STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 000	Initial Comments The Adult Care Licensure Section and the Orange County Department of Social Services conducted an annual survey and complaint investigation on 2/23/2016 - 2/25/2016.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 1 of 4 sampled residents (#1) who had falls and sustained an injury. The findings are: Review of Resident #1's current FL-2 dated 4/15/2015 revealed: -Diagnoses included congestive heart failure, hypothyroidism, chronic obstructive pulmonary disease, atrial fibrillation, dementia, coronary artery disease, hypertension, cardiac failure, osteoporosis and history of falls. -The resident is semi ambulatory and uses a walker. -The resident is intermittently disoriented and verbally abusive. Review of the Resident #1's Resident Register	D 270		

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revealed an admission date of 4/16/14.

Review of Resident #1's current care plan dated 4/15/2015 revealed:
-Resident #1 required extensive assistance with transfers, ambulation, toileting, bathing, dressing and grooming.

Review of incident/accident reports for Resident #1 revealed:
-On 7/12/2015 at 9:30 AM, the resident was found by the medication aide (MA) on her buttocks in the hallway by her room.
-On 7/17/2015 at 2:20 AM (a hand written report on a blank sheet of paper by an MA), personal care aides were doing rounds and found Resident #1 on the floor, the medication aide was notified immediately to check the resident. A small knot was noticed on the right side of the forehead and a skin tear to left hand was cleaned and bandaged. Continue to check on resident every hour. The Medical provider and Administrator were notified. The Resident Care Coordinator (RCC) documented staff continued to monitor the resident for changes and hospice would follow-up.
-On 8/27/2015 at 10:20 AM, the RCC heard Resident #1 yelling. The resident was found on the floor by her bed sitting on her buttocks. No visual injuries noted. Hospice will follow up.
-On 10/19/2015 at 2:00 PM, the resident was lying on the floor. A skin tear was observed on the resident left hand. The resident fell trying to get to the bathroom and fell.
-On 10/26/2015 at 10:30 AM, the resident was found by a personal care aide (PCA) on the floor in her room. The resident has a cut on the left side of her face. Continue to monitor and notify. Hospice will follow up.
-On 10/31/2015 at 9:00 PM, the resident was

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found by staff on the floor by her bed. The resident stated she was trying to get in to her wheelchair. The resident had a bump on the left side of her face that re-opened the laceration on the forehead. Hospice to follow up.
-On 11/3/2015 at 6:45 PM, the medication aide (MA) was notified by the personal care aide that the resident was on the floor beside her bed. The resident said she fell trying to get to her wheelchair. No injuries notes. Continue to monitor, hospice will follow-up.
-On 11/5/2015 at 4:30 PM, the MA was notified by the personal care aide that the resident was on the floor laying on her left side. No injuries were noted. Continue to monitor.
-On 11/6/2015 at 6:00 PM, the resident was found by staff on the floor by her roommates' bed. Continue to monitor for changes and notify MD.
-On 11/29/2015 at 7:00 AM, the resident had received incontinent care. Staff assisted the resident into the wheelchair. The resident tried to stand and fell. The resident obtained skin tears on the elbow and hand. Hospice was coming to see the resident. "Keep a close eye on her".
-On 12/5/2015 at 3:56 PM, the resident was on the floor in the hall. The resident was helped back into her wheelchair. Hospice will evaluate.
-On 12/13/2015 at 6:00 PM, the resident was found by staff on the fall mat by her bed. The resident stated she had fallen. The oxygen cord was wrapped around her. No injuries. Continue to monitor and follow hospice protocol.
-On 12/16/2015 at 5:45 AM, the resident was found on the floor by staff. The resident complained of back pain. No visible injuries. Continue to monitor for changes and notify proper provider.
-On 12/17/2015 at 4:00 PM, the resident was found by staff, on the floor by her bed. The resident had a bump on the right side of her head

