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
	HAL054064	A. BUILDING: _____ B. WING _____	R 12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 and follow-up survey on December 1-4, 2015.	D 000		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review, and interview, the facility failed to assure residents had access to a call bell or signaling device within reach for 2 of 3 residents (#1, #4) who were bedridden. The findings are: 1. Review of Resident #1's current FL2 dated 07/16/15 revealed diagnosis of Dementia, Pressure Wounds to Bilateral Feet, Atrial Fibrillation, Diabetes, Peripheral Vascular Disease, Alcoholism, and Hypopotassemia. Observation of Resident #1 on 12/01/15 at 11:40 AM revealed: -The resident was in a hospital bed. -The call light system in the room was on the wall 6-8 feet from the resident's bed. -There was no other form of singnaling device in the resident's room.	D 119	Hand bells have been purchased for any resident who ad unable to reach the signaling device. The administrator would monitor and ensure all staff have been inserviced to answer call lights promptly RCC and staff would check and make sure during rounds every 2 hrs call light are within reach QA would be done by Administrator / RCC to ensure that bells are within reach and staff are monitoring every month	12/11/15

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kulwant Garcha 6899 | TITLE: Administrator | (X6) DATE: 1/14/16

Reviewed and accepted 2/4/16 KS

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D 119	Continued From page 1 Interview with Resident #1 on 12/01/15 at 3:40 PM revealed: -He did not have a call bell. -There was a call bell on the wall but he could not reach the button. -He could not get out of his hospital bed without assistance. -He would holler out for the staff but they did not always respond when he called out. -Sometimes staff would come immediately and sometimes it might take an hour or two. Interview with the Resident Care Coordinator (RCC) on 12/01/15 at 3:45 PM revealed: -Resident #1 had the call system on the wall in his room. -Resident #1 did not have a call bell at the bedside. -Resident #1 was bedbound and could not get up without assistance. -Resident #1 could yell out if he needed help with anything and staff would always go and help him. Observation of Resident #1 on 12/02/15 revealed Resident #1 had a small call bell in his room on his bedside table. Observation of Resident #1 on 12/03/15 at 1:19 PM revealed: -The resident had a small bell on his bedside table. -The resident was ringing the call bell. Refer to telephone interview with the Administrator on 12/04/15 15 10:50 AM. 2. Observation of Resident #4 on 12/04/15 at 10:18 AM revealed: -The resident was in a hospital bed. -The call light system in the room was on the wall	D 119		

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D 119	Continued From page 2 12-14 feet away from the resident's bed. -There was no other form of call bell in the resident's room. Interview with Resident #4 on 12/04/15 at 10:18 AM revealed: -The resident required assistance to get in and out of the bed. -The resident did not have a call bell that she could reach. -The resident just hollered out for staff when she needed something. Interview with a Medication Aide on 12/04/15 at 10:25 AM revealed: -Resident #4 can only get in and out of the bed with assistance from staff. -The resident did have a call bell at her bedside. -The Mediation Aide was not sure what happened to the resident's call bell. Interview with a Personal Care Aide on 12/04/15 at 10:28AM revealed: -Resident #4 could only get in and out of bed with assistance from staff. -The staff rounded on the Resident every 30 minutes. -The resident would holler out when she needed something and staff would respond. Interview with the Resident Care Coordinator on 12/04/15 at 10:35 AM revealed: -Resident #4 should have a call bell in her room at the bedside. -The staff were to round on the residents every 2 hours. Refer to telephone interview with the Administrator on 12/04/15 15 10:50 AM.	D 119		

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D 119	Continued From page 3 Telephone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -The residents who were bed bound should have a call bell at the bedside. -The staff were to respond immediately to a call bell. -Staff should be right down the hall to respond to residents who were bed bound. -The staff should be rounding on the residents every 2 hours. _____ A Plan of Protection was requested from the facility on 12/21/15. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 18, 2016.	D 119		
D 163	10A NCAC 13F .0504(c) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 163	Administrator had a conference call and also meet with Home Health Agency/staff to ensure that staff of the assistry living facility would not perform/Rx debridement wound on resident without competency validated, and it would be Agency policy to ensure resident's Rx would be done by the Home	

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D 163	Continued From page 4 Based on observations, interviews, and record review, the facility failed to ensure staff were competency validated to apply a debriding agent to wounds on 2 of 2 sampled residents (#1, #2). The findings are: 1. Review of Resident #2's current FL-2 dated 7/08/15 revealed the resident's diagnoses included dementia, diabetes type II, anemia, and colon cancer. Review of the physician's orders dated 10/12/15 and 11/16/15 for Resident #2 revealed: - The resident had a pressure ulcer on the right lower buttock and left buttock. -The physician's orders specified for facility staff to continue dressing changes weekly or as needed. -The orders were to cleanse with normal saline solution, apply iodosorb gel dressing cover with foam, change twice a day (a.m. and p.m); and, to continue preventive skin care measures. -The physician was to be notified of any changes or concerns regarding the resident's wound care status. Interview with the Resident Care Coordinator (RCC) and Administrator on 12/02/15 at 3:56 p.m. revealed: -The RCC and two other staff provide wound care to Resident #2 weekly and/or as needed. -Three staff, including the RCC, were trained by the Home Health Nurse on how to provide wound care to the resident. -When there is a change in physician's orders for wound care, the Wound Care Nurse keeps facility staff informed of any changes made in providing wound care. -The Administrator and the RCC were not aware	D 163	Health Nurse on Scheduled dates per Physician orders. RCC & Medication Aids would be trained and competency validated to perform only dressing change per physician orders by 12/12/15 Home Health Agency Home Health Nurse would be responsible for informing RCC/Administrator of any changes to resident wound or treatment. Administrator/RCC would ensure all Med Tech are trained and competency validated	12/12/15

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D 163	Continued From page 5 that staff, including the RCC, were not following the physician's order for wound care as specified. -The Administrator would follow-up with the home health nurse's agency to have staff retrained on the physician's orders for wound care as written. Interview with the Medication Aide Supervisor (MAS) on 12/03/15 at 9:29 a.m. revealed: -When wound care is provided to Resident #2, she cleaned the area with normal saline and applied a patch to the wound. -The MAS has been using "Island dressing" (a nonstick pad with border tape) for about one week and that prior to that she used gauze and tape to treat the resident's wound. -The MAS has never used foam on the resident's wound and the facility does not have foam dressing -The resident's left buttock wound is completely healed and the ulcer on the right buttock is steadily healing. -The MAS was trained by the wound care nurse. -The physician's orders dated 11/16/15 specified foam use and not "Island dressing" in providing wound care to the resident. (Is this what the MAS said?) Interview with the Wound Care Nurse on 12/03/15 at 11:20 a.m. revealed: -The facility staff are trained according to the physician's orders as specified for wound care for Resident #2. -Staff were trained by demonstration and feedback to ensure understanding of wound care to be provided. -The staff are consistently trained by herself in regards to wound care procedures, care, and treatment. -The resident's wound areas are healing.	D 163	to perform wound dressing change to resident by 12/12/15	12/14/15

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D 163	Continued From page 6 Interview with Medication Aide (MA) on 12/03/15 at 3:30 p.m. revealed: -The MA did not apply foam to Resident #2's wounds when performing wound care but the "Island dressing" (nonstick pad with border tape) was applied. -The MA received training for wound care from the MAS and wound care nurse. Observation of the Home Health Nurse on 12/04/15 at 2:35 PM revealed: -The nurse cleaned Resident #2's wound with normal saline. -The nurse then applied Iodosorb Gel to the wound. -The Nurse placed an Island Dressing on top of the wound, instead of the foam dressing that was ordered. 2. Review of Resident #1's current FL2 dated 07/16/15 revealed: -Diagnoses included Dementia, Pressure Wounds to Bilateral Feet, Atrial Fibrillation, Diabetes, Peripheral Vascular Disease, Alcoholism, and Hypopotassemia. -There was an order for wound care to the right foot and left heel/foot. -Clean both wounds with normal saline, then apply Iodosorb Gel, then cover with foam. -Wound care to be done every 2 days and as needed (PRN). Review of the resident register for Resident #1 dated 06/11/15 revealed the resident was admitted on 06/08/15. Review of Resident #1's Medication Administration Record (MAR) dated 10/01/15 through 10/31/15 revealed: -There was an entry to clean left foot with normal	D 163	Administrator would ensure all med-Tech and RCC would be trained and competency Validated to perform wound dressing on resident as of 12/14/15 Administrator would ensure Home Health Nurse would inform RCC/staff regarding any changes in resident would care and RCC would ensure staff performing dressing changes are competency validated to perform the treatment ~~treatment~~ of the would all resident would be checked by RCC/Administrator every 2 weeks for changes in treatment	12/14/15

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D 163	Continued From page 7 saline, then apply Santyl ointment, then cover with dressing daily. -There was an entry to clean right foot with normal saline, then apply Iodosorb Gel, then cover with foam and secure with kerlex and change every 2 days and as needed (PRN). Review of Resident #1's Medication Administration Record (MAR) dated 11/01/15 through 11/30/15 revealed: -There was an entry to clean left foot with normal saline, then apply Santyl ointment, then cover with dressing daily. -There was an entry to clean right foot with normal saline, then apply Iodosorb Gel, then cover with foam and secure with kerlex and change every 2 days and as needed (PRN). Review of Resident #1's physician's orders revealed: -There were subsequent orders for wound care dated for 11/09/15. -The orders were to clean both right and left foot wounds with normal saline, then apply Iodosorb Gel, then apply foam, and secure with kerlex and tape. -The orders were for the home health nurse to do 3 times per week and the facility staff to do on all other days. Observation of Resident #1's wound care on 12/01/15 at 4:20 PM revealed: -The Medication Aide (MA) cleaned both wounds on Resident #1's feet with normal saline. -The MA applied Iodosorb Gel to both foot wounds. -The MA attempted to apply Calcium Alginate with Silver (an antimicrobrial barrier to penetrate heavy microbrial drainage).	D 163	and orders by Home Health Nurse and also wound Doctor by 12/14/15	

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D 163	Continued From page 8 Interview with Medication Aide (MA) on 12/01/15 at 4:20 PM after reviewing the physicians orders revealed: -There was no orders to put on the Calcium Alginate with Silver. -The Home Health Nurse had told her it was ok to use the Calcium Alginate with Silver for drainage. -The MA did not have orders to apply the Calcium Alginate with Silver. Phone interview with Home Health Nurse on 12/01/15 at 3:20 PM revealed: - There were orders to provide Resident #1 with wound care to both foot wounds daily. -There were orders to clean the left foot with normal saline, then apply Santyl, then cover with foam, then wrap with kerlex and secure with tape. -There were orders to clean the right foot with normal saline, then apply Iodosorb Gel, then cover with foam, then wrap with kerlex and secure with tape. -The Nurse felt somedays the wound care was not being done. -The Nurse would come in to do the wound care and the same bandage that she had done on her last visit would still be on the Resident. Interview with a Mediation Aide (MA) on 12/01/15 at 3:28 PM revealed: -The orders were for the wound care to be done daily on both left and right foot wounds. -The MA's were to do the wound care on Tuesday, Thursday, Saturday, and Sunday. -The Home Health nurse comes on Monday, Wednesday, and Friday to perform the wound care. Phone interview with a Nursing Assistant at Wound Doctors Office on 12/01/15 at 3:56 PM revealed:	D 163		

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D 163	Continued From page 9 -Both foot wounds were to be cleaned with normal saline, then apply Iodosorb Gel, then cover with foam, then wrap with kerlex and secure with tape. -Wound care was to be done every 2 days and as needed (PRN). -The Home Health Nurse was to perform the wound care 3 times per week. -The staff at the facility was to do the wound care on the days the Home Health Nurse was not there. -Resident #1 has a follow up appointment with the wound care doctor on 12/04/15. Interview with Home Health Nurse on 12/02/15 at 3:45 AM revealed: -The Nurse did not do the initial teaching with the staff at the facility. -The resident use to have a different Home Health Nurse coming to see him. -The Nurse would update and train the Medication Aides when there was a change in orders. Interview with Resident Care Coordinator (RCC) on 12/02/15 at 4:00PM revealed: -Resident #1's wound care was usually done on 1st or 2nd shift. -The RCC had done Resident #1's wound care. -A different Home Health Nurse taught her how to do the wound care not the one seeing the Resident now. -The Nurse was going over the wound care changes with the staff performing the wound care. -The Licensed Health Professional Support (LHPS) Nurse had not assessed the skills of any of the staff at the facility in performing wound care for Resident #1.	D 163	The Administrator ensured that the LHPS have been competency checked and validated to perform resident dressing and wound care as of 12/14/15	12/14/15

