 | Continued From page 5 | D 087 | | |

on the ADL log.
-Residents' linens were to be changed 3 to 5 days a week and as needed.
-If it was documented on the ADL log that the linen was changed, it should have been changed.
-He did not assist Resident #3 with any ADLs; usually one of the other PCAs assisted him.
-His initials were documented as having changed Resident #3's bed linen on 02/02/14 and 02/12/14, but he had not changed Resident #3's linen.
-He must not have logged his initials out and one of the other PCAs must have documented Resident #3's linen was changed under his initials.
-Resident #3 let the PCAs know when his sheets needed to be changed, and he did not refuse to have his sheets changed that he knew of.

Interview with a MA on 02/15/24 at 1:58pm revealed:
-Resident #3 slept in his wheelchair and did not sleep in his bed.
-Resident #3 did not want staff to do anything for him.
-She just administered him his medication and that was it.
-She did not know if he was able to change his own sheets.
-She did not know if the PCAs were changing Resident #3's sheets 3 times a week.
-No PCA has told her that he would not allow them to change his sheets.

Interview with a PCA/MA on 02/15/24 at 11:54am revealed:
-She did not remember if she had ever changed Resident #3's bed linen.
-She did not think he could change his own bed linen due to the limited use of his left arm.

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| D 087 | Continued From page 6<br>-He did not like anyone to help him.<br>-PCAs changed Resident #3's bed linen every other day if he let them.<br>-If Resident #3 did not allow PCAs to change his bed linen, the PCA should have documented that he refused on his ADL log and chart note.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/15/24 at 3:03pm revealed:<br>-PCAs were to change all residents' bed linen 3 times a week.<br>-PCAs were to go into the residents' room and look at their bed linen to see if they needed to be changed.<br>-If PCAs documented the residents' linen was changed, then it should have been changed.<br>-She had not seen Resident #3's bed linen.<br><br>Interview with the Operations Manager (OM) on 02/15/24 at 3:30pm revealed Resident #3's bed linen should have been changed 3 times a week.<br><br>Interview with the Campus Director (CD) on 02/15/24 at 4:45pm revealed:<br>-He expected Resident #3's linen to be changed 3 times a week and as needed.<br>-He expected PCAs to change his linen especially if they were documenting that the linen had been changed.<br><br>Attempted telephone interview with the Administrator on 02/15/24 at 4:30pm was unsuccessful. | D 087 | | |
| D 255 | 10A NCAC 13F .0801(c)(1) Resident Assessment<br><br>10A NCAC 13F .0801Resident Assessment<br>(c) The facility shall assure an assessment of a resident is completed within 10 days following a | D 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 255 | Continued From page 7 | D 255 | | |

significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:
(1) Significant change is one or more of the following:
(A) deterioration in two or more activities of daily living;
(B) change in ability to walk or transfer;
(C) change in the ability to use one's hands to grasp small objects;
(D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;
(E) no response by the resident to the treatment for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) threat to life such as stroke, heart condition, or metastatic cancer;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099010 | | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 499 HARRISON AVE NE YADKINVILLE, NC 27055 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 255 | Continued From page 8 | D 255 | | |

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

Based on observations, interviews, and record reviews, the facility failed to ensure an assessment was completed within ten days for 1 of 5 sampled residents (Resident #2) following a significant decline in the resident's ability to perform activities of daily living and who experienced frequent falls.

The findings are:
Review of Resident #2's current FL-2 dated 12/14/23 revealed:
-Diagnoses included dementia, diabetes mellitus, hypertension, muscle weakness, cognitive communication deficit, and permanent tracheostomy.
-The resident was semi-ambulatory with the use of a walker, had functional sight limitations, and required assistance with bathing, feeding, and dressing.

Review of Resident #2's current care plan dated 04/04/23 revealed:
-The resident had no problems with range of motion and strength of his upper extremities and his vision was adequate for daily activities
-The resident ambulated independently with a walker.
- He required supervision from staff for eating, toileting, bathing, grooming, and transferring.
- He required extensive assistance from staff for dressing.
There was no other care plan completed after 04/04/23.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099016 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

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|---|---|---|---|---|
| D 255 | Continued From page 9<br><br>Review of after-visit summary from the local hospital for surgical procedure dated 09/23/23 revealed Resident required a surgical skin graft removal of facial cancer above the resident's right eye.<br><br>Review of Resident #2's accident/incident reports for 5 unwitnessed falls dated 12/27/23 through 02/13/24 revealed:<br>-On 12/27/23, Resident #2 stumbled and fell in the hallway.<br>-On 12/27/23, Resident #2 required a hospital visit due to a fall into a clothes basket while in the hallway and complained about pain in his ribs.<br>-On 02/03/24, Resident #2 required a hospital visit after he fell in his room and received a skin tear on his head.<br>-On 02/12/24, Resident #2 fell in the restroom with a skin tear to his right hand.<br>-On 02/13/24, Resident #2 required a hospital visit after he fell in the hallway and received a laceration on his head.<br><br>Review of Resident #2's progress notes dated between 11/16/23 through 2/13/24 revealed:<br>-On 11/16/23, Resident #2 required a hospital visit after he fell and hit his head.<br>-On 11/26/23, Resident #2 required a hospital visit due to twitching, jerking, low vitals, and appearing off baseline.<br>-On 12/06/23, Resident #2 needed increased assistance in getting back into his room and back to his bed.<br>-On 12/08/23, Resident #2 required more assistance with activities of daily living due to unsteady gait, limited vision, and hearing.<br>-On 12/10/23, Resident #2 was having more falls in the past couple of months.<br>-On 12/27/23, Resident #2 required a hospital | D 255 | | |

| 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 |
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| PATRIOT LIVING OF YADKINVILLE | 499 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| D 255 | Continued From page 10<br>visit due to a fall and complained about pain in his ribs.<br>-On 01/08/24, Resident #2 fell in the lobby and received tears to old scabs.<br>-On 01/27/24, Resident #2 fell while trying to make it to the restroom and received a skin tear on his head.<br>-On 01/28/24, Resident #2 required a hospital visit after he fell in the dining room and hit his head.<br>-On 01/30/24, Resident #2 required a hospital visit after he fell in the hallway.<br>-On 02/03/24, Resident #2 required a hospital visit after he fell in his room and received a skin tear on his head.<br>-On 02/13/24, Resident #2 required a hospital visit after he fell in the hallway and received a laceration on his head.<br><br>Observation of Resident #2 on 02/14/24 at 12:35pm revealed:<br>-He used a rollator walker and was unsteady when he walked down the hall into the dining room.<br>-Resident #2 required staff assistance to his chair at the dining table.<br>-Resident #2 had a skin tear on his head.<br><br>Telephone interview with Resident #2's guardian on 02/15/24 at 4:08pm revealed:<br>-He was aware Resident #2 had increased visits to the hospital due to increased falls.<br>-He noticed Resident #2 had declined since his surgery in September 2023.<br>-He was aware staff assisted Resident #2 more with his eating, transferring, and bathing needs since the September 2023 surgery.<br>-He was aware Resident #2's decline had prompted a Hospice referral but was not aware of when the evaluation was to be conducted. | D 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099018 | A. BUILDING ____ B. WING ____ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| D 255 | Continued From page 11<br><br>Interview with a personal care aide (PCA) on 02/15/24 at 10:01am revealed:<br>-Resident #2 walked around the facility, went to the restroom, and moved in and out of his bed with less assistance prior to his surgery in September 2023.<br>-She was responsible to complete 15-minute checks and activities of daily living (ADL) logs once care was completed for Resident #2 when she assigned to his hall.<br>-Medication aides (MA) documented falls related to Resident #2 on the facility's incident/accident reports.<br>-She was not aware of any updates for Resident #2's care plan.<br><br>Interview with a second PCA on 02/15/24 at 10:30am revealed:<br>-Resident #2 had more falls since his surgery in September 2023.<br>-Resident #2 moved around in his room better, walked around the hallways with little staff assistance, and used the restroom more independently before surgery in September 2023.<br>-Resident #2 required 15-minute checks due to increased falls starting in December 2023.<br>-The scabs on Resident #2's head came from his previous falls<br>-PCA documented 15-minute checks and personal care service (PCS) logs for Resident #2 once tasks were completed.<br>-The Resident Care Coordinator (RCC) and the Operations Manager (OM) conducted a review of the 15-minute checks, ADL logs, and incident/accident reports weekly and were responsible for updates to the resident's care plan.<br>-He was not aware if the care plans were being updated by the RCC or the OM when a resident | D 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| D 255 | Continued From page 12 | D 255 | | |

had a change in their condition.
-Resident #2 required more assistance with transferring, toileting, bathing, walking, and dressing since his September 2023 surgery.

Interview with a PCA/Medication Aide on 02/15/24 at 11:50am revealed:
-Resident #2 had at least 11 falls since his surgery in September 2023.
-Resident #2 required 15-minute checks due to increased falls since December 2023 falling but his falls started more recently after his September 2023 surgery.
-The PCAs completed 15-minute checks and activities of daily living (ADL) logs for residents.
-Medication aides (MA) documented incident/falls reports for resident #2.
-Resident #2 required more assistance with transferring, bathing, and walking down the hall than previously before his September 2023 cancer surgery.
-Resident #2 required extensive assistance with walking because of limited vision.

Interview with a MA on 02/15/24 at 1:45pm revealed:
-She was aware of Resident #2's increased falls.
-He required 15-minute checks but she was not aware when Resident #2 was initially placed on the 15-minute checks.
-She had noticed at least 5 falls and a decline for Resident #2 since his surgery in September 2023.
-Resident #2 had required less assistance from PCA's when he walked to the dining room or went to the restroom before his cancer surgery in September 2023.
-Resident #2 required increased assistance when he walked to the dining room and when he went to the restroom since his September 2023

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| D 255 | Continued From page 13<br>surgery.<br>-PCA completed 15-minute checks and documented any assistance with activities of daily living (ADL) in the ADL logs for Resident #2.<br>-She completed incident/accident reports for falls and reported significant declines to the RCC and OM.<br>-She had not reported any change of condition for Resident #2, but both the RCC and OM were responsible to review the 15-minute checks, ADL logs, and incident/falls reports weekly and were responsible for updates to the resident's care plan.<br>-She was not aware of any communication received from the RCC and OM for a change to Resident #2's care plan related to his decline.<br><br>Interview with the RCC on 02/15/24 at 2:30pm revealed:<br>-She was aware Resident #2's condition had declined because of increased falls and required additional assistance from PCAs and MAs since his surgery in September 2023.<br>-She was aware care plans would indicate what type of assistance residents required and Resident #2's had not been updated since April 2023 because the care plan had been overlooked.<br>-She and the OM were responsible for reviewing the 15-minute checks, ADL logs, and were responsible for updates to the resident's care plan.<br>-She was aware care plans needed to be changed if a resident had a significant change in condition but she had overlooked completing an assessment and updating the care plan for Resident #2.<br><br>Interview with the OM on 02/15/24 at 3:28pm revealed: | D 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL099013 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 405 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| D 255 | Continued From page 14<br>-She was aware Resident #2 had a significant change in condition related to multiple falls since his surgery in September 2023.<br>-She notified the Resident #2's Primary Care Physician (PCP) about his multiple falls and increased supervision in December 2023.<br>-She expected the PCAs and the MAs to inform the RCC and the OM of any needs of the residents when performing care.<br>-She expected the RCC to audit progress notes weekly.<br>-The RCC and the OM were responsible for updating and completing the care plans and would be responsible to complete a new care plan for any residents with changes in condition.<br>-She had not completed a new care plan for Resident #2.<br><br>Telephone interview with Resident #2's PCP on 02/15/24 at 3:45pm revealed:<br>-She was aware of Resident #2's increased falls and required increased assistance from the facility staff for his ADL's.<br>-She had recently signed care plans for the facility but could not recall that Resident #2 was one of the plans completed in her workload.<br>-She expected staff to follow her recommended interventions and she had recommended hospice or skilled nursing care for Resident #2 in late January 2024 due to his decline in health.<br>-She expected staff to contact her by text or phone for any concerns or changes in residents status or condition at the time observed and to document the notification as they normally would.<br><br>Interview with the Campus Director on 02/15/24 at 4:26pm revealed:<br>-He was not aware of Resident #2's recent decline.<br>-He expected a completed care assessment, a | D 255 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL099012 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R-C 02/15/2024 |
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NAME OF PROVIDER OR SUPPLIER: **PATRIOT LIVING OF YADKINVILLE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **409 HARRISON AVENUE YADKINVILLE, NC 27055**

| (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 |
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| D 255 | Continued From page 15<br>follow-up notification completed to the PCP, and updated care plan by staff for a residents' change in condition.<br>-He expected the RCC and OM to review the 15-minute checks, ADL logs, and incident/accident reports weekly and provide updates to a resident's care plan.<br>-He expected the care plans to be updated within 10 days for any resident with a significant change in condition.<br><br>Based on observations, record reviews, and interviews, it was determined Resident #2 was not interviewable.<br><br>Attempted telephone interview with the Administrator on 02/15/24 at 4:30pm was unsuccessful.<br><br>____________<br>The facility failed to ensure an assessment was completed for Resident #2 within 10 days of the resident experiencing a decline in activities of daily living resulting in the resident needing increased staff assistance with dressing, bathing, walking, and grooming; and he experienced 5 falls in 2 months after having surgery in September 2023 resulting in a laceration to the head along with skin tears to the arms and legs. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.<br><br>____________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/15/24 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2024. | D 255 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| {D 270} | Continued From page 16 | {D 270} | | |
| {D 270} | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION<br><br>The Type A2 Violation was abated.<br>Non-compliance continues.<br><br>THIS IS A TYPE B VIOLATION<br><br>Based on observations, record reviews and interviews, the facility failed to provide supervision for 1 of 5 sampled residents (#4) who was a high fall risk and had four falls in two months resulting in pain and a closed head injury.<br><br>The findings are:<br><br>Review of the facility's undated policy on falls revealed:<br>-After a resident's first fall, the resident was to be placed on 30-minute checks and the medication aide (MA)/Supervisor was to notify the resident's primary care provider (PCP) directly after the fall occurred.<br>-After a resident's second fall, the resident was to remain on 30-minute checks and the MA/Supervisor was to notify the resident's PCP directly after the fall occurred; the Resident Care | {D 270} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: _______ B. WING _______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

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| {D 270} | Continued From page 17<br><br>Coordinator (RCC) and Operations Manager (OM) should discuss physical therapy (PT)/occupational therapy (OT) potential for the resident.<br>-After a resident's third fall, the resident was to be placed on 15-minute checks and the MA/Supervisor was to notify the resident's PCP directly after the fall occurred; The RCC or OM would discuss the potential need for a higher level of care for the resident and/or other plans of care for the resident.<br><br>Review of Resident #4's current FL2 dated 12/14/23 revealed:<br>-Diagnoses included muscle weakness, weakness of limb, static encephalopathy, lacunar infarction, cerebral infarction, peripheral vascular disease, and chronic pain syndrome.<br>-Resident #4 was constantly disoriented and semi-ambulatory.<br>-He required personal care assistance with bathing, feeding, and dressing.<br><br>Review of Resident #4's care plan dated 04/04/23 revealed:<br>-Resident had a history of vascular dementia.<br>-He needed limited assistance with toileting, ambulation/locomotion, and transferring.<br><br>Observation of Resident #4 at various times on 02/14/24 revealed:<br>-Resident #4 ambulated independently through the hallways with his walker.<br>-Resident #4 ambulated to and from the dining hall for the lunch meal and transferred independently to and from his chair in the dining hall.<br>-Resident #4 did not receive any assistance from staff or supervision with ambulation. | {D 270} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
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| | HAL099016 | | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| {D 270} | Continued From page 18<br><br>Observation of Resident #4 at various times on 02/15/24 revealed:<br>-Resident #4 ambulated through the hallways with his walker.<br>-Resident #4 leaned forward into his walker as he ambulated and walked with a slight limp.<br>-Resident #4 transferred independently.<br>-Resident #4 did not receive any assistance from staff or supervision with ambulation.<br><br>a. Review of Resident #4's progress note dated 12/21/23 revealed:<br>-Resident #4 hit the door with his walker which resulted in him falling back and hitting his bottom.<br>-There was no other information documented and no documentation of fall prevention intervention implemented after the fall on 12/21/23.<br><br>Attempted telephone interview with the MA who documented Resident #4's 12/21/23 progress note on 02/15/24 at 10:21am was unsuccessful.<br><br>Review of Resident #4's incident/accident reports revealed there was no incident/accident report dated 12/21/23 available for review.<br><br>Review of Resident #4's increased supervision check sheets revealed there were no 15 or 30-minute check sheets for 12/21/23 available for review.<br><br>b. Review of Resident #4's progress note dated 01/07/24 revealed:<br>-Resident #4 went to sit in a chair on the patio and misjudged.<br>-He fell and hit his head on the table.<br>-Resident #4's vital signs were checked, and he was sent out to the local hospital.<br><br>Interview with the MA who documented Resident | {D 270} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 609 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| {D 270} | Continued From page 19<br><br>#4's 01/07/24 progress note on 02/15/24 at 1:58pm revealed:<br>-When Resident #4 fell on 01/07/24, he had gone out onto the patio to smoke, and when he went to sit down, he slid down between the patio table and the chair.<br>-The chair slid back, Resident #4 fell on his bottom, and hit his head on the table.<br>-Another resident came in and told her that Resident #4 had fallen and she went to check on him.<br>-She sent Resident #4 out to the local hospital for assessment.<br>-When Resident #4 returned to the facility, he was placed on 15-minute checks and should have been on the increased safety checks for 24 hours..<br>-The 15-minute checks should have been documented on the 15-minute check log and kept in a binder.<br>-After Resident #4's fall on 01/07/24, staff made sure he used his walker, that his pants were not dragging the ground, and that his shoes were tied.<br>-She did not know of any other interventions put in place for Resident #4 after his fall on 01/07/24<br><br>Review of Resident #4's incident/accident report dated 01/07/24 revealed:<br>-Resident #4 had an unwitnessed fall on the back patio.<br>-He fell while trying to sit in a chair and hit his bottom and his head while he was falling.<br>-There were no visible marks<br>-Resident #4's vital signs were taken.<br>-Resident #4 was taken to the emergency room and returned on 01/08/24.<br><br>Review of Resident #4's triage note dated 01/07/24 revealed: | {D 270} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PATRIOT LIVING OF YADKINVILLE | 400 HARRISON AVENUE YADKINVILLE, NC 27055 |

| (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 |
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| {D 270} | Continued From page 20 | {D 270} | | |

-Resident #4 went to sit down in a chair and missed it.
-He hit his head on a table and was on his way to the local hospital.
-There were orders to notify the PCP upon his return to the facility.

Review of Resident #4's hospital emergency room after visit summary dated 01/07/24 revealed:
-Resident #4 was seen in the emergency room due to a fall.
-Resident #4 had a diagnosis of a closed head injury.

Review of Resident #4's increased supervision check sheets revealed there were no 15 or 30-minute check sheets for 01/07/24 available for review.

c. Review of Resident #4's progress note dated 01/15/24 at 11:48am revealed:
-Resident #4 urinated on his bedroom floor and slipped in it and fell.
-He landed on his hip and back and was a little sore, but nothing seemed to be broken.

Review of Resident #4's progress note dated 01/15/24 at 6:51pm revealed:
-Resident #4 was saying that his back, right hip and both legs and knees hurt badly.
-An incident/accident report was completed and Resident #4's PCP was contacted.

Attempted telephone interview with the MA who documented Resident #4's 01/15/24 progress notes on 02/15/24 at 9:28am was unsuccessful.

