Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL040008	A. BUILDING: _____ B. WING _____	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNOW HILL ASSISTED LIVING	1328 S. E. SECOND STREET SNOW HILL, NC 28580

(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 The Adult Care Licensure Section conducted an annual survey on 11/25/15.	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 provide increased supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 2 of 5 sampled residents (#1, #2) with multiple falls, including falls with injuries requiring Emergency Medical Services. The findings are: 1. Review of Resident #1's FL-2 dated 9/21/15 revealed: -Diagnoses included shortness of breath secondary to congestive heart failure, acute or chronic systolic failure, shortness of breath and cough, superimposed mild pneumonitis, improved history of right sided pleural effusion, history of coronary artery bypass graft, atrial fibrillation, general debility, deconditioning aortic aneurysm and a large hiatal hernia. -The resident was intermittently disoriented to place and time. -The resident was ambulatory.	D 270	The facility will provide increased supervision in accordance with each resident's assessed needs, care plan, and current symptoms with multiple falls, including falls with injuries requiring Emergency Medical Services by the following... Increase Communication between the Nursing Assistances, Supervisors in Charge, Resident Care Coordinator, Executive Director and Administrator to help increase supervision of Residents with falls or incidents recurring injuries requiring Emergency Medical Services.	12/16/15 12/16/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE P Armstrong TITLE (X6) DATE 12/15/15