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D 163	Continued From page 10 Interview with another Medication Aide (MA) on 12/03/15 at 8:00 AM revealed: -Another MA had trained her to do wound care on Resident #1 and Resident #2. -The Licensed Health Professional Support (LHPS) Nurse had not assessed her skills to perform wound care for Resident #1. -The MA had not received any training on wound care from the LHPS Nurse. A second interview with the first Medication Aide (MA) on 12/03/15 at 9:16 AM revealed: -The Licensed Health Professional Support (LHPS) Nurse had not trained her to perform wound care for Resident #1 or Resident #2. -The Home Health Nurse had only trained her the when the wound care first started. -The Home Health Nurse does tell her about changes in wound care. -The Home Health Nurse does not teach and instruct how to perform new wound care. -The MA did train some of the other MA's to perform the wound care so they could do it on her days off. Phone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -When a Resident has wound care, they get a Home Health Nurse to come in and provide wound care. -The Home Health Nurse was also to train the staff on how to do the wound care. -The staff only get trained if the wound care can be done within their scope of practice. -Using any type of debridement agent was out of the scope of practice for the Medication Aides. -The Administrator was not aware that her staff were using the debriding agent. -The Administrator thought they were only cleaning and putting a dry dressing on the	D 163	In order for resident's medication to be received to meet the acute health needs of resident. RCC would ensure resident's Orders are clarified by MD. Facility policy would ensure all resident's meds are reviewed promptly by MD, including new orders. Resident's meds have been review by MD. Received medicaid card and appointment has been made to have his treatment and meds clarified by RCC would ensure every resident would receive their medication in a timely manner and clarify with Resident's medical Director regarding any changes	12/14/15

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D 163	Continued From page 11 wounds. -The Home Health Nurse should have been the only one using the debriding agent. -The staff had not been made aware they could not use debriding agents. _____ The facility submitted a Plan of Protection dated 12/4/15: -Immediately, Resident Care Coordinator will make sure staff are checked by a Licensed Health Professional Support (LHPS) to make sure staff can complete task before working with the resident. -The Resident Care Coordinator will audit files every month to make sure staff have documentation of the LHPS tasks on file. An addendum to the Plan of Protection was received on 12/11/15 as follows: -If a resident had a task for wound care, the physician will write the order and specifiy the task staff can perform. -If staff is not trained on the task, the home health nurse will perfom the task until staff was trained. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 3, 2016.	D 163	Facility ~~Administrator~~ RCC/ ensure that Medication Aides have been competency validated to perform dressing for the residents. Resident care Coordinator will audit files every month to make sure staff have documentation of LHPS task on file Home Health Nurse would perform task as ordered by ~~Physician~~ and RCC/ Medication would only perform task after competency validation 12/14/15	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273	Administrator / RCC would ensure resident to medicaid card would be followed up in a timely order	

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D 273	Continued From page 12 TYPE A2 VIOLATION Based on observation, interview and record review, the facility failed to notify the physician for 3 of 3 residents sampled regarding a resident not having morphine and oxycodone on hand for pain (#1), elevated systolic blood pressures (#2) and low blood sugars (#3). The findings are: 1. Review of Resident #1's current FL2 dated 07/16/15 revealed: -Diagnoses included Dementia, Pressure Wounds to Bilateral Feet, Atrial Fibrillation, Diabetes, Peripheral Vascular Disease, Alcoholism, and Hypopotassemia. -There was an order for Morphine Sulfate Immediate Release (IR) 30 milligrams to be given every 8 hours as needed. (Morphine is given for moderate to severe pain) Review of the resident register for Resident #1 dated 06/11/15 revealed the resident was admitted on 06/08/15. A. Review of Resident #1's record revealed a subsequent order dated on 08/11/15 for Morphine Sulfate 30 milligrams was to be given twice a day scheduled. Observation of Resident #1's medications on hand on 12/02/15 revealed there was no Morphine Sulfate 30 milligrams in the facility. Review of Resident #1's Medication Administration Record (MAR) dated 06/22/15 through 06/30/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours	D 273	and report to Administrator immediately if resident runs out of medication. This change in facility policy was effective on 12/14/15	12/14/15

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D 273	Continued From page 13 as needed for pain. -Thirty five doses of his as needed (PRN) Morphine Sulfate IR 30 milligrams had been documented as being administered. Review of Resident #1's Medication Administration Record (MAR) dated 07/01/15 through 07/31/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -Thirty eight doses of his as needed (PRN) Morphine Sulfate IR 30 milligrams had been documented as being administered. Review of Resident #1's Medication Administration Record (MAR) dated 08/01/15 through 08/31/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -Twenty doses of the resident's as needed Morphine Sulfate IR 30 milligrams were given and thirty six scheduled doses were given. Review of physician's orders on 12/02/15 revealed: -There were discharge orders on 08/11/15 for the Resident's Morphine Sulfate 30 milligrams. -There were subsequent orders written on the MAR on 08/13/15 for the Resident to start Morphine Sulfate IR 30 milligrams take 1 tables by mouth twice a day. Record review for Resident #1's on 12/02/15 revealed: -There were physician orders on 08/11/15 for the Resident to start taking Morphine Immediate Release (IR) 30 milligrams by mouth twice per day.	D 273		

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D 273	Continued From page 14 -There were no refills for this medication ordered. Review of Resident #1's Medication Administration Record (MAR) dated 09/01/15 through 09/30/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -The Resident received twenty three scheduled doses of his Morphine Sulfate IR 30 milligrams. Review of Resident #1's Medication Administration Record (MAR) dated 10/01/15 through 10/31/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -There was no documentation the resident had received any doses of his Morphine Sulfate IR 30 milligrams. -Documentation on the back of the MAR indicated "Morphine Sulfate not given not in facility." Review of Resident #1's Medication Administration Record (MAR) dated 11/01/15 through 11/30/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -There was no documentation the resident had received any doses of his Morphine Sulfate IR 30 milligrams. -Documentation on the back of the MAR indicated "Morphine Sulfate not given not in facility." Review of Resident #1's current Medication Administration Record (MAR) for the month of	D 273		

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D 273	Continued From page 15 December on 12/04/15 revealed: -An entry Morphine Sulfate Immediate Release (IR) 30 milligrams take one tablet every 8 hours as needed for pain. -There was no documentation the resident had received any doses of his Morphine Sulfate IR 30 milligrams. -Documentation on the back of the MAR indicated "Morphine Sulfate not given not in facility." Review of Resident #1's Controlled Substance Record revealed: -The Resident had 60 tablets of the Morphine Sulfate Immediate Release (IR) dispensed on 08/13/15. -Sixty of the sixty tablets had been documented as administered to the resident. -The last dose documented as given to the resident was on 10/02/15 at 10 PM. Interview with a Medication Aide (MA) on 12/02/15 at 8:10 AM revealed: -The MA had called in for a refill on the Resident's Morphine Sulfate Immediate Release (IR) 30 milligrams. -The pharmacy told her there were no refills left on the medication. -The MA contacted the primary medical doctor but no refills have been sent in to the pharmacy. -The nurse at the medical doctor's office said the Resident would have to come in for a visit before the prescription could be filled. -The MA made an appointment for the Resident. -The day of the resident's appointment he refused to go to his doctor's appointment. -Another medical doctor appointment had not been made. -The resident has only seen the wound care medical doctor and no other doctors since he has	D 273		

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D 273	Continued From page 16 been in the facility. Interview with Resident #1 on 12/02/15 at 8:30 AM revealed: -The resident did not remember who his primary medical doctor was. -The resident has not refused any doctor's appointments. -A nurse practitioner was coming to see him but he does not remember her name. -Other than his wound care doctor, he has not seen any other doctors in a few months. -The resident currently was experiencing an 8 out of 10 pain at this time. -The resident had asked for pain medication but the medication aide told him that his Morphine Sulfate IR had run out. -The resident had asked for PRN (as needed) pain medications several times but the staff at the facility just ignore him. Interview with the Resident Care Coordinator (RCC) on 12/02/15 at 8:55 AM revealed: -The in house nurse practitioner had been seeing the Resident until last month due to an insurance change. -The RCC contacted a doctor in town to get the resident an appointment. -The RCC had an appointment scheduled for the resident on 10/22/15 at 9:15 AM with a doctor in town. -The doctors office had said they would not see the Resident until he had a Medicaid card. -The RCC had spoken with the social worker at the local county social services. -The social worker said that his card had already been sent and the facility should have the card by now. -The RCC had some documentation where she had contacted the social worker.	D 273		

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D 273	Continued From page 17 -The resident has not had his Medicaid care since he has been here. Review of the Resident Care Coordinators (RCC) documentation on 12/02/15 revealed: -The RCC had documented she had contacted the County department of social services several times in August from 08/03/15 to 08/06/15 in regards to the resdident's insurance card. -The RCC had documented the social worker had told her the card had been sent out to the facility. -The RCC had documented the last time she had called the social worker was on 10/02/15 and left a message for the social worker to call her back. Phone interview with the Nurse Practitioner (NP) on 12/02/15 at 9:15 AM revealed: -The NP was no longer seeing Resident #1 due to an insurance change. -The NP had only seen the resident once or twice and that was after he was placed at the facility. -The facility had not contacted her about any refills on Resident #1 medications. -Resident #1's current FL2 orders are what she wanted the resident to be on, unless there was a different order that she had written in his chart. -The NP could not remember if she had approved any refills for the Morphine Sulfate Immediate Release (IR) since she does not have the resident's chart in front of her. Interview with a Medication Aide (MA) on 12/03/15 at 9:16 AM revealed: -Resident #1 complains about pain all the time. -The only pain medication the resident had was his scheduled Tramadol (used for mild pain). -The staff try to reposition the resident to assist with pain but it does not work. A second phone interview with the Nurse	D 273		

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D 273	Continued From page 18 Practitioner (NP) on 12/03/15 at 12:05 PM revealed: -Resident #1 was on a scheduled dose of Morphine Sulfate Immediate Release (IR) 30 milligrams. - The NP changed the as needed dose to a scheduled dose sometime in August. -The facility contacted the NP to tell her the scheduled Tramadol 200mg ER 1 tablet daily was not working. -If there were no discontinue orders in the chart, then she did not order to discontinue the medication. Phone interview with a Pharmacist on 12/04/15 at 8:45 AM revealed: -The Morphine Sulfate IR 30 milligrams was last dispensed on 08/13/15. -There were 60 tablets dispensed to the facility. -There was no documentation of the facility contacting the pharmacy for a refill. Phone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -The Administrator was aware that Resident #1 did not have some of his medications. -The facility had been having problems with getting Resident #1's medications due to insurance problems. -The facility had been trying to get the Resident's Medicaid card. -The Administrator had paid out of pocket for some of the Resident's medications. -The Administrator could not get the narcotic medications without a prescription from a doctor. -The Medication Aides were to call in the medication as soon as the medication runs out. -The Medication Aides were to contact the primary medical doctor if the resident is out of refills on their prescription.	D 273		

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D 273	Continued From page 19 -The Medication Ades were to document when they had contacted the medical doctor regarding refills or medication that are not in the facility. B. Review of Resident #1's current FL2 dated 07/16/15 revealed there was an order for Oxycodone HCL 10 milligrams by mouth every 6 hours as needed (Oxycodone is used for moderate to severe pain). Observation of Resident #1's medications on hand on 12/02/15 revealed the Resident did not have any of his Oxycodone HCL 10 milligrams in the facility. Review of Resident #1's Medication Administration Record (MAR) dated 06/22/15 through 06/30/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received twnety one doses of his as needed (PRN) Oxycodone HCL 10 milligrams. Review of Resident #1's MAR dated 07/01/15 through 07/31/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received zero doses of his as needed (PRN) Oxycodone HCL 10 milligrams. Review of Resident #1's MAR dated 08/01/15 through 08/31/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received zero doses of his as needed (PRN) Oxycodone HCL 10 milligrams.	D 273		

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D 273	Continued From page 20 Review of Resident #1's MAR dated 10/01/15 through 10/31/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received zero doses of his as needed (PRN) Oxycodone HCL 10 milligrams. Review of Resident #1's MAR dated 11/01/15 through 11/30/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received zero doses of his as needed (PRN) Oxycodone HCL 10 milligrams. Review of Resident #1's MAR dated 12/04/15 revealed: -An entry for Oxycodone HCL Immediate Release (IR) 10 milligrams take one tablet by mouth as needed for pain. -The Resident received zero doses of his as needed (PRN) Oxycodone HCL 10 milligrams. Interview with Medication Aide (MA) on 12/02/15 at 8:10 AM revealed: -The MA said the Resident did not have any Oxycodone HCL Immediate Release (IR) 10 milligrams in the facility. -The MA said the Oxycodone HCL IR 10 milligrams had been discontinued. Refer to Interview with Resident #1 on 12/02/15 at 8:30 AM. Refer to interview with Resident Care Coordinator on 12/02/15 at 8:55 AM. Refer to the interview with Medication Aide on 12/03/15 at 9:16 AM.	D 273		

