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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on August 19-20, 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: Based on observations, record reviews, and interviews, the facility failed to provide documentation of supervision in accordance with each resident assessed needs, care plan and current symptoms for 1 of 3 sampled residents (Resident #2) with documented falls. Review of Resident #2's current FL-2 dated 11/14/14 revealed: - Diagnoses included Alzheimer's Dementia, hypertension, and anxiety disorder. - The resident was documented as ambulatory and injurious to self (falls). Review of Resident #2's Resident Register revealed an admission date of 11/14/2013. Review of Resident #2's Care Plan dated 11/05/14 revealed: - The resident was assessed for limited assistance with ambulation. - The resident was assessed for limited assistance with transfers.	D 270		

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D 270	Continued From page 1 Review of the facility "Fall Identification, Prevention and Investigation Guideline" revealed: - "Every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, intervention and approaches for every resident who is identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment. The falls prevention approaches will be evaluated by the facility to determine the effectiveness of the approaches." - Residents were to be assessed within 72 hours of admission for fall risk. Residents scoring 0-8 were considered not at risk. Those greater than 8 were considered at risk. - Residents should be re-assessed quarterly. - "Based on the results of the falls assessment, the interdisciplinary team will determine the best approach to implement for fall prevention for those scoring at risk, adjust the care plan, inform the family and resident at the next care plan meeting and have them sign a negotiated risk specific to falls." Review of Resident #2's record revealed Fall Risk Assessment Forms (FRAF) information as follows: - FRAF should be completed on admission, quarterly, and upon significant change. - FRAF scores of 0-8 not considered to be at high risk for falls, 9-15 moderate risk (place on fall precaution and service plan), and 16 plus (place on fall precautions, including every 2 hour check and service plan). - FRAF dated 8/08/14 with a score of 12. - FRAF dated 11/08/14 with a score of 14. - FRAF dated 2/08/15 with a score of 10. - No FRAF after 2/08/15.	D 270		

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D 270	Continued From page 2 Observation of Resident #2 at various times on 8/19/15 and 8/20/15 revealed: - No apparent signs of bruising on any exposed areas of her extremities. - Resident #2 was not observed using any type of assistive device (cane, walker, or wheelchair.) - The resident was observed sitting alone in a lobby/foyer chair on 8/19/15 at 2:00 pm and 8/20/15 at 2:30 pm. (Staff and residents were located in the hallway and around the nurse's desk through the doorway.) - Resident #2 was observed lying on her bed at 1:50 pm on 8/20/15. - The resident was observed walking (shuffling gait with head down) in the dining room hall on 8/20/15 at various times including at 3:00 pm, and 4:00 pm. Review of Resident #2 record revealed no documentation for physical therapy assessment or treatment in the last 9 months. Review of facility staff notes and incident reports revealed Resident #2 had 5 unwitnessed falls from 3/06/15 to 6/14/15 as follows: - On 3/06/15 at 9:30 pm, Resident found sitting on buttocks on the floor - no apparent injury. - On 3/14/15, evening shift, Resident found sitting on buttocks on the floor - no apparent injury. - On 4/05/15 at 2:30 pm, Resident found on left side on floor in hallway, sent to emergency department - treated for contusion. - On 4/13/15, no time listed, Resident was found lying on left side in dining room - no apparent injury. - On 6/14/15 at 6:30 pm, Resident found lying on left side in another resident's room - no apparent injury.	D 270		

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Review of facility staff notes and incident reports revealed Resident #2 had 8 unwitnessed falls from 7/23/15 to 8/17/15 as follows:
- On 7/23/15 at 8:30 am, Resident was found sitting on buttocks on the floor in the hallway - no apparent injury.
- On 7/25/15 at 8:30 am, Resident was found sitting on buttocks on the floor in another resident's room- no apparent injury.
- On 7/27/15 at 1:00 pm, Resident was found in another resident's room- no apparent injury.
- On 7/29/15 at 11:00 am, Resident was found sitting on buttocks on the floor in another resident's room- no apparent injury.
- On 7/30/15 at 9:50 pm, Resident was found lying on the floor in another resident's room- no apparent injury.
- On 8/08/15 at 6:45 pm, Resident was found on back hallway lying on right side - no apparent injury.
- On 8/14/15 at 10:15 pm, Resident was found, sitting on her bottom in resident's room, tangled up in sheet and comforter.
- On 8/17/15 at 9:45 pm, Resident was found on the floor by the nurse's station and the beauty shop - no apparent injury.