Review of Resident #4's incident/accident report for 01/15/24 revealed:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: ______<br>B. WING ______ | R-C<br>02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE<br>YADKINVILLE, NC 27055 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 270} | Continued From page 21<br>-Resident #4 had an unwitnessed fall in his bedroom.<br>-Resident #4 stated that he urinated on his bedroom floor, and then slipped on the urine and fell.<br>-Resident #4 landed on his hip and hurt his back, hip, legs, and knees.<br>-Resident #4 had pain in his lower back, right hip, both legs (knees) where he had previous injuries/surgeries.<br>-Resident #4's vital signs were taken.<br>-Resident #4 was not taken to the emergency room.<br><br>Review of Resident #4's triage note dated 01/15/24 revealed:<br>-Resident #4 slipped and fell and hurt his lower back and hip; he complained of pain in both legs and knees.<br>-Resident #4 had a history of injury to his back and hip, and he stated they were previously broken.<br>-Resident #4 was alert and his vital signs were good.<br>-Staff were to continue to monitor Resident #4 and facility staff requested x-rays for Resident #4's injured areas.<br>-There were orders for x-rays to Resident #4's right hip and bilateral knee.<br><br>Review of Resident #4's increased supervision check sheets revealed there were no 15 or 30-minute check sheets for 01/15/24 available for review.<br><br>d. Review of Resident #4's progress note dated 01/16/24 revealed:<br>-Resident #4 fell coming back from the smoking patio.<br>-He did not have any complaints of injuries. | {D 270} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | HAL099018 | A. BUILDING: ______ B. WING ______ | R-C 02/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PATRIOT LIVING OF YADKINVILLE | 409 HARRISON AVENUE YADKINVILLE, NC 27055 |

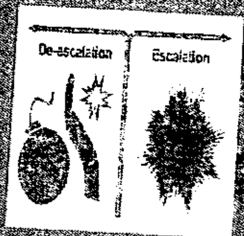
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 270} | Continued From page 22<br><br>Interview with the MA who documented Resident #4's 01/16/24 progress note on 02/15/24 at 1:58pm revealed:<br>-Resident #4 tripped and fell as he was coming in the door from the outside patio.<br>-When Resident #4 fell on 01/16/24, he should have been placed on 30-minute checks because he did not have any injuries.<br>-MAs and PCAs were responsible for completing the 30-minute checks and the PCAs were responsible for documenting that the checks had been completed.<br>-After Resident #4's fall on 01/16/24 staff made sure he used his walker, that his pants were not dragging the ground, and that his shoes were tied.<br>-Sometimes Resident #4 needed physical assistance with walking and transfers.<br><br>Review of Resident #4's incident/accident report dated 01/16/24 revealed:<br>-Resident #4 had an unwitnessed fall coming in the facility from the outside patio.<br>-Resident #4 tripped and fell on his back.<br>-Resident #4's vital signs were taken.<br>-There was documentation Resident #4 continued to be on 15-minute checks.<br><br>Review of Resident #4's triage note dated 01/16/24 revealed:<br>-Resident #4 fell coming in from the back patio.<br>-He landed on his back and stated he did not hit his head.<br>-Resident #4's vital signs were taken, and he had no complaints of pain.<br>-There were orders to continue to monitor Resident #4 per facility fall protocol and notify the PCP with any acute changes or complaints of pain. | {D 270} | | |

## De-Escalation and Disengagement Training

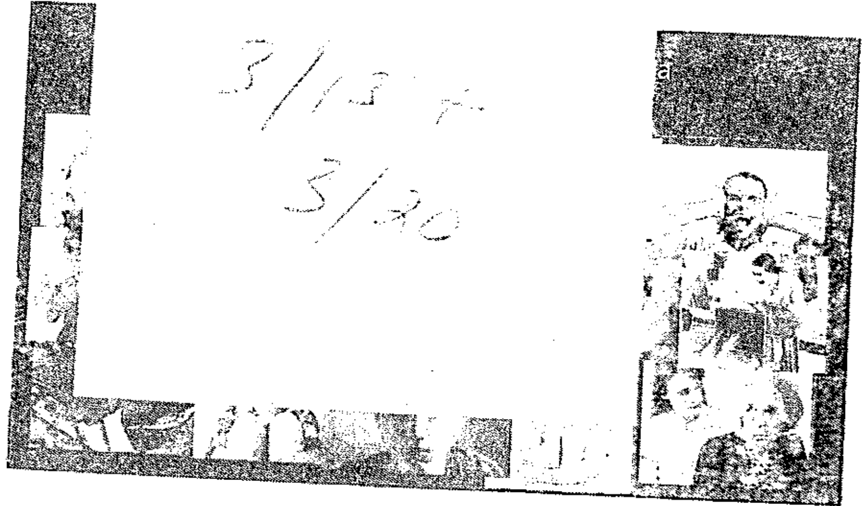
## Purpose is to provide…

- De-escalation tools for crisis intervention
- An understanding of the role that each employee has in regards to those in a crisis situation
- Steps to ensure continued care after an event
- Techniques to use when personal safety is compromised

## What is De-escalation?

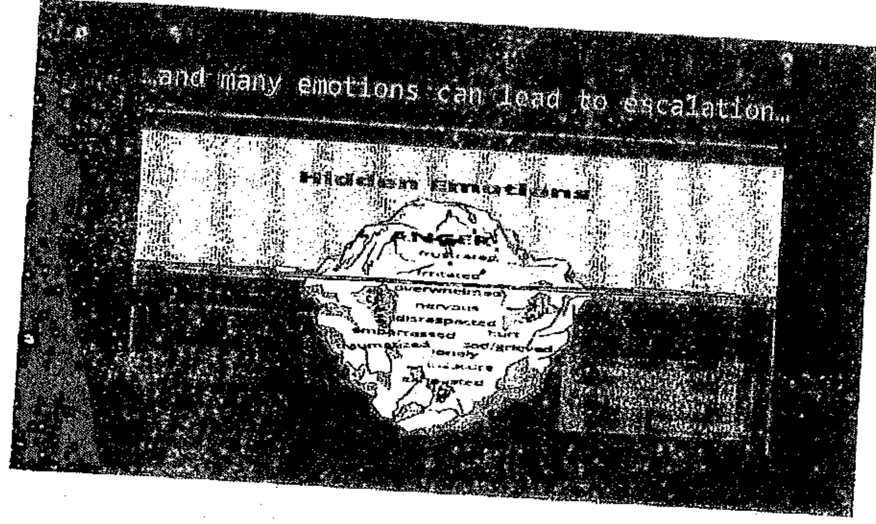



- De-Escalation is **a method to prevent potential violence**.
- Remember to maintain a safe distance and avoid being alone with an individual who is combative or potentially violent.



Trainings
3/13 +
3/20

2/14/2024



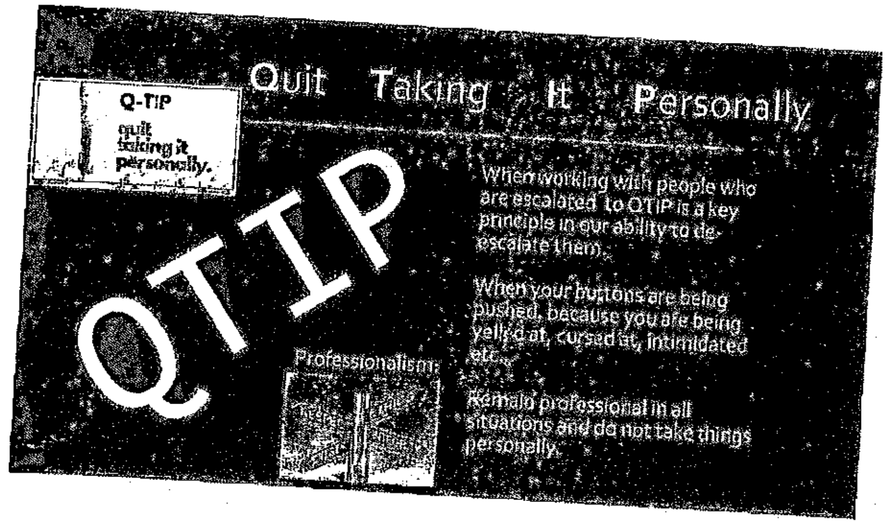

## Taking Purposeful Actions

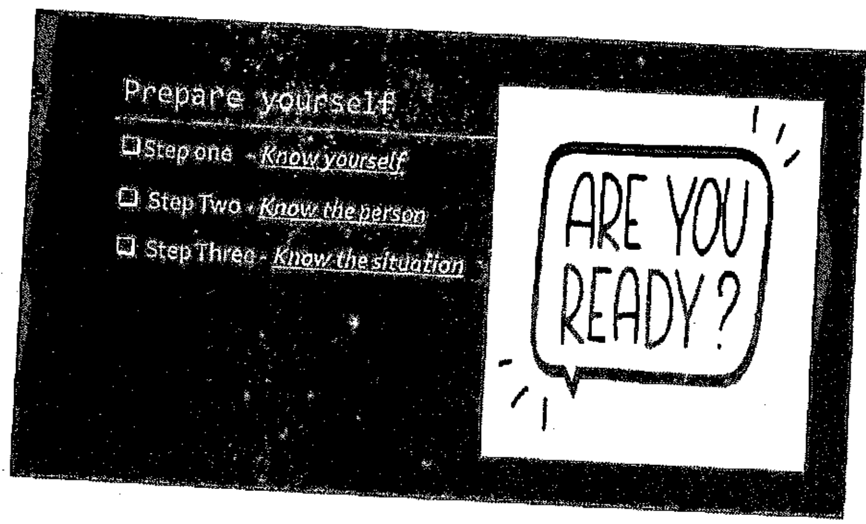
- Assess – the situation to determine the level of escalation, risks and source of conflict
- Adapt – develop a specific approach to addressing the assessed problem
- Act – implement the plan with your selected de-escalation techniques

"one response does not fit all situations"

"different people will have different needs"

"this is a continual process"



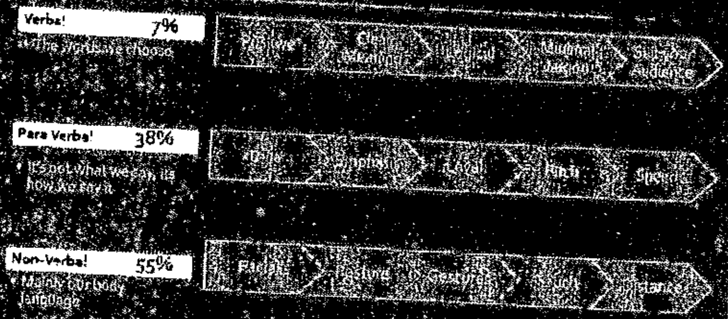
2/14/2024

## Steps to initial introduction

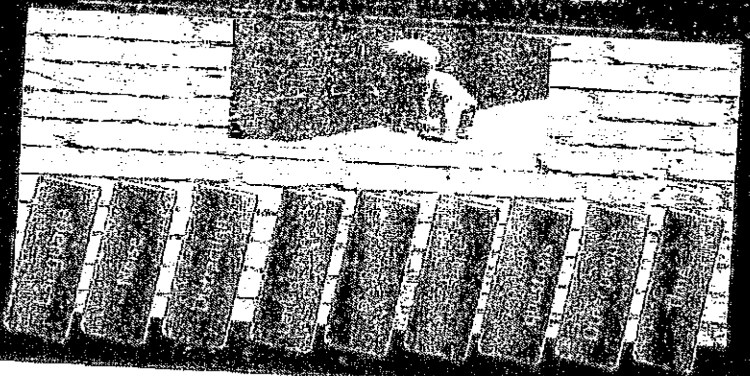
- Know your escape route in case things get worse
- Approach at a 45 degree angle and blade your body at a 45 degree angle
- Hands open (palms up)
- Introduce yourself. "Hello, my name is (BLANK) and I work with (BLANK). What's your name?" Follow up with "I am here because (explain). What can I do to help you?"
- Take the time to listen

## Importance of Communication

"It's not what you say, it's how you say it."




## Barriers to effective communication



## Hand and Body language signals

**HANDS**

- Palms up = open
- Palms out = stop
- Palms down = authority
- Bladed = defensive
- Clenched = aggressive
- Pointing = insulting

**BODY LANGUAGE**

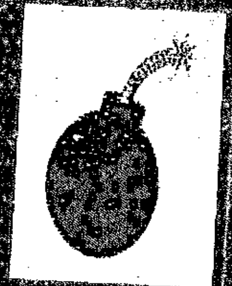
- Smile
- Stand up straight
- Lean in slightly
- Avoid crossing arms
- Nod your head
- Keep your hands visible
- Blade your body

## Scenario

A situation has evolved… you are called to a room where a woman is angry and loudly yelling about not being able to leave… what are your first steps?

## Let's step into the room…

## The art of verbal de-escalation



**D** — DECIDE
Engaged in conversation
Not an active threat to safety

**E** — ENSURE SAFETY
Ensure adequate backup
Respect personal space
(two arms length between you and patient)

**F** — FORM RELATIONSHIP
Introduce yourself by name and title
Ask what they like to be called
Ask "Will you allow us to help?"
Use short sentences, simple vocabulary

**U** — UTILIZE INTERESTS
Reinforce that you will let no harm come to patient

**S** — SET LIMITS

**E** — ENFORCE/EVALUATE
withdraw and mobilize help

## When you are in a situation…

| Do not say: | Say instead: |
|---|---|
| Shut up! | Can I have a chance to respond? |
| Calm Down! | Can you please stop (whatever it is)? |
| You're wrong. | I hope you can understand from my perspective. |
| I can't help with that. | Here's what I can help with… |
| What's your problem? | I want to understand your perspective. |
| I don't have time for this! | I only have (amount of time) to keep discussing this. |
| What do you want me to do about it? | How would you handle this if you were in my position? |

## Continued Care

After an intervention is complete:
- Determine why the incident took place
- What can be done to prevent further incidents

Review the situation with other staff involved to determine:
- What went well
- What could have gone better
- What may have triggered the event

Often overlooked step – Staff decompression
- Consider the mental and physical state of readiness

## Disengagement

KEEP
CALM
AND
DISENGAGE

We hope to be able to verbally de-escalate in all situations, but there will be times that it just doesn't work out that way...

In those times we need to be prepared to disengage by:
- Walking away
- Physically detaching from the individual
- Distraction

## Physical Disengagement

- Several techniques available based on your assessment of the situation and your capability to safely respond
- REACT APPROPRIATELY: You should assess the situation to determine if the person is in need of assistance or if there is hostile intent
- Provide CLEAR, SIMPLE, and SPECIFIC instructions to the individual – Do Not Panic

## Practical Exercise #1

Physical Disengagement

## Practical Exercise #2

Strike Avoidance

## Practical Exercise #3

Create scenarios as a group and discuss things that went well and things that could be improved.

## Discussion Lesson Summary

- At this point, are there any questions about the material we covered so far?
- Do you understand how to effectively engage a person to prevent escalation?
- Do you understand your role in the intervention process?
- Do you understand what is important when we talk about continued care after an intervention?

Personal Care and Supervision,
10A NCAC 13F/13G .0901,

Accident and Incident Reporting
10 NCAC 13F.1212/G.1213

Restraints
10A NCAC 13F.1501 & 13G .1301

Resident Assessments & Care Plans
10A NCAC 13F/G .0801/.0802

Basic Presentation ACLS

# Monitoring Personal Care

# TRAINING OBJECTIVES

after completing this training session the participant will be able to

- demonstrate knowledge of the rules pertaining to personal care, Accident and Incident Reporting, Restraints, resident assessment, and care planning.
- demonstrate the ability to monitor for compliance in these rule areas.

# Sources for all rule areas:

- Observation
- Interview
- Record Review

## Monitoring Personal Care

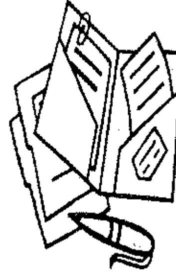
- Observations
- Interviews
  - residents
  - staff
  - family members
- Record Reviews
  - FL-2s
  - DMA 3050-R
  - personal care logs

## 10A NCAC 13F/13G .0901 Personal Care and Supervision

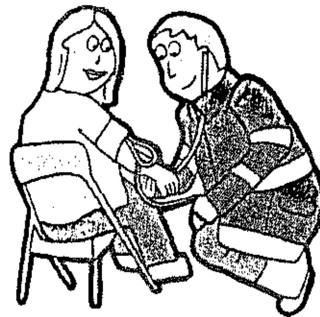
- Provide personal care to residents according to residents' care plan and attend to any other personal care needs residents' may be unable to attend to
- Provide supervision in accordance with each resident's assessed needs, care plan and current symptoms.
- Respond immediately in case of incident or accident and provide care and intervention according to the facility's policies and procedures.

# Monitoring Personal Care

- Observations/Interviews/Record reviews
  - What have you seen?
  - What have you heard?
  - What have you read?
- Analysis?
  - Is there a problem?
  - What is causing the problem?
  - Scope and Severity?
  - Impact to Resident?



# Accident and Incident Reporting 10 NCAC 13F.1212/G.1213



## Accident and Incident Reporting 10 NCAC 13F.1212/G.1213

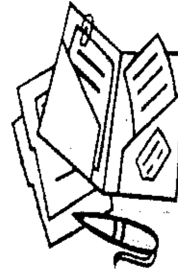
- An adult care home shall notify the County Department of Social Services of any accident or incident resulting in resident death or accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation or medical treatment other than first aid.

## Reportable Incident Yea or Nay?

- A skin tear?
- A fall ?
- Theft of personal belongings?
- Leaving the locked unit and going to the yard?
- Trip to the ER for tx. of chest pain?
- Abuse of a resident by a staff person?

## Monitoring Accidents and Incidents

- Observations/Interviews/Record reviews
  - What have you seen?
  - What have you heard?
  - What have you read?



- Analysis?
  - Is there a problem?
  - What is causing the problem?
  - Impact to Resident?

## Resident Rights
## General Statue 131D-21

- Encourage and assist residents in the full exercise of their rights.
- Responsibility for ensuring residents' rights is shared with regional ombudsman.
- Important to model for facility staff the value placed on resident rights.

## Restraints

- 10A NCAC 13F.1501 & 13G .1301
  - Using appropriate restraints only when absolutely necessary and in compliance with all rule requirements.

## What are restraints?

- Physical restraints are devices attached to or adjacent to the resident's body that the resident cannot remove easily. They are intended to restrict freedom of movement or normal access to one's body.
- Chemical restraints are medications such as antipsychotics, anxiolytics and sedatives used to control behavior.

## Physical restraints

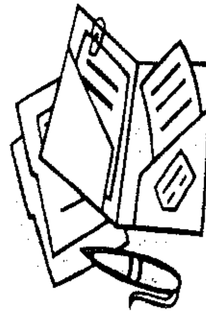
- Sheets used as ties
- Geri-chairs (chairs with locking lap trays
- Geri-tents
- Side rails used to keep a resident in bed
- Posey vests
- Lap belts (that the resident can not remove)
- Wrist and ankle cuffs
- Mittens

## What are enablers?

- Enablers are assistive devices used to enhance the resident's functional abilities.
  - Side rails used to increase a resident's mobility
  - Geri-chairs used for positioning
  - Lap belts that a resident can remove
  - Wheelchair seatbelts that the resident can operate
  - Pillows used for positioning

## Monitoring Restraints

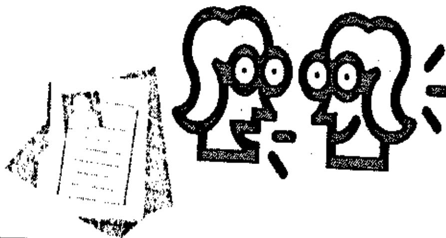
- Observations
  - What have you seen?
  - What have you read?
  - What have you heard?



- Analysis?
  - Is there a problem?
  - What is causing the problem?
  - Impact to Resident?

## Monitoring Assessments & Care Plans
## 10A NCAC 13F/G .0801/.0802

- Observations
- Interviews
- Record Review
  - FL-2s
  - DMA 3050-R
  - Progress Notes
  - Hospital Records
  - Home Health Notes



## 10A NCAC 13F/13G .0801 Resident Assessment

- Resident Register must be completed within 72 hours of admission.
- DMA 3050-R must be completed within 30 days of admission and annually thereafter.
- Complete following a significant change within 10 days.

## Significant Change 10A NCAC 13F/G .0801(c)(1)

- Requires a referral to a mental health professional,RN,MD or other licensed health professional following a significant change.
- This referral must occur within a timely manner consistent with the resident's condition. Not to exceed 10 days from the change and be documented.

## Significant Change is...

- a new diagnosis likely to affect the resident's physical, mental or psychosocial wellbeing.
- change in ability to use one's hands to grasp small objects.
- new onset of impaired decision making.
- change in ability to walk or transfer.

## Significant Change is...

- improved behavior, mood or functional abilities to the extent that the established plan of care no longer applies.
- deterioration in two or more activities of daily living.

## Significant Change is...

- initial onset of unplanned weight loss or weight gain of 5% of body weight within 30 days or 10% within 6 months.
- no response by the resident to the treatment for an identified problem.

## Significant Change is...

- the resident's condition indicates there may be a need to use a restraint and there is no current order.
- threat to life such as stroke, heart condition or metastatic cancer.

## Significant Change is...

- the resident's goes from being continent to incontinent or has an indwelling catheter.
- the resident develops a pressure ulcer that is stage II or higher.

## Significant Change is... 10A NCAC 13F/G .0801(d)

- deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic.

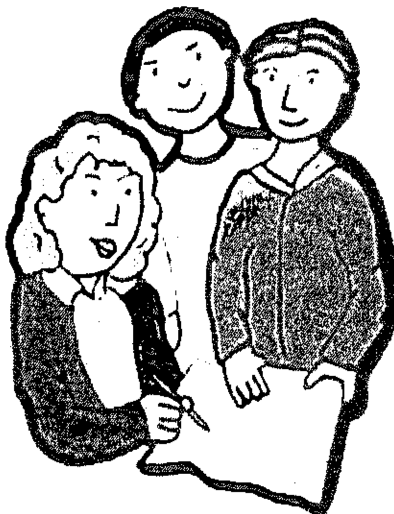
## Significant Change is not...

- Slight changes in the residents' condition.
- Changes that are easily reversed.
- Short term acute problems.
- A well established cyclical pattern.
- Steady improvement due to treatment.

## Significant Change Yea or Nay?

- a skin tear?
- antibiotic therapy?
- change in ability to dress oneself?
- change in ability to walk or transfer from wheelchair?
- UTI?
- change from continence to incontinence?

# 10A NCAC 13F/13G.0802
# Resident Care Plan



## Resident Care Plan

- An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission. The care plan is individualized written program of personal care for each resident. Revised as needed based on further assessments.

## Resident Care Plan shall include:

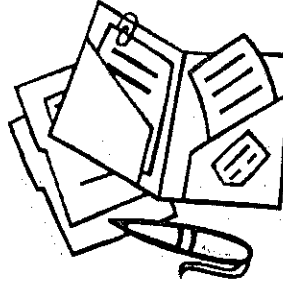
- Statement of care/services to be provided and frequency
- Signature of assessor upon completion of care plan
- Signature of physician within 15 calendar days of completion authorizing services and certifies:
  - The resident under the physician's care
  - The resident has a medical diagnosis with associated physical/mental limitations that justify the personal care services in the care plan.

## 10 NCAC 13 F/G .0802(f) Resident Care Plan

- The facility shall assure the care plan for each resident under the care of a provider of mental health, developmental disabilities, or substance abuse services includes resident specific instructions regarding how to contact the provider, including emergency contact.
- See rule 10 NCAC 13 F/G .0801(c) (1)(D) and rule 10 NCAC 13 F/G 10 NCAC 13 F/G .0801(d)

## Monitoring Assessments & Plan

- Observations
  - What have you seen?
  - What have you read?
  - What have you heard?
- Analysis?
  - Is there a problem?
  - What is causing the problem?
  - Impact to Resident?



changes in the contract and be provided an amended contract or an amendment to the contract for review and signature;

(E) gratuities in addition to the established rates shall not be accepted; and

(F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly.

Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room or a private or semi-private room in a special care unit.