Accepted: DHHS 12/30/15

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D 270	Continued From page 1 -A physician's order for Coumadin 2.5 mg every other day alternating with Coumadin 2 mg every other day. (Coumadin is a blood thinner used to prevent blood clots and for the treatment of atrial fibrillation). -A physician's order for continuous oxygen at 2 liters per minute to be administered via nasal cannula. Review of Resident #1's Resident Register revealed the resident was admitted on 6/10/15. Review of Resident #1's care plan dated 6/15/15 revealed: -The resident required supervision for ambulation and transfers. -The resident required limited assistance with eating, toileting, bathing, dressing and grooming. -There was no subsequent care plan after 6/15/15. Review of Resident #1's September 2015 Medication Administration Record (MAR) revealed: -Resident was on Coumadin 2mg daily at 6:00 pm. -On 9/2/15, Coumadin 2 mg was ordered on Tuesday, Thursday, Saturday and Sunday and Coumadin 3 mg was ordered on Monday, Wednesday and Friday at 5:00 pm. -On 9/21/15, the resident began Coumadin 2.5 mg every other day alternating with Coumadin 2 mg every other day at 5:00 pm. Review of Resident #1's October 2015 and November 2015 MAR revealed Resident #1 was on Coumadin 2.5 mg alternating every other day with Coumadin 2 mg every other day at 5:00 pm. Review of Resident #1's physician	D 270	Nursing Assistances will bring Residents to group activities or out of their room for increased supervision. SIC will communicate during shift change of any incidents or attempts to get up without assistance. SIC will check the bed/chair alarms upon and during their shift to assure working properly by documenting working properly during shift. SIC will have access to extra batteries, supplies for the alarms. A list of Resident with use of Bed/Chair Alarms will be kept current by SIC and/or RCC on the SIC Communication Book and Personal Care Log Book.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 2 communication reports revealed: -The physician commuication reports were to be completed by the staff at the facility to notify the primary care provider of any falls with or without injury, Emergency Department vists, any superficial injury and/or following any first aid administered to a resident -On 9/2/15 at 5:45 am, the resident was found on the floor in her bedroom and was noted to have had bruising on her "mid left arm" (size of bruise unknown). The primary provider signed the report and requested to see the resident in the office. The facility made the resident an appointment (time unknown). -On 10/20/15 at 1:00 pm, the resident was found by hospice nurse kneeling by the bedside with no noted injuries. The resident said she was praying. The primary care provider checked the box "thank you for your information" and signed and dated the form on 10/27/15. -On 10/28/15 at 2:00 pm, the resident had a fall in her bedroom and an injury was noted on her back. Hospice nurse was sent to the facility to evaluate the resident (no time). The box "thank you for your information" was checked. There was an unknown signature on the line for the primary care providers signature that did not match the previous primary care providers signatures. The date was not written in. -On 11/1/15 at 4:30 pm, the resident was attempting to go to the bathroom and fell in her bedroom. The hospice nurse was coming to the facility on 11/2/15 to evaluate the resident (no time indicated). The primary care provider checked the box "thank you for your information" and signed the form. The date was not written in. -On 11/3/13 at 7:50 pm, the resident had a fall in her room. "The resident said she slipped on the floor. Right hip skin dented in to the hip bone, a little red and she could walk. She was laying on	D 270	SIC will contact the Resident's Physician to inform of the fall or incident. SIC will contact the Family Representative of the fall or incident. SIC will contact the Executive Director and RCC of incident or fall. The SIC will contact RCC, Executive Director of any incidents during their shift to assure Resident safety and increased supervision during each incident. The Physician Communication Sheet will indicate whom the SIC has spoken with and what increased task has been put into place to keep Resident safe. Physician Communication Sheet will be completed by the SIC on shift of incident, will fax to the MD to communicate incident.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 3 that hip". The primary care provider checked the box "thank you for your information" and signed and dated the form on 11/4/15. -On 11/7/15 (no time), the resident had a fall in the hallway and there was a "not noted on the side of head ". The hospice nurse was called and would come to evaluate her (time unknown). There was not a primary care providers signature on the form. -On 11/11/15 (no time), the resident had a fall in her bedroom and there was a "bump on head". The hospice nurse was called and would come evaluate resident's need to be sent to the emergency room (time unknown). There was not a primary care providers signature on the form. -On 11/14/15 at 11:25 pm, the resident had a fall in her bedroom and was noted to have an injury on the left side of the head above the eye. The form stated, "Resident fell near bed hit head on left side open wound bleeding". The resident was transported to the emergency room. The primary care provider checked the box "thank you for your information" and signed the form. The date was not written in. -On 11/16/15 at 1:30 am, the resident had a fall in her bedroom. The hospice nurse was called, "she stated as long as resident has no mental status change or apparent injuries she sees no need to send resident out to the ED for evaluation". The hospice nurse would visit on the next morning. The primary care provider checked the box "thank you for your information" and signed and dated the form on 11/17/15. -On 11/19/15 at 2:15 am, the resident had a fall in her bedroom and had complaints of hip pain. The resident was transported to the emergency room for evaluation. There was not a primary care providers signature on the form. -On 11/23/15 (no time), the resident fell getting out of bed and had an injury to her right hip. The	D 270	The SIC of the shift will assure Incident Report completed with properly documenting the situation of the fall. The SIC will obtain copies of the faxed confirmation to MD and file a copy in Resident Chart. The SIC will staple the Physician Communication Sheet, confirmation faxed to MD and Incident Report to Executive Director. The SIC will begin the 30 minute check on the Resident, if not already started. The SIC will inform next SIC in report of the incident.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 4 hospice nurse came out to the facility to evaluate the resident (time unknown). The primary care provider checked the box "thank you for your information" and signed and dated the form on 11/24/15. Review of incident/accident reports for Resident #1 revealed: -The resident had falls in her bedroom on 8/15/15 (no time), 8/26/15 at 5:16 am and 11/14/15 at 11:25 pm. -The fall on 11/14/15 required Emergency Medical Services for injury above the eye. -There were no other reports provided. Review of Resident #1's falls progress notes revealed: -On 10/20/15 (no time), the resident had a fall, she would remain on every 30 minute checks due to falls and staff encouraged her to ring the call bell for assistance. -On 11/7/15 (no time), the resident fell and a new order was obtained after the fall for a bed and chair alarm. Review of Resident #1's Restraint Assessment-Care Plan Team-Responsible Person Consent form revealed: -The responsible party signed the consent on 11/16/15. -The resident was on Hospice for comfort care. -Alternatives that were checked as being provided were: physical therapy, assistive devices, increased staff monitoring, pain managment, family involvement and increased communication. -All alternatives had failed. -The resident was to be checked on every 30 minutes.	D 270	The RCC will be given this Physician Communication Sheet and Incident Report to follow up with Physician and Administrator/Executive Director. The RCC will request for services of Skilled Home Health to help assess safety of the Resident and/or Safe Stride to keep Resident safe upon the first fall or incident. The RCC will complete the Fall Precautions Assessment quarterly or more if needed to help identify factors to prevent falls. The RCC will document on the Fall Assessment Progress Notes after each incident to help keep track of the falls. The RCC, Administrator &/or Executive Director meet daily to discuss falls or incidents, factors put into place to prevent falls.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 5 Review of Resident #1's physician restraint order dated 11/12/15 revealed ½ bed rails were to be used on a hospital bed as an intervention for falls. Review of Resident #1's treatment report from a local hospital Emergency Department (ED) visit revealed: -The resident arrived at the ED on 11/15/15 at 12:26 am. -The resident had an open wound above her left eyebrow caused by a fall. -Sutures were used to close the wound. Review of Resident #1's Physician Restraint Order dated 11/16/15 revealed ½ bed rails on a hospital bed and a geri chair with tray was to be used as an intervention for falls. Review of Resident #1's safety measures for fall reduction form dated 10/20/15 and 11/7/15 revealed the box for "Other interventions were employed as recommended" was checked yes. Interview with the Executive Director on 11/25/15 at 2:00 pm revealed: -The safety measures for fall reduction form was completed by facility representative on residents with falls. -She was unsure of how often the form was completed but could ask the Administrator. -The "other interventions employed as recommended" meant the facility would increase monitoring of the resident to every 15 minutes and discuss with family or guardian. -The needs of individual residents were documented on the personal care flow sheet. Review of the facilities fall risk sheets dated 11/17/15 and 11/25/15 revealed Resident #1 was not listed as a fall risk.	D 270	If a Restraint is started, the Executive Director will assure Restraint Care Plan completed and signed by Resident Representative, LHPS, Physician and by Administrator. If a Restraint is started, the Executive Director will assure Physician Orders for any restraint is obtained quarterly. If a Restraint is started, the Executive Director will assure Restraint Progress Notes are completed quarterly. If a Restraint is started, the Executive Director will inform PCA and SIC of the use of the Restraint. If a Restraint is started, the Executive Director will start 30 minute checks for safety of the use of Restraint. 2 hour Release of the use of the Restraint.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 6 Review of the November 2015 personal care flow sheet revealed: - The Resident #1 was on every 30 minute checks due to fall risk related to unsteady gait. -The Personal Care Assistants (PCA) were to inital beside the time every 30 minutes. -There was no documentation on 11/20/15 from 3:00 pm to 11:00 pm. -There was no documentation on 11/24/15 from 7:30 am to 3:00 pm. Based on observation, interviews and record review revealed Resident #1 was not able to be interviewed. Interview with a Personal Care Assistant (PCA) on 11/25/15 at 11:30 am revealed: -Resident #1 had required more assistance with personal care in the past "few months". -The resident required total assistance with bathing and dressing. -The resident could walk to bathroom with assistance. -The resident could feed herself, but required prompting. -The resident has had multiple falls since "her breathing had gotten worse". -The resident had a personal alarm to be used when in her geri chair and when in bed. -The resident was checked every 30 minutes and it was documented on the personal care flow sheet. Interview with a second PCA on 11/25/15 at 11:40 am revealed: -Resident #1 would get up without assistance. -The resident required total assistance with bathing and dressing. -The resident had a geri chair with a tray that	D 270	Upon Admission and throughout the stay, the RCC will conduct Fall Assessment on Residents after first fall. The Resident Care Coordinator - RCC will inform the Nursing Staff of Fall Precautions by beginning the 30 minute checking. The RCC will be communicate with Personal Care Aides on the Personal Care Logs indicating Fall Precautions. The RCC will follow up with each fall to identify the reason or cause of fall and meet with Executive Director or Administrator to identify the cause of the incident.	12|16|15 12|16|15 12|16|15 12|16|15