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D 273	Continued From page 21 Phone interview with the Nurse Practitioner (NP) on 12/03/15 at 12:05 PM revealed: -The NP said that Resident #1 was to be on Oxycodone HCL Immediate Release (IR) 10 milligrams as needed for pain. -The NP said that the order that as on the current FL2 was the order the facility should be following for the Resident's medications. -The NP said if there was not a discontinue order in the Resident's chart then the medication should still be current. Phone interview with a Pharmacist on 12/04/15 at 8:45 AM revealed: -There was a prescription on file for the Oxycodone HCL Immediate Release 10 milligrams. -The Pharmacist said the facility had not requested a refill on this medication. -The Pharmacist said she was not sure if the facility had to call and request a refill or if it was done automatically. Phone interview with a pharmacy employee on 12/04/15 at 8:50 AM revealed: -The pharmacy employee said the medication was never dispensed from there pharmacy because there was never a prescription on file. -The pharmacy employee said the pharmacy did not start working with the facility until the end of July. -The pharmacy employee said the medication still showed on the medication administration records because there was no discontinue order. -The prescription rolled over from the old pharmacy on the Resident ' s medication profile. -The pharmacy employee said the doctor had been contacted to approve the medication profile. - No order for the Oxycodone HCL Immediate	D 273		

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D 273	Continued From page 22 Release (IR) 10 milligrams had been sent to the pharmacy. -The pharmacy employee said he was not sure if the facility had requested a refill on the Oxycodone HCL IR 10 milligrams. -The pharmacy employee said the facility has to contact the pharmacy for any as needed medications to be dispensed. Refer to phone interview with the Administrator on 12/04/15 at 10:50 AM. 2. Review of Resident #2's current FL-2 dated 7/08/15 revealed the resident's diagnosis included dementia, diabetes type II, hyperlipidemia, anemia, stroke, and colon cancer. -The physician's orders dated 2/16/15 and 8/01/15 specified for the doctor to be notified when the resident's systolic blood pressure is over 165 or less than 90 and when the diastolic blood pressure is over 95 or less than 50. -In the months of October and November 2015, according to the facility's blood pressure log, the resident's BP on 10/14/15 was 187/92, 185/81 on 11/22/15, and 171/77 on 11/30/15. -There was no documentation of the doctor being notified of the three elevated systolic BP's. Interview with Medication Aide (MA) on 12/03/15 at 11:00 a.m. revealed: -MA stated that all staff check the resident's vital signs including blood pressures. -MA shared that she was not aware that the doctor was required per orders to be notified when the resident's blood pressures were too high or low as specified. Interview with Medication Aide Supervisor (MAS) on 12/03/15 at 11:15 a.m. revealed: -MAS stated that she checked Resident #2's	D 273	Administrator ensured RCC and medication Aides were re-trained on medication Administration to observe parameters for resident's medication. RCC is to make sure resident's vitals are monitored per M.D request and reported to MD when any unusual changes per MD orders. Medication Aide would monitor daily B/P and report to RCC/MD and elevated B/P Administrator would have monthly QA	

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D 273	Continued From page 23 blood pressures daily before administering his medications. -The MAS stated that she did not notify the doctor because she was unaware that this was required. -The MAS stated that the resident's systolic readings were "the usual" range for the resident and were not elevated, in her opinion, beyond his "usual" range. Interview with the nurse from Resident #2's doctor's office on 12/03/15 at 11:50 a.m. revealed: -The nurse stated that the resident's BP's are to be checked and the doctor notified according to the current orders as specified. -The nurse shared that there was no documentation of their office or the doctor being notified of elevated BP's for the resident. The nurse added that the doctor would have wanted to have been notified of elevated BP's for the resident as specified in the doctor's orders. Interview with a Supervisor on 12/4/15 at 10:00 a.m. revealed if a resident's systolic blood pressure is above 150 the resident's phyisician was supposed to be notified. 3. Review of Resident #3's current FL-2 dated 6/5/15 revealed: -The resident's diagnoses were mild dementia, insulin dependent diabetes mellitus, high blood pressure, end stage renal disease, acute encephalopathy secondary to uremia versus sepsis, schizophrenia with mild mental retardation and seizure disorder. -The resident was intermittently disoriented. -An order to check blood sugars before meals. -There was an order if the blood sugars are less than 80 to contact the resident's primary care physician.	D 273	reports done to monitor any changes in Blood Pressures. 12/21/15 RCC would perform weekly checks of documented B/P to monitor any abnormal ranges by 12/21/15 12/21/15 Administrator would ensure bi-annual medication Aide administration training for RCC/Medication aides as ongoing Quality Assurance 12/21/15	

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D 273	Continued From page 24 Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/30/12. Review of Resident #3's October 2015 Medication Administration Record (MAR) from 10/1-10/31/15 revealed the blood sugar taken on 10/23/15 at 7:30 a.m. was 78 and on 10/28/15 at 7:30 a.m. was 68. Review of Resident #3's November 2015 MAR from 11/1-11/30/15 revealed: -The blood sugar taken on 11/6/15 at 7:30 a.m. was 68. -The blood sugar taken on 11/23/15 at 4:30 p.m. was 66. Review of Resident #4's December 2015 MAR from 12/1-12/2/15 revealed the blood sugar taken on 12/1/15 at 4:30 p.m. was 73. Interview with the Supervisor/Medication Aide (MA) on 12/2/15 at 3:39 p.m. revealed: -She normally worked from 7:00 a.m. to 3:00 p.m. -Resident #3 went to dialysis on Mondays, Wednesdays and Fridays at 9:30 a.m. and returned back to the facility between 3:00 p.m. to 3:30 p.m. -Resident #3 had orders to take blood sugars before meals. -The order included if the blood sugars are less than 80 to call the resident's physician or the physician on call. -They call the physician, give the resident a peanut butter and jelly sandwich and retake the blood sugars. Interview with a second MA on 12/2/15 at 4:45 p.m. revealed:	D 273		

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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 273	Continued From page 25 -She normally worked from 3:00 p.m. to 11:00 p.m. -The order included if the blood sugars are less than 80 to call the resident's physician. -She took Resident #3's blood sugar on 11/6/15 at 7:30 a.m. The blood sugar reading was 68. -She called the physician on call, which may have been the hospital physician. -The physician said since the resident was getting ready to eat breakfast, the resident would be fine. Telephone interview with Resident #3's primary care physician's nurse on 12/3/15 at 10:00 a.m. revealed: -The resident has a current order dated 10/13/15 for fingers stick checks. -The order included if the blood sugars are less than 80 to contact the primary care physician. -There was no documentation the physician was contacted if blood sugars were less than 80. -If the facility called the on call physician, they would not have access to the information. Interview with the RCC on 12/4/15 at 4:46 p.m. revealed: -If Resident #3's blood sugar was less the 80, the resident's primary care physician shold be called. -She did not know if staff had called Resident #3's primary care physician in November 2015 and October 2015 when the resident's blood sugar was less than 80. Telephone interview with the Administrator on 12/04/15 at 10:50 a.m. revealed: -The MA's should contact the Resident's primary care physician if the blood sugars are low. -The MA's were responsible for contacting the doctor for order clarification. -The MA's are responsible for documenting when	D 273	Administrator would ensure bi-annual medication aide Administration training for RCC all Medication aides as ongoing Quality Assurance	12/21/15

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D 273	Continued From page 26 and if they had contacted the doctor or pharmacy for medication changes. Resident #3's Responsible Party could not be reached by the end of the survey. The facility submitted a Plan of Protection dated 12/4/15: -Immediately, the Resident Care Coordinator will make sure staff are documenting blood sugar and blood pressure readings. -The resident's physican will be contacted immediately when staff are unsure about the orders and if there is a concern. An addendum to the Plan of Protection was received on 12/11/15 as follows: -The Resident Care Coordinator will contact the resident's primary care physician for orders on the residents with blood pressure checks and blood sugar checks. -The Resident Cafe Coordinator will make sure all of the mediations are on hand and contact the resident's physician before the medication gets low. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 3, 2016.	D 273	Administrator would implement policy of re-training RCC/Medication Aides on medication Administration RCC/medication Aides to follow facility policy of calling residents physicians documenting and following up with residents regarding B/P checks and blood sugars	12/12/15
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; and	D 276	Policy implemented by Administrator would require RCC to check weekly all MAR to ensure abnormal Blood sugars are reported to MD in immediately and	

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D 276	Continued From page 27 (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, interview and record review, the facility failed to assure implemenation of physician's orders as evidenced by not obtaining fingerstick blood sugars as ordered by the physician for one resident (#1). The findings are: Resident register for Resident #1 dated 06/11/15 revealed the resident was admitted on 06/08/15. Review of Resident #1's current FL2 dated 07/16/15 revealed: - Diagnoses of Dementia, Pressure Wounds to Bilateral Feet, Atrial Fibrillation, Diabetes, Peripheral Vascular Disease, Alcoholism, and Hypopotassemia. –Orders to check Resident #1 ' s finger stick blood sugar (FSBS) with meals and at bedtime (AC/HS) and cover with Novolog sliding scale insulin. Review of Resident #1's July 2015 Medication Administration Record (MAR) revealed: -An entry to check the finger stick blood sugar (FSBS) twice a day and cover with sliding scale Novolog (a fast acting mealtime insulin). -The FSBS was documented as checked at 7:30 AM and 4:30 PM daily. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10 units, 401-450=12 units, greater than 450 give 14 units and call doctor).	D 276	new Changes are documented and pharmacy informed of any changes	12/14/15

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D 276	Continued From page 28 Review of Resident #1's August 2015 Medication Administration Record (MAR) revealed: -An entry to check the finger stick blood sugar (FSBS) twice a day and cover with sliding scale Novolog (a fast acting mealtime insulin). -The FSBS was documented as checked at 7:30 AM and 4:30 PM daily. -An entry to check FSBS three times per day and cover with sliding scale that had a note on it to discontinue order rewritten on 08/31/15. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10 units, 401-450=12 units, greater than 450 give 14 units and call doctor). - Review of Resident #1's September 2015 Medication Administration Record (MAR) revealed: -An entry to check the finger stick blood sugar (FSBS) twice a day and cover with sliding scale Novolog (a fast acting mealtime insulin). -The FSBS was documented as checked at 7:30 AM and 4:30 PM daily. -An entry to check FSBS three times per day and cover with sliding scale that had a note on it to discontinue order rewritten on 08/31/15. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10 units, 401-450=12 units, greater than 450 give 14 units and call doctor). Review of Resident #1's October 2015 Medication Administration Record (MAR) revealed: -An entry to check the finger stick blood sugar (FSBS) twice a day and cover with sliding scale Novolog (a fast acting mealtime insulin).	D 276		

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D 276	Continued From page 29 -The FSBS was documented as checked at 7:30 AM and 4:30 PM daily. -An entry to check FSBS three times per day and cover with sliding scale that had a note on it to discontinue order rewritten on 08/31/15. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10 units, 401-450=12 units, greater than 450 give 14 units and call doctor). - Review of Resident #1's November 2015 Medication Administration Record (MAR) revealed: -An entry to check the finger stick blood sugar (FSBS) twice a day and cover with sliding scale Novolog (a fast acting mealtime insulin). -The FSBS was documented as checked at 7:30 AM and 4:30 PM daily. -An entry to check FSBS three times per day and cover with sliding scale that had a note on it to discontinue order rewritten on 08/31/15. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10 units, 401-450=12 units, greater than 450 give 14 units and call doctor). Review of Resident #1's December 2015 Medication Administration Record (MAR) revealed: -An to check the finger stick blood sugar (FSBS) three times a day and at bedtime and cover with sliding scale Novolog (a fast acting mealtime insulin). -The FSBS was documented as checked at 7:30 AM, 11:30 AM, and 4:30 PM. -The sliding scale insulin was to be administered as follows (0-199=0 units, 200-250=3 units, 251-300=5 units, 301-350=7 units, 351-400=10	D 276		