(2) a written copy of all house rules, including facility policies on smoking, alcohol consumption, visitation, refunds and the requirements for discharge of residents consistent with the rules of this Subchapter, and amendments disclosing any changes in the house rules;

(3) a copy of the Declaration of Residents' Rights as found in G.S. 131D-21;

(4) a copy of the home's grievance procedures which shall indicate how the resident is to present complaints and make suggestions as to the home's policies and services on behalf of himself or others; and

(5) a statement as to whether the home has signed Form DSS-1464, Statement of Assurance of Compliance with Title VI of the Civil Rights Act of 1964 for Other Agencies, Institutions, Organizations or Facilities, and which shall also indicate that, if the home does not choose to comply or is found to be in non-compliance, the residents of the home would not be able to receive State-County Special Assistance for Adults and the home would not receive supportive services from the county department of social services.

(b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

*History Note: Authority 131D-2.16; 143B-165;*
*Temporary Adoption Eff. July 1, 2004;*
*Eff. July 1, 2005.*

## SECTION .0800 - RESIDENT ASSESSMENT AND CARE PLAN

### 10A NCAC 13F .0801 RESIDENT ASSESSMENT

(a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.

(b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.

(c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:

(1) Significant change is one or more of the following:

(A) deterioration in two or more activities of daily living;

(B) change in ability to walk or transfer;

(C) change in the ability to use one's hands to grasp small objects;

(D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;
(E) no response by the resident to the treatment for an identified problem;
(F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
(G) threat to life such as stroke, heart condition, or metastatic cancer;
(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
(I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

(2) Significant change is not any of the following:
(A) changes that suggest slight upward or downward movement in the resident's status;
(B) changes that resolve with or without intervention;
(C) changes that arise from easily reversible causes;
(D) an acute illness or episodic event;
(E) an established, predictive, cyclical pattern; or
(F) steady improvement under the current course of care.

(d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other appropriate licensed health professional such as a mental health professional, nurse practitioner, physician assistant or registered nurse in a timely manner consistent with the resident's condition but no longer than 10 days from the significant change, and document the referral in the resident's record. Referral shall be made immediately when significant changes are identified that pose an immediate risk to the health and safety of the resident, other residents or staff of the facility.
(e) The assessments required in Paragraphs (b) and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments.

*History Note:* *Authority G.S. 131D-2.16; 131D-4.4; 131D-4.5; 143B-165;*
*Temporary Adoption Eff. January 1, 1996;*
*Eff. May 1, 1997;*
*Temporary Amendment Eff. September 1, 2003; July 1, 2003;*
*Amended Eff. July 1, 2005, June 1, 2004.*

**10A NCAC 13F .0802 RESIDENT CARE PLAN**

(a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident.
(b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section.
(c) The care plan shall include the following:
(1) a statement of the care or service to be provided based on the assessment or reassessment; and
(2) frequency of the service provision.
(d) The assessor shall sign the care plan upon its completion.
(e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment:
(1) the resident is under the physician's care; and
(2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan.
(f) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance abuse services includes resident specific instructions regarding how to

**North Carolina Department of Health and Human Services**
**Division of Health Service Regulation**
**Adult Care Licensure Section**
2708 Mail Service Center • Raleigh, North Carolina 27699-2708
http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Barbara Ryan, Chief
Phone: 919-855-3765
Fax: 919-733-9379

ADULT CARE LICENSURE SECTION
SELF SURVEY MODULE

Rule: 10A NCAC .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.
(b)Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.
(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

Data Collection:

Observation:

- Are residents dressed appropriately?
- Are residents' hair, clothing, face and nails clean?
- Does the resident have an odor?
- Are residents wearing glasses, hearing aides and dentures if needed?
- Are residents using canes, walkers and wheelchairs if needed? Are these devices clean and in good repair?
- Do residents have access to needed grooming items?
- If needed is the call bell within reach?
- Do you see staff actively assisting residents with bathing, dressing, smoking, eating etc…?
- What is the quality of the interactions you observe? Is personal care assistance provided with the dignity and safety of the resident in mind?
- How does staff respond to resident requests?
- Is grooming provided in the manner that the resident desires it?
- Are call lights answered in a timely manner?
- Are staff aware of where residents are and what they are doing?
- Are residents who smoke doing so safely and in accordance with your smoking policy?
- Do you see respect for residents and their personal belongings in the way staff speaks to and cares for the residents?

Record Review:

- Does the FL-2 indicate
  - any problems with orientation?
  - the resident requires personal care assistance?
  - the resident has functional limitations?
  - any appropriate behaviors?
  - bowel and / or bladder incontinence?

- assistive devices or staff assistance required for ambulating?
- any difficulties in speech or hearing that would make communication difficult?

- Does the DMA 3050-R assessment and Care Plan
  - reflect a picture of the resident that is consistent with what is documented on the FL-2?
  - accurately reflect the care and services your staff provides?

Resident Interviews:

- Do you need any help with bathing, dressing, toileting etc…?
- Are you getting the help you need?
- Tell me about the help you get here?
- Are your choices honored?
- How are you treated by the staff?

Family Interviews:

- In what condition do you find the resident when you visit?
- Have you had any problems or concerns about the care here?
- Who is aware of your concerns and what have they done to help?
- Tell me about your family member's situation here.

Staff Interviews:

- Tell me about the care you provide for this resident.
- What kind of assistance do you give them?
- Can the resident tell you when they need help?
- If not, how do you monitor the resident's needs?
- Are there things you are supposed to be doing and are not? Why?
- Are you able to complete the care tasks assigned to you? Why not?
- How do you monitor where residents are and what they are doing?
- What are your responsibilities when an accident or incident occurs?

Problem Analysis:

- What is causing the problem?
- Are residents refusing personal care?
- Is there adequate staff to provide the needed care?
- Are staff adequately trained to provide the care?
- Are the necessary supplies available and accessible?
- Are staff adequately supervised?
- Are staff aware of facility policies and procedures?

Good Practice Tools

Environment and Resources

1. Conduct environmental rounds at regular intervals: keep hazardous materials secured.
2. Monitor and document water temperatures at regular intervals.
3. Inventory linens, toilet paper, gloves, soap and other necessary supplies to ensure supplies sufficient to meet needs.
4. Ensure call bell system is operational or signaling devices are accessible to residents who need them.

Staffing and Staff Qualifications:

1. Provide on the job training and facility orientation to newly hired staff to ensure they are competent and prepared to provide personal care to residents.
2. Ensure that all staff complete personal care aide training (unless CNA or have completed training documentation) within six months of employment.
3. Assign staff to personal care tasks of specific residents and provide supervision of direct care staff to ensure tasks are performed as assigned.
4. Provide inservice for staff regarding "person- centered" care. Emphasize the importance of safety, dignity and resident choice.
5. Ensure that all staff are trained regarding the expected response to door alarms and providing supervision to residents identified as having wandering behaviors or disorientation.
6. Develop a system for alerting staff to potential behavioral issues. Ensure that staff are aware of the facility policy on how to intervene when residents are threatening or aggressive.
7. Ensure that staff are trained on the facility policy regarding accidents and incidents and are prepared to immediately respond.

Resident Assessment and Intervention:

1. Ensure that residents' needs for personal care assistance and supervision are assessed prior to admission, upon admission, within 30 days of admission, annually thereafter and as needed when significant changes arise.
2. Identify heavy care residents and ensure that staff training and competency are equal to tasks assigned.
3. Identify residents with wandering behaviors and those at risk due to disorientation.
4. Assess resident's need for supervision when smoking to ensure safety.
5. Develop an individualized plan for intervention for residents with challenging behaviors, such as aggression.
6. Develop a system for reviewing accidents and incidents and evaluating for root causes of resident injuries.
7. Develop a system of responding when residents refuse personal care. Document staff efforts to encourage participation of residents in grooming and self care.

# ADULT CARE HOME
# PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN

Assessment Date ___/___/___
Reassessment Date ___/___/___
☐ Significant Change___/___/___

(Please Print or Type)

## RESIDENT INFORMATION

RESIDENT ______________________________ SEX (M/F) ___ DOB ___/___/___ MEDICAID ID NO. ______________

FACILITY ______________________________________________________________

ADDRESS ______________________________________________________________

______________________________________ PHONE ___________ PROVIDER NUMBER ___________

DATE OF MOST RECENT EXAMINATION BY RESIDENT'S PRIMARY CARE PHYSICIAN _____/_____/_____

## ASSESSMENT

1. MEDICATIONS – Identify and report all medications, including non-prescription meds, that will continue upon admission:

| Name | Dose | Frequency | Route | (✓) If Self-Administered |
|---|---|---|---|---|
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

2. MENTAL HEALTH AND SOCIAL HISTORY: (If checked, explain in "Social/Mental Health History" section)

☐ Wandering
☐ Verbally Abusive
☐ Physically Abusive
☐ Resists care
☐ Suicidal
☐ Homicidal
☐ Disruptive Behavior/ Socially Inappropriate

☐ Injurious to:
☐ Self ☐ Others ☐ Property

Is the resident currently receiving medication(s) for mental illness/behavior?
☐ YES ☐ NO

Is there a history of:
☐ Substance Abuse
☐ Developmental Disabilities (DD)
☐ Mental Illness

Is the resident currently receiving Mental Health, DD, or Substance Abuse Services (SAS)? ☐ YES ☐ NO

Has a referral been made? ☐ YES ☐ NO

If YES:

Date of Referral ___________

Name of Contact Person ___________

Agency ___________

Social/Mental Health History: ______________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

DMA-3050-R

Resident ______________________

3. AMBULATION/LOCOMOTION: ☐ No Problems ☐ Limited Ability ☐ Ambulatory w/ Aide or Device(s) ☐ Non-Ambulatory
Device(s) Needed ______________________
Has device(s): ☐ Does not use ☐ Needs repair or replacement

4. UPPER EXTREMITIES: ☐ No Problems ☐ Limited Range of Motion ☐ Limited Strength ☐ Limited Eye-Hand Coordination
Specify affected joint(s) ______________________
☐ Other impairment, specify ______________________ ☐ Right ☐ Left ☐ Bilateral
______________________
Device(s) Needed ______________________ Has device(s): ☐ Does not use ☐ Needs repair or replacement

5. NUTRITION: ☐ Oral ☐ Tube (Type) ______________________ Height __________ Weight __________
Dietary Restrictions: ______________________
______________________
______________________
______________________
Device(s) Needed ______________________
Has device(s): ☐ Does not use ☐ Needs repair or replacement

6. RESPIRATION: ☐ Normal ☐ Well Established Tracheostomy ☐ Oxygen ☐ Shortness of Breath
Device(s) Needed ______________________ Has device(s): ☐ Does not use ☐ Needs repair or replacement

7. SKIN: ☐ Normal ☐ Pressure Areas ☐ Decubiti ☐ Other ______________________
Skin Care Needs ______________________
______________________
______________________
______________________

8. BOWEL: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
☐ Ostomy: Type ______________________ Self-care: ☐ YES ☐ NO

9. BLADDER: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence
Catheter: Type ______________________ Self-care: ☐ YES ☐ NO

10. ORIENTATION: ☐ Oriented ☐ Sometimes Disoriented ☐ Always Disoriented

11. MEMORY: ☐ Adequate ☐ Forgetful – Needs Reminders ☐ Significant Loss – Must Be Directed

12. VISION: ☐ Adequate for Daily Activities ☐ Limited (Sees Large Objects) ☐ Very Limited (Blind); Explain __________
Uses: ☐ Glasses ☐ Contact Lens ☐ Needs repair or replacement
Comments ______________________
______________________
______________________

13. HEARING: ☐ Adequate for Daily Activities ☐ Hears Loud Sounds/Voices ☐ Very Limited (Deaf); Explain __________
☐ Uses Hearing Aid(s) ☐ Needs repair or replacement
Comments ______________________
______________________

14. SPEECH/COMMUNICATION METHOD: ☐ Normal ☐ Slurred ☐ Weak ☐ Other Impediment ☐ No Speech
☐ Gestures ☐ Sign Language ☐ Writing ☐ Foreign Language Only __________ ☐ Other ☐ None
☐ Assistive Device(s) (Type ______________________) Has device(s): ☐ Does not use ☐ Needs repair or replacement

Resident ______________________ __________

# CARE PLAN

15. IF THE ASSESSMENT INDICATES THE RESIDENT HAS MEDICALLY RELATED PERSONAL CARE NEEDS REQUIRING ASSISTANCE, SHOW THE PLAN FOR PROVIDING CARE. CHECK OFF THE DAYS OF THE WEEK EACH ADL TASK IS PERFORMED AND RATE EACH ADL TASK BASED ON THE FOLLOWING PERFORMANCE CODES: **0** - INDEPENDENT, **1** - SUPERVISION, **2** - LIMITED ASSISTANCE, **3** - EXTENSIVE ASSISTANCE, **4** - TOTALLY DEPENDENT. (PLEASE REFER TO YOUR ADULT CARE HOME PROGRAM MANUAL FOR MORE DETAIL ON EACH PERFORMANCE CODE.)

| ACTIVITIES OF DAILY LIVING (ADL)<br>*DESCRIBE THE SPECIFIC TYPE OF ASSISTANCE NEEDED BY THE RESIDENT AND PROVIDED BY STAFF, NEXT TO EACH ADL:* | SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | **PERFORMANCE CODE** |
|---|---|---|---|---|---|---|---|---|
| EATING | | | | | | | | |
| TOILETING | | | | | | | | |
| AMBULATION/LOCOMOTION | | | | | | | | |
| BATHING | | | | | | | | |
| DRESSING | | | | | | | | |
| GROOMING/PERSONAL HYGIENE | | | | | | | | |
| TRANSFERRING | | | | | | | | |

**OTHER:** (Include Licensed Health Professional Support (LHPS) Personal Care Tasks, as listed in Rule 42C .3703, and any other special care needs)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
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## ASSESSOR CERTIFICATION

I certify that I have completed the above assessment of the resident's condition. I found the resident needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs.

☐ Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.

Name ______________________ Signature ______________________ Date ______________

## PHYSICIAN AUTHORIZATION

I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.

☐ The resident may take therapeutic leave as needed.

Name ______________________ Signature ______________________ Date ______________

## INSTRUCTIONS FOR COMPLETING THE *REVISED* ADULT CARE HOME PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN (DMA-3050-R)

The block in the upper right hand corner of the form denotes the type of assessment that is completed: Include Assessment date, Reassessment date, or Significant Change. Refer to the glossary in the Adult Care Home Services manual for the definition of significant change.

**RESIDENT INFORMATION:** In the Resident Information area include the resident's name as it appears on the blue Medicaid ID card. Complete all information.

**DATE OF MOST RECENT EXAMINATION:** Includes a yearly physical by the resident's attending physician.

**ASSESSMENT:**

1. **MEDICATIONS:** List the name of each medication, include non-prescription meds that the resident will continue upon admission. Check appropriate box for self-administered.

2. **MENTAL HEALTH AND SOCIAL HISTORY:** Identify by checking the appropriate box. Review records from discharging facility to monitor if there was any indication about history of injury to self, property, or others. Include meds for mental illness/behavior, and include if there is a history of Mental Illness, Developmental Disabilities, or Substance Abuse.

   - **Is the resident currently receiving Mental Health (MH), Developmental Disabilities (DD), or Substance Abuse Services (SAS)?** If a referral has been made for an evaluation, indicate the date of referral, name of contact person at the agency, and the agency name.

   - **Social/Mental Health History:** Include any history that can be gathered from assessment by the resident, family, friends, etc. that provide information about the resident's preferences, activities and living status. This is also an area that needs to identify any Mental Health history such as institutionalization, out patient, compliance history, police record, etc.

**TOP OF SECOND PAGE: RESIDENT________________:** Place name as on Medicaid ID card in this blank.

3. **AMBULATION/LOCOMOTION:** Check applicable block and list devices needed.

4. **UPPER EXTREMITIES:** Check applicable box and list devices needed.

5. **NUTRITION:** Check appropriate box. Indicate height and weight. Include any restrictions to diet, i.e. NAS, soft, etc.

6. **RESPIRATION:** Check appropriate box. Indicate any devices needed.

7. **SKIN:** Check appropriate box. Explain in detail treatment necessary and include any MD orders for skin care.

8. **BOWEL:** Check appropriate box. Indicate if the resident is independent of activity. Explain what resident needs from staff.

9. **Bladder:** Check appropriate box. Indicate if the resident is independent of activity. Explain what residents need from staff.

10. **Orientation:** Check appropriate box.

11. **Memory:** Check appropriate box.

12. **Vision:** Check appropriate box. Expand on concerns in comments area.

13. **Hearing:** Check appropriate box. Expand on concerns in comments area.

14. **Speech/Communication Method:** Check appropriate box.

**Top of Third Page: Resident**________________: Place name as on Medicaid ID card in this blank.

## CARE PLAN:

15. Refer to the Adult Care Home Services manual for more detail on Performance Codes.

    **Activities of Daily Living:** Include a description of the specific type of assistance provided by staff next to each ADL and code the activity in the Performance Code area. In Other, list any Licensed Health Professional Support tasks as well as any special care needs in this area.

    **Assessor Certification:** Check box for Medical Care Decisions and Advance Directives education. Signature of assessor certifies that the care plan is developed based on assessment findings.

    **Physician Authorization:** The form is forwarded to the attending physician. The physician's authorization certifies that the individual is under the physician's care and has a medical diagnosis that warrants the provision of personal care services as indicated in the care plan. The physician prints his/her name, signs, and dates the form. The physician also may indicate and provide standing orders for an individual to take therapeutic leave by checking the block.

**North Carolina Department of Health and Human Services**
**Division of Health Service Regulation – Adult Care Licensure Section**
**Tel. 919-855-3765 Fax 919-733-9379**
**2708 Mail Service Center, Raleigh, North Carolina 27699-2708**

# RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL FOR ADULT CARE HOMES

This self- instructional manual is based on the Division of Medical Assistance (DMA) 3050R, **THE PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN FORM**, the resident assessment instrument established and accepted by the Department as the assessment tool for residents of adult care homes, including family care home. Staff authorized to complete the Resident Assessment shall document on the DMA 3050R information obtained on the FL2, any hospital records that accompany the resident, or any documents from prescribing practitioner or Licensed Health Professional Support, resident observations, and interviews with family and the resident. Residents are to be assessed within 30 days following admission and reassessed at least annually thereafter or after a significant change in condition as specified in Rule **10A NCAC 13F .0801** for Adult Care Homes (7+ beds) and Rule **10A NCAC 13G. 0801** for Family Care Homes.

The care plan is to be developed within 30 days of admission based on the Resident Assessment. The facility shall assure the resident's physician authorizes personal care services and certifies by signing and dating the care plan within 15 ***calendar*** days of completion of the assessment as specified in Rule **10A NCAC 13 F. 0802** for Adult Care Homes (7+ beds) and Rule **10A NCAC 13G. 0802** for Family Care Homes.

As required by Rules **10A NCAC 13F .0508** and **13G .0508,** this self-instructional manual is to be completed by staff responsible for completing the Resident Assessment prior to performing the assessment. Upon completion of the self-instructional manual, staff shall date and sign the last page, **which shall be maintained in the facility files for review by State and County monitors.**

This manual may be reproduced and is also available on the DHSR website at http:www.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf

**NOTE: The information is presented in the order as it is shown on the DMA 3050R.**

## DATES OF ASSESSMENTS

The block in the upper right hand corner of the form denotes the type of assessment and date the assessment was completed. Document only one of the following three options:

### ASSESSMENT DATE
At the top of page 1, the assessment date should be the date of the resident's initial 30-day assessment.

### REASSESSMENT DATE
At the top of page 1, the reassessment date should be the date annual reassessment was completed.

**SIGNIFICANT CHANGE**
At the top of page 1, the significant change date should be the reassessment after a significant change in condition as described in **10A NCAC 13 G .0801 for Family Care Homes** and **10A NCAC 13F .0801 for Adult Care Homes.**

## RESIDENT INFORMATION

Complete all identified areas under resident information.
Line 1. Resident name, sex (Male or Female), date of birth, and Medicaid identification number if applicable.

Line 2. Facility Name

Line 3. Facility Address

Line 4. Telephone number and Medicaid Provider Number if applicable.

Line 5. Date of most recent examination by the resident's primary care physician. **NOTE: This means most recent physical exam- not necessarily hospitalization.**

## 1. MEDICATIONS

List the name of each medication; include non-prescription medications that the resident will continue upon admission. Document the dose, frequency, the route and if the resident will self-administer the medication. Obtain the medications from the physician or prescribing practitioner orders. A copy of the current physician orders or Medication Administration Record (MAR) may be attached instead of recopying the orders. The documentation in this section should read "See Attachments." Keep the attachments with the Resident Assessment DMA Form 3050R.

## 2. MENTAL HEALTH AND SOCIAL HISTORY

**INTENT**
To identify past or present behavior symptoms that cause distress to the resident, or is distressing or disruptive to facility residents and staff members. Such behaviors include those that are potentially harmful to the resident or disruptive in the environment. Acknowledging and documenting the resident's behavioral symptom patterns on the resident assessment form provide a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards improving the behavior.

**If any of the areas in the first column are checked, explain or document in "Social/Mental Health History Section. Review all records (FL2, records from discharging facility, etc.) to determine if there was any indication about history of injury to self, others or property.**
**Example:** 1. Wandering is identified problem. Document wandering i.e. the resident frequently attempts to leave the facility. Has wandered away from home prior to admission. 2. Suicidal is identified. Document recent or past behavior i.e. resident attempted suicide 20 years ago. 3. Assaultive behavior is

identified. Document what behavior was i.e. resident became combative at the last facility and was in psychiatric hospital where medications were adjusted. Sexual assault occurred at previous facility. 4. Resists care is identified. Document how the resident has resisted care and if family, responsible person or health care professional is available to help staff or give information that will help staff assist the resident with care needs. What information or tools is available to help resident be less resistive, i.e. resists taking a bath and will fight staff. Family states the resident will bathe if cigarettes are given prior to bath and after.