Continued review of Resident #2's record revealed:
- On 6/26/15, resident was treated for urinary tract infection with an antibiotic.
- On 7/31/15 at 12:00 noon, Resident #2 received an order for an antibiotic to treat urinary tract infection as result of urine analysis and culture report on 7/31/15.

Review of the facility's "Incident Report Investigation Forms" for Resident #2 revealed documentation for interventions to be taken to prevent same or similar incident from recurring

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were as follows:
- On 3/10/15, "check on resident every 2 hours or every 1 hour".
- On 3/16/15, "toileting every 2 hours and as needed by staff".
- On 4/12/15, "toileting every 2 hours and as needed by staff. Have staff to assist resident with transfers".
- On 4/14/15, "toileting every 2 hours and as needed by staff. Staff to assist with patient sitting down in chairs in lobby".
- On 6/14/15, "Resident redirected to own room and re-oriented to surroundings".
- On 7/25/15, "Monitor resident as she wanders".
- On 7/25/15, "Educate staff on closely monitoring residents who wander".
- On 7/27/15, "Monitor resident, provide safe environment".
- On 8/08/15, "Increase safety check, every hour".
- On 8/14/15, "Staff will check environment for safety hazards even while in bed. Make sure resident extremities can move freely in blanket".

Review of the facility's post fall documentation for Resident #2 from 3/06/15 to 8/17/15 revealed:
- Documentation for one hour checks for 12 hours after each fall per facility policy.
- Documentation on nurses's shift notes for monitoring the resident's condition, including blood pressure check, pulse check, and comments regarding any signs of pain or bruising, and documenting at least once on each of 3 shifts (24 hours) after each fall per facility policy.

Review of Resident #2's record revealed no documentation for increased supervision after the 24 hour post fall period.

Interview on 8/20/15 at 1:15 pm with a Nurse Aide

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D 270	Continued From page 5 (NA) revealed: - She routinely worked the day shift and assisted residents with bathing, transfer, dressing, and other daily activities. - The staff performed routine checks on residents about every 2 hours. - The morning routine was to make rounds to check on all the residents when she arrived for her shift (7:00 am), make a second round starting around 9:30 am, around 11:30 the NAs started rounds for assisting residents to lunch, and around 1:30 pm NAs did toileting checks; which would be checking on residents about every 2 hours. - The NAs were responsible for checking on residents every 2 hours but the Medication Aides were responsible for the more frequent 1 hour checks, for 12 hours, after a resident had fallen. - Resident #2 was independent with ambulation and was able to get out of bed on her own. - She had to re-direct Resident #2 several times during the day because the resident would wander into other resident's rooms and try to sit down in a chair or on a bed. - Resident #2 needed re-directing to get from the shower to her room. - Resident #2 did not have a walker or wheelchair. - Resident #2 would not stay put once seated. - She was aware Resident #2 had experienced numerous falls with some of the falls in July 2015 being almost back to back. - She was not aware of any resident receiving increased supervision. (More than 2 hours checks). - She did not recall ever being directed to check on Resident #2 more often than every 2 hours. Interview on 8/20/15 at 1:30 pm with a day shift Medication Aide (MA) revealed:	D 270		

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- The facility staff, NAs, were responsible to check on all residents every 2 hours.
- The MAs were responsible to also document follow up checks at least one time each shift for 3 shifts (24 hours) after a fall.
- The resident would then go back on 2 hour supervision.
- The MA stated he had not seen Resident #2 fall but that he had been alerted by staff for falls on his shift.
- The Resident Care Coordinator or Administrator were responsible to inform staff for any increased supervision beyond the current fall protocol.
- The MA was not aware of any resident, including Resident #2, with instructions to be monitored more frequently than every 2 hours, unless they were in the 12 hours post fall when the MA checked on the resident every one hour and documented on the post fall sheet.
- The MA stated Resident #2 usually fell in another resident's room.
- Resident #2's mental status appeared to be worse; not really aggressive but more reactive with resistant behavior.
- Resident #2 did not routinely refuse medications except when she ended up being diagnosed with a urinary tract infection.