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D 276	Continued From page 30 units, 401-450=12 units, greater than 450 give 14 units and call doctor). Review of Resident #1's record on 12/02/15 revealed there were no subsequent orders changing the Resident's finger stick blood sugar (FSBS) to twice per day. Telephone interview with the Nurse Practitioner on 12/01/15 at 9:15 AM revealed: -She wanted Resident #1's finger stick blood sugar checked with meals and at bedtime (AC/HS). -There were no discontinue orders that she had signed in the record then the orders should be the same as on the FL2. -She did not remember getting any phone calls from the facility for order clarification or changes to orders. Telephone interview with a Pharmacist on 12/02/15 at 10:50 AM revealed: -The Pharmacist had said she received a phone order from the Nurse Practitioner on 07/28/15. -The phone order was for Resident #1 to get enough test strips to check finger stick blood sugar twice per day. -The Pharmacist had said there were not orders to change sliding scale insulin or frequency of finger stick blood sugar on the medication administration record. Review of the faxed order from the Pharmacist provided on 12/02/15 revealed: -A telephone order taken by the Pharmacist from the Nurse Practitioner. -The order read Accu check Test Strips and check blood sugar (BS) twice per day (BID). Interview with a Medication Aide (MA) on	D 276		

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D 276	Continued From page 31 12/02/15 at 8:10 AM revealed: -Resident #1 was getting his finger stick blood sugar (FSBS) checked twice per day. -She said before breakfast and before dinner. -Resident #1 was getting sliding scale coverage after his FSBS with Novolog Insulin (fast acting meal time insulin). Interview with a second Medication Aide (MA) on 12/03/15 at 8:58 AM revealed: -Resident #1 had always been getting his finger stick blood sugar (FSBS) checked twice a day. -She was covering the resident with sliding scale insulin Novolog (a fast acting meal time insulin) when he got his FSBS checked. -She does not review the orders she only followed what showed up on the medication administration record. Interview with the Resident Care Coordinator (RCC) on 12/03/15 revealed: -Resident #1 had always had his finger stick blood sugar checked twice per day. -The order the facility was using was on the old FL2. -The old order just kept getting transcribed over to the new Medication Administration Records (MAR) each month. -The Medication Aides (MA) responsibility to transcribe the orders from month to month to the new MAR ' s. -A MA from each shift were to review and sign off on the new MAR each month. -She was responsible for reviewing the MAR's before they are used. -She had not been reviewing the MAR's. Interview with the Administrator on 12/04/15 at 10:50 AM revealed: -The Administrator had said the Medication Aides	D 276		

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D 276	Continued From page 32 (MA) were responsible for contacting the doctor for order clarification. -The Administrator had said the MA's are responsible for documenting when and if they had contacted the doctor or pharmacy for medication changes.	D 276		
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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the kitchen's walls, floor, reach-in-cooler, reach-in-freezer, racks and food storage bins and the dining rooms' walls, floor and dining room chairs were cleaned and protected from contamination: The findings are: Observation of the reach-in-cooler, which was located in the kitchen, on 12/1/15 at 11:40 p.m. revealed: -Six racks inside of the cooler had brown and red food stains. -The bottom shelf had brown food stains. -The rubber door seal around both doors had black mold around it. Observation of the reach-in-freezer on 12/1/15 at 11:50 a.m. revealed: -Inside of the freezer, the top two compartments	D 282	Administrator and RCC would ensure Kitchen staff have a schedule that would by signed and dated to ensure cleaning of floors, freezer, racks, food storage bins dinning room flwrs, Chairs are cleaned. Daily checks by RCC at the end of shift and signed by Supervisor in charge to ensure scheduled are done and signed of by SIC/RCC 12/10/15	

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D 282	Continued From page 33	D 282		

had dried white food particles.
-The two bottom compartments had dried white food particles and white and red crumbs around the door seal.
-Two of four side compartment bars dried brown crumbs in the corner.
-Outside of the reach-in-freezer, the vent cover had white dried substance, the top of the freezer were dusty and the metal area above the compartments were greasy and had a dried brown substance.

Further observation in the kitchen on 12/1/15 at 12:11 p.m. revealed:
-The bottom of all four walls near the baseboards had brown dried stains.
-The floor tile under the three compartment sink was broken.
-The tile near the stove had built-up brown stains.

Observation of the storage area, which contained the cooking pans, on 12/1/15 at 11:55 a.m. revealed:
-Four racks contained a dried brown and white substance.
-All four walls had dried brown stains.

Observation of the pantry on 12/1/15 at 12:02 p.m. revealed:
-Thirteen bin lids had dried brown stains.
-All four walls had brown dried stains.

Interview with a Cook on 12/2/15 at 8:02 a.m. revealed:
-She worked four days weekly.
-The walls were cleaned at least once a week.
-Sometimes she cleaned the floor daily.
-The floors in the kitchen needed to get redone.
-The broken tile under the three compartment sink had been broken at least for the past two

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D 282	Continued From page 34 weeks. -The food was removed from the reach-in-cooler and freezer and was cleaned once a month and it was last cleaned 4 days ago. -She cleaned the shelves daily by the end of the shift. -She last cleaned the storage bins four days ago. -She did not realize the racks in the storage area needed to be cleaned. -Dietary staff cleaned the kitchen. There was no assigned person to clean a task in the kitchen. Observation of the floor in the dining room on 12/1/15 at 12:16 p.m. revealed: -A large tiled area by the water fountain was stained brown. -The corners of the floor near the baseboards had dried brown stains. -The bottom of both sides of the entrance door to the dining room had dried red stains. Observation of the dining room on 12/2/15 at 8:21 a.m. revealed: -Fifteen metal chairs in the dining room had chipped paint around the back and the legs of the chairs. -One of two floor vent covers had rust on them. Interview with a Cook on 12/2/15 at 8:42 a.m. revealed: -The Administrator said she would get new chairs. -The chairs paint had been chipped for the past 5 months. -Dietary staff did not clean the floor vents. Interview with the Resident Care Coordinator (RCC) on 12/3/15 at 12:40 p.m. revealed: -She Supervised dietary staff. -As dietary staff cleaned the kitchen, they were supposed to document on the cleaning schedule.	D 282	Administrator have ensured that all tiles in the kitchen have been removed and replaced by Jan 3rd 2016 Scheduled maintenance for the building which had been started for the building since November 2015 have been ongoing after painting of the building and renovations. New dining tables and chairs would be provided for residents by 1/29/16	1/3/16 1/29/16

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D 282	Continued From page 35 -The reach-in-cooler should be wiped down daily. -The reach-in-freezer should be cleaned weekly. -The floors should be cleaned after each meal and as needed. -The tile behind the three compartment sink needed to be repaired. -She was aware the kitchen and dining room needed to be repainted. -One month ago someone was hired to paint and fix repairs in the kitchen and dining room, but the person had not started with painting and repairing the kitchen and dining room. -The storage racks should be cleaned at least weekly and as needed. -The storage bins should be cleaned as needed. It was just cleaned two weeks ago. Interview with the RCC on 12/4/15 at 4:46 p.m. revealed: -She does walk throughs in the kitchen and monitors the cleanliness of the kitchen daily. -She last observed the cleanliness of the kitchen on today (12/4/15). Interview with a Supervisor on 12/4/15 at 10:00 a.m. revealed no residents or family members had complained about the cleanliness in the dining room. Interview with a second Cook on 12/4/15 at 11:46 a.m. revealed: -She worked two days weekly. -The floors, walls, reach-in-cooler and freezer and shelves were cleaned daily. -The shelves were cleaned daily. -The tile behind the three compartment sink had been broken since 2010. -There was a cleaning list, but no one checked off the list. -Someone was supposed to be coming to paint	D 282		

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D 282	Continued From page 36 the walls in the kitchen and dining room. Observation of the "Dietary Cleaning List" posted on the wall in the kitchen on 12/4/15 at 11:46 a.m. revealed: -The cleaning schedule had tasks listed, but had not been checked off by staff. -Floors should be mopped daily. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -The RCC was over dietary staff. -The RCC should check the dietary staff weekly to make sure staff were cleaning the kitchen. -She checked the cleanliness of the kitchen twice weekly. -She last checked the cleanliness of the kitchen on 12/2/15. -The walls should be cleaned as needed. -The floors should be cleaned at the end of each shift. -She was thinking about getting the floor tiles replaced in the kitchen. The floor will be repaired by "the end of the year." -The reach-in-cooler and freezer should be cleaned at least weekly. -The shelves should be cleaned at least weekly. -The storage bins should be cleaned at least monthly.	D 282	New Policy by facility would ensure dietary staff cleaning schedule to be listed and signed by dietary staff on days worked RCC/SIC will sign at the end of the shift to inspect and ensure it has been done. This above change has been implemented by 12/30/15 Administrator would perform QA audit every month to ensure compliance with change	12/30/15
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	D 296	RCC would ensure residents diet have been clarified to Therapeutic menus and follow guide according to	

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D 296	Continued From page 37 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure matching therapeutic menus for food service guidance for 2 of 3 sampled residents with physician orders for low salt, 1800 American Diabetic Association (ADA), No Concentrated Sweets (NCS) and No Added Salt (NAS) diets (Resident #1, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 7/16/15 revealed: -The resident's diagnoses included dementia, pressure wounds to bilateral feet, atrial fibrillation, diabetes, peripheral vascular disease. -An order for the Low Salt 1800 ADA diet. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 6/8/15. Review of Resident #1's record revealed there was no subsequent diet orders. Review of the diet list posted on the board in the kitchen revealed Resident #1 was on a LCS/Low Fat/Low Salt diet. Review of the diet list provided by the Resident Care Coordinator (RCC) revealed Resident #1 was on a NCS Low Fat Low Salt diet. Interview with the Cook on 12/1/15 at 11:26 a.m. revealed: -She did not add salt to the food while cooking. -The NCS diets were prepared the same way as the Regular diet, but it did not have any sugars in the beverages.	D 296	Physician order. RCC would call dietician to get order clarification of resident as ordered by physician to ensure resident gets appropriate diet recommendation. All diet orders have been clarified and appropriate diet changes done by 12/14/15 Dietary staff have been inserviced to provide appropriate diet orders for residents by 12/14/15	12/14/15 12/14/15

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D 296	Continued From page 38 Interview with the Cook on 12/2/15 at 8:02 a.m. revealed the diet list she had posted on the board was the list she followed. Interview with the Cook on 12/2/15 at 12:57 p.m. revealed she modified the menu at a glance when preparing meals for therapeutic diets. Review of "Week 5" Day 4 Breakfast NAS diet menu revealed the residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of syrup, 1 cup coffee/tea, 1 cup skim milk and 1 cup water. Review of "Week 5" Day 4 Breakfast "NCS/1800" menu revealed the residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of sugar free syrup, 1 cup sugar free coffee/tea, 1 cup skim milk and 1 cup water. Observation of Resident #1 during the breakfast meal on 12/2/15 at 8:45 a.m. revealed: -The resident was eating the meal in the room. -The resident was served 1 sausage pattie, 1 french toast, 1 cup of milk, 1 cup of water, syrup. Observation on 12/2/15 at 8:55 a.m. revealed Resident #1 had eaten all of the meal, had drank all of the milk and drank ¾ cup of the water. Telephone interview with Resident #1's Nurse Practitioner on 12/2/15 at 9:15 a.m. revealed whatever diet was on the resident's FL-2 (Low Salt 1800 ADA diet) was the diet the resident should be on. Interview with a second Cook on 12/4/15 at 11:46 a.m. revealed:	D 296		

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D 296	Continued From page 39 -Resident #1 was on a LCS/Low Fat/Low Salt diet. -Residents on the low fat diet did not receive fried foods. -Diabetics received a plain dessert with no frosting, fruit or sherbet ice cream. Interview with the RCC on 12/4/15 at 2:40 p.m. revealed: -When preparing the 1800 ADA diet menu staff were to follow the NCS menu. -The facility did not have a Low Salt 1800 ADA diet menu. -The facility did not have a low fat diet menu. -She was not aware there had to be a combination diet menu for every combination diet order. Observation on 12/4/15 at 11:46 a.m. revealed: -The RCC pulled out a 2015-2016 menu book from the contracted food service company. -A low fat low cholesterol menu was in the menu book. Interview with the RCC on 12/4/15 at 11:46 a.m. revealed she was not aware of the low fat low cholesterol menu in the menu book. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -For Residents on the NCS diet there was no sugar in desserts. -If Resident #1 is on a low concentrated sweets/low fat low cholesterol diet, staff should have gotten the order clarified from the resident's physician. -The facility did not have a low fat diet menu. -She was not aware there was a low fat diet menu in the 2015-2016 food service menu book. -She was not aware she needed a combination	D 296		