**Definition**

a. **Wandering-** Ambulation or locomotion with no recognizable, rational purpose. A wandering resident may not be aware of his or her physical or safety needs. Wandering behavior may be shown by walking or by wheeling aimlessly in a wheelchair. Do not automatically include pacing as wandering behavior. Pacing back and forth may not be wandering but repetitive movements.

b. **Verbally Abusive-**Other residents or staff were threatened, screamed at or cursed at, etc.

c. **Physically Abusive-** Other residents or staff were hit, shoved, scratched or sexually abused etc.

d. **Resists Care-** Resists or has resisted taking medications/injections or assistance with one or more activities of daily living (eating, toileting, ambulating, bathing, dressing, grooming/personal hygiene, or transferring).

e. **Suicidal-** Demonstrates or has demonstrated verbally or non-verbally the intent/ to harm/kill oneself.

f. **Homicidal-** Demonstrates or has demonstrated or expresses verbally or non-verbally the intent to kill another person.

g. **Disruptive Behavior/Socially Inappropriate-** Includes sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings, etc.

h. **Injurious to Self, Others, or Property-** The resident has harmed him/herself including cutting, burning, scratching or injured other residents' including hit, shoved, scratched, sexually abused. Property has been damaged including, burning, breaking, cutting, etc.

**Is the resident currently receiving medication(s) for mental illness/behavior?**
Mark yes or no on the DMA 3050R. Refer to medications ordered for the resident.

**Is there a history of: Substance Abuse?**
Check on the DMA 3050R if there is a history. This includes excessive use of addictive substances especially alcohol and narcotic drugs such as marijuana, cocaine, heroin, crack, as well as prescription narcotic medications such a morphine, oxycodone, codeine, valium, librium, etc.

**Is there a history of Developmental Disabilities? (DD)?**
Check on the DMA 3050R if there is a professional diagnosis of developmental disability or mental retardation and a documented history. Use the FL2/MR2 or hospital discharge summary to identify developmental disabilities.

**Is there a history of Mental Illness?**
Check on the DMA 3050R if there is a documented history. Use the FL2/MR2 or hospital discharge summary to identify a history of mental illness.

Mental illness includes such disorders as schizophrenia, schizoaffective disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, borderline personality disorder, and other severe and persistent mental illnesses that affect the brain."

**Is the resident currently receiving Mental Health, DD (Developmental Disabilities), or Substance Abuse Services (SAS)?**
Mark yes or no on the DMA 3050R.
**Example:** Services are: Private psychiatrist or psychologist, Area Mental Health Clinic services, Day Hospital Program, Alcoholic Anonymous (AA) meetings etc.

**Has a referral been made?**
Mark yes or no on the DMA 3050R.
**Example:** Has a referral been made to private psychiatrist or psychologist, Area Mental Health Clinic, Day Hospital Program, Alcoholic Anonymous (AA) meetings, etc?

**If yes:**
Date of referral
Name of the contact person (name of the individual you spoke with to arrange the referral)
Agency (name of the clinic, psychiatrist, or psychologist or service)

## 3. AMBULATION/LOCOMOTION

**Intent**
**To record how the resident moves (walking or wheeling a wheelchair) in and out of the facility or how limited the resident is in walking, moving or propelling a wheelchair around in and out of the facility.**

**Definition:**
**A limitation in how the resident moves (walking or wheeling a wheelchair) that interferes with daily functioning particularly with activities of daily living, eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring or places the resident at risk of injury.**

**a. No problems**
Document here if the resident can move (walking or wheeling a wheelchair) about the facility on his/her own without need of any assistance from another person or devices/aides.
**Example:** 1. The resident walks in and out of the facility without need of assistance. 2. The resident self propels the wheelchair in and out of the facility.

**b. Limited Ability**
Document here if the resident can move (walking or wheeling a wheelchair) about the facility with some limitations such as walks only short distances alone. This may interfere with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

**Example:** 1. The resident is able to walk from bed to bathroom, bed to chair or short distance in hallway. 2. The resident moves about the facility in a wheelchair without the need of staff assistance for short distances.

**c. Ambulatory w/aide or Devices**
Document here if the resident is able to move (walking or wheeling a wheelchair) about the facility with the assistance of some equipment such as a cane, quad cane, crutch, wheel chair, prosthesis (artificial leg) splint, brace etc. This may interfere with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, or grooming/personal hygiene) or place the resident at risk of injury.
**Example:** 1. Resident uses a wheel chair to move about the Home. 2. The resident uses a walker with wheels to move about the Home. 3. The resident walks only with staff assistance.

**NOTE:** Prior to staff assisting with ambulation, Licensed Health Professional Support must complete the training and competency validation of the staff. Licensed Health Professional Support must evaluate the resident within 30 days of admission or within 30 days of developing the need for ambulating with assistive devices and staff assistance and reevaluate the resident at least quarterly thereafter.

**d. Non-Ambulatory**
Document here if the resident is not able to move (walking or wheeling a wheelchair) about in the facility. This may interfere with daily functioning particularly with activities of daily living. (eating, toileting, bathing, dressing, or grooming/personal hygiene) or place the resident at risk of injury.
**Example:** 1.The resident remains in bed or remains seated after staff has placed the resident in a bed, chair, wheel chair, geri chair or another person must push the resident in wheel chair.

**NOTE:** Prior to staff completing transfer of a non-ambulatory resident Licensed Health Professional Support must complete the training and competency evaluation of the staff, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**e. Device(s) Needed**
Document all devices the resident needs or uses to move (walking or wheeling a wheelchair) around in the facility.
**Examples**: Wheelchair, electric wheel chair, scooter, walker, cane, quad cane, crutches, prosthesis, brace, splint, Hoyer lift etc.

**Has Device(s) Document if applicable Does not use**
**Example:** 1. The resident has a cane/quad cane but does not use it. 2. The resident has a walker but does not use it. 3. The resident has a wheel chair but does not use it.
**or**

**Needs repair or replacement**
**Example:** 1. Resident has a walker but it needs repair/replacement wheel missing. 2. The wheelchair has broken seat/back/armrests, needs to be repaired. 3. The electric wheelchair does not run. 4. The resident has wheelchair but size not appropriate for resident; feet do not touch floor. The resident needs leg extensions for support due to feet/legs swelling.

## 4. UPPER EXTREMITIES

**Intent**

**To record how the presence of functional limitation in range of joint motion or loss of voluntary movement of arms, wrists, hands fingers affects the resident. Can the resident comb his hair, remove clothing, brush teeth, shave, pick up spoon, button or zip clothing?**

**Definition:**

**A limitation in arms, wrists, hands and fingers that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.**

**a. No problems**

Document here if the resident has full use/movement of arms, wrists, and hands and fingers on his/her own without need of any assistance from another person or devices/aides.
**Example:** 1. The resident has full use of upper body, arms and hands.

**b. Limited Range of Motion**

Document here if the resident has a limitation of movement of arms, wrists, or hands and fingers. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.
**Example:** The resident has a history of a stroke with paralysis on one side of the body. The resident has diagnosis of arthritis and pain in wrist and hand joints. As a result the resident has limited movement or use of hands.

**c. Limited Strength**

Document here if the resident can use the upper extremities but is not strong in the arms, wrists, hands or fingers. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.
**Example:** 1. The resident has diagnosis of arthritis and can bathe but cannot dress self due to pain and/or loss of movement in the hands and fingers. The resident requires assistance with buttons, zippers.
2. The resident has to use both hands to hold a cup of liquids.

**d. Limited Eye-hand Coordination**

Document here if the resident has combined visual and muscle coordination problems to complete tasks. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.
**Example:** 1. The resident is unable to feed self, misses the mouth.

**e. Specify affected joint(s)**

Document which joint of the arm, wrist, hand or fingers the resident has decreased range of motion or strength.

**Example:** Fingers on right hand are swollen due to diagnosis of arthritis and the resident cannot grasp objects such as spoon, toothbrush, or razor.

**Right or Left or Bilateral (both)** Document the appropriate side(s) where the resident has the limited range of motion or strength that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

**f. Other Impairment, Specify**
Document any other area of limited function or range of motion that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.
**Example:** The resident can only turn head to left side due to arthritis or injury.

**g. Device(s) Needed**
Document all devices needed or used by the resident to maintain function, range of motion or strength of upper extremities such as ace wraps, splints, braces etc.
**Example: 1.** The resident has a hand splint/brace, built up spoon, ace wrap, arm sling.

**NOTE:** Prior to staff completing task of application of ace wraps, splints, braces, the Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**Has Device(s)**

**Does Not Use** Document if applicable.
**Example:** The resident has a splint for the left hand to prevent contractures after stroke but does not wear it.
**Or**
**Needs Repair or Replacement** Document if device needs to be repaired or replaced.
**Example:** 1. The resident has brace for the left arm but the Velcro straps are missing.

## 5. NUTRITION

**Intent**
**To record how the resident consumes food and fluids to maintain adequate nutrition and hydration and identify any problems that would interfere with nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional interventions.**

**Definition**
**How the resident uses food and fluids for maintenance of a healthy body.**

**a. Oral**
Document if the resident takes the food and liquids by mouth.

**b. Tube (Type)**
Document the use of the gastrostomy tube (feeding tube placed into the stomach through which the resident receives liquid feedings and medications).
**Example:** The resident has a gastrostomy tube (G- tube) and staff administers feedings every 4 hours as ordered by the physician.

**NOTE:** The Licensed Health Professional Support must complete the training and competency evaluation of the staff prior to the staff feeding the resident with tube feedings, evaluate the resident within 30 days, and at least quarterly thereafter.

**c. Height**
Document how tall the resident is. **Example:** 5'6" (five feet 6 inches)

**d. Weight**

Document how much the resident weighs in order to monitor nutrition and hydration over time. If the last recorded weight was more than one month ago or previous weight is not available, it is best to weigh in the facility during the 30 -day assessment period to obtain an initial weight. If the resident has been hospitalized the resident could have weight loss during the hospitalization from the "usual weight". The resident could be receiving a diuretic (fluid pill) and weight could be different.
**Example:** The resident weighs178 pounds.

**Note: Abstracts of Interpretations of Adult Care Home Rules and Residents' Rights, 1998, reads: "There should be at least an annually documented 'baseline' weight from which to determine weight loss or gain. Weight is to be recorded on the FL2 and will therefore provide the annual weight documentation. The administrator needs to assure that this information is on the FL2 or that a weight measurement and date is documented in the resident's record at least annually.**

**On observation of unplanned weight loss or gain, or of conditions that would cause loss or gain such as a noticeable change in appetite/food consumption that continues for several days, a resident's weight should be determined and recorded. There should be follow-up measurements and documentation within at least 30 days thereafter if an observable or measured decline or gain in weight continues."**

**e. Dietary Restrictions**

Document any dietary restrictions including a modified diet that is prepared to alter the consistency of food in order to help the resident eat the diet.
**Example:** Resident needs soft solids, pureed foods, ground meat, thickened liquids, limited fluid intake, document any food allergies such as no peanuts or peanut butter, has swallowing problem and needs to be fed by staff, etc.

**NOTE:** If resident has a swallowing problem and is fed by staff, the Licensed Health Professional Support must complete the training and competency evaluation of the staff prior to the staff assisting with feeding the resident, evaluate the resident within 30 days and at least quarterly thereafter.

**f. Device(s) Needed**

Document any type of specialized, altered or adaptive equipment to help resident to feed him/herself. Document any devices to assist the resident with eating. Document any specialized or altered feeding techniques, including positioning to prevent choking at meals, i.e. resident sitting upright facing forward. Any orders or feeding recommendations such as chin tucks, food placed on only one side of mouth etc.
**Example:** The resident uses a built up spoon, divided plate, plate guard, chin tuck to help with swallowing; resident is to be seated upright in geri chair facing forward for all meals.

**NOTE:** If resident has any assessed swallowing difficulties, the Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident, and reevaluate the resident at least quarterly thereafter.

**Has Device(s) Document if applicable Does not use**

**Example:** 1. The resident has a built up spoon but does not use it. 2. The resident has a divided plate and a plate guard but does not use it.

**or**

**Needs repair or replacement**

**Example:** The built up spoon needs handle to be re-padded. The resident has used a built up spoon, plate guard/divided plate, but the built up spoon, plate guard/divided plate needs to be replaced.

## 6. RESPIRATION

**Intent**

**To record how the resident breathes and to identify any problems the resident may have with breathing.**

**Definition**

**The act of breathing.**

**a. Normal**

Document if the resident breathes without any difficulties or devices such as oxygen.

**b. Well Established Tracheostomy**

Document if the resident has a tracheostomy (an operation of cutting into the trachea or windpipe and inserting a tube to assist the resident to breathe). Well established means that the surgical opening has healed and there is only minimal cleaning of secretions around the area. The resident may complete self-care or require staff to complete the care.

**Example:** The resident has a tracheotomy since surgery 10 years ago. The resident cleans skin around the tracheostomy 2 to 3 times daily.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**c. Oxygen**

Document if the resident uses continuous oxygen or intermittent oxygen by nasal cannula. Document if the resident uses an oxygen concentrator or tanks of oxygen. Does Home Health or respiratory therapist visit regularly to clean, change or adjust equipment?

**Example:** 1. The resident has oxygen concentrator and uses oxygen just at night due to shortness of breath when lying down. 2. The resident uses oxygen continuously. Oxygen concentrator in room and also uses portable oxygen when leaving the room. Respiratory therapy comes in monthly to assess the resident and the oxygen equipment.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**d. Shortness of Breath**

Document if the resident has difficulty breathing. There may be many causes of the shortness of breath. This difficulty may be slight or severe. More effort is required for breathing, and the resident is more aware of the difficulty in breathing. This is a tiring and unpleasant sensation for the resident. With the increased difficulty in breathing the resident may become apprehensive and panicky.

**Example:** The resident has shortness of breath with any exertion, and cannot walk further than to the bedside commode.

**e. Device(s) needed**

Document any devices the resident has to assist with breathing. This may be oxygen concentrators or tanks, BiPAP (bilevel positive airway pressure) or CPAP (continuous positive airway pressure) machines, nebulizers etc.

**Example:** 1. The resident uses BiPAP during sleep for sleep apnea (moments during sleep when breathing stops). Home health in monthly to assess resident and equipment. Staff to document resident use or non-use of BiPAP at night. 2. The resident always sleeps with head of bed elevated and with 2 pillows to help with breathing.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to staff performing the task (using oxygen, BiPAP, bilevel positive airway pressure, or CPAP, continuous positive airway pressure, machines, nebulizers etc). Within 30 days the Licensed Health Professional Support must evaluate the resident and reevaluate the resident at least quarterly thereafter. The Licensed Health Professional Support should document any special positioning or instructions to aid the resident in breathing such as head of bed elevated, extra pillows, sleeping in semi-upright or up-right position.

**Has Device(s) Document if applicable Does not use**

**Example:** The resident has oxygen concentrator but refuses to use it.

**or**

**Needs repair or replacement**

**Example:** The resident has BiPAP unit but stated it is not currently working properly.

## 7. SKIN

**Intent**

**To determine and record the condition of the resident's skin. Document the presence of pressure areas including ulcers (breaks or holes in the skin), skin tears, abrasions, burns, open sores (cancer sores), rashes, cuts, surgical wounds, etc after thoroughly observing the resident's body, including legs and feet, including the bottom of the feet. Additionally to document any skin treatments for current conditions as well as any protective or preventive skin care treatments the resident is currently receiving.**

**Definition**

**Skin is the tissue covering the outer body. For purposes of the resident assessment any surface area from the head to the feet and toes.**

**a. Normal**

Document if the resident's skin is free of any pressure areas, open areas, rashes, skin tears, abrasions, burns, open sores, rashes, cuts, surgical wounds etc.

**b. Pressure Areas**

Document any area the resident has that is persistent area of skin redness (without a break in the skin) that may or may not disappear when the pressure is relieved.

**Example:** 1. The resident sits all day in the wheel chair. The lower buttocks are red and do not return to normal color when resident is returned to bed on his/her side. 2. The resident has a leg brace and there is a reddened area on the outer right ankle. The resident's right foot is swollen and the brace puts pressure on the ankle. The area returns to the normal color when the brace and shoe are removed.

**c. Decubiti (Pressure Ulcer)**

Document any skin ulcer/open lesion (sore). Decubiti (pressure sores) are defined as an area of skin redness (without a break in the skin) that does not disappear when the pressure is relieved **or** any open lesion (sore) caused by unrelieved pressure resulting in damage of underlying tissue. Decubiti (pressure sores) are usually over bony areas and are graded or staged to denote the degree of tissue damage observed. Observe resident's entire body including feet and legs.

**Example:** 1. Home Health visits twice weekly to assess and treat decubitus ulcer on the resident's left buttock. 2. Staff are to apply duoderm every 3rd day and as needed due to incontinence. 3. Home health visits daily to treat decubitus on resident's left heel and left buttocks. Staff are to keep the foot elevated on a pillow to keep pressure off the heel. Reposition resident every 2 hours to relieve pressure from the buttocks

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff, who provide treatment for decubiti, prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**d. Other**

Document any other skin problem the resident may have. These may include skin tears, abrasions, burns, open sores (cancer sores), rashes, cuts, surgical wounds, etc.

**Example:** 1. The resident has a very red area with rash under both breasts. 2. The resident has 2 skin tears, one on the right elbow and one on the lower left leg.

**c. Skin Care Needs**

Document any skin care needs the resident has. This includes any prescribing practitioner's treatment orders or may also include the need for application of lotions or creams to protect the skin. Any other skin care needs such as frequent bathing, repositioning, or pressure relieving devices such as pads for the chair or pads for the bed, etc should also be documented.

**Example:** Home Health visits weekly to assess and treat decubitus ulcer on the resident's left buttock. Staff are to apply duoderm every 3rd day and as needed due to incontinence. 2. Home health visits daily to treat decubitus on resident's left heel. Staff are to keep the foot elevated on a pillow to keep pressure off the heel. 3. The resident had an alternating air mattress on the bed. 4. Staff are to wash under resident's breasts daily and apply physician ordered treatment. 5. Resident has very dry skin on feet and legs. Staff to assist resident in applying lotion to the feet and legs daily. 6. Resident likes to stay up all morning for activities. Return to bed after lunch and apply Vaseline to bottom, etc.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task for decubiti (pressure sore) care and if medications are applied the staff should have had medication administration skills validation form completed prior to staff applying treatment. Within 30 days the Licensed Health Professional Support must evaluate the resident who has decubiti (pressure sores) and at least quarterly thereafter.

## 8. BOWEL

**Intent**

**To determine and record the resident's pattern of bowel continence.**

**Definition**

**The area of the body, through which, the resident eliminates solid waste (fecal) material. This area describes the resident's bowel pattern even with toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self-e.g., the resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. Incontinence means the resident has lost ability to control the bowel movements.**

**a. Normal**

Document normal if the resident's bowel elimination is at least one bowel movement every three days. The resident has complete control of bowel function and is continent (including control achieved by care that involves, habit training, reminders, etc.).

**b. Occasional Incontinence (less than daily)**

Document if bowel incontinent episodes occur once a week.
**Example:** The resident is occasionally incontinent of bowel, usually this occurs if the resident has had to have a laxative due to constipation.

**c. Daily Incontinence**

Document if the resident has lost or has inadequate control of bowel elimination. Bowel incontinence is all the time or almost all the time.
**Example:** The resident is not able to notify staff when there is the need for a bowel movement. The resident has daily (twice weekly, etc.) incontinent bowel movements.

**d. Ostomy**

Document if the resident has a well established colostomy. A colostomy is a surgical opening made through the abdomen into the colon (large intestine) to the outside. This is how the resident eliminates solid waste (feces/bowel movements). Document if the resident had a well established ileostomy. An ileostomy is a surgical opening through the abdomen into the small intestine to the outside through which the solid waste (feces/bowel movement) is eliminated.

**e. Type**

Document the type of ostomy the residents has colostomy or ileostomy.
**Example:** 1.The resident has an ileostomy. 2. The resident has had a colostomy for 5 years as a result of surgery for an obstruction.

**f. Self Care:**

**Yes or No**

Document **YES** if the resident does own care of the ostomy.

**NOTE:** The Licensed Health Professional Support must evaluate the resident within 30 days and at least quarterly thereafter.

Document **NO** if resident does not care for the well -established ostomy.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to staff performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

## 9. BLADDER

**Intent**
**To determine and record the resident's pattern of bladder continence.**

**Definition**
**The area of the body, through which, the resident eliminates urine. This section describes the resident's bladder pattern even with toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self-e.g., the resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. Incontinence means the resident has lost the ability to control urination.**

**a. Normal**
Document normal if the resident's bladder elimination is completely controlled and the resident is continent (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

**b. Occasional Incontinence (less than daily)**
Document if the resident's bladder incontinent episodes occur two or more times a week but not daily.
**Example:** The resident has incontinent episodes 2 to 3 times weekly, usually during sleep.

**c. Daily Incontinence**
Document if the resident has inadequate bladder control or has lost all bladder control. Bladder incontinent episodes occur multiple times daily.
**Example:** The resident is incontinent of urine and wears adult incontinence briefs at all times.

**d. Catheter**
Document if the resident has a tube in the bladder for eliminating urine.
**Example:** 1. The resident has an indwelling catheter. Staff is to wash around the catheter daily, position the catheter drainage bag below the bladder, and empty the drainage bag each shift. 2. Resident has an indwelling catheter but does self care of the catheter and the drainage bag. Home Health in monthly to change catheter.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task of positioning, cleaning and emptying drainage from the catheter, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

**e. Self Care**
Document if the resident takes care of the catheter.
Document **YES** if the resident does own care of the catheter.

**NOTE:** The Licensed Health Professional Support must evaluate the resident within 30 days and at least quarterly thereafter.

Document **NO** if resident does not care for the catheter.