Interview on 8/20/15 at 1:50 pm with the Activity Director (AD) revealed:
- Resident #2's disposition had changed more in the last 1 to 2 months.
- Resident #2 used to participate in activities but had gotten a lot less focused and required frequent redirecting.
- The AD had not witnessed Resident #2 fall.
- Resident #2 only went on outings if the AD had additional staff available to help with supervision.

Interview on 8/20/15 at 1:50 pm with a second

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day shift Nurse Aide revealed:
- She routinely worked day shift but had also worked evening shift.
- The NA stated Resident #2 wandered around the building.
- Resident #2 did not mess with the belongings of others, she mainly just wandered into other residents' rooms and attempted to sit down in the chairs on the beds.
- The NA stated she had found her on the floor before but never witnessed her fall.
- The NA stated nobody from Administration or no MA had instructed her to check on Resident #2 more often than every 2 hours. (Not one hour or 30 minute checks.)

Interview on 8/20/15 at 2:05 pm with a second day shift MA revealed:
- He had worked at the facility more than 10 years.
- He was aware Resident #2 had experienced multiple falls in the last 6 months.
- He stated the MAs did 1 hour checks for 12 hours after a fall and documented each shift for 24 hours.
- He was not aware of any resident that was receiving routine checks more frequently than every 2 hours.

Interview on 8/20/15 at 2:10 pm with an evening shift MA revealed:
- The MA stated the facility routinely had 2 MAs and 3 to 4 Nurse Aides working on the evening shift.
- Resident #2 had fallen on the evening shift, when she worked.
- She had witnessed one fall, a long time ago, but recently she only heard the Resident #2 crying out for help or staff calling for her to come for a fall.

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D 270	Continued From page 8 - The MA stated Resident #2 wandered into other residents' rooms and appeared to be attempting to sit in a chair or on the bed when staff found her on the floor. - Resident #2 could not explain how she ended up on the floor. - Resident #2 was always walking around inside the facility. - The facility had tried using a wheel chair for Resident #2 but she would not stay in the chair. - Resident #2's wandering seemed to have increased over the last 2 to 3 months. - Resident #2 used to walk in the halls mostly, but now she seemed to be going into rooms more. - Resident #2 was less cooperative with toileting, however her medications had been changed at least 3 times in the last 3 to 4 months to help with the behaviors. - Resident #2 seemed to fall more often on the evening shift. - No resident was currently receiving increased supervision more than routine 2 hour check. Interview on 8/20/15 at 2:45 pm with Resident #2's family member revealed: - Resident #2 had fallen several times over the last 6 months. - The facility notified the family member every time Resident #2 fell. - The family member had asked the facility about the resident using a walker, however, the facility informed her that the resident was very mobile and would not remember to use the walker. - Resident #2 had received physical therapy (PT) a long time ago. - The facility had mentioned a wheelchair to the family member but the family member had expressed concerns that a wheelchair should only be a last resort due to the resident losing the ability to walk after being placed in a wheelchair.	D 270		

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- The family member had not been contacted for participating in updating the resident's Care Plan.
- The facility had not discussed any addition fall prevention measure with the family member.
- The facility had not discussed trying PT again or increasing supervision for Resident #2 with the family member.

Telephone interview on 8/20/15 at 3:40 pm with Resident #2's Physican's Assistant (PA) revealed:
- The PA was aware Resident #2 had experienced several falls recently.
- The PA stated Resident #2 had been treated for urinary tract infections on at least 2 occasions.
- The PA had changed her medications to help with the potential for medications adding to the fall risk.
- The PA was aware of recent changes in behaviors for Resident #2, especially for resisting staff assistance and increased wandering around inside the facility.
- The PA continued to work with a mental health provider (changing medications) to help improve behaviors but the resident's cognitive status was not improving.
- The PA had not recommended PT due to the resident's mental status and inability to remember to do recommendations.
- The facility did not routinely use chair alarms and she was not sure the resident would be a good candidate for the alarm because of her ability to ambulate and cognitive status.