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and complained of hip pain. Hospice notified.
-On 1/3/2016 at 6:30 PM, the resident was found on the mat in front of her bed by the medication aide. No injuries noted. Continue to monitor.
-On 1/5/2016 at 12:00 PM, the resident was found sitting on the fall mat by her bed. The resident stated she slid out of the bed. Continue to monitor.
-On 1/19/2016 at 1:45 PM, the resident was found lying on the floor in her room. The resident had skin tears on the right elbow, arm and leg. Wounds cleaned and bandaged. Continue to monitor, hospice to evaluate.
-On 1/25/2016 at 8:30 PM, the resident had fallen on the mat beside her bed. The resident had a large bleeding gash above her eye. The resident was sent out to the local emergency room.
-On 1/26/2016 at 11:38 AM, the resident was trying to stand up in the hallway, she lost her balance and slid down the wall unto her knees. Continue to monitor and notify primary care provider and hospice of any changes.
-On 2/2/2016 at 4:00 AM, the (MA) heard Resident #1 yell out. The MA found the resident sitting on the bed with blood all over the floor and resident. The resident had a cut over the eye. The resident was sent out to the local emergency room.
-On 2/3/2016 at 6:15 AM, the resident was found on the floor in her room, she had removed her incontinent brief and was lying in urine. " It appeared she was trying to go to the bathroom ". The resident had some bleeding from a previous injury. Hospice notified.
-On 2/14/2016 at 2:45 PM, the resident was found on the floor in the sitting room by the PCA. The resident had fallen from her wheelchair onto the floor. Continue to monitor.

Review of Resident #1's

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progress/nurse's/provider notes revealed:
-On 12/7/2015 the resident returned from the emergency room after a fall. Proper providers notified will continue to monitor for changes in care needs. (There was no incident report or discharge summary for this date in the residents' record)
-On 1/26/2016 the resident returned from the emergency room where she was sent out by the hospice nurse after a fall with an abrasion to the forehead. (There was an incident report dated 1/25/2016 for this occurrence in addition to hospital discharge summary visit for a fall with an abrasion)
-On 2/2/2016 the resident returned from the emergency room for a fall where a previous injury reopened on the forehead. Sutures were placed. Will continue to monitor and notify proper provider of changes.
-There were no other entries in the progress/nurse's/provider notes with dates of 12/17/2015 through 2/15/2016.

Observation on 2/24/2016 at 10:25 AM to 11:00 AM revealed:
-The medication room door was closed. The Resident's room was located across from the medication room.
-Resident #1 was in her room lying on the bed with her door closed, a fall mat was on the floor.
-One PCA was assisting residents on the back hall (300).
-At 10:38 AM, the MA came out of the medication room with a pitcher and headed towards the dining room. The MA returned to the medication room with the pitcher in hand and closed the door. The RCC walked past the resident's room and went into the medical provider office.
- A housekeeper was mopping the floor near the housekeeping storage room entrance on the 100

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hall.
-At 10:43 AM the PCA assigned the 100/300 hall was assisting another resident with incontinent care.
-The other PCA was assigned to the 400/200 hall.
-At 10:45 AM the PCA in training came out of a resident room at the end of 300 hall with a dirty linen barrel.
- At 10:52 AM the housekeeper knocked on the door to enter the residents' room the resident was lying on her bed.

Interview with a Medication aide (MA) on 2/23/2016 at 5:00 PM revealed:
-During shift change on 2/14/2016 staff notified the MA that Resident #1 was found in the sitting room on the floor.
-When the resident was in her wheelchair she moved swiftly throughout the facility and it can be difficulty for staff to watch her.
-The resident had gotten out of the wheelchair in the sitting room and fell.
-On 1/3/2016 staff were either assisting other residents from the dining room and or giving medications. The resident was found on the fall mat in her room.
-On 12/13/2015 staff were assisting other residents' from the dining room and the MA was administering medications. The PCA found the resident on the fall mat by her bed by staff.
-[Resident #1's name] was on falls precautions, "we are supposed to watch her".
-[Resident #1 name] room was on the middle hall and she was moved to a room across from the medication room about two months ago because she had so many falls.
-Staff try to "keep an eye on the resident". "We should have eyes on the resident at all times".
-Most of her falls were during times when the medication aides were administering medications

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and the aides were helping other residents.
-Resident that were on fall precautions are supposed to be monitored closer than every two hours.
-"[Resident #1 name] room was changed a few months ago across from the medication room so staff could watch her more".
-"[Resident #1 name] was always tying to get up on her own either out of her chair or the bed".
-"Staff try to monitor her closer when she is in the wheelchair".
-"When she was in the wheelchair we keep her in the medication room with staff to monitor her and keep her occupied". "Sometimes we will take her to the activity room or dining room to be with staff".