**NOTE:** The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the positioning, cleaning and emptying the drainage bag, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

## 10. ORIENTATION

**Intent**

**To determine and record the resident's ability to remember, think coherently, and organize daily self-care activities. Ask resident his name, where he lived, name of facility, day of the week, year etc.**

**Definition**

**This means the resident's awareness of the real world in relationship to him/herself, and awareness to person, place and time. This also means the ability to comprehend and adjust one's self in the environment with regard to identity of persons, location, time and situation.**

**a. Oriented**

The resident's decisions in organizing daily routine and making decisions are consistent, reasonable, and organized reflecting lifestyle, culture and values.

**b. Sometimes Disoriented**

Document if the resident is confused at times and unaware of person, place or time. At times does not think coherently, and is unable to organize daily self-care routines such as bathing, dressing grooming, etc. The resident's decisions are
poor requires reminders, cues, supervision in planning, organizing Activities of Daily Living (ADL).
**Example:** The resident is usually oriented to person, place and time but occasionally will become disoriented in the early evening. The resident forgets she is in adult care home.

**c. Always Disoriented**

Document if the resident is not aware of person, place or time, cannot think coherently or organize daily self-care activities such as bathing, dressing grooming, etc. Decisions making is severely impaired: the resident never or rarely makes decisions about activities and self care.
**Example:** 1. The resident is not aware of who he is, where he is, or time. 2. The resident rides in wheel chair through home looking for children. The resident is able to feed himself but unable to meet any of the other ADL tasks.

## 11. MEMORY

**Intent**

**To determine and record the resident's memory/recall within the environment of the adult care home. A resident may have social graces and respond to staff and others with a look of recognition yet have no idea who they are.**

**Definition**

**The mental ability to retain and recall past experiences, remembering recent and past events.**

**a. Adequate**

Document if the resident has sufficient memory to recall past experiences. Document resident is able to identify self, where he/she is (able to identify that he/she is currently living in an adult care home/home for older people), and able to identify the current day/month/year/season etc. The resident is able to locate own room, able to distinguish staff from family members, strangers, visitors, and other residents.
**Example:** 1. Resident is oriented to person, place and time can find his/her room. 2. The resident knows staff from family members, other residents and visitors.

**b. Forgetful-Needs Reminding**
Document if the resident does not remember past experiences without being given cues or prompted.
**Example:** 1. The resident has to be reminded to change into bedclothes. 2. The resident has to be reminded to go to the dining room to eat.

**c. Significant Loss-Must Be Directed**
Document if the resident has lost most of memory/recall of past experiences. The resident is unable to remember and complete ADL tasks and must be directed by staff or have staff complete task for the resident.
**Example:** 1. The resident does not leave the room unless going with staff. 2. The resident will complete some of the ADL tasks with assistance from staff, e.g. will wash his face and hands but staff must complete the rest of the bath and dress the resident. The resident can button the shirt after staff puts the shirt on. 3. The resident does not remember where the dining room is and must be taken to the dining room for each meal.

## 12. VISION

**Intent**

**To document the resident's visual abilities and limitations, including eye pain and irritation (redness), assuming adequate lighting and assistance of visual appliances, if used.**

**Definition**

**How the resident sees; whether the resident experiences difficulties related to disease (e.g., cataracts, glaucoma, pain, dryness, redness etc.). Functional impairment may diminish the resident's ability to perform everyday activities (bathing, dressing, eating, using the toilet, walking, getting around inside and outside the facility) and participate in hobbies, or leisure activities (e.g., reading or watching television, using the computer etc.).**

**a. Adequate for Daily Activities**
Document the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses contact lens, magnifying glass, etc.). The resident sees fine detail, including regular print in newspapers/books.
**Example:** The resident is able to read the newspaper and books with glasses using the bedside table lamp (or overhead room light).

**b. Limited (Sees Large Objects)**
Document the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., eyeglasses, contact lens, magnifying glass, etc.). The resident has limited vision, is not able to see newspaper print, but can identify objects in the environment.
**Example:** The resident is unable to read the newspaper but can see people and objects well enough to walk inside of the adult care home. Resident is unable to walk outside without assistance.

**c. Very Limited (Blind); Explain**
Document if the resident has no vision or may see only light colors, or shapes; eyes do not appear to follow objects (especially people walking by). The resident may have limited or no sight in one or both eyes.

**Example:** 1. The resident is blind. 2. The resident can see large objects with the right eye only. The resident has no vision in the left eye. Place night table on the right side of the bed.

**d. Uses: Glasses, Contact lens, Needs Repair or Replacement**
Document if the resident uses any of these visual appliances regularly. Document if the visual appliances need repair or replacement.
**Example:** 1. The resident has glasses and uses them daily. The ear -piece on the right side is broken and needs to be repaired. 2. The resident has glasses but the lenses are broken and need replacement.

**e. Comments:**
Document any information about the resident's visual abilities or need of visual aides to see in this space.
**Example:** 1. The resident has glasses and uses them daily. The ear -piece on the right side is broken and needs to be repaired. 2. The resident refuses to wear the glasses and states he cannot see with them.

## 13. HEARING

**Intent**

**To document the resident's ability to hear (or hear with hearing aides, if they are used), understand, and communicate with others. To document any problems the resident may have with the ability to hear.**

**Definition**

**To perceive sounds by the ear.**

**a. Adequate for Daily Activities.**
Document if the resident hears all normal conservational speech, including when using the telephone, watching television, and engaged in group activities.
**Example:** Resident has no problems hearing.

**b. Hears Loud Sounds/Voices**
Document if the resident hears only loud sounds or voices.
**Example:** 1. Resident has problems hearing. Staff must speak loud and distinctly. 2. The resident does not like group activities, as he does not hear what the members of the group are saying. 3. Although hearing deficient, the resident compensates when the speaker adjusts tonal quality (speaks loudly) and speaks distinctly; or the resident can hear only when speaker's face is clearly visible or requires the use of a hearing-enhanced telephone.

**c. Very Limited (Deaf); Explain**
Document if the resident is highly impaired or there is absence of useful hearing. The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly or is positioned face to face. There is no comprehension of conservational speech, even when the speaker makes maximum adjustments.
**Example:** 1. The resident is totally deaf for the past 10 years. 2. The resident is able to hear some sounds if you speak loudly and face to face.

**d. Uses hearing Aid(s)**
Document if the resident uses hearing aid(s).

**Example:** 1. The resident has hearing aid for the left ear. The resident can hear with the use of hearing aid if staff speak distinctly and face the resident. Without the hearing aid the resident does not hear staff speaking to him. 2. The resident has hearing aids but refuses to wear them.

**e. Needs Repair or Replacement**
Document if the resident's hearing aid(s) needs to be repaired or replaced.
**Example:** 1. The resident has hearing aid for the left ear. The battery is not working and the resident needs a new one. 2. The resident has lost hearing aid and needs a new one.

**f. Comments:**
Document any information about the resident's hearing abilities or need of hearing aid(s) in this space.
**Example:** 1. The resident has hearing aid for the left ear and uses it daily. The hearing aid is broken and needs to be repaired. 2. The resident refuses to wear the hearing aide and he cannot hear anything without it.

## 14. SPEECH/COMMUNICATION METHOD

**Intent**
**To document the resident's ability to speak and communicate with others (using assistive devices, e.g., communication board). To document any problems the resident may have with the ability to communicate.**

**Definition**
**The expression of words, how the resident makes his or her needs and wishes known to others, use of verbal and non-verbal gestures or behaviors to make wants and needs known.**

**a. Normal**
Document if the resident uses speech to communicate with others. There is no problem with communication.
**Example:** The resident speaks clearly and has no problem communicating what he wants or needs of others.

**b. Slurred**
Document if the resident uses speech but slurred or mumbles words.
**Example:** The resident can speak but some of the words are slurred/mumbled and it is difficult to understand what the resident is saying.

**c. Weak**
Document if the resident uses speech to communicate, but there is a lack of strength or clarity making it difficult to understand what the resident is trying to communicate.
**Example:** 1. The resident can speak but only says a few words at a time. It is not easy to hear due the resident's inability to project the words.

**d. Other Impediments**
Document if the resident has any other impediments to his or her speech, e.g., stuttering, cleft lip or cleft pallet, esophageal speech (taking in air through to esophagus gradually "belching' the air to say words), etc.

**Example:** 1. The resident stutters but can make his wants and needs known to others. 2. Resident has a cleft lip making it difficult to understand the resident's speech but if the resident takes time and staff is patient the resident can make wants and needs known.

**e. No speech**
Document if there is absence of words or no speech from the resident.
**Example:** The resident has no speech due to stroke.

**f. Gestures**
Document if the resident uses movements or non-verbal expressions rather than speech to make wants and needs known including actions such as pointing, facial expressions, nodding head twice for yes and once for no, squeezing another's hand in the same manner. Sounds may include grunting, banging, ringing a bell, etc.

**Example:** 1. The resident grunts and points to objects and people to get wants or needs communicated to others. 2. The resident will take staff's hand and leads to what she or he wants or needs.

**g. Sign Language**
Document the resident's use of hands to spell words or phrases. This is a highly developed language, which takes a long period of time to learn. The resident or family may teach staff certain hand signs to help get the resident's wants and needs met.
**Example:** The resident has been deaf since age 20. The resident uses sign language to communicate with his family. The resident and family are teaching the staff some words to help the resident meet his needs. The resident also writes out what he wants or needs.

**h. Writing**
Document if the resident writes notes to communicate with others.
**Example:** The resident writes on a pad what she needs and wants from others.

**i. Foreign Language Only**
Document if the resident speaks only a foreign language.
**Example:** The resident speaks only Spanish. The resident does not speak or understand English.

**j. Other**
Document if the resident uses flash cards, communication board or various electronic assistive (electrolarynx) devices to communicate his or her wants and needs to others.
**Example:** The resident uses a homemade board with words and phrases to communicate want and needs to others. The resident has an electrolarynx, which is a sound device that is held against the neck while it produces sounds.

**k. None**
Document if there is no vocal communication. Resident may hear sounds but does not have any speech, gestures, or sounds.
**Example:** The resident has no verbal nor non-verbal expressions to communication want or needs to others.

**l. Assistive Devices**
Document if the resident has any communication devices such as electrolarynx, communication board, flash cards, etc. **Example:** 1. The resident has flash cards but they are worn and difficult to use. 2. The resident has a homemade communication board but it is torn and needs to be replaced.

**Has Device(s) Document if applicable Does not use**

**Example:** The resident has a communication board but refuses to use it.

**or**

**Needs repair or replacement**

**Example:** Resident has electrolarynx and it is not currently working properly.

## 15. CARE PLAN

**If the assessment indicates the resident has medically related personal care needs requiring assistance, show the plan for providing care. Check off the days of the week each ADL task is performed and rate each ADL task based on the following performance codes: 0-Independent 1-Supervision 2-Limited Assistance 3-Extensive Assistance 4-Totally Dependent (Please refer to the Adult Care Home Program Manual for more detail on each performance code or refer to the performance codes listed below.)** ***NOTE: This statement is documented on the care plan.***

**ACTIVITIES OF DAILY LIVING (ADL)**

**Describe the specific type of assistance needed by the resident and provided by the staff, next to each ADL:**

Refer to the DMA-3050R for the care plan, day, and performance code grid and document findings from the Resident Assessment.

**PERFORMANCE CODES**
**(EFFECTIVE 01-01-2000)**
**(From Division of Medical Assistance)**

**0 - INDEPENDENT**

The resident performs the activity without help, or may require minimal supervision or assistance only once or twice during a week. For example the resident who usually transfers on and off the toilet unassisted may need a staff member to stand by the toilet room door after especially tiring day away from the facility.

**1-SUPERVISION**

The resident can perform the activity when a staff member provides oversight, encouragement, and prompting, or with supervision plus some physical assistance only once or twice during a week. For example, an incontinent resident may be able to use the toilet room unassisted if regularly reminded to do so. Another example would be a resident who bathes daily with supervision and encouragement. The resident is able to wash himself completely with oversight from a staff member. Once or twice during a week, he may need a staff member to hold his hand and provide some support while he gets in and out of the tub.

**2-LIMITED ASSISTANCE**

The resident is highly involved in performing the activity for him/herself. The resident also requires help from staff in guided maneuvering of limbs or other non-weight bearing assistance three or more times during a week, or limited assistance plus more physical assistance only once or twice during a week. For example a resident may need a staff
member to hold his shirt and physically guide his hand to the sleeve opening, but the resident can push his arm through the sleeve. Another example would be a resident who walks independently throughout the facility during the daytime, but wants staff to hold his hand and guide him while walking to the toilet room during the night.

**3-EXTENSIVE ASSISTANCE**

The resident can perform part of the activity for him/herself. The resident also requires either weight-bearing support from staff three or more times during a week, or staff member to perform the task for him/her (three or more times) during
part (but not all) of the week. The following are examples: (a) on three occasions in one week, the resident needed a staff member to lean against and steady him while transferring from standing with a walker into a bed or chair; (b) a resident feeds himself breakfast and lunch with staff supervision; however due to fatigue the resident must be fed dinner by a staff member daily; (c) resident can walk within a room but requires weight-bearing assistance to walk outside of the room; (d) a resident is able to propel self in a wheelchair, however due to fatigue the resident requires a staff member to push the wheelchair three or more times a week; (e) resident is able to use an assistive device(s) (i.e. walker, cane, rollator walker), however he/she requires a staff member to provide weight-bearing assistance three or more times a week.

**4-TOTALLY DEPENDENT**

A staff member must complete the task for the resident at all times. For example, a resident who cannot do any part of dressing for himself, and requires total assistance with dressing from the staff. Another example is a resident who receives tube feeding administered completely by the staff. Another example would be a resident who is unable to walk,
with or without, an assistive device(s), or a resident who is unable to propel self in a wheelchair and requires total assistance from the staff.

**OTHER**

**(Include Licensed Health Professional Support (LHPS) Personal Care tasks, as listed in Rule10A NCAC 13F .0903 for Adult Care Homes and 10A NCAC 13G .0903 for Family Care Homes)**

**Example:** 1. The resident receives FSBS (finger stick blood sugar) 4 times daily and sliding scale insulin based on the MD orders. 2. The resident wears TED hose, on each morning and off at night during sleep. 3. The resident is non-ambulatory and is transferred from bed to chair with a hoyer lift, or with two staff, etc. 4. The resident receives oxygen 2 liters per minute by nasal cannula as needed. The resident uses the oxygen approximately 2 to 4 times weekly usually at night.

## ASSESSOR CERTIFICATION

"I certify that I have completed the above assessment of the resident's condition. I found the resident's needs personal care services due to the resident's medical condition. I have developed the care plan to meet those needs."

**Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission.** Document if the above was completed.

Print assessor's name, signature and date at the completion of the Resident Assessment.

## PHYSICIAN AUTHORIZATION

"I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan."

The physician may document that **the resident may take therapeutic leave as needed.**

Physician to print name, signature and date. **(NOTE: The care plan is to be signed by the resident's physician within 15 calendar days of completion of the Resident Assessment.)**

## Attention: Adult Care Home Providers *(North Carolina Medicaid Bulletin November 2000)*

## Policy for Correcting the DMA-3050

The Division of Medical Assistance (DMA) has implemented a policy to allow Adult Care Home (ACH)
providers to make limited corrections to the ACH assessment and care plan form (DMA-3050).

**Acceptable Format**

Corrections to the DMA-3050 are acceptable when the incorrect information is lined through once with the new
information noted, initialed, and dated by the assessor. Example: supervise toileting, assist on and off toilet.

**Conditions**

- The crossed out information must be legible.
- The corrected information must be dated before or on the date the assessor signs the DMA-3050.
- The corrections must be initialed and dated by the assessor.

**Bill Hottel, Adult Care Home Services Unit, Medical Policy Section**
**DMA, 919-857-4020**

# RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL

# FOR ADULT CARE HOMES

**AS THE STAFF DESIGNATED BY THE ADMINISTRATOR TO PERFORM RESIDENT ASSESSMENTS, I CERTIFY THAT I HAVE COMPLETED THE RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL FOR ADULT CARE HOMES PRIOR TO PERFORMING THE REQUIRED RESIDENT ASSESSMENTS.**

**PRINT NAME**________________________________________

**SIGNATURE**________________________________________

**DATE**____________________________________________

**NOTE: Retain in facility files.**

# ACCURATELY MEASURING WATER TEMPERATURE

We have learned the following from the DHSR Construction Section. To obtain accurate water temperature measurements, use either a digital or a kerosene thermometer that the calibration can be checked. Checking the calibration instructions are below. Sometimes, it is helpful to assist facilities in checking the calibration of their thermometer.

To order a scientific glass bulb thermometer like our office uses, you may call Fisher Scientific at 1-800-766-7000. The cost is about $8.00-$20.00 depending upon the vendor

The method that DHSR Construction Section recommends for checking the accuracy of thermometers:

Fill a cup (Styrofoam is usually best) with crushed ice.

Add some cold water to make an ice bath slush.

Wait approximately 10 minutes.

Place thermometer(s) in the ice bath

After 2 to 3 minutes read the temperature on the thermometer

An accurate thermometer should read 32 degrees F.

The more the number of degrees the thermometer is from 32 degrees F, the more inaccurate the thermometer is.

**North Carolina Department of Health and Human Services**
**Division of Health Service Regulation**
**Adult Care Licensure Section**
2708 Mail Service Center • Raleigh, North Carolina 27699-2708
http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Barbara Ryan, Chief
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## ADULT CARE LICENSURE SECTION
## SELF SURVEY MODULE

### RULE: 10A NCAC 13F .0311 (d) Other Requirements-Hot Water Temperatures

d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.

### Rule: 10A NCAC 13G .0317 (d) Building Service Equipment-Hot Water Temperatures

(d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).

Data Collection:

**Observation:**

1. Sample areas, accessible to residents, (common bathrooms/sinks/showers/whirlpools/tubs and individual resident's rooms, any area accessible to residents) are checked.
   a) Allow the hot water to run for awhile, record the temperature in your notes, documenting the area, the date and time of the test as well as who was present.
   b) Is there steam seen? If so document.

2. If the hot water temperatures are 96 degrees F or below, or 120 degrees F or above, inform the administrator/designee, and re-check the hot water with staff. Re-check hot water temperatures later prior to leaving the facility. If going back into the facility the next day, re-check hot water temperatures after entering; document the area, date, time and interviews with staff or residents about the hot water.

3. Calibrate both the facility's thermometer and the surveyor's thermometer using the following method:

**CALIBRATION PROCEDURE:** This procedure is referenced from the 1997 Food Code, DHHS, FDA, and PHS. A wet ice procedure may be used for field checks of the thermometer and sensor. The ice should be broken into very small pieces, packed into an insulated container or cup, and stirred with cold water into very thick slurry. The thermometer should be placed at the very center of the container to a depth of at least 2 inches and should be frequently agitated. The temperature should be noted when the temperature has stabilized after about 3 minutes and should be +/- 2 degrees F from 32 degrees F.

If temperature range is equal to or greater than 120 degrees, continue observations as follows:

- Observe staff bathing residents, if possible. Are they testing the temperature of the water prior to exposing the resident to the water?
- Are staff using gloved hands when water tested? If so document what you observe, date, time, staff.

**INTERVIEWS**

A. Direct Care Staff

1. What do you do as you prepare to give residents a bath/shower?
2. Do you remain with residents throughout their bathing?
3. Have you ever had problems with water temperatures (too cold, too hot)?
4. What happens if the water seems to hot-what do you do?
5. Who do you report problems with water temperatures?
6. What were you told to do?
7. Have you had any problems recently? Resident complaints of water temperatures?
8. If yes, what happened?

B. Residents

1. How is the water temperature?
2. Have you ever had problems with the water temperatures (too cold, too hot)?
3. What do you do if the water seems too hot?
4. Who do tell about the hot/cold water temperatures?
5. What have staff told you to do when the water temperature was too cold or too hot?

C. Administrator/Maintenance Staff

1. Are you aware of any problems with hot water temperatures?
2. If yes, when was it brought to your attention?
3. What has been done to address the problem?
4. What have you directed the maintenance staff to do?
5. Can you tell me how your hot water system works—is the kitchen/laundry on the same lines as resident rooms/common baths?
6. Do you check the water temperatures?
7. How often are the water temperatures checks completed?
8. Do you maintain a log of water temperature checks? Do you document all temperatures taken? Or after adjustments are made? Or both?
9. How do you calibrate your thermometer? How often?
10. If there is a problem how do you fix it?
11. When was the last time you made adjustments?
12. When was the last time work or repair was completed on you water system?
13. Is there any work on the hot water system scheduled? When?
14. Any parts on order; when was part ordered; when do expect receipt?
15. What has direct care staff been directed to do?

**Record Review:**

1. Review the temperature logs for the facility. If there have been problems with the hot water temperatures, the facility should monitor the temperatures more frequently to assure the temperatures are within the acceptable range (100 degrees F -116 degrees F).
2. Review any other records or work orders that would show the facility had been attempting to maintain the water temperatures within the acceptable range.

**Problem Analysis for Survey:** When you determine the water system is not in compliance with the licensure rule, determine the scope/severity of the problem. Based on the information gathered, determine if the water system is in compliance with the rule:

1. 100 degrees F-116 degrees F- The facility is in compliance with the regulation.

2. 99 degrees F to 97 degrees F. Inform the facility of the hot water temperatures.

3. 96 degrees or below inform the facility of the temperatures and cite a deficiency **unless** findings show the facility was aware, working on the problem and informed staff and residents of the problem or residents were not concerned.

4. 117 degrees F to 119 degrees F. Inform the facility of the hot water temperatures.

5. 120 degrees F to 124 degrees F. Inform the facility and cite a deficiency **unless** findings show the facility was aware, working on the problem and informed staff and residents of the problem. Ask the administrator/designee to post signs that the water is too hot. Water use is to be supervised.

6. 125 degrees F to 129 degrees F. Inform the facility this is a possible Type B Violation. Ask the administrator/designee to inform the staff and residents that the hot water is too hot. Ask if the temperatures can be lowered by staff or if the facility will need to contact a plumber. Ask the administrator/designee to post signs that the water is too hot. Water use is to be supervised.