Interview on 8/20/15 at 3:50 pm with the Administrator in Training (AIT) revealed:
- The AIT was aware Resident #2 had experienced several falls in the last few months.
- The facility had put interventions in place including: urine culture and sensitivity test and treating for urinary tract infections (6/29/15 and

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D 270	Continued From page 10 7/31/15) which can lead to confusion, weakness and falls; re-directing the resident to own room and re-orienting to surroundings, checking room and facility for safe environment (looking for trip hazards) as documented on the incident reports. - The facility procedure for monitoring residents after a fall was routinely followed. (One hour checks for 12 hours, then documentation the resident's condition each shift for 24 hours). - The facility did not have a policy for increasing routine supervision for residents more often than every 2 hours. - The AIT thought staff were trying to check on Resident #2 more often than every 2 hours but there was no documentation. - The AIT did not think Resident #2 would benefit from PT due to cognitive status but would check with the PA for an evaluation. - The AIT was not sure why the Resident #2 did not have a signed Falls Risk Agreement in her record. - The AIT stated Resident #2's family member was contacted for each fall. - The AIT was not sure why the resident did not have a more current Falls Risk Assessment than 2/08/15 or why the care plan had not been updated to reflect the increased falls. Based on record review, and observation of Resident #2 on 8/19/15 and 8/20/15, it was determined Resident #2 was not interviewable.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional;	D 276		

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D 276	Continued From page 11 and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure implementation of a physician's order for 1 of 5 sampled residents (Resident #4) related to blood pressure measurements three times weekly. The findings are: Review of Resident #4's current hospital discharge FL-2 dated 5/15/15 revealed diagnoses included dyspnea, nosocomial pneumonia, Chronic Kidney Disease III, Pacemaker, Mitral Valve replacement, diabetes mellitus II, and Paroxysmal Atrial Fibrillation. Review of a subsequent post hospital order verification completed on 5/21/15, revealed an order for "Check B/P [blood pressure] M, W, F." Review of physician's order sheets signed and dated 5/11/15 and 7/14/15 revealed both order sheets included a continuation of the physician's order for B/P measurements to be taken three times weekly Further review of the resident record revealed the original date of the order for three times weekly blood pressure measurements originated on 4/9/14. Review of Resident #4's Medication Administration Record (MAR) for January 2015	D 276		

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D 276	Continued From page 12 through June 2015 revealed: -An entry for B/P measurements to be taken three times weekly on Monday, Wednesday and Fridays. -Documentation B/P measurements were taken on Mondays, Wednesdays and Fridays with a June 2015 range of 122/76 to 140/76. Review of the July 2015 MAR revealed: -No entry for B/P measurements to be taken three times weekly. -No documentation of three times weekly B/P measurements. Review of the August 2015 MAR revealed: -No entry for B/P measurements to be taken three times weekly. -No documentation of three times weekly B/P measurements. Review of the facility's "Vital Signs Log" revealed the last recorded monthly B/P measurement for Resident #4 was taken on 6/19/15 with a result of 110/52. Interview with Resident #4 on 8/20/15 at 9:35 am revealed: -He believed he had his B/P taken yesterday (8/19/15) by the Medication Aide (MA). -He thought he had his B/P taken frequently but did not recall the results nor how often his B/P was taken. -He was aware he had elevated blood pressure in the past but received medication to keep it down. Interview with a MA on 8/20/15 at 8:55 am and 9:40 am revealed: -He took Resident #4's B/P yesterday at the resident's request and documented all B/P readings on the MARs.	D 276		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 13 -When the MA reviewed the current MAR and did not find the B/P measurement documented, he stated "I must have written it on my scratch paper and forgot to document on the MAR." -He recalled the B/P measurement was normal and only took it because Resident #4 requested his B/P be checked. -The MA stated he relied on the MAR to determine which residents need treatments or vital signs completed and how often. -If the order was not transcribed to the MAR, the MA would not know it was scheduled to be done. -There was no other list or prompt the facility used to informed the staff vital signs or treatments needed to be completed. Interview with another MA on 8/20/15 at 11:00 am revealed: -He did not take Resident #4's B/P measurement this morning. -Since the three times weekly B/P collection was not transcribed to the MAR, he would not know it was required that day. -He relied on the MAR for directions on which Residents needed vital signs taken other than routinely once a month. Interview with the Resident Care Coordinator (RCC) on 8/20/15 at 9:15 am revealed: -He was responsible for checking the previous monthly MARs to the current MARs for accuracy and completeness. -He was not aware the B/P measurements for Resdient #4 had not been done for 7 weeks. -He stated the missing B/P transcription should have been picked up and handwritten on the MAR. -The RCC stated the pharmacy sometimes left off the vital signs transcription in the medication section.	D 276		