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D 270	Continued From page 7 would keep her from getting up without assistance. -A personal alarm was used to notify staff when the resident was getting up without assistance from the geri chair or from bed. -The resident was checked every 30 minutes due to her frequent falls. -The resident was taken to the bathroom every 2 hours. Interview with a third PCA on 11/25/15 at 3:30 pm revealed: -He did not provide personal care to Resident #1. -He assisted other staff in providing visual checks of all resident's. -He attended a class on falls the "first of the year". -The class taught how to transfer residents using a gait belt and the use of personal alarms. -The personal care log instructed the PCA's on how frequently to monitor residents. Interview with a Medication Aide on 11/25/15 at 12:00 pm revealed: -Resident #1 was on every 30 minute checks due to falls. -The would keep the resident in a visually monitored area when she was out of bed. -Every 30 minute checks were documented on the personal care flow sheets. Interview with a second MA on 11/25/15 at 3:35 pm revealed: -She had started working there in September 2015. -She had not attended a class on falls. -She was informed on 11/25/15 that Resident #1 would begin on every 15 minute checks. Interview with the Executive Director on 11/25/15	D 270	The Executive Director will inform DSS of the incident and what safety measures have been put into place to help assure safety. The Executive Director will inform Family Member or Resident Representative of factors put into place to prevent falls. The Quality Assurance Team will meet within the quarter to review Residents with at least 3 falls to assure needs and safety can be met in the facility or before the 3rd fall depending on the severity. The Quality Assurance Team will review all falls and/or incidents quarterly to assure staff. The Quality Assurance Team includes the LHPS, RCC, Executive Director, an SIC and a PCA.	12/16/15 12/16/15 12/16/15 12/16/15