7. 130 degrees F and above, inform the facility this is a possible Type A Violation. Ask the administrator/designee to inform the staff and residents that the hot water is too hot. Ask if the temperatures can be lowered by staff or if the facility will need to contact a plumber. Ask the administrator/designee to post signs that the water is too hot. Water use is to be supervised.

Note: See attached Construction Section directive regarding hot water safety in nursing homes.

**North Carolina Department of Health and Human Services**
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# FACTORS TO BE CONSIDERED WHEN ANALYZING HOT WATER SAFETY ISSUES IN RESIDENT CARE AREAS OF ADULT CARE FACILITIES

- Licensure Rule 10A NCAC 13F .0311: 100-116 degrees F. is the hot water temperature required by State Licensure.
- Any temperature above 120 degrees F. is considered to be a significant deficiency. As the temperature increases upward, the patient is exposed to more danger as shown in the table below:

Extracted from Technical Document 14:2-82 - American Society for Hospital Engineering (1982)

| Temperature $^{O}$F | First Degree Burn* | Second Degree Burn** |
|---|---|---|
| 116.6 $^{O}$F | 20 minutes | 45 minutes |
| 118.4 $^{O}$F | 15 minutes | 20 minutes |
| 120 $^{O}$F | 8 minutes | 10 minutes |
| 124 $^{O}$F | 2 minutes | 4.2 minutes |
| 125.6 $^{O}$F | 45 seconds | 1.5 minutes |
| 127.4 $^{O}$F | 30 seconds | 60 seconds |
| 131 $^{O}$F | 17 seconds | 30 seconds |
| 140 $^{O}$F | 3 seconds | 5 seconds |
| 151 $^{O}$F | - | 2 seconds |

* No Irreversible Damage ** Full Thickness Injury

- Do all direct care staff and administration know and understand the hot water regulations and ramifications of elevated hot water delivered to the patient use areas?
- Have new and existing staff been trained in testing hot water temperatures by hand prior to patient showering or using sinks? Are these training procedures repeated on a regular basis and is training documented?
- Is a hot water temperature log kept with at least once a week testing done? (more frequently for systems without monitoring devices ?) **(OVER)**

- Are monitoring thermometers accurate and calibrated on a regular basis? Are thermometers mechanical, glass bulb, or electronic?
- Are mixing valves cleaned and checked in accordance with valve manufacturer's instructions? (very important) Is the maintenance of valves documented with supporting copies of invoices and/or service tickets?
- Are hot water re-circulating loop pumps checked and maintained in good working order in accordance with pump manufacturer's maintenance instructions? Is the maintenance of re-circulating loop pumps documented with supporting copies of invoices and/or service tickets?
- Are hot water systems fitted with any type of high temperature alarm system? (suggestion only, not a requirement)
- Are policy and procedures in place to address problems when they occur to protect residents in the event of elevated hot water temperature? (immediate action required when the hot water temperature is elevated above 120 $^{O}$ F.)

Other important points to consider:

- Fluctuating hot water temperature may be a sign of a defective mixing valve, defective cold water pressure reducing valve, fluctuating incoming water pressure, improper or damaged pipe insulation, inoperative re-circulating pump, defective boiler control, or improperly piped or sized mixing valve assembly. Review valve manufacturer's installation instructions and consult with a technical representative if there are questions.
- If low temperature, **large** hot water storage tanks are used, the tanks should be cleaned, disinfected, and temperature elevated to approximately 160 $^{O}$ F for 12-24 hours in accordance with the most current CDC guidelines, flushed completely and put back in service. This should be done only by a qualified individual or company. (procedures vary depending on situation)
- Additional information is available on the Internet regarding hot water scald prevention, anti-scald plumbing fixtures, and hot water scald data, and legionella bacteria control.

Prepared by: Bill Warren, Chief (Bill.Warren@ncmail.net)
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Division of Health Service Regulation
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# COMMON MEDICAL ABBREVIATIONS

| WORD | MEANING |
|---|---|
| AAA | abdominal aortic aneurysm |
| ABD | abdominal / abdomen |
| ABG | arterial blood gases |
| ADL | activities of daily living |
| Ad Lib | as desired |
| AKA | above knee amputation |
| ALL | acute lymphoblastic leukemia |
| AML | acute meolicytic leukemia |
| AOMD | adult-onset diabetes mellitus |
| AP | angina pectoris |
| ARF | acute renal failure |
| ASA | aspirin (acetylsalicylic acid) |
| ASCVD | arteriosclerotic cardiovascular disease |
| ASHD | arteriosclerotic heart disease |
| ASO | arteriosclerosis obliterans |
| B & B | bladder & bowel |
| BIL | bilateral |
| BR | bathroom |
| BKA | below knee amputation |
| BMR | basal metabolic rate |
| B/P | blood pressure |
| BPH | benign prostatic hypertrophy |
| BS | bowel sounds |
| BSA | bilateral salpirgoopherectomy |
| Bx | biopsy |
| C | with |
| Ca | cancer |
| CAD | coronary artery disease |
| CAT | computerized axial tomography |
| CBC | complete blood count |
| CBS | chronic brain syndrome |
| CC | chief complaint |
| CCU | coronary care unit |
| CHD | coronary heart disease |
| CHF | congestive heart failure |
| CNS | central nervous system |
| C/O | complaints of |
| COLD | chronic obstructive lung disease |
| COPD | chronic obstructive pulmonary disease |
| CPR | cardio-pulmonary resuscitation |
| CRF | chronic renal failure |
| CSF | cerebrospinal fluid |
| CT | computed tomography |

COMMON MEDICAL ABBREVIATIONS

| | |
|---|---|
| CVA | cerebrovascular accident |
| CVP | central venous pressure |
| CXR | chest x-ray |
| D & C | dilation and curettage |
| D/C | discontinue |
| DJD | degenerative joint disease |
| DM | diabetes mellitus |
| DNR | do not resuscitate |
| DOA | dead on arrival |
| DVT | deep venous thrombosis |
| Dx | diagnosis |
| ECG or EKG | electrocardiogram |
| ECT | electric convulsive therapy |
| EEG | electroencephalogram |
| EENT | eye, ear, nose, and throat |
| ESR | erythrocyte sedimentation rate |
| ESRD | end stage renal disease |
| FBS | fasting blood sugar |
| FNP | family nurse practioner |
| FSBS | fingerstick blood sugar |
| FTT | failure to thrive |
| F/U | follow up |
| FUO | fever of unknown origin |
| Fx | fracture |
| GB | gallbladder |
| GERD | gastroesophageal reflux disease |
| GI | gastrointestinal |
| GT | gastrostomy tube |
| GTT | glucose tolerance test |
| GU | genitourinary |
| GYN | gynecology |
| HA | headache |
| HBP | high blood pressure |
| Hgb | hemoglobin |
| HPI | history of present illness |
| HTN | hypertension |
| Hx | history |
| ICU | intensive care unit |
| IDDM | insulin dependant diabetes mellitus |
| IHD | ischemic heart disease |
| IM | intramuscular |
| IMP | impression |
| IPPB | intermittent positive pressure breathing |
| IV | intravenous |
| IVC | inferior vena cava |
| JVD | jugular vein distention |

# COMMON MEDICAL ABBREVIATIONS

| | |
|---|---|
| KUB | kidney, ureter, and bladder |
| L | left |
| LBP | lower back pain |
| LFT | liver function tests |
| LLQ | left lower quadrant |
| LUQ | left upper quadrant |
| MAR | medication administration record |
| MDS | minimum data set |
| MI | myocardial infarction |
| MOM | milk of magnesia |
| MRI | magnetic resonance imaging |
| MS | morphine sulfate multiple sclerosis |
| MSDS | material safety data sheets |
| NAD | no apparent distress |
| N & V | nausea and vomiting |
| NG | nasogastric |
| NKA | no known allergies |
| NKDA | no known drug allergies |
| NNO | no new orders |
| NPN | nonprotein nitrogen |
| NPO | nothing by mouth (non per os) |
| NIDDM | non-insulin dependant diabetes mellitus |
| NTS | nontropical sprue |
| OBS | organic brain syndrome |
| OD | right eye |
| OR | operating room |
| ORIF | open reduction/internal fixation |
| OS | left eye |
| OT | occupational therapy |
| OU | both eyes |
| P | after |
| PA | physician assistant |
| PAT | paroxysmal atrial tachycardia |
| Pb | phenobarbital |
| PCM | protein-calorie malnutrition |
| PEARL | pupils equal and reactive to light |
| PEG | percutaneous endoscopic gastrostomy |
| PPD | purified protein derivative |
| PR | per rectum |
| Pt | patient |
| PT | physical therapy prothrombin time |
| PTA | prior to admission |
| PUD | peptic ulcer disease |
| PVC | premature ventricular contraction |
| PVD | peripheral vascular disease |
| R | right |

# COMMON MEDICAL ABBREVIATIONS

| | |
|---|---|
| RAP | resident assessment protocol |
| RCP | resident care plan |
| RE | regarding |
| RHD | rheumatic heat disease |
| RLQ | right lower quadrant |
| R/O | rule out |
| ROS | review of systems |
| RUQ | right upper quadrant |
| S | without |
| S/S | signs and symptoms |
| SBO | small bowel obstruction |
| SLE | systemic lupus erythematosus |
| SNO | see new order |
| SOB | shortness of breath |
| S/P | status postop |
| SUPP | suppository |
| Sx | symptoms |
| SZ | seizure |
| T & A | tonsillectomy and adenoidectomy |
| TAH | total abdominal hysterectomy |
| TB | tuberculosis |
| THA | total hip arthroplasty |
| TIA | transient ischemic attack |
| TKA | total knee arthroplasty |
| TPN | total parenteral nutrition |
| TPR | temperature, pulse, respirations |
| TUR (P) | transurethral resection |
| TX | treatment |
| U/A | urine analysis |
| UGI | upper gastrointestinal |
| URI | upper respiratory infection |
| UTI | urinary tract infection |
| VH | vaginal hysterectomy |
| VS | vital signs |
| W D | wet to dry |
| WNL | within normal limits |
| + | present |
| - | absent/negative |
| = | equal |
| ^ | change |
| | increased |
| | decreased |

**OPTIONAL FORM** BASIC ORIENTATION

# MONITORING PERSONAL CARE AND HEALTH CARE
# LHPS, Resident Assessment & Care Plans

Select appropriate sample of the residents to monitor based on license. If problems identified in specific rule areas, expand the sample

- Ask the Administrator or SIC for a list of residents with personal care tasks listed under Licensed Health Professional Support. These would be residents who are diabetics with insulin injections and finger-stick blood sugar checks, residents with swallowing difficulties, residents with TED hose, oxygen, indwelling urinary catheters, pressure sores, nebulizer treatments, restraints, etc.

- Ask the Administrator for a list of residents who have recently been transferred to/or from hospital and residents who are being seen by home health.

- Take a tour of the facility. Look for residents who have TED hose, oxygen, CPAP or BiPAP machines, indwelling urinary catheters, restraints, residents who are semi-ambulatory, residents who appear sick and residents who are alert and oriented who need moderate assistance with personal care are good residents to interview.

Observations to make while monitoring personal grooming of residents. Note if there are body or body fluid odors, nails not clean & trimmed, dressed appropriate, hair combed.

- Position of residents in chairs. Are legs supported with wheel-chair footrests or stools, or do legs reach the floor? Are legs elevated as ordered or needed? Are residents who tend to lean in their chairs provided supportive devises?

- Positioning of residents in bed. Are residents who can't turn themselves, turned at least every two hours? Is their position supported? Are limbs supported to relieve stress? Are special pressure reducing mattresses being used?

- Application of restraints. Are they applied according to manufacturer's instructions? Are they tied to the back of the seat? Are restraints removed at least every two hours and the resident's position changed? Is there a physician order for restraint? Are all restraint rules followed?

  LHPS. Transferring semi and non-ambulatory residents. Does the transfer appear safe and with minimal discomfort for the resident.

- Assisting residents to the bathroom. Are residents who can ambulate with assistance and sit on the commode being assisted to the bathroom?

  LHPS. Physician orders and good techniques being followed. Are TED hose on resident's legs without wrinkles? Is oxygen set at the correct liter flow and being used by the resident if needed? Is oxygen tubing changed and are filters clean? Are skin dressings clean and without odor? Is minimal tape used on the resident's skin for dressings? Are urinary drainage bags kept off the floor and placed below level of the resident's bladder?

OPTIONAL FORM/BASIC ORIENTATION

# MONITORING PERSONAL CARE AND HEALTH CARE
## Monitoring Change of Condition

### Reviewing the Resident's Medical Record

- Review the most recent FL-2 and all physicians' orders written since the FL-2.
- Review medication administration records (MARs), progress notes, and vital sign and weight charts and compare with physician's order to determine if they are being followed. Which staff persons signed off giving insulin, doing finger-stick blood sugar checks, taking blood pressures, applying TED hose and changing dressings? Check these staff for competency validation by the registered nurse.
- Review documentation of residents' physician visits and telephone contacts with residents' physicians.
- Review progress notes for changes in resident's condition. Was care provided?
- Review the resident register and DMA 3050-R assessments and care plans and the LHPS evaluations.

### Identifying Residents Who Had a Change in Condition

- Observe and interview residents. Observe residents for noticeable changes. These will be residents that you know from past monitoring visits, who are now observed to be different. Interview cognitively intact residents about the changes you notice.
- Interview Staff. Ask specific questions such as:
  - Which residents have been to the hospital, either emergency department visits or admissions?
  - Which residents have lost weight, developed pressure sores, had orders written for restraints, etc.?
  - Which residents have had a change in their ability to bath, dress, toilet, feed, or ambulate themselves?
  - Which residents have had a change in their mental status such as level of orientation, ability to make decisions, mood, and behaviors?
- Review Medical Records. Review progress notes written by facility staff, physicians, and home health agency staff. Review any changes in the physicians' orders. Look for any documentation that indicates a change in the resident's condition.

# Monitoring Change of Condition

## Monitoring Residents Who Had A Change in Their Condition

- What are the changes in the resident's condition?

- When were the changes first noted?

- How long did the changes continue before the physician was contacted? Was the physician contacted timely? Is physician contact documented in the medical record?

- Are the changes significant, requiring a reassessment and a new care plan? Refer to the list of significant changes in rule .0801. Significant change usually changes the resident's ability to perform activities of daily living.

- For significant change, was a reassessment and care plan completed within 10 days of the change, indicating the changes in the resident's condition?

- Was the care plan signed and dated by the physician within 15 days of the completion of the reassessment and care plan?

- Was a Licensed Health Professional (RN, PT, OT and RT) review and evaluation required?

- Did the changes include tasks that require staff competency validation? Were staff that provided and continue to provide the care validated for the tasks?

# OPTIONAL FORM/BASIC ORIENTATION

## Monitoring Resident Assessment and Care Plans

- Select a sample of residents. Select residents who have been in facility at least 30 days. Include residents who have a variety of needs.

- Verify assessments and care plans match resident's current condition. Review the medical records, interview the residents, and staff and make observations of the residents. Do the current assessments and care plans match your findings?

- Check the date assessments and care plans were completed. Were resident registers completed within 72 hours of residents' admissions? Were the care plans completed by staff within 30 days of admission and signed by the physician within 15 days of completing the assessments? Are assessments and care plans completed within 10 days of significant change and annually?

- Check, who completed the assessments and care plans. Were they completed by the administrator or someone designated by the administrator? If problems were identified with the assessments and care plans, did the staff person completing them receive orientation on assessments and care plans?

## 10A NCAC 13F .1212 REPORTING OF ACCIDENTS AND INCIDENTS

(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

(b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information:

- (1) resident's name;
- (2) name of staff who discovered the accident or incident;
- (3) name of the person preparing the report;
- (4) how, when and where the accident or incident occurred;
- (5) nature of the injury;
- (6) what was done for the resident, including any follow-up care;
- (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and
- (8) signature of the administrator or administrator-in-charge.

(c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.

(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.

(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:

- (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
- (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

(f) When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority.

(g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately:

- (1) seek the assistance of the local law enforcement authority;
- (2) provide additional supervision of the threatening resident to protect others from harm;
- (3) seek any needed emergency medical treatment;
- (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
- (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

(h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.

*History Note:* *Authority G.S. 131D-2.16; 143B-165;*
*Eff. July 1, 2005;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.*

# Accident / Injury Report

(Report all accidents of injuries, even if no apparent injury)

**Facility:**______________

| Last Name | First Name | MI | Room No. | Bed No. |
|---|---|---|---|---|
| | | | | |

| Date of accident or incident | Time a.m. p.m | Location of Incident: Hallway ☐ | Bathroom ☐ Other ☐ | Bedroom ☐ Specify: |
|---|---|---|---|---|
| | | | | |

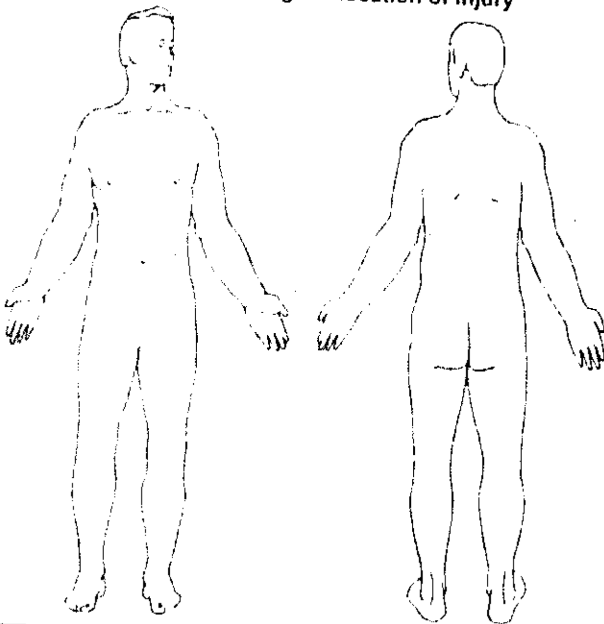
Did you witness the accident/incident or was it reported to you? Witnessed ☐ Reported ☐

Describe what you observed or what was reported to you:

Was resident alone? Yes ☐ No ☐

What does the resident say happened?

**Indicate on diagram location of injury**



**Temperature:** ________ **B/P:** ________

**Respirations:** ________ **Pulse:** ________

**Blood Sugar:** ________

**Type of Injury**

1. Laceration ☐
2. Bruising ☐
3. Abrasion ☐
4. Skin Tear ☐
5. Burn ☐
6. Swelling ☐
7. Deformity ☐
8. None Present ☐
9. Other:

**Level of Consciousness (LOC):**

1. Alert and Oriented ☐
2. Able to state name & answer ?'s ☐
3. Will arouse when name called ☐
4. Unable to arouse ☐

**Additional Notes:**

Was First Aid administered? Yes ☐ No ☐

If Yes, type of care given and provided by whom:

| Where: | Date: | Time: |
|---|---|---|
| | | |

Was resident taken to the ER? Yes ☐ No ☐

If ***Yes***, was the resident hospitalized? Yes ☐ No ☐

If ***No***, was resident seen by private physician? Yes ☐ No ☐

Name of physician:

| How Transported: | Date: | Time: |
|---|---|---|
| Where: | Date: | Time: |

| Name of family member or responsible party notified: | Time of notification: | Spoke with ☐ Left Message ☐ |
|---|---|---|
| Name of private physician notified: | Time of notification: | Spoke with ☐ Left Message ☐ |

Regulatory Agency Notified: Yes ☐ No ☐ Mailed: ☐ Faxed: ☐ Date: Time:

| Printed Name of Person Preparing Report: | Printed Name of Administrator: |
|---|---|
| Signature/Title/Date: | Signature/Date: |

Created 7/1/09

# Writing Right

There is a correct way to write. Items written incorrectly can harm you or the company if a lawsuit is ever filed. Every employee at this facility is expected to understand that documenting is part of his or her job. Employees cannot let someone else write the documentation for them.

Although some people working in residential care assisted living are medical professionals, the vast majority is not. Unless you are a medical professional, you should not document opinions, suppositions or diagnoses. What you need to document are the **facts**, and **the exact statements made by the resident or employee**, written with "quotes", and any personal observations based on sight, smell and touch.

**The best protection from liability is good resident care.**

**The best protection in a lawsuit is good documentation.**

Residential care assisted living providers who are not medical people should not be making summations or diagnoses. If asked to give their opinions, it must be done using business-protected documents. See ~~**Documentation Classification.**~~

It is extremely important that you don't document your negative opinion, or make criticisms about your co-workers or the medical professionals involved with the resident's care. In the long run, criticisms make you look bad. If you have a problem with someone, write it out on a **Communication Note**, and give it to the Administrator, the top management or his or her designee. If you disagree with a co-worker or medical professional, let the Administrator know of your concerns. She or he will contact the Resident or the Resident's Responsible Party, and express the concerns if she or he feels it is indicated. Communication Notes are Business Confidential Information, extremely confidential, and not allowed to be disclosed to other persons.

**Negligent – from Latin "negligo" which means, "to neglect". Careless, heedless, neglectful; apt to neglect or omit that which ought to be done or attended to; inattentive.**

Most malpractice proceedings involve charges against the facility or provider for negligence. Negligence is defined as failure to provide a resident with the standard of care that a reasonable caregiver would provide under the same or similar circumstances. See **Duty Of Care.**

*"O negligence, fit for a fool."* ***Shakespeare***

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Describe events without labeling or using negative characterizations. Stick to the facts and what you see, hear, feel or smell. Use direct quotes as much as possible. Always date your entry and make sure to initial it!

Don't state your opinion. Don't document the resident was "mean", "constantly complaining", "rude", "arrogant", "helpless", or "stupid". These are negative characterizations and judgments. Instead, quote exactly what the resident said. Let the reader form his or her own opinion.

**The most common form of care service documentation is called S.O.A.P. S.O.A.P stands for:**

**S – Subjective statements** made by the resident, or direct quotes from others who may have participated. This includes the resident's perception of their condition or changes to their condition. Care staff is asked to refrain from writing subjective statements, (their opinion).