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D 296	Continued From page 40 menu for every combination diet. -The only combination menu the facility had was the "NCS/1800" menu. Review of Resident #1's record revealed the resident was the resident's Responsible Party. 2. Review of Resident #3's current FL-2 dated 6/5/15 revealed: -The resident's diagnoses were mild dementia, insulin dependent diabetes mellitus, high blood pressure, end stage renal disease, acute encephalopathy secondary to uremia versus sepsis, schizophrenia with mild mental retardation and seizure disorder. -The resident was intermittently disoriented. -A physician's order for a No Concentrated Sweets (NCS)/No Added Salts (NAS) diet, 1200 milliliter (ml) fluid restriction, Ensure plus vanilla drink 240 ml at bedtime. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/30/12. Review of Resident #3's record revealed: -A current diet order dated 9/29/15 which included a NCS/NAS diet, 1200 ml fluid restriction plus ensure plus. -A "standing order" from dialysis dated 10/25/15 revealed to "provide patient with double portions at meal times." -A "standing order" signed by the Registered Dietitian at the dialysis clinic dated 12/1/15 to provide double portions of meat and eggs at each meal time. Review of the diet list posted on the board in the kitchen and the diet list provided from the RCC revealed Resident #3 was to receive a NCS/NAS	D 296		

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D 296	Continued From page 41 diet. Interview with the Cook on 12/1/15 at 11:26 a.m. revealed: -She did not add salt to the food while cooking. -The NCS diets was prepared the same way as the Regular diet, but it did not have any sugars in the beverages. Interview with the Cook on 12/2/15 at 8:02 a.m. revealed the diet list she had posted on the board was the list she followed. Interview with the Cook on 12/2/15 at 12:57 p.m. revealed she modified the menu at a glance when preparing meals for therapeutic diets. Interview with Resident #3 on 12/3/15 at 9:11 a.m. revealed: -The food could taste better. -The resident went to dialysis. -The resident did not get enough to eat. -The resident did not know if the resident was on a special diet. -"I am supposed to get double portions, but I don't. " Review of "Week 5" Day 4 Breakfast NAS diet menu revealed the residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of syrup, 1 cup coffee/tea, 1 cup skim milk and 1 cup water. Review of "Week 5" Day 4 Breakfast " NCS/1800 menu revealed residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of sugar free syrup, 1 cup sugar free coffee/tea, 1 cup skim milk and 1 cup water.	D 296		

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D 296	Continued From page 42 Observation of Resident #3 during the breakfast meal on 12/2/15 at 8:30 a.m. revealed: -The resident was eating the meal in the dining room. -The resident was served 1 sausage pattie, 1 french toast, ¾ cup of milk, syrup. -The resident was not served double portions of meat. Observation on 12/2/15 at 8:36 a.m. revealed Resident #3 had eaten 100 percent of the meal and drank all of the milk. Review of "Week 5" Day 5 lunch NAS diet menu revealed the residents were to receive 3 ounces baked chicken, ½ cup rice, ½ cup Brussel sprouts, 1 slice bread, 1 pack of margarine, 4 ounces of low fat ice cream, 1 cup cold beverage of choice and 1 cup water. Review of "Week 5" Day 4 breakfast "NCS/1800" menu revealed the residents were to receive 3 ounces baked chicken, ½ cup rice, ½ cup Brussel sprouts, 1 slice bread, 1 pack of margarine, 4 ounces of low fat ice cream, 1 cup cold sugar free beverage of choice and 1 cup water. Observation of Resident #3 during the lunch meal on 12/3/15 at 12:24 p.m. revealed: -The resident was served ½ cup greens, 1 slice bread, 1 chicken leg, ½ cup mashed potatoes and ½ cup manderine oranges. -The resident was not served double portions of meat. Observation on 12/3/15 at 12:35 p.m. revealed: -Resident #3 had eaten ¾ of the greens, ate ¼ of the bread and drank all of the milk. -The resident had gotten up from the table and staff was walking the resident back to the room.	D 296		

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D 296	Continued From page 43 Interview with Resident #3 on 12/3/15 at 12:35 p.m. revealed: -The resident did like what was served for the meal. -The resident did not want to try to eat anything else. Interview with a Supervisor on 12/3/15 at 12:24 p.m. revealed Resident #3 had not been served double meats, because they were waiting to get the order signed by the provider. Interview with a second Cook on 12/4/15 at 11:46 a.m. revealed diabetics received a plain dessert with no frosting, fruit or sherbert ice cream. Telephone interview with Resident #3's primary care physician's Nurse on 12/3/15 at 10:00 a.m. revealed: -She did not see a diet order for the resident. -The resident should be on a diabetic diet. -Staff should follow the orders from dialysis in reference to the resident's diet. Telephone interview with a Nurse at the dialysis clinic on 12/3/15 at 10:24 a.m. revealed: -She was not sure what diet Resident #3 was currently on. -The facility's Renal Dietitian had information about Resident #3's diet. Telephone interview with the Renal Dietitian from the local dialysis clinic on 12/3/15 at 2:32 p.m. revealed: -On 10/28/15, she made a recommendation for Resident #3 to have double portions of meat, because of the resident's low protein levels. -On 12/1/15, she made a recommendation for double portion with meats and eggs and to follow	D 296		

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D 296	Continued From page 44 a NAS/NCS diet. -She rewrote the recommendation on 12/1/15 for double portions of meat and eggs, because Resident #3 had complained of not receiving the double portions with meals. Review of Resident of Resident #3's record revealed there was no protein or albumin labs in the record. Interview with the RCC on 12/4/15 at 2:40 p.m. revealed: -When preparing the NAS diet, salt is not added to the meal. -NAS/NCS staff prepare like a diabetic diet, but do not add salt. -The facility did not have a NCS/NAS menu. -The facility did not have a low fat diet menu. -She was not aware there had to be a NCS/NCS diet menu. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -For Residents on the NCS diet there was no sugar in desserts. -Resident #3 was on a NCS/NAS diet. Staff were to follow the NCS and NAS menu when preparing the meal. -She was not aware she needed a combination menu for every combination diet. -The only combination menu the facility had was the "NCS/1800" menu. Resident #3's Responsible Party could not be reached by the end of the survey.	D 296		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service	D 306		

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D 306	Continued From page 45 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure residents were served/offered water and another beverage during the lunch meal. The findings are: Review of the "Week 5" Regular Diet Menu revealed: -For Breakfast on Day 3 residents were to receive coffee or tea, milk and water. -For lunch on Day 3 residents were to receive a cold beverage of choice and water. -For lunch on Day 4 residents were to receive a cold beverage of choice and water. Observation of the breakfast meal in the dining room on 12/2/15 at 8:30 a.m. and the lunch meal on 12/2/15 at 12:40 p.m. revealed all of the residents served in the dining room received water and another beverage. Observation of the lunch meal on 12/3/15 at 12:10 p.m. revealed: -Sixteen residents were sitting at the dining room tables. -One resident had 6 oz milk. -Fifteen residents only had a cup of water. Interview with the Supervisor on 12/3/15 at 12:10 p.m. revealed she would check with the Cook to	D 306	Administrator / RCC would ensure dietary staff will serve residents water in addition to order beverages for each meal Check residents menu to ensure dietary staff follow menus. Administrator will do monthly QA audits to ensure above changes are done and follow through by 12/19/15	12/19/15

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D 306	Continued From page 46 see if the residents were getting another beverage with the water for the meal. Observation on 12/3/15 at 12:10 p.m. revealed: -The Supervisor asked the Cook if the residents were getting another beverage with the lunch meal. -The Cook revealed he had juice to give the residents and he would give it to them. Based on observation, interview and record review of a resident, revealed the resident was not interviewable. Interview with a Personal Care Aide on 12/3/15 at 12:31 p.m. revealed: -The residents usually received water and another beverage during the meals. -"I don't know what happened today." Interview with the Resident Care Coordinator (RCC) on 12/3/15 at 12:32 p.m. revealed: -She did not realize the resident were not served another beverage with water. -The residents were supposed to had received another beverage with the water. Observation in the dining room on 12/3/15 at 12:36 p.m. revealed: -Ninety five percent of the residents had finished their meal and had walked out of the dining room. -A second beverage had not been offered or served to the residents. Interview with the RCC on 12/3/15 at 12:40 p.m. revealed: -The Supervisor was responsible for making sure dietary staff served what was supposed to be served to the residents. -Dietary staff are aware residents should be	D 306		

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D 306	Continued From page 47	D 306		

served water and another beverage at meals.
-She was not aware residents were not served or offered two beverages during the lunch meal on 12/3/15 until the surveyor informed her.

Interview with the Supervisor, who had assisted with the lunch meal on 12/3/15 and on 12/4/15 at 11:45 a.m. revealed:
-The Cook who served the lunch meal on 12/3/15 knew residents were supposed to be served water and koolaid or tea.
-When she informed the Cook the residents only had water on the table, he did not attempt to put out another beverage.

Interview with the RCC on 12/4/15 at 3:55 p.m. revealed she supervised the kitchen.

Interview with the RCC on 12/4/15 at 4:46 p.m. revealed:
-She does walk throughs in the kitchen and monitors meals daily.
-She last observed the meals on today (12/4/15).

Telephone interview with the Administrator on 12/4/15 at 5:30 p.m. revealed:
-Residents should receive water and juice or milk with each meal.
-Staff should be following the menu.
-She was not aware residents had not received another beverage during the lunch meal on 12/3/15.
-If she would have known, she would have told staff to give the residents another beverage.

Review of the "Week 5" Regular Diet Menu revealed for lunch on Day 5 residents were to receive a cold beverage of choice and water.

Observation on 12/2/15 at 8:30 a.m., 12/2/15 at

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D 306	Continued From page 48 12:40 p.m. and on 12/4/15 at 12:42 p.m. revealed all of the residents served in the dining room received water and another beverage. Resident #3's Responsible Party could not be reached by the end of the survey.	D 306		
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: Based on observation, interview and record review, the facility failed to assure therapeutic diets were served as ordered for 1 of 3 sampled residents (#3) on a No Concentrated Sweets (NCS)/No Added Salts (NAS) diet, double portions of meat and eggs at each meal time. The findings are: Review of Resident #3's current FL-2 dated 6/5/15 revealed: -The resident's diagnoses were mild dementia, insulin dependent diabetes mellitus, high blood pressure, end stage renal disease, acute encephalopathy secondary to uremia versus sepsis, schizophrenia with mild mental retardation and seizure disorder. -The resident was intermittently disoriented. -A physician's order for a No Concentrated Sweets (NCS)/No Added Salts (NAS) diet, 1200	D 310	Administrator / SIC / RIC would ensure therapeutic diets are served as ordered by physician during meals. All dietary aides would be inserviced to ensure all therapeutic diets are served during meals by 12/14/15	12/14/15

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D 310	Continued From page 49 milliliter (ml) fluid restriction, Ensure plus vanilla drink 240 ml at bedtime. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/30/12. Review of Resident #3's record revealed: -A current diet order dated 9/29/15 which included a NCS/NAS diet, 1200 ml fluid restriction plus ensure plus. -A "standing order" from dialysis dated 10/25/15 revealed to "provide patient with double portions at meal times." -A "standing order" signed by the Registered Dietitian at the dialysis clinic dated 12/1/15 to provide double portions of meat and eggs at each meal time. Review of the diet list posted on the board in the kitchen and the diet list provided from the RCC revealed Resident #3 was to receive a NCS/NAS diet. Interview with the Cook on 12/1/15 at 11:26 a.m. revealed: -She did not add salt to the food while cooking. -The NCS diets was prepared the same way as the Regular diet, but it did not have any sugars in the beverages. Interview with the Cook on 12/2/15 at 8:02 a.m. revealed the diet list she had posted on the board was the list she followed. Interview with the Cook on 12/2/15 at 12:57 p.m. revealed she modified the menu at a glance when preparing meals for therapeutic diets. Interview with Resident #3 on 12/3/15 at 9:11	D 310		

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D 310	Continued From page 50 a.m. revealed: -The food could taste better. -The resident went to dialysis. -The resident did not get enough to eat. -The resident did not know if the resident was on a special diet. -"I am supposed to get double portions, but I don't. " Review of "Week 5" Day 4 Breakfast NAS diet menu revealed the residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of syrup, 1 cup coffee/tea, 1 cup skim milk and 1 cup water. Review of "Week 5" Day 4 Breakfast " NCS/1800 menu revealed residents were to receive ¾ cup juice of choice, 2 sausage links, 1 waffle, 1 pack of margarine, 1 pack of sugar free syrup, 1 cup sugar free coffee/tea, 1 cup skim milk and 1 cup water. Observation of Resident #3 during the breakfast meal on 12/2/15 at 8:30 a.m. revealed: -The resident was eating the meal in the dining room. -The resident was served 1 sausage pattie, 1 french toast, ¾ cup of milk, syrup. -The resident was not served double portions of meat. Observation on 12/2/15 at 8:36 a.m. revealed Resident #3 had eaten 100 percent of the meal and drank all of the milk. Review of "Week 5" Day 5 lunch NAS diet menu revealed the residents were to receive 3 ounces baked chicken, ½ cup rice, ½ cup Brussel sprouts, 1 slice bread, 1 pack of margarine, 4 ounces of low fat ice cream, 1 cup cold beverage	D 310		

