STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL029007	A. BUILDING: _____ B. WING _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MALLARD RIDGE ASSISTED LIVING	9420 NORTH HIGHWAY 150 CLEMMONS, NC 27012 County: Davidson

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D 000	Initial Comments The Adult Care Licensure Section and the Davidson County Department of Social Services conducted an annual and follow-up survey on July 22, 2015 and July 23, 2015.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure supervision for 1 of 3 sampled residents (Resident #3) with multiple falls. The findings are: Review of Resident #3's current FL2 dated 01/19/15 revealed: -Diagnoses included atrial fibrillation, chronic kidney disease stage IV, history of multiple facial fracture, stroke with left side weakness, history of concussion with loss of consciousness, bradycardia, hypertension, left frontal hemorrhage, and decreased responsiveness with confusion. Review of the Resident #3's Resident Register revealed: -Resident #3 was admitted to the facility on	D 270	Pre-Fix Tag-D270 All residents care needs related to falls were re-evaluated on 8/14/15. New shared risk agreements and intervention checklist were updated. If the resident met the qualifications for increased supervision the resident's ADL records were updated and messages were sent to all staff via Quick MAR to inform and educated them on these new supervision requirements. ED/RCD/HCD and AL Coordinator received training on the new Fall Risk protocol on Friday 8/7/15.	

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D 270	Continued From page 1 11/08/13. Review of the Resident #3's personal care plan signed by the nurse practitioner dated 07/21/15 revealed: -The Resident Care Coordinator completed the assessment for Resident #3 on 07/21/15. -Documentation under social and mental health history revealed the resident had multiple falls resulting in injury. -The resident was assessed as needing supervision with toileting, ambulation, and grooming. -Documentation the resident required limited assistance and needed staff to help with bathing, dressing, transferring and eating. Review of Resident #3's Licensed Health Professional Support evaluation dated 06/10/15 revealed: -The resident had a wheelchair and staff was to propel the wheelchair outside the room; -Staff was to assist the resident to the bathroom every two hours or as needed; -Staff was to supervise use of the rolling walker and assist as needed with unsteady gait. Review of incident/accident reports for Resident #3 revealed falls on the following dates: -01/12/15 at 10:00 pm "resident feet got tangled (tripped), she went down on one knee, scrapping her knee." -01/15/15 at 5:00 am "fell in the bathroom, 4 inch skin tear on right upper arm." -01/30/15 at 9:30 pm "resident feet got tangled, she fell, skin tear on right arm near the elbow." -02/02/15 at 3:15 pm "resident found on floor inside the shower, she didn't remember how she fell." Resident went to hospital, laceration on face, right elbow and skin tear on right hand.	D 270	ED/RCD/HCD or designee will view Incident Report Tracking logs on a weekly basis to help identify any new residents that may become at risk. Completion date for all above correction will be 8/14/15 and on-going.	

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D 270	Continued From page 2 -03/27/15 at 8:00 pm "resident missed chair and fell, no injuries." -04/02/15 at 7:25 am "found resident on the bathroom floor bleeding from the head and right hand, and scrape on the right knee. " Resident went to hospital, laceration to head received 4 staples. -06/01/15 at 6:25 am "resident found naked and sitting on the floor, laceration on left index toe." -06/08/15 at 6:45 pm "POA (Power of Attorney) stated resident turned and fell against the toilet." Skin tear on upper and lower right arm. -06/12/15 at 10:00 am " Resident found on the floor, pain in ribs from a previous fall." -07/04/15 at 5:10 pm "resident found on the floor." -X-Ray on 07/07/15 was due to the fall on 7/04/15, the resident's right foot was swollen and the resident was in pain. -As a result of the X-ray the Nurse practitioner instructed to take Resident #3 to the hospital for a fracture to the right great toe. -07/13/15 at 7:50 am "resident found on the floor." Laceration on upper right arm (wound treated by home health). -The physician and POA were notified for all falls. Review of the facility's incident/fall intervention checklist (falls policy) revealed: -Resident #3 was assessed for fall intervention 01/17/15 and 03/27/15. -The resident was placed on every 2 hours toileting program. Review of the facility's safety checklist program (falls policy protocal) Resident #3 in July 2015 revealed: -Staff initialed they toileted Resident #3 every 2 hours on 07/02 from 2:00 pm to 10:00 pm; 07/13/15 from 4:00 pm to 10:00 pm; 07/14/15	D 270		