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D 270	Continued From page 8 at 12:05 pm revealed: -Resident #1 was on every 30 minute checks. -There was an order obtained for a bed alarm, personal alarm, geri chair and ½ bed side rails obtained from the physician in November 2015 due to falls. Interview with the Administrator on 11/25/15 at 12:20 pm revealed: -Resident #1 had multiple falls. -The staff had completed a falls reduction checklist quarterly which involved a resident assessment and interventions. -The resident did not have an updated care plan or licensed health professional support tasks. -She was responsible for updating the care plan. -She was going to complete a change in condition care plan (time unknown). -She was going to update the care plan to indicate Resident #1 needed total assistance with toileting, ambulation, bathing, dressing, grooming and transfers and moderate assistance with eating. -The licensed health professional support (LHPS) nurse would be in Monday 11/30/15 to update the resident's LHPS tasks. Interview with the Hospice Nurse on 11/25/15 at 2:30 pm revealed: -She had taken over care of Resident #1 "a few weeks ago". -She worked closely with the resident's previous hospice nurse and was up to date on her care. -Hospice visited the resident 2 times a week and as needed. -The previous hospice nurse had discussed concern with the facility regarding the resident's frequent falls (time unknown). -The current hospice nurse was going to discuss care of the resident with her responsible party.	D 270	Executive Director will have the Home Health Agency, LHPS, East Behavior Health and other agencies continue to provide in-service training for the staff monthly to help inform them of the importance of supervision for the next 3 months then quarterly thereafter. The Administrator or Executive Director will receive each Incident Report to assess the incident to assure safety precautions are put into place such as Bed/Chair Alarm, 30 Minute Checks, ½ bed rails as discussed with Family, Physician and LHPS.	12/16/15 12/16/15

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D 270	Continued From page 9 Telephone interview with the Primary Care Provider on 11/25/15 at 1:38 pm revealed: -The facility should monitor Resident #1 more frequently due to falls. -It was her expectation that the facility monitor the resident every 15 minutes. -She discussed the need for increased monitoring with the previous Resident Care Coordinator (time unknown). -It was her understanding that the facility would increase monitoring of Resident #1. -The Resident Care Coordinator told her they would implement increased monitoring of Resident #1 (time unknown). Telephone interview with Resident #1's Responsible Party (RP) on 11/25/15 at 4:00 pm revealed: -The RP thought she was notified every time the resident had a fall, but was not sure. -She was made aware by the facility of the resident's increased falls over the last 3 months. -She was concerned that the resident's fall had increased because she was on a blood thinner. -She understood the facility was using a geri chair with tray as a restraint to help prevent further falls. -The resident was unable to understand the use of the call bell to call for assistance. -The resident had always gotten up frequently at night to use the bathroom. Refer to interview with the Administrator on 11/25/15 at 3:00 pm. Refer to interview with the Administrator on 11/25/15 at 4:15 pm.	D 270		