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D 276	Continued From page 14 Interview with the primary care physician's nurse on 8/20/15 at 11:00 am revealed: -Resident #4 had several hospitalizations in the past six months and was being closely monitored by the doctor. -The three times weekly B/Ps were used as part of the "monitoring process as his cardio-vascular status was unstable." -The resident was seen often in the office and the B/P had been monitored. The RCC reported on 8/20/15 at 11:30 am, the B/P measurement for Resident #4 was 122/80 and the doctor had changed the order to reflect once weekly B/P measurements in the future.	D 276		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (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. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide feeding assistance in a manner that maintained or enhanced resident dignity and respect to 3 of 3 residents who required feeding assistance (Resident #5, #6, and #7). The findings are:	D 312		

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D 312	Continued From page 15 A. Review of Resident #5's current FL2 dated 12/15/14 revealed: -Diagnoses included degenerative arthritis and esophagus. -Resident #5 required personal care assistance with feeding at times. -Resident #5 was ordered a regular diet. -Resident #5 was intermittently disoriented, personal care was total care. Review of Resident #5's record revealed the following diet orders: -On 12/18/15 diet order for mechanical soft diet with ground meats. -On 04/12/15 diet order for pureed meals. Review of Resident #5's Personal Service Plan and care plan dated 12/18/14 revealed the resident required supervision with eating. Review of the Resident Diet List posted in the kitchen revealed Resident #5 was on a pureed diet and required feeding assistance. Observation on 08/19/15 from 11:00 am to 11:50 am of the lunch meal revealed: -Resident #5 was seated in the dining room, in her wheelchair. -The resident seated at the horse-shoe shaped table along with three other residents. -At 11:03 am the resident's meal was served in two 4 ounce bowels. -The meal consisted of pureed goulash and pureed carrots. -A Nurse Aide (NA), Staff B, walked to the inner circle of the horse-shoe shaped table and while standing, she picked up Resident #5's spoon and gave the resident one spoonful of food. -After giving Resident #5 a spoonful of the meal, (still standing) the NA picked up the spoon of the	D 312		

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resident sitting next to Resident #5, and gave that resident a spoonful of the meal that was in front of the resident.
-The NA repeated the same process for the third resident.
-The NA continued to repeat this process while standing and feeding all the residents at the table.
-The NA also provided cuing to a fourth resident, even at times picking up the resident's spoon and handing it to the resident.
-Resident #5 consumed 80% of her meal.

Observation on 08/20/19 from 10:30 am to 11:50 am of the lunch meal process revealed:
-Resident #5 was seated at the horse-shoe circular table with two other residents (Resident #6 and #7).
-At 11:08 am the NA, Staff A served Resident #5 and two other residents their meal.
-The meal served consisted of pureed chicken pot pie, mashed potatoes and pureed peach cobbler.
-The NA left the table twice after serving the meal, and did not serve Resident #5 or the other residents any of their meal.
-At 11:11 am the NA walked to the inner circle of the horse-shoe table and while standing started to feed the three residents.
-The NA left the table a third time and went to the kitchen.
-At 11:14 am a different NA came to the dining room, and walked to the inner circle of the table.
-While standing the NA proceeded to feed Resident #5, and the other three residents seated at the table.
-The NA gave Resident #5 a spoonful of the pureed food, then using a systematic pattern the NA gave the second resident a spoonful of food, and then the third resident a spoonful of food.
-The NA was observed to place her left elbow on

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the table and leaning in a curved position, bended over the table while feeding residents.
-At 11:20 am the NA got a chair and sat in the inner circle of the table and continued feeding the three residents in the same systematic pattern until the meal was completed.