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D 270	Continued From page 3 from 8:00 pm to 10:00 pm; 07/15/15 from 8:00 am to 2:00 pm; 07/16/15 at 4:00 pm; 07/17/15 from 12:00 am to 6:00 am; 07/18/15 from 12:00 am to 2:00 pm; and 07/22/15 from 12:00 am to 2:00 pm. -Staff initialed for safety checks, where they observed the resident every hour from July 1st through July 7/23/15. -The resident still had falls on 07/04/15 and 07/13/15. Interview on 07/22/15 at 5:10 pm with the second shift Medication Aide revealed: -Resident #3 "falls a lot." -Most falls usually result in an injury. -She observed the resident's right leg as being a little slower and the resident sometimes seemed to drag her right leg causing her to fall. -The resident was always found on the floor. -One time the resident fell in her room, the door was closed, so the resident was knocking on the door for staff to help her. -She believed the resident's gait was unsteady causing her to fall. -The resident was to be checked every 2 hours. -No one at the facility had instructed her to supervise or check on the resident more frequent than every 2 hours. -Staff initialed the safety check every hour because they were able to observe Resident #3 from the hallway, when walking past the room, if the resident's room door was open. Observation 07/23/15 on from 9:25 am to 9:28 am revealed: -The resident had dark pink, purple, blackish marks all over her upper and lower right and left arms. -There was a five inch gauze wrap on the resident's upper right arm.	D 270		

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D 270	Continued From page 4 -The resident had a hard non-bendable open-toe support shoe on her right foot. Interview on 07/23/15 at 9:28 am with Resident #3 revealed: -A week ago she fell trying to open her blinds. -She fell and hit her arm on the heat/air register unit underneath her window causing all the "black/blue and other discoloration to her arms." -She also had a big laceration on her upper right arm under the gauze wrap. -Two weeks prior to the above fall, she broke or sprang her toe on her right foot. -She fell going into the bathroom reaching for the light, causing her to trip. -There was nothing on the floor causing her to trip, but "I just went down." -It was painful but was getting better. -One time she fell into the shower, hitting her head and received 5 stitches. -Sometimes when bending over to put her shoes on, she ended up on the floor. -She was never near her call bell when she fell. -She had even had to bang on her door for staff to come and help her or sometimes other residents hear her banging on the door or yelling, and they called staff to help her. -The resident felt she needed a call bell around her neck. -The resident said "physical therapy was for the birds," because she did not do anything good, and all they do is try to get her to walk. -She had a joint disease (name unknown) which sometimes prevented free movement of her legs making it difficult to move her legs. -Her legs sometimes feel weak and they will just give out. -The resident did not comment but stared and did not respond when asked if she was aware the NP ordered neurology consult.	D 270		

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D 270	Continued From page 5 -The resident said staff sometimes came to her room and ask if she needs help. Interview on 07/23/15 at 9:50 am with the Assistant Resident Services Director revealed: -Resident #3 had been put on safety checks since June 2014. -The checks were scheduled every two hours. -Staff was to come to the resident's room and observe the resident. -She had observed the resident out in the community and staff assisting the resident as she started to fall, and staff was there to help prevent the fall. -Staff also often reminded the resident to bring her walker with her when out of her room. -She was unaware how often the resident used her walker in the room. -The resident had been verbally told to use her walker when in her room. Interview on 07/23/15 at 10:23 am with the nurse at Resident #3's physician's office revealed: -Resident #3 was ordered physical therapy last year in October 2014 due to falls. -According to notes in the resident's record, the resident should be using a wheelchair at all times. -The nurse practitioner (NP) saw the resident at the facility on 07/06/15, and was aware of the resident's continued falls. -The nurse practitioner ordered a neurology consult in April and May 2015 suspecting the resident may have beginning symptoms of Parkinsonism, but the resident's POA refused both consults. Interview on 07/23/15 at 11:40 am with home health nurse caring for Resident #3's wounds and fracture revealed: -The resident frequently had falls.	D 270		