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D 270	Continued From page 10 2. Review of Resident #2's current FL-2 dated 6/16/15 revealed: -Diagnoses of Traumatic Brain Injury, Progressive Dementia and static Encephalopathy. -The resident was intermittently disoriented to place and time. -The resident was ambulatory. Review of Resident #2's Resident Register dated revealed the resident was admitted on 6/1/15. Review of Resident #2's initial care plan dated 6/18/15 revealed: -The resident required assistance with toileting, bathing, dressing and grooming. -The resident was able to ambulate, transfer and eat with minimal assistance. -There was no subsequent care plan after 6/18/18. Review of Resident #2's incident reports for falls revealed: -On 6/25/15, the resident fell in the lobby which resulted in a "bump" to the back of his head. Resident was transported by ambulance to the hospital emergency room and the primary care provider, Respite Care Coordinator and Resident #2's family were notified at 4:30pm. -On 7/20/15, the resident was found on the floor in his room on his knees and stated he had fallen out of bed. Resident was transported by ambulance to the hospital emergency room, and the primary care provider, Respite Care Coordinator and Resident #2's family were notified at 11:50pm. -On 7/21/15, the resident was found on the floor in his room with a bleeding right elbow. Resident was transported by ambulance to the hospital emergency room, and the primary care provider, Respite Care Coordinator and Resident #2's	D 270		

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D 270	Continued From page 11 family were notified at 8:43pm. -On 7/28/15, the resident fell out of the wheelchair in the hallway "bumping his head and right elbow". Resident was sent to the hospital emergency room, and the primary care provider and Respite Care Coordinator and Resident #2's family were notified at 8:25pm. -On 8/8/15, the resident was found on the bathroom floor and complained of head injury after a fall. Resident was transported by ambulance to the hospital emergency room, and the primary care provider, Respite Care Coordinator and Resident #2's family were notified at 11:35pm. -On 8/22/15, the resident was found on the bedroom floor with complaint of head injury due to fall. . Resident was transported by ambulance to the hospital emergency room, and the primary care provider, Respite Care Coordinator and Resident #2's family were notified at 11:30pm. On 9/4/15 at 4:35am, the resident was found on the floor beside the bed by the Supervisor In Charge (SIC) with no visible injury. The SIC reported the event. The resident was not sent to the emergency room but the primary care provider was notified at 6:30am. Resident #2's family was not notified. On 11/16/15, the resident as found on the floor aside the wheelchair's foot rest. Resident was sent to the hospital emergency room where bruising was noted on both arms. The primary care provider, Respite Care Coordinator and Resident #2's family were notified at 2:30pm, Resident #2's record review revealed: - Restraint order, half raised bed rails and 30 minute staff checks were in place since July 2015. - Resident had fallen 9 times since June 2015 with 8 of the 9 falls requiring Emergency Medical	D 270		

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D 270	Continued From page 12 Services to transport the resident to the hospital. - Resident had a skin tear on his elbow and a knot on his head identified in 2 of the 9 falls upon return from the hospital. - Resident #2 had bruising on both arms identified in 1 of the 9 falls upon return from the hospital. - Resident #2 was transported to hospital by EMS after 8 of 9 falls occurring on 6/25/15, 7/20/15, 7/21/15, 7/28/15, 8/8/15, 8/22/15, 9/4/15, 9/22/15, and 11/6/15. - The facility had notified the provider that the 30 minute checks, half rails, and lowered bed position for Resident #2 were ineffective after Resident #2's fall on 11/6/15. - On 11/16/15, the provider ordered a wheelchair with seatbelt. - There were no documented fall prevention protocol changes for Resident #2 between 7/20/15 and 11/16/15. - The fall prevention protocols remained unchanged after each fall with exception of the newly added seatbelt on 11/16/15. Telephone interview with the medical provider for Resident #2 on 11/25/15 at 2:30pm revealed: -Resident #2 should be in a skilled nursing facility. -She recommended to the previous RCC (Resident Care Coordinator) at the facility that Resident #2 needed to be in a skilled nursing facility in October 2015. -She told the facility on more than one occasion that Resident #2 needed 1-on-1 observation, and to provide at minimum 15-minute checks while the facility found another home for this resident. -She was unaware the facility was not providing 15-minute checks on Resident #2. -She had related the recommendation of skilled nursing facilities and a minimum of 15-minute checks to the previous RCC of the facility.	D 270		