Based on record review and observation it was determined that Resident #5 was not interviewable.

Refer to interview on 08/20/15 at 12:30 pm with the NA, Staff A.

Refer to interview on 08/20/15 at 12:45 pm with the NA, Staff B.

Refer to interview on 08/20/15 at 4:20 pm with the Administrator-in-training.

B. Review of Resident #6's current FL2 dated 06/15/15 revealed:
-Diagnoses included dementia and candida esophagitis.
-Resident #6 was constantly disoriented.
-Personal care assistance was bathing, feeding and dressing.
-Resident #6 was ordered a pureed diet.

Review of Resident #6's Personal Service Plan and care plan dated 06/15/15 revealed the resident required extensive assistance with eating.

Review of the Resident Diet List posted in the kitchen revealed Resident #6 was on a pureed diet and required feeding assistance.

Observation on 08/19/15 from 11:00 am to 11:50 am of the lunch meal revealed:

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D 312	Continued From page 18 -Resident #6 was in the dining room, in her wheelchair. -The resident was seated at the horse-shoe shaped table along with three other residents. -At 11:03 am Resident #6's meal was served in two 4 ounce bowels. -The meal consisted of pureed goulash and pureed carrots. -A Nurse Aide (NA), Staff B, walked to the inner circle of the horse-shoe shaped table and while standing, picked up Resident #6's spoon and gave the resident a spoonful of her meal. -Still standing, the NA picked up the spoon of the resident seated next to Resident #6 and gave that resident a spoonful of the meal that was in front of the resident. -The NA repeated the same systematic process of one spoonful per resident, rotating in a circular pattern throughout the meal. -The NA also provided cuing to a fourth resident, at times picking up the resident's spoon and handing it to the resident. -Resident #6 consumed 100% of her meal. Observation of the lunch meal process on 08/20/19 from 10:30 am to 11:50 am of the lunch meal revealed: -Resident #6 was seated at the horse-shoe circular table with two other residents (Resident #5 and #7). -At 11:08 am the NA served Resident #6's meal. -The meal served consisted of pureed chicken pot pie, mashed potatoes and pureed peach cobbler. -The NA left the table twice after serving the meal, without feeding the resident any portion of the meal. -The NA returned to the table and walked to the inner circle and while standing started to feed the three residents.	D 312		

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-The NA left the table a third time and went to the kitchen.
-At 11:14 am a different (second) NA, Staff A, came to the dining room, and walked to the inner circle of the table.
-While standing the NA started to feed Resident #6, and the other two residents.
-The NA started with the resident to the left of Resident #6.
-The NA gave Resident #6 a spoonful of food, and then gave the resident to the right of Resident #6 a spoonful of food.
-The NA repeated the systematic process of one spoonful of food per resident throughout the meal.
-After five spoons of food Resident #6 was given a drink of her beverage.
-The NA was observed to place her left elbow on the table, and leaning her body over the table in a curved position continued to feed the three residents.
-At 11:20 am the NA got a chair and sat in the inner circle of the table.

Refer to interview on 08/20/15 at 12:30 pm with the NA, Staff A.

Refer to interview on 08/20/15 at 12:45 pm with the NA, Staff B.

Refer to interview on 08/20/15 at 4:20 pm with the Administrator-in-training.

C. Review of Resident #7's current FL2 dated 03/07/15 revealed:
-Diagnoses included Alzheimer's type dementia.
-Resident #7 was constantly disoriented.
-Personal care assistance was bathing and dressing.
-Resident #7 was ordered a regular diet.

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D 312	Continued From page 20 Review of Resident #7's Personal Service Plan and care plan dated 03/07/15 revealed the resident required supervision with eating. Review of the Resident Diet List posted in the kitchen revealed Resident #7 was on a regular diet and required feeding assistance. Observation on 08/19/15 from 11:00 am to 11:50 am of the lunch meal revealed: -Resident #7 was seated in her wheelchair, in the dining room. -The resident was seated at the horse-shoe shaped table along with three other residents. -At 11:03 am Resident #7's meal was served goulash, carrots, and a dinner roll (broken in pieces). -A Nurse Aide (NA), Staff B, walked to the inner circle of the horse-shoe shaped table and while standing, spoon feed three other residents and instructed Resident #7 to eat her food. -Several time the NA picked up Resident #7's spoon and handed it to the resident. -Resident #7 still did not independently eat her meal. -The NA assisted Resident #7 throughout her meal. -Resident #7 consumed 70% of her meal. Observation of the lunch meal process on 08/20/19 from 10:30 am to 11:50 am of the lunch meal revealed: -Resident #7 was seated at the horse-shoe circular table with two other residents (Resident #5 and #6). -At 11:08 am the NA served Resident #7's meal. -The meal served consisted of chicken pot pie, mashed potatoes and peach cobbler. -The NA left the table twice after serving the	D 312		