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D 270	Continued From page 6 -The residents was okay when doing physical therapy and when therapy was completed the resident forgot all the skills learned and started falling again. -The resident had a hard time about dependency and thought she was still able to maneuver without staff assistance. -The resident was active in activities, but most falls occurred in the resident's room. -The resident did not want to use the walker, and a wheelchair had been suggested, but the resident "hated" the thought of using the wheelchair. Interview on 07/23/15 at 12:50 pm with the nurse practitioner revealed: -She saw Resident #3 two weeks ago. -She was aware of the resident's many falls. -She was unsure if more supervision would prevent the falls. -She observed the resident continually walking in the hallway without her walker. -She was concerned the resident had early symptoms of Parkinson disease, but the family refused two orders for neurology consult. Interview on 07/23/15 at 2:50 pm with a first shift Medication Aide revealed: -Resident #3 tried to be independent but needed more assistance than she would admit or allow. -She recalled 4 to 5 times Resident #3 had locked her door to keep staff out of her room. -Even today the resident locked her door to try and keep staff out of her room. -The resident was on 2 hour checks, but staff do monitor the resident often because the resident needed standby assist when walking and occasionally allowed staff to push her in the wheelchair. -The resident had several falls, at least 6 or more	D 270		

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in the past 6 months, and the resident hurt her arm with the last two falls.
-One fall required the resident to obtain stitches in her head.
-Resident #3 would not use her call bell when she needed assistance in her room, and had occasionally refused personal care from the staff.
-She felt Resident #3 was just overall declining, not able to balance herself when standing and walking.
-No one had instructed staff to supervise Resident #3 more frequent than every 2 hours.
-Staff were currently initialing they checked or observed Resident #3 at least hourly, but that was observing the resident when her room door was open.

Interview on 07/23/15 at 2:55 pm with the first shift Resident Care Assistant revealed:
-Resident #3 falls at least once a month.
-She observed the resident had something wrong with one of her legs, and believed that caused the resident to fall.
-She observed the resident would be walking, and then would stop and say "I can't do it."
-The resident was unable to move her legs anymore.
-The resident had problems with her legs were an ongoing issue, and staff continually reminded the resident to use her walker.
-She had been instructed to check on the resident at least every 2 hours.
-No instructions had been given to supervise the resident more often than every 2 hours.

Interview on 07/23/15 at 3:01 pm with the second shift Resident Care Assistant revealed:
-Resident #3 was checked on or supervised every 2 hours.
-The resident often would close her door so staff

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D 270	Continued From page 8 could not see into her room. -She tells Resident #3 all the time to ask for staff assistance, but the resident was non-compliant and would not ask. -No one at the facility had instructed to supervise the resident more frequent than every two hours. -Staff initialed safety checks were done every hour because if the resident's room door was open they were able to observe the resident when walking up and down through the hallway. Interview on 07/23/15 at 3:08 pm with a second shift Medication Assistant revealed: -Recently, Resident #3 had a lot of falls. -The resident had a bad fall a month ago resulting in a skin tear to her right arm. -The resident's door was closed mostly on the second shift, especially at bedtime. -The resident was checked every 2 hours. -No instructions had been given to check more frequently. Interview on 07/23/15 at 3:15 pm with the Quality Improvement staff revealed: -She had instructed staff to monitor/supervise Resident #3 at least every 2 hours. -No other system for supervising or monitoring had been put in place. Observation of the hallway where Resident #3 resided on 07/23/15 at 3:40 pm revealed: -The surveyor was walking down the hallway past Resident #3's room. -A Resident Care Assistant was walking 10-12 steps in front of the surveyor and past Resident #3's room. -As the surveyor walked passed Resident #3's room, it could be seen the resident up standing in front of her television set. -The resident's walker was in her room by a	D 270		

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lounge chair, which was at least 6 and ½ feet from where the resident was standing.
-The surveyor observed 6-7 minutes with no staff in sight.
-The same Resident Care Assistant walked back past Resident #3's room and did not look or observe the resident.
-The surveyor stopped the Resident Care Assistant and asked to assist Resident #3.
-The Resident Care Assistant "She is supposed to have her walker with her."