Division of Health Service Regulation

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D 270	Continued From page 13 Interview with Administrator on 11/25/15 at 2:45pm revealed: -The previous RCC was terminated 4 weeks earlier at the end of October, 2015. -She was unaware of the medical provider's recommendation that Resident #2 needed to be placed in a skilled nursing facility. -The previous RCC did not relay any recommendations related the need of a higher level of care by any of the medical providers for any of the facility's residents. -The previous RCC was fired due to poor management ability. Observation of Resident #2 on 11/24/15 at 11:30am revealed: -He was being encouraged by staff to eat his lunch. -He sat in a wheelchair with a seatbelt around his waist. Resident #2 was unable to be interviewed. Two confidential staff interviews revealed: - Each was aware of Resident #2's frequent falls. - Resident #2 was able to open his seatbelt latch. - Resident #2 will "get away from you in two seconds and try to stand when we turn our backs" - Staff check on him every 30 minutes as required but "he needs constant supervision." - They toileted Resident #2 every 2 hours while resident was in the wheelchair with seatbelt. Refer to interview with the facility's Executive Director on 9/23/13 at 2:30pm Interview with Administrator on 11/25/15 at 3:00pm revealed: -She was aware of the frequent falls with Resident #1 and Resident #2.	D 270		

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D 270	Continued From page 14 -She was in the process of discharging Resident #1 and Resident #2 to skilled nursing facilities which she had already found bed placement. -Both Resident #1 and Resident #2 were to be placed within the 48 hours. -She had spoken with both families of Resident #1 and Resident #2. -Resident #2's son was presently looking for another facility closer to his home where he could transfer Resident #2. -Resident #2's family was willing to pay for 1-on-1 sitter for his father which was agree upon 30 minutes earlier by telephone call. -She felt the facility was doing the most they could despite the continued falls. -The facility did not provided 1-on-1 resident monitoring. -The facility did not provide 15-minute checks, only 30 minute checks for all residents. -She felt the facility was providing the care as written by the doctors. -Resident families would have to pay for provider-recommended 1-on-1 sitters at the facility as the facility did not provide this service. -The families of Resident #1 and Resident #2 were each notified of the need for 1-on-1 monitoring on 11/25/15 at 2:30pm after the Administrator confirmed the medical provider's recommendation of skilled nursing facility need and 1-on-1 monitoring for both Resident #1 and Resident #2. Interview with Resident #2's family member on 11/25/15 at 4:00pm revealed: -He was "blindsided 30 minutes ago with this new information for the need that my [family member] needs immediate 1-on-1 monitoring and to transfer out of the facility". -The Administrator had called him 30 minutes ago to alert him and to update him on the need for	D 270		

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D 270	Continued From page 15 1-on-1 care at his expense until he found new accommodations for his family member. -He was aware of his family member's fall history and poor appetite. -He lived in Minnesota and wanted to bring his family member near to his home. -He was happy with the care his father received at the facility. -He did not know his father required a higher level of care until the administrator called him 30 minutes earlier. Interview with the Administrator on 11/25/15 at 4:15pm revealed: -She made arrangements to transfer Resident #1 to an interim skilled nursing facility moments ago after a telephone conference with Resident #1's family member. -She called another facility for placement of Resident #2 after a telephone conference with Resident #2's family member. -She spoke with Resident #2's family member who would pay for the 1-on-1 monitoring for his father until a skilled nursing facility bed became available. -She will ensure all resident who fall will be put on a 15 minute checks automatically. -She would ensure all staff are trained on a new fall policy created and printed on 11/25/15. -She did not have a limit to the number of falls for any resident which would initiate a reassessment as to whether the facility could provide proper supervision of each resident. -She was only following what the doctor ordered. -She did not know that the same doctor for both Resident #1 and Resident #2 had insisted on a minimum of 15 minute checks. -She did not know that the same doctor for both Resident #1 and Resident #2 had insisted on skilled nursing facilities for both residents.	D 270		