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D 312	Continued From page 21 meal, without feeding the resident any portion of the meal. -The NA returned to the table and walked to the inner circle and while standing started to feed the three residents (no cueing for Resident #7). -The NA left the table a third time and went to the kitchen. -At 11:14 am a different NA, Staff A, came to the dining room, and walked to the inner circle of the table. -While standing the NA started to feed two other residents, and Resident #7. -The NA was observed to place her left elbow on the table, and leaning her body over the table in a curved position continued to feed the three residents. -At 11:20 am the NA pulled a chair over to the table and sat in the chair. Refer to interview on 08/20/15 at 12:30 pm with the NA, Staff A. Refer to interview on 08/20/15 at 12:45 pm with the NA, Staff B. Refer to interview on 08/20/15 at 4:20 pm with the Administrator-in-training. _____ Interview on 08/20/15 at 12:30 pm with Staff A, NA revealed: -It did not matter if she was seated or standing while feeding residents. -She started out standing while feeding residents, but decided to sit because it was easier to feed residents seated at eye level. Interview on 08/20/15 at 12:45 pm with Staff B, NA revealed: -Sometimes she sat while feeding residents their meal.	D 312		

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D 312	Continued From page 22 -It was easier to stand because residents were spread around the table. -No one at the facility had instructed her not to stand when feeding residents. Interview on 08/20/15 at 4:20 pm with the Administrator-in-training revealed: -Facility staff were aware not to stand when feeding residents. -She was filling in for the Administrator, and unaware if feeding assistance was observed to ensure staff did not stand.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications and treatments were administered as prescribed to 1 of 5 residents (Resident #1) with an order for Tramadol. The findings are: Review of Resident #1's current FL2 dated 12/19/14 revealed: -Diagnoses of dementia, diabetes mellitus, hyperlipidemia, and chronic back pain.	D 358		

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D 358	Continued From page 23 -Medication orders included Tramadol (pain relieving medication) 50mg, ½ tablet four times daily. Review of Resident #1's record revealed an order dated 08/07/15 for Tramadol 25mg three times daily. Review of Resident #1's August 2015 Medication Administration Record (MAR) revealed: -An entry for Tramadol 50mg take ½ tablet (25mg) four times daily was printed on MAR scheduled for administration at 6:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. -Staff documented the administration of Tramadol 25mg four times daily from August 1, through August 18, 2015, and at 6:00 am, 12:00 pm, and 4:00 pm on 08/19/15. Observation on 08/19/15 at 3:50 pm of the medication pass revealed: -The second shift medication aide administered to Resident #1 Tramadol 25mg. -The medication aide initialed the MAR for administration at 4:00 pm. Observation on 08/19/15 at 4:50 pm of Resident #1's medications on hand at the facility revealed: -Tramadol 25mg was available for administration. -The medication was packaged punch through card system. -The pharmacy printed label on the medication revealed Tramadol 25mg with no instructions for administering the medication. -The facility put a sticker on the medication label instructing "Direction change refer to chart." -The medication was filled on 08/07/14 for 90 tablets. -73 tablets were left in the punch card package.	D 358		