Interview on 07/23/15 at 4:10 pm with the home health therapist revealed:
-The resident had received physical therapy twice in a year.
-The resident was very strong willed and it took a lot of encouragement to get the resident to participate in therapy.
-When the resident was compliant with therapy she met all goals.
-Due to history of stroke Resident #3 may had lost her safety awareness skills, and did not realize that she lost balance causing her to fall.
-The resident continually refused to use her walker.
-She had many conversations with the resident about her falling, and the importance of notifying staff, and than waiting for staff to assist her, but the resident says "what's in a fall."
-At this point the best option may be for the resident to use a wheelchair to prevent falling.
-Checking the resident more frequently may help, but if the resident does inform staff before she gets up, falls still happen.

The facility provided the following plan of protection on 07/23/15:
-Immediately, the resident identified during the

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D 270	Continued From page 10 survey will be placed on 30 minute safety checks. -All staff will be promoted by quick MAR to perform 30 minute checks. -A care plan meeting will be scheduled with the resident identified family members. -All residents will be evaluated for care needs related to falls and implement intervention per resident assisted needs. -Management will review and revise the corporate fall protocol. -The Resident Care Director and Health Care Director will check daily to assure documentation has been completed. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 22, 2015.	D 270	Pre-Fix Tag-D310	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews the facility failed to assure therapeutic diets were served as ordered for 2 of 2 sampled residents (Residents #8 and #9) with physician orders for a pureed diet and nectar thickened liquids.	D 310	All dietary staff will receive training on Dysphagia and Mechanically Textured Diets no later than 8/20/15 by Executive Director of Dinning Services. All new dietary staff will receive one on one training from the Food Services Director upon hire prior to working independently.	

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D 310	Continued From page 11 The findings are: A. Review of Resident #9's record revealed an FL2 dated 04/13/15: -Diagnoses included dementia, depressive disorder, subdural hemorrhage, and diverticulitis of colon. -Order for chopped diet with nectar liquids. Review of Resident #9's record revealed a physician diet order dated 04/27/15 for pureed diet with nectar thickened liquids. Review of Resident #9's personal care physician authorized care plan signed by the physician on 07/08/15 revealed: -Nutrition was pureed diet with nectar thick liquids. -The resident required supervision with the meal by staff to setting up the meal. Review of the diet list (posted in the kitchen) on 07/22/15 at 9:20 am revealed Resident #9 was on pureed diet with nectar thickened liquids. Review of the therapeutic diet menu for pureed diets served on 07/22/15 lunch meal revealed: -Residents ordered a pureed diet was to be served: 6 ounces of pureed beef stroganoff, pureed seasoned rice, pureed baby carrots, pureed bread of choice, margarine, and sherbet, and beverage of choice. Observation of the lunch meal on 07/22/15 from 11:40 am to 1:00 pm revealed: -Resident #9 was at the dining room table sitting in her wheelchair. -The resident's place setting consisted of 8 ounces of nectar pre-thickened tea, 8 ounces of nectar pre-thickened milk, and 8 ounces of nectar	D 310	All Dietary staff will receive training at least annually on Dysphagia and Mechanically Textured Diets. Food Service Director or designee will spot check a minimum of 5 Therapeutic Diets per week. Completion date for all above correction will be 8/20/15 and on-going.	