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D 270	Continued From page 16 -The doctor never told her anything about more frequent checks. -The previous RCC (Resident Care Coordinator) was fired at the end of October 2015. PLAN OF PROTECTION: The facility provided a Plan of Protection on 11/25/15 as follows: -1st and 2nd shift stand up staff meeting scheduled for 11/26/15will address fall prevention guidelines, -A new 15-minute check policy after a resident experiences a fall. -All residents will immediately be reassessed for new fall risk protocols. -The Executive Director and the facility's RN will lead this process and reassess each resident's care plan to assure the care plan is accurate. -Immediate search for placement for a skilled nursing facility for Resident #1 and Resident #2 will begin and their families notified. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2015.	D 270	Executive Director will check daily for the Dietary Daily Cleaning Sheet has been completed the previous day, and items have been cleaned. Executive Director will check Maintenance Daily and Monthly Check and Cleaning Sheets to assure items are being completed by Maintenance and Dietary Staff. Executive Director will report items in writing to Management Team to assure they are aware of items need replaced. And assure these items are fixed within reasonable time frame. Quality Assurance will meet on these items quarterly or more as needed.	12/16/15 12/16/15 12/16/15 12/16/15
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.	D 282		

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D 282	Continued From page 17 This Rule is not met as evidenced by: Observation of the kitchen floor on 11/24/15 at 10:30 a.m. revealed the floor was dirty with food particles in multiple areas including around the food preparation station, stove, entry/exit doors, food storage rack and under sink areas as well as multiple fruit flies in all areas of the kitchen and pantry. The findings are: Observation of the walk-in pantry located in the kitchen on 11/24/15 at 10:45 a.m. revealed: -There were 2 or more live fruit flies on each plastic storage container on each shelf on both the left and right side of the pantry. -The light switch on the inside of the cooler was 90% covered in a brown sticky substance. -The shelves in the walk-in pantry had white sticky substance on each shelf. -The pantry floor was sticky. -There was an unclosed plastic storage container labeled gelatin which had an open bag with spilled red powder. -The left side of the pantry floor under the bottom shelf had several unidentifiable food particles. -The floor had a 6-inch wide stain along the entrance and to the left inside of the pantry. Observation of the ice machine located in the kitchen at on 11/24/15 at 10:55 a.m. revealed: -The ice machine had frosting-like substance on the inside lid. -The ice machine stainless steel exterior was dirty with brown drip marks. -The ice machine had multiple greasy hand prints on the exterior. -The air intake vent had a sticky film covered with dust.	D 282	The Cook and Dietary Aide will completed Daily Cleaning Schedule. The Cook and Dietary Aide will work as a team to assure all daily cleaning is completed. The Cook and Dietary Aide will clean the Pantry containers weekly or more as needed. The Cook and Dietary Aide will report any bug control needed to the Executive Director daily and write down in the Maintenance Log Book. The Dietary Aide will clean the outside of the Ice Machine daily or more as needed. The Dietary Aide or Cook will report any items that needs to be replaced in the kitchen such as seals around Ice Machine, Refrigerators, and freezers.	12/16/15 12/16/15 12/16/15 12/16/15 12/16/15 12/16/15