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	HAL054064	A. BUILDING: _____ B. WING _____	R 12/04/2015

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D 310	Continued From page 51 of choice and 1 cup water. Review of "Week 5" Day 4 breakfast "NCS/1800" menu revealed the residents were to receive 3 ounces baked chicken, ½ cup rice, ½ cup Brussel sprouts, 1 slice bread, 1 pack of margarine, 4 ounces of low fat ice cream, 1 cup cold sugar free beverage of choice and 1 cup water. Observation of Resident #3 during the lunch meal on 12/3/15 at 12:24 p.m. revealed: -The resident was served ½ cup greens, 1 slice bread, 1 chicken leg, ½ cup mashed potatoes and ½ cup manderine oranges. -The resident was not served double portions of meat. Observation on 12/3/15 at 12:35 p.m. revealed: -Resident #3 had eaten ¾ of the greens, ate ¼ of the bread and drank all of the milk. -The resident had gotten up from the table and staff was walking the resident back to the room. Interview with Resident #3 on 12/3/15 at 12:35 p.m. revealed: -The resident did like what was served for the meal. -The resident did not want to try to eat anything else. Interview with a Supervisor on 12/3/15 at 12:24 p.m. revealed Resident #3 had not been served double meats, because they were waiting to get the order signed by the provider. Interview with a second Cook on 12/4/15 at 11:46 a.m. revealed diabetics received a plain dessert with no frosting, fruit or sherbert ice cream. Telephone interview with Resident #3's primary	D 310		

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D 310	Continued From page 52 care physician's Nurse on 12/3/15 at 10:00 a.m. revealed: -She did not see a diet order for the resident. -The resident should be on a diabetic diet. -Staff should follow the orders from dialysis in reference to the resident's diet. Telephone interview with a Nurse at the dialysis clinic on 12/3/15 at 10:24 a.m. revealed: -She was not sure what diet Resident #3 was currently on. -The facility's Renal Dietitian had information about Resident #3's diet. Telephone interview with the Renal Dietitian from the local dialysis clinic on 12/3/15 at 2:32 p.m. revealed: -On 10/28/15, she made a recommendation for Resident #3 to have double portions of meat, because of the resident's low protein levels. -On 12/1/15, she made a recommendation for double portion with meats and eggs and to follow a NAS/NCS diet. -She rewrote the recommendation on 12/1/15 for double portions of meat and eggs, because Resident #3 had complained of not receiving the double portions with meals. Review of Resident of Resident #3's record revealed there was no protein or albumin labs in the record. Interview with the RCC on 12/4/15 at 2:40 p.m. revealed: -When preparing the NAS diet, salt is not added to the meal. -NAS/NCS staff prepare like a diabetic diet, but do not add salt. -The facility did not have a NCS/NAS menu. -The facility did not have a low fat diet menu.	D 310		

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D 310	Continued From page 53 Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -For Residents on the NCS diet there was no sugar in desserts. -Resident #3 was on a NCS/NAS diet. Staff were to follow the NCS and NAS menu when preparing the meal. -The only combination menu the facility had was the "NCS/1800" menu. Resident #3's Responsible Party could not be reached by the end of the survey.	D 310		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide activities to 1 of 1 bed bound resident who were competent. The findings are: Observation of the activities calendar on 12/04/15 at 10:42 AM revealed: -There were 30 hours per week scheduled on the activities schedule. -The Activities scheduled for each week in	D 319	Administrator / RCC and Activity Aide would ensure staff / Aide spend 1:1 time with bed bound resident's have activity done documented in residents folder Administrator would perform monthly Quality Assurance to ensure activities are performed and documentation done if resident's refuses.	12/31/15

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D 319	Continued From page 54 December included games, walks, devotion, movies, and free style days on Saturdays. -The activities calendar was repetitive with the same activities offered every week. -There were no scheduled outings for the residents for the month of December 2015. Interview with Resident #1 on 12/01/15 at 11:40 AM revealed: -The Resident said the staff never offer to do activities with him. -The staff only took him out of the facility when he had doctor's appointments. -The staff never take him out on outings because he is bed bound. Interview with the Resident Care Coordinator on 12/04/15 at 11:42 AM revealed the free style day on the calendar was a day for residents to do whatever they wanted and for family to come and visit. Interview with Medication Aide (MA) on 12/03/15 at 3:30 p.m. revealed: -MA stated that activities are scheduled weekly on the monthly calendar. -The MA shared that all residents, who can go on outings outside of the facility, do so at least twice a month. -Those residents who are bedridden do not go on outings outside of the facility but are offered indoor activities. Observations at facility on 12/01/15 through 12/03/15 revealed: -No indoor facility activities occurring during a.m. and p.m. tours of facility. -No outings outside of the facility were scheduled or held except for scheduled medical appointments for the residents.	D 319	Administrator / RCC Activity Aide would ensure Residents activity Calender would reflect resident preference and also document residents refusal to participate in activity. As a Dementia unit Resident activities require consistency because of diagnosis of dementia. Changing activities with different requirements/ activity can be challenging to a dementia client. Resident would be encouraged to leave facility for planned group activities per resident preference and document refusal.	

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D 319	Continued From page 55 Observation on 12/04/15 at 10:15 a.m. revealed residents were participating in devotion in the living room area, which included singing. Interview with Personal Care Aide (PAC) on 12/04/15 at 12:29 p.m. revealed: -PAC stated that a variety of activities are provided in the facility to include tabletop games, card games, bingo, coloring/drawing, singing and watching movies. -The residents that can go outside the facility go out at least weekly, in most cases, to church or to the park. -Residents who are bedridden or unable to ambulate and cannot go are offered choices of indoor or in facility activities. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -The RCC was certified as the Activity Coordinator. -Residents are encouraged to participate in activities. -Some residents do not want to participate in activities. -The residents who are confined to bed staff do one on one activities with the residents. -The bed bound residents do not go off campus for activities, because she needed to purchase a van to accommodate those residents. -Bedridden residents had not complained about wanting to go off campus for activities. -She was not aware staff had not been doing activities with Resident #1.	D 319	RCC would ensure resident are offered different activities as prefered by resident and documentation of refusal reported in resident's file by	12/12/15
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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D 338	Continued From page 56 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure staff spoke to residents in a considerate and respectful manner and treated residents respectfully as evidenced by staff yelling at residents and residents who were bedridden having to holler when assistance needed. The findings are: 1. Observation on 12/3/15 at 12:00 p.m. revealed: -Staff A, Supervisor, was bringing residents in the dining room for lunch. -Resident #5 was sitting at the table in the dining room on the right side of the entrance door to the kitchen. -Staff F, Cook, yelled at Resident #5 and said, "you don't sit at that table! You know you sit at the other table! I don't know why you keep trying to sit at that table! Get up and move to that table." -The Cook was 1-1/2 feet in front of the resident's face, slightly leaning over the resident, pointing his left index finger to the table on the left side behind the resident. -The resident clutched down, looked confused and looked at the table behind the resident. -The resident got up and went to the other table and smiled. -The Supervisor was in the dining room as Staff F was yelling at Resident #5.	D 338	Administrator reported to HCPR and staff was terminated immediately. After interviewing staff who were present (incident report failed to state) All staff were inserviced by Administrator on residents rights abuse, abuse and neglect 12/19/15 All staff would have Bi-annual training on Residents rights and abuse	

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D 338	Continued From page 57 -The Supervisor did not intervene. Interview with Staff F, Cook, on 12/3/15 at 12:03 p.m. revealed: -Sometimes Resident #5 sits at the wrong table. -It was hot in the kitchen and sometimes he elevated his voice. -He did not mean to elevate his voice at Resident #5. -He had been working at the facility since 2000. Review of Staff F's personnel file revealed: -Staff F was hired to work at the facility on 12/3/01. -Staff F had training in Residents' Rights on 12/4/02 and 12/19/14. Interview with RCC on 12/3/15 at 12:40 p.m. revealed: -Staff should treat residents with respect, be patient and talk respectful to the residents. -Every time she had a meeting, staff was trained on Residents' Rights. -Dietary staff are only supposed to serve the residents in the dining room. -Dietary staff are not supposed to direct the residents where to sit. If there is a problem with the seating arrangements, the dietary staff should tell a personal care aide or nurse aide. -This was the second time Staff F had talked disrespectful to the residents -A couple of months ago she was informed Staff F talked disrespectful to the residents and she talked to Staff F about not talking disrespectful to the residents. -She would talk with Staff F on today (12/3/15) to see what happened. Interview with Staff A on 12/4/15 at 11:45 a.m. revealed:	D 338		

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D 338	Continued From page 58 -All staff know Resident #5 was confused. -When time to eat in the dining room, staff know they had to redirect Resident #5 in the dining room, because the resident sat at the wrong table often. -One month ago around lunch time, Staff F yelled at Resident #5 in the dining room for sitting at the wrong table. Staff F calmed down and Staff A made sure Resident #5 sat at the correct table. -If the Supervisor see staff mistreating residents, the Supervisor was supposed to talk to the staff and report the incident to the RCC. -She could not remember if she reported the incident to the RCC. -On 12/3/15, she observed Staff F "hollering" at Resident #5. -She reported the incident to the RCC on 12/3/15. -She had only known of two incidents when Staff F yelled at residents. -Residents or family members had not complained about Staff F. Interview with the RCC on 12/4/15 at 2:55 p.m. revealed: -A Supervisor reported Staff F yelled at a female resident two months ago. -She could not remember which Supervisor reported the incident. -She was not aware Staff F had gotten into Resident #5's face yelling at the resident in the dining room one month ago. -If she would have known, "he (Staff F) would have been gone." -The Supervisor should have informed her of the incident. -Residents or family members had not complained about Staff F's behaviors. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed:	D 338		

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D 338	Continued From page 59 -Her expectation was for staff to treat residents with dignity and respect. -The RCC informed her of the incident which happened on 12/3/15, by Staff F. -She had not had any prior complaints about Staff F. -She was not aware there were prior incidents where Staff F had yelled at residents. Based on observation, interview and record review, Resident #5 was confused and not interviewable. 2. Observation of Resident #1 on 12/01/15 at 11:40 AM revealed: -The resident was in a hospital bed. -The call light system in the room was on the wall 6-8 feet from the resident's bed. -There was no other form of singnaling device in the resident's room. Interview with Resident #1 on 12/01/15 at 3:40 PM revealed: -He did not have a call bell. -There was a call bell on the wall but he could not reach the button. -He could not get out of his hospital bed without assistance. -He would holler out for the staff but they did not always respond when he called out. -He said sometimes they would come immediately and sometimes it might take an hour or two. Interview with the Resident Care Coordinator (RCC) on 12/01/15 at 3:45 PM revealed: -Resident #1 had the call system on the wall in his room. -Resident #1 did not have a call bell at the bedside.	D 338		

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D 338	Continued From page 60 -Resident #1 was bedbound and could not get up without assistance. -Resident #1 could yell out if he needed help with anything and staff would always go and help him. Observation of Resident #1 on 12/03/15 at 1:19 PM revealed: -The resident had a small bell on his bedside table. -The resident was ringing the call bell. Observation of Medication Aide (MA) on 12/03/15 at 1:24 PM revealed: -The MA was standing by the nurse's station 16-18 feet away. -The MA did not respond to the resident's call bell. -The MA was standing at the nurse's station watching TV. -The MA was observed going to check on Resident #1 after being prompted by the surveyor that Resident #1 had been ringing his call bell for about 15 minutes. -There were no other staff around Resident #1's room at this time. Interview with Resident #1 on 12/03/15 at 1:25 PM revealed: -He had been ringing his call bell for 2 hours. -No one had been in to check on him since he had been ringing the call bell. Observation of Resident #4 on 12/04/15 at 10:18 AM revealed: -The resident was in a hospital bed. -The call light system in the room was on the wall 12-14 feet away from the resident's bed. -There was no other form of call bell in the resident's room.	D 338	Administrator / RCC have inserviced All staff regarding Call lights and making sure call lights are within reach and answered promptly by 12/19/15 12/19/15	