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D 310	Continued From page 12 thickened coffee (surveyor observed the medication aide preparation process). -The resident consumed the beverages before the meal was served. Observation at 11:46 am on 07/22/15 Resident #9 was served: 6 ounces of nectar pre-thickened water; 8 ounces of nectar pre-thickened milk; -Pureed beef stroganoff that was watery and loose with liquid dripping from the spoon when extracting the meal from the bowl. -Pureed carrots that were loose and runny able to be seen through and the carrots were spread over the bottom of the entire plate; -Two slices of bread soaked in 8 ounces of milk, 6 ounces of the milk was not absorbed by the bread and was not thickened to nectar consistency. The milk with the bread was loose and the liquid moved when the bowl was moved; -Pureed pineapples with one and one-half inch of froth on top and 2 ounces of liquid at the bottom of the cup. -The resident used her spoon to eat the beef stroganoff. -Each spoon of stroganoff dripped liquid on the table and on the resident as the resident moved the spoon from the bowl to her mouth. -The resident was unable to pick up the carrots with the spoon because they were so liquidly. -The resident took three spoons of the liquidly non-thickened stroganoff, then put down the spoon. The resident picked up the cup of nectar thickened coffee. As the resident put the cup of coffee to her mouth she began to cough. -The resident coughed two wet coughs back-to-back, then took a drink of the nectar thickened coffee. -The resident did not cough anymore, and proceeded to eat more of the liquidly non-thickened food.	D 310		

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	HAL029007	A. BUILDING: _____ B. WING _____	07/23/2015

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D 310	Continued From page 13 -There were two staff members in the dining room during the meal, one was feeding another resident and another staff that was new to the unit. -No staff assisted the resident when coughing. -The surveyor intervened and asked staff to remove the food and seek appropriate meal for the resident. Based on record review and observation it was determined that Resident #9 was not interviewable. Interview on 07/22/15 at 11:50 am with the Medication Aide revealed: -Resident #9 had lived at the facility a little over one year. -The resident's health had started to decline and was put on nectar thickened liquids. -She was unaware of tests or consults done to determine the need for thickened liquids. -She was aware the meal was thin and runny. -Resident #9 was ordered a pureed diet with nectar thick liquids. -She did not have thickener to add to the meal. -She served what the cook sent. -There had been times when she sent Resident #9's meal back to the kitchen, because it was not correct, but thin, loose and runny. Interview on 07/22/15 at 11:56 am with the Resident Care Assistant revealed: -He had observed the pureed meals were thin and runny. -No feeding assistance was provided to Resident #9. -Sometimes Resident #9 coughed when consuming meals, but he did not realize it could possibly be a result of the meal not being the correct consistency.	D 310		

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D 310	Continued From page 14 Refer to interview on 07/22/15 at 11:54 am with the Medication Aide. Refer to interview on 07/22/15 at 12:10 pm with the Food Service Director. Refer to interview on 07/22/15 at 1:05 pm with the Cook. B. Review of Resident #8's record revealed an FL2 dated 03/02/15: -Diagnoses included dementia, diabetes mellitus, hyperlipidemia, and hypertension. -Order for pureed and no concentrated sweets (NCS) diets. Review of Resident #8's record revealed a physician diet order dated 03/10/15 for pureed and NCS diet with nectar thickened liquids. Review of Resident #8's personal care physician authorized care plan signed by the physician on 07/08/15 revealed: -The resident had a significant change. -Nutrition was pureed NCS diet. -The resident required extensive assistance with eating, requiring staff to assist with feeding meal. Review of the diet list (posted in the kitchen) on 07/22/15 at 9:20 am revealed Resident #8 was on pureed and NCS diet with nectar thickened liquids. Review of the therapeutic diet menu for pureed diets served on 07/22/15 lunch meal revealed: -Residents ordered a pureed diet was to be served: 6 ounces of pureed beef stroganoff, pureed seasoned rice, pureed baby carrots, pureed bread of choice, margarine, and sherbet,	D 310		

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D 310	Continued From page 15 and beverage of choice. Observations of the lunch meal on 07/22/15 from 11:40 am to 1:00 pm revealed: -Resident #8 was at the dining room table sitting in her wheelchair. -At 11:50 am on 07/22/15 Resident #8 was served. -The resident received 8 ounces of nectar pre-thickened tea; and 6 ounces of nectar pre-thickened water; -Pureed beef stroganoff that was watery and loose with liquid dripping from the spoon when extracting the meal from the bowl. -Pureed carrots that were loose and runny able to be seen through. -The carrots were spread over the bottom of the entire plate. -Two slices of bread soaked in 8 ounces of milk, 6 ounces of the milk was not absorbed by the bread and was not thickened to nectar consistency. -The milk with the bread was loose and the liquid moved when the bowl was moved; -Pureed pineapples with one and one-half inch of froth on top and 2 ounces of liquid at the bottom of the cup. -The resident received feeding assistance from a Medication Aide (MA). -The MA spoon feed the resident the beef stroganoff, and proceed to give the resident bread with milk dripping from the spoon. -The surveyor stopped the MA and asked to obtain an appropriate meal for the resident. -The resident did not cough, choke for strangle as a result of the meal. Based on record review and observation it was determined that Resident #8 was not interviewable.	D 310		