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D 282	Continued From page 18 -The air filter was clogged with brown dust. -The seal around the ice machine door was uniformly cracked and dry. Observation of kitchen plumbing and floor drain below the dishwasher on 11/24/15 at 11:00 a.m. revealed: -Multiple fruit flies were hovering around the drain and drain pipe. -The floor was dirty. -The cracked plastic drain grate had a black tar-like substance around each grate opening. Observation of the stove located in the kitchen on 11/24/15 at 11:10 a.m. revealed: -Each of the 4 round gas burners were covered in a ring of multi-colored food particles approximately 1/4-inch in depth. -Each burner grate was covered in a thick black tar-like grease. -The left and right side of the stove was uniformly covered with a brownish sticky substance. Observation of the reach-in cooler located in the kitchen on 11/24/15 at 11:15 a.m. revealed: -The bottom of the cooler had multi-colored pools of frozen liquid. -There was a sealed tube-shaped package of hamburger meat with liquid drippings on the outer packaging from the meat stored directly above. -The ventilation intake grate at the base of the cooler was covered in dried white liquid spatter. -There was a note on the cooler from the facility's director dated 9/28/15 with directions on proper storage of food. Observation of the kitchen door on 11/24/25 at 11:25 a.m. revealed: -There was daily a cleaning schedule for each area of the kitchen.	D 282	The Maintenance Person will check daily for any items that may need to be fixed and/or Bug control. 12/16/15 A Procedure will be developed Weekly Check by Maintenance and cleaned as need: 12/21/15 1- Kitchen Appliances such as seals, 2- Bugs, 3- Stove Burners and Grates and 4- Floor Drains 5- Dry Storage Shelving. A Procedure will be developed for Monthly Maintenance to clean: 12/21/15 1- Ice Machine, 2- Dry Storage Shelving 3- Can Rack 4- Floor Drains 5- Stove Burners & Grates 6- Pest Control	

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D 282	Continued From page 19 -The schedule had a blank space for the name of each person responsible for cleaning each day to be designated by the Administrator. -The schedule was blank for designating a staff name responsible for cleaning on each day. -The schedule listed responsibilities including wiping down of containers, cleaning floors and wiping down appliances. -There were no previous daily schedules available for review. Interview with a dietary aide on 11/24/25 at 11:30 a.m. revealed: -The schedule was not filled out for this week by the Administrator. -Kitchen staff were supposed to mop floors and walls after each meal. -Surface areas were to be wiped down every shift. -The walk-in cooler racks did not have a cleaning schedule. -The dietary aide did not inform the Administrator of the need for kitchen's deep cleaning need. Interview with the maintenance man on 11/24/25 at 1:30 p.m. revealed: -He was aware of the floor stain around the walk-in cooler. -He was unable to clean the white stained floor areas after several attempts. -He was unaware the ice-machine needed cleaning and maintenance. -He was unaware the ice machine seal needed replacement. -He was aware of the fruit flies around the floor drains and walk-in pantry. -He had recently unsuccessfully attempted to get rid the fruit fly problem. -No policy existed for the scheduled maintenance of kitchen appliances.	D 282		

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D 282	Continued From page 20 -No policy existed for the deep cleaning of kitchen and pantry areas. -Dietary staff should report to him when things needed to be repaired in the kitchen. Interview with the Administrator on 11/24/25 at 1:30 p.m. revealed: -The kitchen should be cleaned regularly after each meal including floors and walls. -She was aware of the need for staff adherence to the cleaning schedule in the kitchen. -She was aware of the inconsistency of the floor and wall cleanliness in the kitchen. -She would address the fruit fly problem in the kitchen. -She was going to address the kitchen cleanliness issues.	D 282		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure resident rights were maintained to appropiate care and services. The findings are: Based on observations, interviews and record reviews, the facility failed to provide increased supervision in accordance with each resident's	D912	The facility will assure the Resident's Right to receive care and services which are appropriate, adequate to the individual needs as indicated through their care plan and symptoms with supervision in which they deserve will be met. Increase Communication between the Nursing Assistances, Supervisors in Charge, Resident Care Coordinator, Executive Director, Administrator, Physician, and LHPS to help increase supervision of Residents with falls and/or incidents.	12/16/15 12/16/15

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D912	Continued From page 21 assessed needs, care plan, and current symptoms for 2 of 5 sampled residents (#1, #2) with multiple falls, including falls with injuries requiring Emergency Medical Services.	D912		