**O – Observations** – Objective and factual statements only. Objective statements are based on fact. Document what you factually observe, i.e. what you see, hear, feel and smell. Instead of saying, "I think the resident's ankle is broken." You should say, "the resident is complaining of pain in his right ankle, there is noticeable swelling, and the color is slightly blue." Stick to the facts. For example, you should not write that the resident was a sloppy eater. Instead, you can say, I observed the resident dropped food everywhere, including the front of his clothes. Another example, you should not say the resident is "stinky and dirty." Instead, document, " I observed the resident had a strong body odor, and his clothes were soiled and stained." See **Resident Care Notes**

**A – Assessment** – the types of assessments we do are for non-medical purposes. They are used as guidelines to help facility management make decisions about the custodial care and services the resident may need. Assessment areas include:

- Medication Needs
- Mental Status – our non-professional opinion
- Mobility status – the ability to get around
- Personal Hygiene
- Physical Abilities and Disabilities
- Psychological and Social Needs
- Rehabilitation- Retention Potential – our non-professional medical opinion
- Relationship Resources
- Safety and Security Needs
- Social Behavior
- Special Diets
- Specific Care Needs
- Support of Third Party Providers
- Who will be responsible for the various aspects of care

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**P** – Plan – See **Care Service Plan, Care Service Schedule** and **Care Plan Conference** Be sure to include all safety precautions, which need to be taken on behalf of the resident. See **Complete Care Plan.**

Be sure to document your attempts to reach the doctor and the resident's responsible party ~~on the~~ **Incident Phone Call Log** or use ~~the~~ **Confidential Fax** . If the physician becomes abusive or does not respond appropriately, notify the Administrator, or Facility Manager so that they can resolve the matter. If a resident's doctor or other medical care service provider is not responding to urgent care requests, the Administrator will notify the non-responding party, that he/she is neglecting the resident. If they do not immediately respond an Adult Abuse Report will be filed against that person, the facility will invoke it's right to require the resident to find a different medical care service provider.

**Special Note:** Be sure to document compliments. They can be extremely valuable if you ever have to go to court.

Remember: Don't release Privileged or Confidential Information. Give the request and/or information to the Administrator or Top Management. Always, follow the rules for confidential information.

Most Importantly, be sure to read and understand the **Documenting Do's**, and **Documenting Don'ts.**

~~Don't forget to keep~~ confidential documents protected. See **Documentation Classifications**

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# Documenting - Do's

## Do Remember:

- Keep confidential records confidential, do not leave unattended.
- No felt tip pens or markers, No colored inks, No pencils, always in dark blue or black ink
- On every entry document date, time, signature, or initials
- Make back up disks of confidential records stored on the computer, be sure to check the back up disk to ensure the data was recorded on it
- Be Complete - Complete every question. Not knowing is okay. Acknowledge that you considered the question by writing "N/A" or "unknown" or "inconclusive at this time"
- Address each issue separately and give each issue a response
- Keep Abbreviation List - Use only authorized abbreviations - See **Care Service Diagnostic Abbreviations.** Document telephone calls with family members, responsible parties, doctors and other members of the health care team. Be sure to document all compliments.
- Document Doctors appointments pre-times (put on the calendar so we don't forget, and can prepare the resident) be sure to log that the resident visited the doctor o[illegible] Plan for time staff needs to document, documenting needs to be done as soon as the care has been given, or ASAP.

## Do Write Right

- Subjective What the resident perceives, or what others perceive
  Use direct quotes, write down word for word what the resident says if you can.
- Objective - Facts and observations about what you actually see, hear, feel or smell, do not give personal opinions, or conclusions.
- Assessment use facility approved assessment forms.

S[illegible]

## When documenting about a Resident:

- Check to make sure you have the correct resident's record
- Be factual and Resident specific
- Use quotes "resident says…"
- Encouragement of wellness measures

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- Remember your writing may come under legal scrutiny someday. Be very careful with what you write. Differentiate in your mind before you write, know what you are going to write before you write it.
- Use quotation marks
- Keep attitude in check, don't rush the resident
- Observe and listen, always ask questions
- Use present or past tense verbs, use "I observed", or "the resident said"
- Be professional, not emotional
- Document only your work - not the work of others
- Write down "discussed with supervisor" if you did
- A late entry is better than no entry, but be sure to date and time as "late entry"
- Write down any significant events proceeding that may have had an impact
- Document goals, expected outcome, time frame, and care services to be rendered
- Check current state regulations for any changes in documentation requirements

## Resident and Employee Confidential Records

At all times employee with authorized access are to protect against unauthorized access:

- Resident Care Records
- Employee/Staff Records

## Protected Confidential Business Information

The following is a partial list of "Protected Confidential Business Information". Please note we have set guidelines for restricted disclosure.

- Protected Confidential Business Information "PCBI"
- Risk Management Confidential Information "RMCI"
- Accident Analysis Reports
- Risk Management Committee Recommendations
- Accident-Incident-Injury Analysis or Unusual Occurrence Investigations
- Safety Audits and Reports
- Employee opinions, summations, beliefs
- Interpretation of Resident, Responsible Party, or Supervised Employee's Response
- Review Employee documenting quality during **Employee Evaluations** and **Performance Goal Review**

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# Documenting - Don'ts

## Don't forget:

- To use direct quotes as much as possible (what the person said)
- To make sure you have the right resident's record.
- To protect records from peeping eyes
- To stick to the facts
- To document "Follow up" care. For every problem you document, you are required to document what you did about it. *Did you fax the doctor? Notify the family or responsible party? Call the Home Health agency or Fax the Pharmacy if indicated.*
- To document telephone calls, use direct quotes as much as possible.

## Don't Document the following:

- Don't refer to Risk Management Investigation Reports, or other Protected Business Documents. See RMCI and RBCI Document Classifications.
- Your interpretations, summations or personal feelings, unless requested by Top Management
- Complaints you have. See **Company Communication Note**, or **Anonymous Communication Note**.
- Excuses like "meds not available" therefore not given, instead, you can document *"meds not given, doctor ____ called at: (date and time), family ____ called at: (date and time), pharmacy called at: (date and time), waiting for meds now, doctor said okay to miss one dose."*
- Your personal feelings about the resident his/her family, the facility or other staff members. If you have personal feelings you need to express, use a Company Communication Note (which is Protected Business Confidential Information), and give it to the Administrator or the Facility Manager.
- Don't write negative statements about the doctor's care or other health team members, including your co-workers, even if it's true, unless asked by Top Management.
- Your thoughts on the resident's diagnosis
- The resident or staff person's safety being in danger, ~~unless it's on a **Protected Business Confidentiality Form**~~.

## When Correcting (Remember: Altering records is a criminal offence):

- You can add a "late entry" with accurate info, but be sure to date and time when you really made the late entry.
- Single line through, write "entry mistake" date and initial.
- Don't leave blank lines, follow chronological order
- Don't label "error" instead use "mistaken entry" or "entry mistake"
- Don't use white out or correction fluid

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- Don't re-write
- Don't back date
- Don't write "oops" or smiley faces
- Don't make any alterations
- Don't write in margins
- Don't write "written by mistake", or "accidentally written", or say you unintentionally, miscalculated, or were confused. Instead write "entry error" and leave it at that.

## Other Don'ts:

- Don't destroy records
- Don't be careless about what you write
- Do not include facts that are not relevant
- Don't use a second resident's name for confidentiality reasons; (if the resident care falls under the HIPAA regulations a medical record id number must be used), we are under the normal confidentiality laws, therefore we can use the resident's initials and room number.
- Don't write down care notes for someone else. Each staff member must write his or her own notes.
- Don't lie or make assumptions
- Don't use messy handwriting. Everyone should be able to read it. Print neatly if your handwriting is too difficult for others to read.
- Don't use felt tip, color inks (other than black or dark blue), and don't use pencil.
- Don't write things that would embarrass another, stick to the facts.

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# Documentation of Observations and Incidents or Situations

## Case Study 1:

This is what a resident said that they saw:

- "I've been not feeling the best and my head aches. I saw Bollie over by the screen door and he was just a vaping, probably vaping either crack, meth, or who knows what. He does that all the time and he sells it to everyone, including the med tech who was . Everyone vapes you know. After he vaped he got real mean, yelled, and threw the lamp. I thought he was going to hit me, actually he might hit everyone. He does that all the time."

Note that a med tech was watching this on 8/15/2023 and saw the same incident. Bollie broke up with his girlfriend yesterday. Informally the med tech told the RCC that she thought Bollie was vaping something like Delta 8, but she says she is just guessing and has no evidence that this is the case. The girlfriend of Bollie said that he masturbates regularly and doesn't want to be his girlfriend anymore. The resident took the lamp in the activity room and threw it out the door and it has been destroyed. Med tech approached Bollie and he apologized for breaking the lamp and understands he will have to pay for it. He agreed to take his PRN and after 45 minutes he appears very calm in his room.

**The administrator wants you (the med tech) to write a note in Bollie's chart regarding the above situation to document Bollie's behaviors. Also, are there any additional actions to take place?**

**Appropriate note in chart:**

**LATE ENTRY:**

On 8/13/23 resident was agitated and broke a lamp. Broken lamp was reported to financial. He was offered a PRN and he took it. After 45 minutes he appeared calm. It was reported that resident recently broke up with his girlfriend. Incident reported to resident's mental health provider.

**NOTE: That is all that should go in their chart. Vaping is not illegal. Delta 8 is not illegal, and we have no evidence anyway. We need to find out cost of lamp and use that as consequence for his behavior. Administrator must be notified and give Bollie consequence for his actions and have him sign an agreement that he understands that his action was inappropriate, and he will be paying $5 per month until the $20 lamp is paid for.**

Staffing Meeting 2/19/24
+ Training

Danny Boone
Heather Gentle
Margan Barker
Jessica Houston
Nataysha Jackson
Leora Flynn
Debra Davidson
Korean Bristol
Maria Bryant
[signature] (Jason Evens)
Nyan Evans
[signature]

1. When a Resident Falls + fall prevention
2. Collaborative Care
3. Nutrition and Food Service 13F.090
4. Therapeutic Diets and Menus
5. Personal Care Assessment

Resident Name ______________________

Guardian/responsible party Name ______________________

Phone number ______________________

Email address ______________________

Date of Assessment ______________________

Resident DOB ______________________

Approx height / weight ______________________

Home health / Hospice yes / no

Do they have an ACT team? If so,
Name ______________________
Phone ______________________

**10-14 Day Follow up after admission Personal Care Assessment**

***Ask pre-admission questions, note in response area if changes in condition occurred***

Med-mangement ? ______________________
(Mental Health medications)

| Questions to ask resident and/or referal source | Response |
|---|---|
| Do you have any pain when- you bring your hands above your head? | |
| - reach around to your back | |
| - bend down to your feet | |
| Do you have any pain in your hands and feet? | |
| Do you have any swelling in hands, legs, feet? | |
| Have you had any falls in the last 6 months? | |
| Do you have pain in your back and/or neck? | |
| Do you get tired easily? | |
| Tell me what a day looks like for you. | |
| How far can you walk before you need to stop and take a break? | |
| Do you get dizzy or lightheaded? | |
| Do you have your own teeth, if no do you have dentures? | |
| Do you have a hard time chewing food? | |
| Do you need to hold on to anything at times to get your balance? | |
| Do you ever have a hard time breathing? | |
| Has there ever been a time that you didn't make it to the bathroom on time? | |
| Is it hard for you to get up at night after taking night meds? | |
| Is it hard for you to get up in the morning to eat breakfast? | |
| Do you have any muscle weakness? | |
| Can stand up on their own? Transfer? | |
| Incontinence? - Do you wear briefs/pull ups? | |
| Wheelchair/walker? | |
| Do you have a good memory? Are you forgetful at times? | |
| | |
| | |

| Questions to ask the referal source | Response |
|---|---|
| Any history of combative behavior | |
| Any hyperactivity | |
| Any history of verbal abuse? | |
| Does the resident get turned around easily? | |
| History of injurious behavior to self or others? | |
| Any vision issues like cataracts? | |
| Any shuffling gait? | |
| Eating habits? Disorders? | |
| Any signs of dementia/ elopement risk? | |

Name/Title ______________________

**Pre-admission Screening Tool**

Resident Name ______________________________

Date of Assessment ______________

Guardian/responsible party Name ______________________

Resident DOB ______________

Phone number ______________________________

Approx height / weight ______________

Email address ______________________________

Home health / Hospice yes / no

Do they have an ACT team? If so,
Name ______________________
Phone ______________________

Med-mangement ? ______________
(Mental Health medications)

**Pre-admission Personal Care Questions**

| **Questions to ask resident and/or referal source** | **Response** |
|---|---|
| Do you have any pain when- you bring your hands above your head? | |
| - reach around to your back | |
| - bend down to your feet | |
| Do you have any pain in your hands and feet? | |
| Do you have any swelling in hands, legs, feet? | |
| Have you had any falls in the last 6 months? | |
| Do you have pain in your back and/or neck? | |
| Do you get tired easily? | |
| Tell me what a day looks like for you. | |
| How far can you walk before you need to stop and take a break? | |
| Do you get dizzy or lightheaded? | |
| Do you have your own teeth, if no do you have dentures? | |
| Do you have a hard time chewing food? | |
| Do you need to hold on to anything at times to get your balance? | |
| Do you ever have a hard time breathing? | |
| Has there ever been a time that you didn't make it to the bathroom on time? | |
| Is it hard for you to get up at night after taking night meds? | |
| Is it hard for you to get up in the morning to eat breakfast? | |
| Do you have any muscle weakness? | |
| Can stand up on their own? Transfer? | |
| Incontinence? - Do you wear briefs/pull ups? | |
| Wheelchair/walker? | |
| Do you have a good memory? Are you forgetful at times? | |
| | |
| | |

| **Questions to ask the referal source** | **Response** |
|---|---|
| Any history of combative behavior | |
| Any hyperactivity | |
| Any history of verbal abuse? | |
| Does the resident get turned around easily? | |
| History of injurious behavior to self or others? | |
| Any vision issues like cataracts? | |
| Any shuffling gait? | |
| Eating habits? Disorders? | |
| Any signs of dementia/ elopement risk? | |

Name/Title ______________________________

Resident Name ______________________________ Date of Assessment ______________

Guardian/responsible party Name ______________________ Resident DOB ______________

Phone number ______________________________ Approx height / weight ______________

Email address ______________________________ Home health / Hospice yes / no

Do they have an ACT team? If so,
Name ______________________
Phone ______________________

**Change in Condition Personal Care Assessment**

***Ask pre-admission questions, note in response area if changes in condition occurred***

Med-mangement ? ______________
(Mental Health medications)

| **Questions to ask resident and/or referal source** | **Response** |
|---|---|
| Do you have any pain when- you bring your hands above your head? | |
| - reach around to your back | |
| - bend down to your feet | |
| Do you have any pain in your hands and feet? | |
| Do you have any swelling in hands, legs, feet? | |
| Have you had any falls in the last 6 months? | |
| Do you have pain in your back and/or neck? | |
| Do you get tired easily? | |
| Tell me what a day looks like for you. | |
| How far can you walk before you need to stop and take a break? | |
| Do you get dizzy or lightheaded? | |
| Do you have your own teeth, if no do you have dentures? | |
| Do you have a hard time chewing food? | |
| Do you need to hold on to anything at times to get your balance? | |
| Do you ever have a hard time breathing? | |
| Has there ever been a time that you didn't make it to the bathroom on time? | |
| Is it hard for you to get up at night after taking night meds? | |
| Is it hard for you to get up in the morning to eat breakfast? | |
| Do you have any muscle weakness? | |
| Can stand up on their own? Transfer? | |
| Incontinence? - Do you wear briefs/pull ups? | |
| Wheelchair/walker? | |
| Do you have a good memory? Are you forgetful at times? | |
| | |
| | |
| **Questions to ask the referal source** | **Response** |
| Any history of combative behavior | |
| Any hyperactivity | |
| Any history of verbal abuse? | |
| Does the resident get turned around easily? | |
| History of injurious behavior to self or others? | |
| Any vision issues like cataracts? | |
| Any shuffling gait? | |
| Eating habits? Disorders? | |
| Any signs of dementia/ elopement risk? | |

Name/Title ______________________________

Submitted request to Liberty/manged care for assessment

Date ______________

# Collaborative Care Review Log

**Date: ________**

| NAME: | RM # | COMMENTS | VERIFIED BY |
|---|---|---|---|
| CHANGE IN SKIN CONDITION | | | |
| FALLS | | | |
| BEHAVIORS/ CHANGE IN MOOD | | | |
| CONTINENCE ELIMINATION | | | |
| INFECTION | | | |
| NUTRITION/ EATING/ WEIGHT CHANGE | | | |
| PAIN MANAGEMENT | | | |
| ADL CHANGE | | | |
| RESPIRATORY/HOME HEALTH-OT/PT/ST/ HOSPICE | | | |
| NEW ADMISSION/ ANNUAL SCREENING | | | |
| Signature: | | | |

# Collaborative Care Review Log

| Room | Resident | Change in skin condition | Falls | Behaviors/Change in Mood | Continence Elimation | Infection | Nutrition/Eating/Weight Change | Pain Management | ADL change | Respiratory/Home Health-OT/PT/Speech/Hospice | New Admission/Annual/Significant Change | Comments | Verified Follow up Completed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | |
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DATE OF MEETING ______________ NAMES OF STAFF PRESENT ______________

INTEGRITY

# When a Resident Falls:

**1st Fall:** Resident is to be placed on 30 minute checks and MT/Supervisors are to notify the residents PCP directly after the fall happens.

**2nd Fall:** Resident is to remain on 30 minute checks and MT/Supervisors are to notify the residents PCP directly after the fall happens. RCC/OM is to discuss PT/OT potential for resident.

**3rd Fall:** Resident is to be placed on 15 minute checks and MT/Supervisors are to notify the residents PCP directly after the fall happens. RCC/OM is to discuss the potential need for a higher level of care for the resident and/or other different plans of care for the resident.

(18) oral suctioning;
(19) care of well-established tracheostomy, not to include indo-tracheal suctioning;
(20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule);
(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);
(22) application of prescribed heat therapy;
(23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

(b) The appropriate licensed health professional, as required in Paragraph (a) of this Rule, is:
(1) a registered nurse licensed under G.S. 90, Article 9, for tasks listed in Subparagraphs (a)(1) through (28) of this Rule;
(2) an occupational therapist licensed under G.S. 90, Article 18D or physical therapist licensed under G.S. 90-270.90, Article 18E, for tasks listed in Subparagraphs (a)(17) and (22) through (27) of this Rule;
(3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of this Rule; or
(4) a registered nurse licensed under G.S. 90, Article 9, for tasks that can be performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36;

(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

(d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary.

*History Note:* *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
*Temporary Adoption Eff. January 1, 1996;*
*Eff. May 1, 1997;*
*Temporary Amendment Eff. September 1, 2003; July 1, 2003;*
*Amended Eff. June 1, 2004;*
*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;*
*Amended Eff. July 1, 2021.*

**10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE**

(a) Food Procurement and Safety in Adult Care Homes:
(1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions.

(2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.

(3) Only meat processed at a USDA-approved processing plant shall be served.

(4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.

(b) Food Preparation and Service in Adult Care Homes:

(1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.

(2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments.

(3) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.

(c) Menus in Adult Care Homes:

(1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule.

(2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff.

(3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.

(4) Menus shall be planned to take into account the food preferences of the residents as documented on the Resident Register.

(5) Menus as served, invoices, and other receipts for food or beverage purchases shall be maintained in the facility for 30 days.

(6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets.

(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.

(d) Food Requirements in Adult Care Homes:

(1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost.

(4) Water shall be served to each resident at each meal, in addition to other beverages.

(e) Therapeutic Diets in Adult Care Homes:

(1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram, or consistency, such as for calorie-controlled ADA diets, low sodium diets, or thickened liquids, unless there are written orders that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician, physician assistant, nurse practitioner, or a licensed dietician/nutritionist as delegated by the physician that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand-specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency.

(3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Adult Care Homes:

(1) The facility shall provide staff for individual feeding assistance in accordance to residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record. Each resident shall receive three meals in accordance with resident preferences as documented in the resident's record.

*History Note:* *Authority G.S. 131D-2.1(4); 131D-2.16; 131D-4.4; 143B-165;*
*Eff. January 1, 1977;*
*Readopted Eff. October 31, 1977;*
*Amended Eff. April 1, 1984;*
*Temporary Amendment Eff. July 1, 2003;*
*Amended Eff. June 1, 2004;*
*Readopted Eff. March 1, 2023.*

**10A NCAC 13F .0905 ACTIVITIES PROGRAM**

(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director shall:

(1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents;

(2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities

ii. Furnishing Provided by Community. Resident's room/unit will be furnished with bed, beside table, dresser, wall or dresser mirror, comfortable chair, window blinds and smoke detectors.

iii. Furnishing Appliances Provided by Resident. Subject to applicable fire and safety codes or other applicable state or federal laws; Resident may utilize in his/her unit items approved by Community.

iv. The Accommodations and Servies Charges are set forth in exhibit A

b. Basic Services Included in this Agreement. Community will provide the following basic services to resident.

i. Meals and Snacks. Community shall provide three nutritionally well-balanced meals per day. Snacks are also available to resident on a scheduled and unscheduled basis. These meals and snacks are included in your monthly rate.

ii. Modified Diets. If resident's physician or another appropriately licensed health professional orders a modified diet, Community shall provide a modified diet to resident which meets the physician's specifications.

iii. Activities. Community will provide or arrange for a program of planned activities including a social, cultural and recreational activities. There are at least 14 hours of planned group activities per week plus individual activities. Each resident will have the opportunity to participate in at least one-off campus outing a minimum of every other month.

iv. Common Areas. So long as there are no contraindications identified by resident's necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities and religious activities of resident choice. Resident will not be charged an additional fee for this service. Such transportation may be a combination of Community vehicles, local community resources, public transportation systems, volunteer programs and/or family members.

v. Housekeeping. Community shall provide basic housekeeping services for resident's room/unit. Community has a policy on new admission personal item treatment. That policy will be at the end of this Agreement.

c. Health and Personal Care Services

i. Assessments. Community will conduct or arrange for an initial assessment of resident within 72 hours of admitting the resident and at least annually thereafter, using a uniform assessment instrument developed by the N.C. Department of Health and Human Servies. Community will conduct or arrange for an assessment of resident within 30 days following admission and at least annually thereafter which shall be a functional assessment to determine the resident's level of functioning including psychosocial well-being, cognitive status and physical functioning in activities of daily living

8. After touching anything that would contaminate your hands when they are clean, including contact with residents in the facility or objects that are not clean.