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D 338	Continued From page 61 Interview with Resident #4 on 12/04/15 at 10:18 AM revealed: -The resident required assistance to get in and out of the bed. -The resident did not have a call bell that she could reach. -The resident just hollered out for staff when she needed something. Interview with a Personal Care Aide on 12/04/15 at 10:28AM revealed: -Resident #4 could only get in and out of bed with assistance from staff. -The staff rounded on the resident every 30 minutes. -The resident would holler out when she needed something and staff would respond. Telephone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -The residents who were bed bound should have a call bell at the bedside. -The staff were to respond immediately to a call bell. -Staff should be right down the hall to respond to residents who were bed bound. -The staff should be rounding on the resident's every 2 hours. A Plan of Protection was requested from the facility on 12/21/15. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 18, 2016.	D 338		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders	D 345		

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D 345	Continued From page 62 (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure physician's orders for Atorvastatin (Lipitor) was maintained in resident's record for the resident on 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 7/08/15 revealed: - The resident's diagnoses included dementia, diabetes type II, anemia, and colon cancer. -There was an order for Pravachol take 40 mg at night (used to lower cholesterol). Review of Resident #2's October 2015, November 2015, and December 2015 Medication Admonistration Records (MAR's) revealed Pravachol 40 mg was not transcribed on the MAR's. Review of Resident #2's October 2015 MAR revealed: --Atorvastatin (Lipitor) 20mg at bedtime was transcribed MAR (used to help lower cholesterol). -The medication was given at 20 mg at bedtime as prescribed from October 1, 2015 through October 31, 2015. Review of Resident #2's November 2015 MAR revealed: -Atorvastatin (Lipitor) 20mg at bedtime was transcribed MAR (used to help lower cholesterol).	D 345	Administrator is to ensure RCC checks MAR at the end of the month before Medication Aide administer the medications for the following month. Second check would be done by medication Aide to make sure all medications are accurately transcribed. Administrator would perform monthly QA to ensure compliance. 12/29/15	

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D 345	Continued From page 63 -The medication was given at 20 mg at bedtime as prescribed from November 1, 2015 - November 23, 2015 and November 25, 2015 through November 30, 2015. Review of Resident #2's December 2015 MAR revealed: -Atorvastatin (Lipitor) 20mg at bedtime was transcribed MAR (used to help lower cholesterol). -The medication was given at 20 mg at bedtime as prescribed from December 1, 2015 through December 4, 2015. Review of Resident #2's record revealed no physician's order for Atorvastatin (Liptor) in the resident's record. Telephone interview with the pharmacist from the local pharmacy on 12/04/15 at 11:02 a.m. revealed: -There was no order on file for Pravacol. -The resident wuld be on either Pravacol or Atorvastatin (Liptor) but not on both medications at the same time. Telephone interview with the pharmacist for Resident #2 on 12/04/15 at 10:43 a.m. revealed: -The current medication order in their system file for the resident was for Atorvastatin (Lipitor) 20mg at bedtime. -The current medication order was dated as of 7/08/15 with the last refill dated 11/01/15. Review of Resident #2's medications on hand revealed: -The Pravacol was not on hand. -The medication label on the Atovastatin (Liptor) revealed that Interview with the Resident Care Coordinator	D 345		

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D 345	Continued From page 64 (RCC) on 12/4/15 at 2:40 p.m. revealed: -When blank spaces are found on the MAR, this means the medication was not administered. -The RCC conducted weekly checks of all of the resident's MAR's to ensure the medications were administered properly. -For the past month she had gotten behind in reviewing the resident's MAR's and began to check the MAR's every two weeks. -The RCC and Medicaition Aide Supervisor (MAS) checked the resident's MAR's to ensure the orders were matching the medication label at the end of every month and they last checked the MARs the end of November 2015. -The RCC and MAS were unable to locate a physician's order for the Atorvastatin (Lipitor) in Resident #2's record. -The RCC stated that a current medication order for Atorvastatin (Lipitor) was requested from the doctor's office of the resident and will be filed when received. Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -When a physician's order is received from a resident's primary care physician, the order should be transcribed on the MAR correctly. -Although the physician's order was transcribed to the MAR, the physician's order was not located in the resident's record. -The RCC and a MA checked the MARs to make sure the orders were matching the medication labels at the end of every month for all residents.	D 345	Administrator would ensure RCC/SIC/ medication aide are inserviced every six months to ensure ~~Medication~~ aides/RCC can administer meds effectively as ordered by the physician. Administrator would perform monthly Quality control to audit files to ensure compliance	12/31/15
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	D 358		

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D 358	Continued From page 65 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: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure medications were administered as ordered to 3 of 3 residents as evidenced by the failure to provide treatments for wound care as ordered for 2 residents (#1 and #2) and failure to provide cream with wrap according the the physician's orders for 1 resident (#3). The findings are: 1. Review of Resident #1's current FL2 dated 07/16/15 revealed: -Diagnoses of Dementia, Pressure Wounds to Bilateral Feet, Atrial Fibrillation, Diabetes, Peripheral Vascular Disease, Alcoholism, and Hypopotassemia. -An order for wound care to the right foot and left heel/foot. -Orders to clean both wounds with normal saline, then apply Iodosorb Gel, then cover with foam. Wound care to be done every 2 days and as needed (PRN). Review of Resident #1's subsequent physician's orders revealed: -Orders for wound care dated for 11/09/15 to clean both right and left foot wounds with normal saline, then apply Iodosorb Gel, then apply foam,	D 358	RCC / SIC / medication aide would be inserviced on medication Administration to ensure orders from physicians are correctly transcribed to MARS and filed in residents file. RCC / SIC would ensure orders are checked twice before administering the following months MARS by 12/29/15 12/29/15	

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D 358	Continued From page 66 and secure with kerlex and tape. (Iodosorb Gel is a sterile formulation of Cadexomer Iodine. When applied to the wound, it cleans it by absorbing fluids, removing exudate, slough and debris and forming a gel over the wound surface.) -Orders dated 11/09/15 included orders for the home health nurse to do 3 times per week and the facility staff to do on all other days. Observation of Resident #1's wound care on 12/01/15 at 4:20 PM revealed: -The Medication Aide (MA) cleaned wounds on both feet with normal saline. -The MA applied Iodosorb Gel to wounds on both feet. -The MA attempted to apply Calcium Alginate with Silver (a barrier to microbrial penetration for heavy exudate). Upon surveyor intervention at 4:20 PM on 12/01/15, the medication aide stopped the treatment and stepped into the hallway to review the physician's orders for Resident #1's wound care. Interview with Medication Aide (MA) on 12/01/15 at 4:20 PM revealed: -Orders for Resident #1's wound care did not include application of Calcium Alginate with Silver. -The Home Health Nurse had told her it was ok to use the Calcium Alginate with Silver for drainage. -The MA could not find any orders to use the Calcium Alginate with Silver for Resident #1's wound care. Telephone interview with Home Health Nurse on 12/01/15 at 3:20 PM revealed: -There were orders to provide Resident #1 with	D 358		

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D 358	Continued From page 67 wound care to wounds on both feet daily. -Orders to clean the left foot with normal saline, then apply Santyl, then cover with foam, then wrap with kerlex and secure with tape. (Santyl is an enzymatic debriding ointment and used for removing dead skin from wounds and burned areas.) -Orders to clean the right foot with normal saline, then apply Iodosorb Gel, then cover with foam, then wrap with kerlex and secure with tape. -She felt somedays the wound care was not being done. She would come in to do the wound care and the same bandage that she had done on her last visit would still be on the Resident. Telephone interview with a Nursing Assistant at Wound Physician's Office on 12/01/15 at 3:56 PM revealed: -Both foot wounds were to be cleaned with normal saline, then apply Iodosorb Gel, then cover with foam, then wrap with kerlex and secure with tape. -Wound care was to be done every 2 days and as needed (PRN). -The Home Health Nurse was to perform the wound care 3 times per week. -The staff at the facility was to do the wound care on the days the Home Health Nurse was not there. Interview with the Home Health Nurse on 12/02/15 at 3:45 PM revealed: -The Nurse had said she did not do the initial teaching with the staff at the facility. -She would update and train the Medication Aides when there was a change in orders. Interview with Resident Care Coordinator (RCC) on 12/02/15 at 4:00PM revealed: -A different Home Health Nurse taught her how to	D 358		

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D 358	Continued From page 68 do the wound care not the one seeing the Resident now. -The Nurse was going over the wound care changes with the staff performing the wound care. -The Licensed Health Professional Support (LHPS) Nurse had not assessed any of the staff at the facility with performing wound care for Resident #1. A second interview with the first Medication Aide (MA) on 12/03/15 at 9:16 AM revealed: -The Home Health Nurse does tell her about changes in wound care. -The Home Health Nurse does not teach and instruct how to perform new wound care. -She did train some of the other MAs to perform the wound care so they could do it on her days off. Telephone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -When a Resident has wound care the facility has a Home Health Nurse to provide the wound care. -The Home Health Nurse was also to train the staff on how to do the wound care. -The staff only get trained if the wound care can be done within their scope of practice. 2. Review of Resident #2':s current FL-2 dated 7/08/15 revealed: - The resident's diagnoses included dementia, diabetes type II, anemia, and colon cancer. -The resident had bilateral buttocks ulcer. Clean with normal saline solution (nss) iodosorb gell. Cover with foam and change daily and as needed. Review of Resident #2's physician orders dated 11/16/15 revealed:	D 358		

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D 358	Continued From page 69 -The physician's orders noted a pressure ulcer on right lower buttock and a left buttock ulcer for resident. -The physician's orders specified for staff to continue dressing changes weekly or as needed, to cleanse with nss, apply iodosorb gel dressing (dsg) cover with foam change once twice a day (q2d) a.m. and p.m., and to continue preventive skin care measures. -Notify the physician of any changes or concerns regarding the resident's wound care status. -The physician's orders specified foam use and not " Island dressing " in providing wound care to the resident. Review of Resident #2's physician orders dated 10/12/15 revealed: -The physician's orders noted a pressure ulcer on right lower buttock and a left buttock ulcer for resident. -The left buttock ulcer resurfaced. Continue protective dressing weekly and as needed. -For the right buttock, staff to continue dressing changes weekly or as needed, to cleanse with nss, apply iodosorb gel dressing (dsg) cover with foam change once twice a day (q2d) a.m. and p.m., and to continue preventive skin care measures. -Notify the physician of any changes or concerns regarding the resident's wound care status. Interview with the Resident Care Coordinator (RCC) on 12/02/15 at 3:56 p.m. revealed: -The RCC and two other staff provide wound care to Resident #2 weekly and/or as needed. -The RCC and three other staff were trained by the Home Health Nurse on how to provide wound care to the resident in June 2015 or July 2015. -When there is a change in doctor's orders for wound care, the Wound Care Nurse keeps facility	D 358		

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D 358	Continued From page 70 staff informed of any changes made in providing wound care. Interview with the Administrator on 12/02/15 at 3:56 p.m. revealed: -The Administrator was not aware that staff, including the RCC, were not following the doctor's order for wound care as specified. -The Administrator will follow-up with the home health nurse's facility to have staff retrained on the doctor's orders for wound care as written. Interview with the Supervisor on 12/03/15 at 9:29 a.m. revealed: -When wound care is provided to Resident #2, the she cleaned the area with normal saline and applied a patch to the wound. -She had been using " island dressing " (a nonstick pad with border tape) for about one week and that prior to that she used gauze and tape to treat the resident's wound. -She had never used foam on resident's wound and that the facility does not have foam dressing -The resident's left buttock wound is completely healed and the ulcer on the right buttock is steadily healing. -She was trained by the wound care nurse. Telephone interview with the Wound Care Nurse on 12/03/15 at 11:20 a.m. revealed: -The wound care nurse stated that facility staff are trained according to the doctor's orders as specified for wound care for Resident #2. -The wound care nurse stated that staff are consistently trained by herself in regards to wound care procedures, care, and treatment. -The resident's wound areas are healing. Interview with Medication Aide (MA) on 12/03/15 at 3:30 p.m. revealed:	D 358		