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D 358	Continued From page 24 Interview on 08/19/15 at 4:50 pm with the second shift medication aide revealed: -She administered Resident #1's Tramadol 25mg at 3:50 pm and had planned to administer the medication again at 8:00 pm. -She worked the second shift, and usually administered Tramadol 25mg twice during her shift, at 4:00 pm and at 8:00 pm. -She had observed the new directions sticker on Resident #1's Tramadol punch card. -She referred to the MARs, and the MARs instructed to administer the medication four times daily. -If there was an order to administer the medication more or less than four times daily she was unaware of the order. -The facility's protocol for new medications or medication order changes was the person receiving the order was to put a copy of the order in the MARs, and hand write the order on the MAR. -The medication aide on each shift (1st, 2nd, and 3rd) was to initial the order showing they had reviewed the changes as written by the physician or Nurse Practitioner (NP). -The medication aide was to check to ensure the hand written entry on the MAR was according to physician's instructions. -After the order was signed by the medication aide on each shift, the order was put in the Resident Care Coordinator's (RCC) folder. Interview on 08/19/15 at 4:30 pm with the NP revealed: -Prior to coming to the facility on 08/07/15 she called facility staff and informed them that she would be coming to the facility on 08/07/15. -The NP informed staff that as of 08/08/15 she would be on vacation for two weeks, and would not be available to write refill prescriptions.	D 358		

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D 358	Continued From page 25 -She informed staff to determine which residents would need medication refills during the two weeks that she would be gone. -On 08/07/15 staff told her that Resident #1's Tramadol would need a refill. -She wrote the refill order for Tramadol 25mg three times daily. -On 08/07/15 the pharmacy called to clarify the order, and she informed them that she was out of town for two weeks and facility staff needed to administer the Tramadol according to her order written on 08/07/15. -The NP said on 08/08/15 a staff person from the facility (unable to recall the same) called to ask about the order she wrote on 08/07/15 for Resident #1's Tramadol. -She informed staff that she was out of town and there was nothing that she could do, so they needed to administer the medication according the order that she wrote on 08/07/15 (three times daily). Interview on 08/19/15 at 5:00 pm with the pharmacy that filled Resident #1's Tramadol revealed: -The facility faxed them an order on 08/07/15 from the NP that changed Tramadol 25mg to three times daily. -They dispensed 90 tablets. -The pharmacy printed the label for the Tramadol on the punch card label. -If there was no instructions to administer the medication, then clarification needed to be done by the facility. -The pharmacy would not send a new MAR for the Tramadol 25mg three times daily until September 2015. -Facility staff were responsible for changing the medication instructions on the MAR. -No one at the facility had inquired about the	D 358		

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medication change from four times daily to three times daily.

Interview on 08/20/15 at 8:05 am with a first shift medication aide revealed:
-He usually worked the first shift.
-Most of his time was spent passing medications.
-Prior to today he administered Resident #1's Tramadol twice daily at 6:00 am and at 12:00 pm as printed on the MAR.
-He did not recall seeing an order that changed the resident's Tramadol from four times daily to three times a day.
-Even as of this morning he had not observed an order that changed Resident #1's Tramadol.
-He observed that someone had drawn a line through the Tramadol four times daily printed by the pharmacy, and hand wrote Tramadol 25mg three times daily on the MAR.
-He thought maybe an order came in yesterday, in the evening that changed Tramadol to three times daily.
-It was the facility's protocal when an order was received (new or changed) it was faxed to the pharmacy, and hand written on the MAR.
-A copy of the order was put in the MAR book and signed or initially by the medication aide on all three shifts.
-The order was then given to the RCC to be filed.

Interview on 08/20/15 at 8:25 am with the RCC revealed:
-When new medication orders were received he called the family to ensure they were aware of the order.
-He sent the orders to the pharmacy to have the new order filled.
-He wrote the new order on the MARs.
-A copy was put in the MAR book for the medication aide on each shift to view the new or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034090	A. BUILDING: _____ B. WING _____	R 08/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEMMONS VILLAGE I	6401 HOLDER ROAD CLEMMONS, NC 27012

(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 358	Continued From page 27 changed orders and initial they had reviewed. -Another copy of the order was put in the "what's happening" book for 1- 2 weeks, to observe side effects of the medication. -The order was additionally reviewed again by him (RCC), assistant RCC, and campus (facility nurse) nurse to make sure the order was carried out according to the facility's policy. -Resident #1's order for Tramadol 25mg three times daily was missed. Based on record review, observation, and attempted interview on 08/19/15 and 08/20/15 it was determined, Resident #1 was not interviewable.	D 358		