## Personal Hygiene --- Clean Clothes/Hair Restraint

Personal hygiene is also a part of preventing the spread of harmful bacteria. Be sure when you show up for work that *you* are clean, and your *clothes* are clean. You also need to wear some type of hair restraint if you will be working around food.

## Personal Hygiene--- Infections/Communicable Diseases

What if you have a cold or some other communicable or infectious disease? Sanitation rules restrict your work in food service in any capacity if there is a chance that you will contaminate food or food-contact surfaces. So, if you have the "flu", a cold with a cough or runny nose, a boil, an infected wound or any other communicable disease, it would be best to stay home! The elderly and sick cannot fight off infections as well as younger, healthy adults, so if you spread your cold or flu, it could be life-threatening for someone who is chronically sick or frail!

## Therapeutic Diets

Therapeutic diet menus are designed and written by registered dietitians. The dietitian has written these menus to ensure that meals meet guidelines for treating certain medical conditions and that they are nutritious, palatable, and provide a balance of different foods that will be well tolerated by the resident. The administrator of the home should provide you with a list of residents on special (or therapeutic) diets so that you will know who should receive a therapeutic diet. It is very important that you follow these menus in preparing special diets. Following the menus will help ensure that what you serve to the resident is appropriate for the resident's medical condition and that it will be well tolerated by the resident. You should see a therapeutic menu column for each diet that is listed on the therapeutic (or modified) diet list. If you see a resident listed to receive a diet that is not represented on the menus, notify the administrator immediately. The administrator may need to contact the resident's physician to obtain an appropriate diet order. You'll need to review the menus of all the diets your facility offers. Here is an overview of *some* of these special diets that you may be preparing.

### Puree

This diet consist of foods that have a smooth, soft texture, much like fluffy whipped potatoes. It may be used for residents who have difficulty swallowing or chewing. Thickening agents may be used to produce the right consistency. You will need a blender or food processor to prepare foods to the consistency of fluffy whipped potatoes. It is important to prepare the diet exactly as outlined on the menu to ensure residents receive foods that are appropriate and safe to eat.

### Mechanical Soft

This diet may be used for residents who have problems chewing food due to facial paralysis, poorly fitting dentures or few teeth. Meats are typically chopped or ground. Raw and dried fruits and vegetables, nuts and seeds are typically not allowed. You will

need to follow your facility's menu guide for this diet. Many times menus vary in what is included and also what they are called. For instance, a regular ground menu pattern may be very similar to a mechanical soft menu pattern, but vary in what foods are actually included on the menu. Just be sure to follow your facility's menus and ask questions if you aren't sure.

## No Concentrated Sweets

This diet may be used for residents who have diabetes mellitus, a disease that affects how your body handles food. The diet is limited in concentrated sweets. Some examples of concentrated sweets are regular cakes, pies, candies, regular sodas and table sugar. Serving this diet correctly is important to help these residents manage their diabetes. Be sure to follow your facility's menu pattern for what can be served on these diets. Sometimes it may allow for *small* portions of regular desserts, or it may restrict sweets all together. Just be sure to read the menu column for this diet carefully.

## Calorie Controlled ADA

These diets are also designed to help residents control their diabetes, but in addition to restricting concentrated sweets, it restricts *calories*. Limiting portions and preparing foods with as little fat as possible are two ways to restrict calories. So, you will notice the menu pattern for these diets are very specific in what can be served. Be sure you note portion sizes and different preparation methods, such as baking instead of frying, fat-free seasoning instead of butter, or differences in what type of bread is served, for example, rolls instead of biscuits or cornbread.

## No Added Salt (4-gram sodium)

This diet is restricted in the addition of salt to meals at the table. It may also restrict certain foods high in salt. This means that generally salt can be used in cooking the food, but the resident should use no additional salt at the table. Let's explain the difference between salt and sodium. Sodium is found in salt, and it is sodium that is linked to health problems such as high blood pressure and fluid retention. When you see the word sodium, think salt and salty foods--they are a big source of sodium. That's why they are limited in the diet. Be sure to follow your facility's menu pattern for this diet since menus may vary and some items allowed on a regular diet may not automatically be allowed on a No Added Salt diet.

## 2-Gram Sodium

This diet is much more restrictive than the No Added Salt diet. Processed or prepared foods such as frozen entrees, luncheon meats, or canned soups that are high in sodium are eliminated. Milk is limited to 2 cups per day. The menu for this diet will outline exactly what should be served. As a rule, salt is not added during cooking or at the table. Generally, it will be necessary to prepare foods for this diet separately since salt cannot be used in cooking.

It is very important to follow the menu pattern for this diet because the sodium content has been calculated by a registered dietitian and any substitutions made should be done ensuring the item substituted will also be low in sodium. Pay particular attention to

No Salt at Table - Just as it states -

canned vegetables and processed meats– these are generally high in sodium and a low-sodium version must be used. In many cases, breads such as biscuits or cornbread and desserts will vary from the regular menu on a 2-gram sodium diet – so be sure to check the menu pattern before you start preparing the meal!

N/A

**Renal**

Now here is a diet that really needs your attention. This diet generally restricts the amount of protein, sodium, and potassium in the diet. That means there are quite a few foods that are limited both in variety and portion. Some residents may also have their fluid intake restricted. Once again, a registered dietitian has calculated this diet to contain a certain amount of nutrients and minerals, so the menu pattern must be followed closely.

Depending on the facility's menus, this diet may also require that you prepare foods separately (without added salt) to ensure that it meets the guidelines for sodium. Look at your facility's menus closely to see if the menu specifies "salt free" or "low sodium" versions of vegetables or meats for this diet. Also pay attention to the types of breads and desserts this menu calls for. It can make a big difference in the sodium and potassium content of the food that you serve!

It's a good idea to avoid making substitutions on this diet because of all the different foods that provide potassium, sodium and protein. For example, the food you substitute may contain a lot more potassium than what the menu calls for, so you may end up serving something that is not allowed on the diet! Portion size is also very important because it ensures the resident receives the right amount of protein, sodium and potassium. All of these nutrients can affect the resident's health if they are consumed in excess, so read your menu closely *before* preparing this diet. Be sure to ask questions if you are unsure about something.

N/A

## Low Cholesterol/Low Fat

Like the name implies, this diet restricts the amount of fat and cholesterol in the diet. Be sure to follow your facility's menus for portion size and preparation methods for this diet. For example, pay close attention if the menu calls for "low fat" versions of entrees or vegetables. Make note of differences with the type of bread or dessert that is called for. Be sure to ask questions if you are unsure about something.

## Dysphagia Diets / Thickened Liquids

Thickened liquids are used to help residents with swallowing difficulties. A thickened liquid is easier to swallow than an unthickened liquid for residents who have trouble swallowing. It is important that the diet and liquids are prepared correctly to ensure that the resident does not choke and that food or liquid does not "go down the wrong pipe". This can put the resident in serious danger if foods and liquids enter the "wind wipe", so correct preparation is extremely important. There are three levels of consistency that liquids may be thickened to : (1) "nectar" thick, (2) "honey" thick, and (3) "pudding" thick. What is important is that you prepare them according to the directions on the label of the canister or packet of thickener.

Pay attention to the amount of fluid and the amount of thickener called for to achieve one of the consistencies mentioned above. You will need measuring cups to measure the fluid and measuring spoons to measure the thickener. Be sure to ask the administrator if you do not know the specific consistency (nectar, honey or pudding thick) of a beverage you need to prepare for a resident. Also, remember that ice should never be added to a thickened beverage-- just chill the beverage in the refrigerator instead. Your facility may have pre-thickened beverages for these residents. If so, be sure that the level of thickness of the beverage you serve matches the thickness specified on the diet list for that particular resident.

Let's look briefly at dysphagia diets. Dysphagia diets are also designed for residents that have swallowing difficulties and may be used along with thickened liquids to help them swallow their food and beverages without choking. You may see dysphagia diets on your facility's menus-- this may be a puree diet. Be sure to read your menu carefully and prepare the diet according to what is specified there.

## Therapeutic Menus – Reading Spread Menus

You've heard a lot about menus up to this point. So now would be a good time to pull out your facility's menus! Menus can be set up differently depending on what facility you are in, which is why you need to take a good look at your facility's menus. Don't try to rely on your knowledge of special diets from previous jobs in preparing foods-- menus often vary and should be prepared according to what is required for each therapeutic diet. You may need to discuss the menus with your supervisor to fully understand them, but in general, there are a couple of things you may see. Some menus may have a "week at a glance" menu showing a full 7 days of the *regular* menu. If your facility serves therapeutic diets, you should see a "spread menu" for each day of the week showing the menu (breakfast, lunch, dinner) that should be served for *each therapeutic diet*, such as mechanical soft, puree, no concentrated sweets, etc. These diets usually appear in columns and the names of the therapeutic diets are across the top of the columns.

Under the name of each diet is the menu for that particular day for that particular diet. You will need to know which menu *day* you need to prepare. Many times the menus are dated, so you will find and prepare food for the menu with the current date. Always check with the administrator if you are unsure. Most menus have "cycles"; in other words, the same 3 or 4 weeks rotate over and over again. Some menus change with the seasons, and you may see different menus for fall/winter and spring/summer. These are all things that you will need to be clear about before preparing meals. Always check with the administrator if you are not sure!

## Therapeutic Menus – Making Substitutions

You may find that on occasion you don't have a particular food that the menu calls for that day. What do you do? Of course you will need to substitute something else. But you want to make sure that the substitution you serve is appropriate for *all* of the diets, including the therapeutic diets. Not sure what can be substituted on a therapeutic diet? Look at another day's menu on

that same therapeutic diet column to see other foods that would be allowed within that particular diet

It's best not to make a lot of substitutions. If you find that you are making a lot of substitutions, you will need to notify the administrator. This may indicate that there is a problem with ordering foods or that the menus need to be adjusted by the registered dietitian. Making too many substitutions can interfere with ensuring variety and balance in meals that are served day after day. One way you can have a big impact is by noticing which entrees are not well liked or accepted by a majority of the residents. In this case, the registered dietitian can alter the menus to suit the food preferences of the majority of residents. Be sure to notify the administrator if you notice a lot of food waste from plates or complaints with certain foods that are served.

## Recipes

Many times you will need to refer to a recipe to prepare a certain dish or entree. This may especially be true if it is a dish for a therapeutic diet such as no concentrated sweets, 2-gram sodium, low fat low cholesterol, no added salt or renal diet, in which case the dish or entrée may need to be prepared differently than the regular diet. The facility should have recipes to go with the menus. Be sure to familiarize yourself with where the recipe book is and how to quickly find and use a recipe when you need it. Check with the administrator if you aren't able to find something or have questions.

## Resident Rights

Well, you are just about done with your orientation to food service! But what we will talk about now is very important and should affect all of your interactions with the residents. Do you know what rights a resident has in a home such as the one you work in? The State of North Carolina has made a Declaration of Residents' Rights, which you should see posted in your facility. Consider the following in dealing with residents and serving of meals:

- Residents have the right to have their food preferences honored.
- Residents have a right to request an alternate meal or sandwich if what is served is not to their liking.
- Residents have the right to refuse their therapeutic diet—if you observe this, the administrator should be notified to ensure the resident's needs are met.
- Residents have the right to be treated with respect, courtesy, and dignity in *all* of their interactions with you.

Meal times should be as pleasant as possible. The dining room should be clean, neat and decorated for the season if possible. Flowers or some time of centerpiece can help make a table pretty. If music is played, it should be kept at a low volume and be appropriate for, and liked by the residents. Mealtime is not a time to play *your* favorite music. Keep in mind that you are in *their* home. If music is played in the kitchen while preparing meals, it should be turned off while the kitchen door is open and residents are being served in consideration of them. There should not be loud talking or screaming across the dining room during meal times by staff. Remember that we want to make dining a pleasant experience for the *residents*.

Decide ahead of time how you will get all the meals out in a timely and organized manner. Residents at one table shouldn't have to watch others at their table eat while they sit there without their food for an extended amount of time. If residents make requests they should always be honored if possible and assistance given in a courteous, timely, and respectful manner. Be careful not to tease, "talk down to", or "make fun" of residents. Never order a resident around. All of your interactions with the residents should be respectful, courteous and helpful.

****************************

Now take the post-test and see how much you know! Please be sure to go back and re-read the information for questions you missed. At the bottom of the post test is an area for you to sign that verifies you have read all of this information and taken the post test. The administrator or administrator/supervisor-in-charge should also sign below to verify that you have been given this information and taken the test. The Post Test with signatures is to be maintained in the facility.

It may be necessary that the administrator discuss the information in this manual with you in order for you to fully understand your role in food preparation. Most likely, if you are reading this, you are either the kitchen supervisor or responsible for preparing meals for residents. You'll want to share your knowledge with everyone who works in food service or assists in serving meals. You have an extremely important job! Take pride in your work and share your knowledge!

# POST TEST FOR FOOD SERVICE ORIENTATION

Circle the best answer for each question.

1. Sanitation of kitchen surfaces is different than "clean" in that it means it has been treated to kill what? A. harmful bacteria B. rodents C. flies D. animals

2. Kitchen equipment such as blenders and meat slicers should be sanitized: A. once a month B. once a week C. once a day D. after each use

3. Dishes can be sanitized by using: A. soap and water B. a fan to air dry C. water temperatures of 171 degrees or sanitizing chemicals such as bleach D. a drying rag.

4. Food can be stored on the floor as long as it is in dry storage area and the floor is clean. True or False

5. What is the appropriate temperature for refrigerators? A. 50 degrees or below B. 0 degrees C. 41 degrees or below D. 32 degrees or below

6. Which food may contain harmful bacteria? A. raw chicken B. fresh eggs C. raw meat D. all of these may contain harmful bacteria

7. Cross-contamination occurs *only* when *hands* are not washed after handling raw meat or poultry. True or False

8. An acceptable way to thaw hamburger would be to: A. let it sit on the counter B. in a sink full of water C. in a pan in the bottom of the refrigerator D. outside on a hot day.

9. Your hands should be washed after which of the following: A. touching raw meat, poultry or seafood B. after a trip to the restroom C. after touching garbage or other unclean surfaces. D. All of these

10. After hot foods have been prepared and are ready to be served, they should be held at what temperature to ensure bacteria do not grow rapidly? A. 0 degrees Fahrenheit B. at least 135 degrees Fahrenheit C. 35 degrees Fahrenheit D. 500 degrees Fahrenheit

11. You should **not** work in food service if you have which of the following? A. a cold or the "flu" B. an infected wound C. both A and B D. a bad hair day

12. Therapeutic diets are made up by chefs. True or False

13. What appliance is needed to prepare pureed diets? A. oven B. sharp knife C. a blender or food processor D. toaster

14. Which diet provides meats chopped or ground for residents who have problems chewing? A. No Concentrated Sweets B. Renal C. No Added Salt D. Mechanical Soft

15. Which diet limits sweets such as regular cakes, pies, candy and regular sodas and drinks? A. Renal B. No Concentrated Sweets C. Puree D. No Added Salt

16. Which diets may require that foods be prepared separately from regular foods because of salt? A. Renal and 2-gram Sodium B. puree and mechanical soft C. Finger Foods D. Dysphagia

17. A Low Fat/Low Cholesterol menu may call for low-fat preparation methods, such as baking instead of frying. True or False

18 Which diet is used for residents with swallowing problems? A. No concentrated Sweets B. Dysphagia C. Low Cholesterol Low Fat D. No Added Salt

19. What equipment is needed to prepare thickened liquids using a powdered thickener? A. measuring cups B. measuring spoons C. microwave D. both A and B

20. Where can you find directions for how much thickener should be added to a 4-ounce beverage to achieve nectar thickness? A. on the label of the canister or packet of thickener B. the menus C. the recipe book D. the phone book

21. A teaspoon of thickener will work in *any amount* of beverage. True or False

22. Therapeutic diet menus are the same in all facilities. True or False

23. It's OK to pick *any* day from the menus for meal preparation? True or False

24. When making substitutions on therapeutic diets, what is an easy way to know what other foods can be substituted? A. look at a different day under the same therapeutic menu column. B. ask the residents C. just use your imagination D. pick something the same color

25. There is no need to follow recipes when preparing therapeutic diets. True or False

26. You can order residents around only if they are not doing what you want them to do. True or False

27. It is the cook's responsibility to provide alternative foods if a resident refuses the meal served and to honor each resident's food preferences. True or False

28. Loud music of your liking should only be played occasionally in the dining room. True or False

29. You can tease residents just like you would your own friends. True or False

30. You should always be helpful to residents except when you are not feeling well or too busy. True or False

**I have read the Food Service Orientation Manual and completed the Post Test.**

______________________________ ____________

**Signature of person who completed food service orientation** **Date**

**I verify that the person whose signature is above received the Food Service Orientation Manual and completed the Post Test.**

______________________________ ____________

**Signature of Administrator or Administrator/Supervisor-in-Charge** **Date**

**The Post Test with signatures is to be maintained in the facility.**

Reviewed 2/21/24

Sanitation Standards – The Kitchen Must Be Very Clean Always! Always meaning at ALL TIMES. Keeping the kitchen and dining area clean is not a negotiable point. By always being clean it will never be a fire drill if the health inspector should come in. Take Pride in your Kitchen and you will feel the positive impacted it will have on you and your kitchen crew.

Daily Serving and Substitutions - Must keep a record of what is served to every resident every meal each day.

*Use of a weekly cycle menu, with some "special event days" ie... Resident Choice days ect..

*Use of "Daily Menu Served Form" Meal based sheet showing the original cycle menu with serving size and what was served showing serving size. (NOTE: We use this for the substitution log, in that; EVERY meal is recorded so it HAS TO INCLUDE any substations.) This is also used 3 to 5 days out to make sure you have all the food that is planned to be served. Also use this to "burn out" leftovers or food obtained outside normal procurement (donation food including restaurant donations (DOM). This from will also provide ongoing inventory of all frozen and non-frozen food present. Overall inventory to see how you are going to use it. Items one hand, amount need and amount to order. Three simple steps to obtain a full inventory each week. See your order guide. (we "I" will need to make this)

Weekly inventory Guidelines for appropriate substitutions of both type and chloric quantity. No meal substitution should be made outside the guide lines set forth by the state rules. Consult your substitution guide line sheet when making substitutions.

What should take place for a meal time?

*Supervisor to sign off who is there and who is not. (Census count) The daily meals are posted in the dining room and are visible for each resident each day.

ACTION ITEM:

How to audit a meal time. Check all temps and document those findings on the substitutions "Daily Menu Served Form". Prepare plates based on diet orders and serve in a timely manner. No one likes cold "hot" food. With that said, cold food should be served cold. Our residents look forward to meal times. It's our job as a community to make this time enjoyable and worth getting up for. They don't have a lot to look forward to so let's keep meal time great so it will help balance the day!

PRACTICES:

*Ways to make food more appealing thru creative cooking. Not a big fan of "From the Can to the Pan cooking". Creative cooking can be fun and more appealing for everyone. Seasoning and prep work can add a lot to a meal. That why it's so important to plan your meals ahead. Your creative cooking log will help you accomplish that goal. Make sure it is in Resident Register and/or Admission Packet that we only serve "no concentrated sweets" in our normal practices. Also, note all soda machines only have diet drinks.

Review of coming plans:

New Standardized Diets – Diets are to be served per doctor's orders. Diets will be displayed for easy review at each meal.

SUGGESTIONS: To make whole environment better.
Layout of the tables. Ticket system for turning in trays/silverware/plates. Tickets can be used in community store. This is a fun way to get your residents involved.
Paging of meal time. Make it fun, meal time stuff.

FUTURE:
Going to new standardized menus (same across entire company by week)

Temperature Logs:
Freezer, Cooler, Temperature Logs; This is to be checked daily. When you come in and before you go home. Keep this log in a notebook so it easily obtainable for audits. (test for Quaternary Ammonium (QAC, Multi-Quat) or Chlorine test paper. Which type does your facility use.

ServSafe:
Each kitchen manager should receive the following training.
https://onfocussolutions.com/servsafe-manager-online-course/?gclid=CjwKCAiAz--OBhBIEiwAG1rIOlrWpES93ORm43jMDGTggVTJ67JccH_OtfJJXGPqsS-WXdORh9CkMRoCbHsQAvD_BwE

HEALTH DEPARTMENT

# HAZARDOUS FOOD TEMPERATURE CHART

Environmental Help Line 1-888-777-9613

| Food | | Temperature |
|---|---|---|
| Refrigerated Foods | | 4 °C / 40 °F or colder |
| Frozen Foods | | -18 °C / 0 °F or colder |

**All temperatures to be maintained for a minimum of 15 seconds**

| Food | | Temperature |
|---|---|---|
| Whole Poultry | | 82 °C / 180 °F |
| Ground / Cut Poultry | | 74 °C / 165 °F |
| Food Mixtures | | 74 °C / 165 °F |
| Pork / Pork Products | | 71 °C / 160 °F |
| Ground Meat | | 71 °C / 160 °F |
| Fish | | 70 °C / 158 °F |
| Other Hazardous Foods | | 70 °C / 158 °F |

After cooking, all hazardous foods must be held at a minimum 60 °C / 140 °F until service.

**All temperatures to be maintained for a minimum of 15 seconds**

All hazardous foods must be reheated, within a 2 hour period, to at least their specified minimum required internal cooking temperature. All poultry must be reheated to at least 74 °C / 165 °F.