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D 310	Continued From page 16 Interview on 07/22/15 at 11:58 am with the MA revealed: -Resident #8 had lived at the facility for a few years. -The resident was ordered a pureed diet with nectar liquids. -She was unable to recall when or why the resident was ordered thickened liquids. -She usually worked Monday through Friday, and provided feeding assistance to Resident #8 during the breakfast and lunch meals. -Resident was on a NCS and pureed diet with nectar thickened liquids. -She did not thickened any liquids for the resident because they were all pre-thickened. -She was aware the bread in the milk was not thickened correctly, but she served what was ordered. Interview on 07/22/15 at 11:56 am with the Resident Care Assistant revealed: -He had observed the pureed meals were thin and runny. -He used caution providing feeding assistance to Resident #8 mainly to ensure she did not strangle or choke because foods were thin and runny. Refer to interview on 07/22/15 at 11:54 am with the Medication Aide. Refer to interview on 07/22/15 at 12:10 pm with the Food Service Director. Refer to interview on 07/22/15 at 1:05 pm with the Cook. Interview on 07/22/15 at 11:54 am with a Medication Aide revealed: -She was aware the pureed meals were not the	D 310		

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D 310	Continued From page 17 correct consistency. -The meals were even thin for nectar consistency. -On many occasions she sent the meals back to the kitchen because the cook made them thin and runny. -She was aware the pureed meals should be thicker than today's meal, and the meals were not even nectar consistency. -She served what the cook sent, because sometimes the cook will get upset when she sends the meal back. -Meals were not thin and runny every day, some cooks got the meal correct. -There was one cook that they had a problem with for a long time and that cook made meals thin and runny. Interview on 07/22/15 at 12:10 pm with the Food Service Director (FSD) revealed: -He had worked at the facility for two months. -He did not prepared the lunch meal today, it was prepared by the cook. -He was aware that pureed meals should be pudding consistency. -He did not observed the lunch meal was incorrect until the MA called to inform him the meals were incorrect. -The cook preparing pureed meals incorrectly had been an ongoing concern. -The cook had worked at the facility for six years. -He had addressed the problem with the cook, but was unsure what else needed to be done. -No in-service training had been provided to the cook since he started working at the facility because he had not had time. -He only had discussions with the cook how to prepare meals. Review of the FSD employment record revealed, he had completed the food service orientation.	D 310		

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D 310	Continued From page 18 Interview on 07/22/15 at 1:05 pm with the Cook revealed: -He had worked at the facility for six years. -The only training he had regarding pureed meals was five years ago. -He was told that pureed food consistency should be between nectar and honey consistency. -No one returned food back to the kitchen stating the consistency was incorrect. -The new FSD told him to soak the bread in the milk. -The FSD did not mention how much milk to put in the bowl. -The facility had menus for pureed diets but he did not follow them, he had not seen them since the FSD received them two weeks ago. A Plan of Protection was submitted by the facility on 07/22/15 that included: -Immediately, the FSD will visually inspect all pureed meals and nectar thickened liquids. -Immediately, the executive director of dining services will provide training to all food service staff. -The FSD will monitor meals daily. THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 06, 2015.	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 19 This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Supervision and therapeutic diets including thickened liquids. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure supervision for 1 of 3 sampled residents (Resident #3) with multiple falls. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. B. Based on observation and interview, the facility failed to provide repairs to wheelchairs for 6 of 6 residents (Residents #3, #4, #6, #18, #19 and #20). [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation).]	D912		