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D 358	Continued From page 71 -She did not apply foam to Resident #2's wounds when performing wound care but the " Island dressing " (which is a nonstick pad with border tape) was applied. -MA received training for wound care from the Supervisor and wound care nurse. Observation of the Home Health Nurse on 12/04/15 at 2:35 PM revealed: -The Nurse cleaned Resident #2's wound with normal saline. -The Nurse then applied Iodosorb Gel to the wound. -The Nurse placed an Island Dressing (Non Stick pad with a tape border) on top of the wound. Phone interview with the Administrator on 12/04/15 at 10:50 AM revealed: -When a Resident has wound care they get a Home Health Nurse to come in and provide wound care. -The Home Health Nurse was also to train the staff on how to do the wound care. -The staff only get trained if the wound care can be done within their scope of practice. 3. Review of Resident #3's current FL-2 dated 6/5/15 revealed: -The resident's diagnoses were mild dementia, insulin dependent diabetes mellitus, high blood pressure, end stage renal disease, acute encephalopathy secondary to uremia versus sepsis, schizophrenia with mild mental retardation and seizure disorder. -The resident was intermittently disoriented. -An order for Lido/Prilo cream 2.5 % apply small amount to access sites 1 or 2 hours before dialysis; wrap with saran wrap (used to numb the skin at an injection site).	D 358		

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D 358	Continued From page 72 Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 10/30/12. Review of Resident #3's October 2015 and November 2015 Medication Administration Records (MARs) revealed Lido/Prilo cream was not transcribed on the MARs and there was no documentation the cream was administered. Review of Resident #3's December 2015 MAR revealed: -Lido/Prilo cream 2.5 % apply small amount to access sites 2 hours before dialysis; wrap with saran wrap was transcribed on the MAR. -The cream was documented as administered on 12/2/15 by a Medication Aide (MA). Review of the Lido/Prilo cream medication label revealed: -Lido/Prilo cream 2.5 % was last dispensed from the local pharmacy on 3/4/15. -The directions were to apply small amount to access sites 2 hours before dialysis; wrap with saran wrap. -Three fourth of the cream had been used. Interview with the Resident Care Coordinator (RCC) on 12/2/15 at 11:30 a.m. revealed Resident #3's Lido/Prilo cream had not been documented as administered on the MARs. Interview with Resident #3 on 12/2/15 at 9:11 a.m. revealed: -The resident went to dialysis. -The resident could not say how often the resident went to dialysis. -The resident did not provide any other information about dialysis.	D 358		

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D 358	Continued From page 73 Interview with the Supervisor on 12/2/15 at 3:39 p.m. revealed: -When scheduled to work, she normally worked from 7:00 a.m. to 3:00 p.m. -Resident #3 went to dialysis on Mondays, Wednesdays and Fridays at 9:30 a.m. and returned back to the facility between 3:00 p.m. to 3:30 p.m. -Before Resident went to dialysis, she administered the Lido/Prilo cream to the resident's fistula site, wrapped the site with saran wrap and documented the administration on the MAR. The MAR was the only place the administration of the Lido/Prilo cream would have been documented. -She thought she had documented the administration of Lido/Prilo cream on the October 2015 and November 2015 MARs. Telephone interview with a Nurse from the local dialysis clinic on 12/3/15 at 9:02 a.m. revealed: -There was an order faxed to Resident #3's pharmacy dated 6/28/15 for Lido/Prilo cream 2.5% apply a small amount to access sites 1 to 2 hours before dialysis and wrap with saran wrap. -The Lido/Prilo cream was usually ordered to be administered before a resident had dialysis treatment. -There had not been any problems or irritation at Resident #3's fistula site. -She had spoken with a dialysis technician (while the surveyor was on hold) and the technician had not noticed Lido/Prilo cream or saran wrap on Resident #3's arm when the resident came to dialysis. -Resident #3 came to dialysis on 12/2/15, but the resident did not receive dialysis, because the resident was "soiled". The resident was rescheduled to come to dialysis on 12/3/15.	D 358		

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D 358	Continued From page 74 Further telephone interview with a nurse from the local dialysis clinic on 12/3/15 at 10:24 a.m. revealed: -There was an order dated 3/4/15 for Prilo/Lido cream for a 90 day supply. -There was no other order after the 90 day supply in Resident #3's record. -If Resident #3's primary care physician had written a current order for Lido/Prilo cream, the facility should have given dialysis a copy of the order. -If there was a current order for Lido/Prilo cream in Resident #3's record, the facility should have been following the order. -The same dialysis technician had not noticed the Lido/Prilo cream or saran wrap on Resident #3's arm for the past couple of weeks. Interview with the Supervisor on 12/3/15 at 9:55 a.m. revealed: -Resident #3 was supposed to go to dialysis today (12/3/15), but the facility was waiting on dialysis to contact them for an opening. -Currently, dialysis had not contacted the facility for an opening. -If the dialysis clinic did not have an opening, the resident would go to dialysis on 12/4/15. Further interview with the same Supervisor on 12/4/15 at 1:05 p.m. revealed: -When an order is received, it was transcribed on the MAR by a MA. -The date the order was received was also transcribed on the MAR. -The Supervisor and the RCC checked the MARs to make sure the orders were matching the medication label. -She last checked the MARs with the RCC September 2015.	D 358		

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D 358	Continued From page 75 Telephone interview with Resident #3's primary physician's Nurse on 12/3/15 at 10:00 a.m. revealed the facility needed to follow the dialysis physician's orders for any treatment related to the resident's dialysis. Observation on 12/3/15 at 11:30 a.m. revealed: -Resident #3 was sitting in the living room. -The MA was administering insulin in Resident #3's right forearm. -Per surveyor's request, the MA pulled Resident #3's left sleeve up. -The resident's left front upper arm had a fistula site. There were two cotton balls taped to the fistula site. -The fistula site dressing was not soiled and the area around the dressing did not appear reddened or irritated. Observation on 12/4/15 at 10:00 a.m. revealed Resident #3 had gone to dialysis. Interview with the RCC on 12/4/15 at 2:40 p.m. revealed: -If a medication was not transcribed on the MAR, then the medication was not administered. -The RCC checked behind the MAs to make sure there was documentation the medication was administered weekly. -For the past month she had gotten behind and had been checking behind the MA's for documentation every two weeks. -She and the Supervisor checked the MARs to make sure the orders were matching the medication label at the end of every month and she and the Supervisor last checked the MARs the end of November 2015. -She did not realize Resident #3's Lido/Prilo cream was not documented on the MAR. She	D 358		

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D 358	Continued From page 76 stated, "I take the blame." Telephone interview with the Administrator on 12/4/15 at 3:55 p.m. revealed: -When an order was received from a resident's primary care physician, the order should be transcribed on the MAR correctly. -The RCC and a MA checked the MARs to make sure the orders were matching the medication label at the end of every month. -She was not aware the Lido/Prilo cream was not transcribed on the October 2015 and November 2015 MARs and there was no documentation of the administration of the cream. Resident #3's Responsible Party could not be reached by the end of the survey. _____ The facility submitted a Plan of Protection dated 12/4/15 as follows: -Immediately, the Resident Care Coordinator will look at the resident's orders when a resident returns from an appointment. -A nurse will inservice staff on medication administration, orders and changes. -The Resident Care Coordinator will contact the physician for any concerns. -The Resident Care Coordinator will check with pharmacy daily to see if there were any orders received from the resident's physicians. An addendum to the Plan of Protection was received on 12/11/15 as follows: -If a resident had a task for wound care, the physician will write the order and specifiy the task staff can perform. -Staf will be trained as needed for woud care. -If staff is not trained on the task, the home health nurse will perfom the task until staff was trained.	D 358		

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
	HAL054064	A. BUILDING: _____ B. WING _____	R 12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 77 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 18, 2016.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents living in a special care unit was treated with respect and dignity by staff not yelling at residents and staff responding to a resident at a reasonable time who was bedridden. The findings are: Based on observation, interview and record review, the facility failed to assure staff spoke to residents in a considerate and respectful manner and treated residents respectfully as evidenced by staff yelling at residents and residents who were bedridden having to holler when assistance needed. [Refer to Tag D338, 10A NCAC 13F .0909. (Type B Violation)]	D911	Administrator terminated staff involved in yelling at residents and was also reported to DHSR. All staff were inserviced 12/11/15 on residents rights, answering of call light, monitor residents in bed and have call lights within reach by 12/11/15	
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	D912	Administered ensured RCC/SIC/Medication Aide were competency validated to provide wound care by physician	

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	HAL054064	A. BUILDING: _____ B. WING _____	R 12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

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D912	Continued From page 78 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents received care and services related to call bells, staff competency validation for Licensed Health Professional Support (LHPS) task for wound care, health care referral and follow-up and medication administration. The findings are: 1. Based on observation, record review, and interview, the facility failed to assure residents had access to a call bell or signaling device within reach for 2 of 3 residents (#1, #4) who were bedridden. [Refer to Tag D119, 10A NCAC 13F .0311 (j). (Type B Violation)] 2. Based on observations, interviews, and record review, the facility failed to ensure staff were competency validated to apply a debriding agent to wounds on 2 of 2 sampled residents (#1, #2). [Refer to Tag D163, 10A NCAC 13F .0504 (c). (Type A2 Violation)] 3. Based on observation, interview and record review, the facility failed to notify 1 of 3 sampled resident (#1) physician about a resident not having morphine and oxycodone on hand for pain, 1 of 3 sampled resident (#2) with elevated systolic blood pressures and 1 of 3 sampled resident (#3) with low blood sugars. [Refer to Tag D273, 10A NCAC 13F .0902 (b). (Type A2 Violation)]	D912	for dressing Change by LHPS. Inserved Staff on promptly responding to call lights. RCC would perform QA audit weekly Administrator would perform ongoing QA monthly audits to ensure ongoing Compliance	12/29/15

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 79 4. Based on observation, interview and record review, the facility failed to assure medications were administered as ordered to 3 of 3 residents as evidenced by the failure to provide treatments for wound care as ordered for 2 residents (#1 and #2) and failure to provide cream with wrap according the the physician's orders for 1 resident (#3). [Refer to Tag D358, 10A NCAC 13F .1004 (a). (Type B Violation)]	D912		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to meet the requirements for infection control on 2 out of 5 sampled staff members (Staff A and Staff D). The findings are:	D934	Employees are trained on infection control practices as part of orientation during hire and biannual also done as inservice training during the year. copies of training are filed and kept in employees file and inservice documentation records Administrator would ensure all files of ongoing and prevail inservices documentation records are filed on infection control effectively	12/19/15

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

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D934	Continued From page 80 Review of Staff A's record revealed: -Staff A had been hired on 04/05/07. -Documentation of infection control training was completed on 04/12/14. Review of Staff D's record revealed: -Staff D had been hired on 10/17/12. -Documentation of infection control training was completed on 04/10/14. Interview with Resident Care Coordinator (RCC) on 12/03/14 at 10:00 AM revealed: -The RCC had said that there were no more current infection control trainings other than the ones in the staff ' s charts. -The RCC had said she knew that the training needed to be done and she was going to contact the Licensed Health Professional Support (LHPS) Nurse to get the training set up. -The RCC had said she was aware it was an annual requirement.	D934		

Posted Transactions

Date	Description	Withdrawals	Deposits
01/08/2016	ONLINE TRANSFER TO [redacted]		
01/06/2016	CORPORATE ACH [redacted] EFUNDS NCDHHSEBT		$404.00
12/31/2015	ACH CREDIT [redacted] SEC		$29.00
12/31/2015	ACH CREDIT [redacted] SEC		$723.00
12/31/2015	ACH CRED [redacted]		$724.00
12/31/2015	ACH CREDIT [redacted] SEC		$733.00
12/31/2015	ACH CREDIT [redacted] SEC		$733.00
12/31/2015	ACH [redacted] SEC		$733.00
12/31/2015	ACH CRED [redacted]		$965.00
12/31/2015	ACH CREDIT [redacted]		$1,177.00
12/14/2015	ONLINE TRANSFER T [redacted]		
12/03/2015	CORPORATE ACH [redacted]		$404.00
12/03/2015	ACH CREDIT [redacted]		$724.00
12/03/2015	ACH CREDIT [redacted]		$965.00
12/03/2015	ACH CREDIT [redacted]		$1,177.00
12/01/2015	ACH CREDIT [redacted]		$29.00
12/01/2015	ACH CREDIT [redacted]		$723.00
12/01/2015	ACH CREDIT [redacted]		$733.00
12/01/2015	ACH CREDI [redacted]		$733.00
12/01/2015	ACH CREDIT [redacted]		$733.00
12/31/2015	ACH CREDIT [redacted]		$55.00
12/31/2015	ACH CREDIT [redacted]		$698.00
12/31/2015	ACH CREDIT [redacted]		$733.00
12/31/2015	ACH CREDIT [redacted]		$1,000.00
12/31/2015	ACH CREDI [redacted]		$1,145.00
12/31/2015	ACH CREDIT [redacted]		$1,212.00
12/31/2015	ACH CREDIT [redacted]		$1,574.00

To send to [redacted]