Interview with a second medication aide concerning Resident #1's incident report on 2/23/2016 at 4:45 PM revealed:
-On 11/3/2015 staff were getting other residents' ready for bed.
-"I was administering medications in the dining room or on one of the hallways".
-"The PCA came and told me that [Resident #1 name] was on the floor".
-On 12/5/2015 the resident had been moving around in the facility in her wheelchair.
-The MA found the resident on the floor (middle hallway).
-"I helped the resident to get back into the wheelchair and notified hospice".
-On 1/25/2016 the resident had a cut on her head.
-"I applied pressure to make the bleeding stop and the notified the hospice nurse. They told me to send the resident out to the hospital".
- Staff had to watch her she can move very fast when she was in the wheelchair.
- Staff check on Residents' every two hours.

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D 270	Continued From page 7 -Residents that were on falls precautions were supposed to be checked every 30 minutes to one hour. -Staff do not document any checks performed for any resident unless they were turning the resident, toileting the resident or assisting the resident with ambulation. Interview on with the Resident Care Coordinator (RCC) 2/24/2016 at 2:40 PM revealed: -"[Resident #1's name] has frequent falls". -A fall mat was supposed to be placed on the floor by the resident bed when she was in bed. -The resident has a concave mattress. -"Everyone was to monitor [Resident #1's name] as much as possible, at least every hour". -"The resident required constant supervision, we cannot provide 24/7 supervision". -The resident required extensive assistance with transfers from bed to chair. -"Most of [Resident #1's name] falls occur in her room". -"Resident #1 room door should remain open so that staff can visually look at the resident if going past her room. That is why we relocated her room a few months ago across from the medication room, so the medication aides could monitor the resident closer". -On 1/26/2016 after the incident " I viewed the cameras and saw [Resident #1's name] on the hallway holding to the rail trying to pull herself up out of the wheelchair". "There were no staff visible on the hall at that time". "I assume they were assisting other residents". -"[Resident #1 name] was a very quick mover when she is in her wheelchair. Staff reported to me that she was found in the sitting room on the floor during shift change". -"Staff should know where residents were at all times,specifically those on fall precautions".	D 270		

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D 270	Continued From page 8 Interview with Resident #1's Primary Care provider on 2/24/2016 at 2:55 PM revealed: -"[Resident #1's name] has had reoccurring falls". "I document "staff to stay on top of falls". " Keep me informed" -The resident was a hospice patient and had been declining in health within the last 3 months. -The resident needed to be monitored for falls and will be reassess for possible higher level of care. " I will meet with the staff and family to discuss her multiple falls". - "The staff are doing the best they can do". Interview with the Administrator on 2/24/2016 at 3:15 PM revealed: -Residents' that were on fall precautions had a sticker placed on the door so that staff would know that the resident should be monitored. -"[Resident #1's name] had a falls precautions sticker on her room door." -"[Resident #1's name] thinks she can walk and would try to get up out of her bed or wheelchair, staff try to keep her safe". -"[Resident #1's name] room was moved to a room across from the medication room at 1 ½- 2 months ago so that the medication aides could monitor the resident every 15-20 minutes to an hour". -"I can't say that the residents' door should remain open when she is in her room. The resident can be in her room with the door closed". -"Everybody should be watching Resident #1 she needs constant monitoring" keep eyes on the resident". -The RCC was responsible for reviewing every incident/accident report, notifying the physician. - "Staff need to just watch her". The facility provided a Plan of protection on	D 270		

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D 270	Continued From page 9 2/24/2016 as follows: -Resident #1 will be provided a chair alarm/bed alarm and staff watch and check off every 15 minutes. -The physician will be notified for evaluation and protective devices considered. -The Administrator and Supervisor will ensure safety by checking staff watch sheets and safety equipment in place. -Any resident with frequent falls will be assessed for safety equipment often after all other plans have failed. -The physician and facility will assess for adaptive equipment including floor padding, safety belts and rails. -Will increase monitoring until falls are resolve or seek appropriate placement. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 26, 2016.	D 270		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 287		

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failed to assure table service included a place setting consisting of at least a knife, fork, and spoon, for residents in the dining room.

The findings are:

Observation of the breakfast meal in the facility dining room on 2/24/2016 at 8:30 AM revealed:
-There were 71 residents seated at 4 different long tables.
-All residents were given a spoon or a fork to use for breakfast.
-There was one resident that was given a spoon and fork because she requested cold cereal.
-There were no residents with a knife.

Observation of Resident #1 on 2/24/2016 at 8:40 AM revealed:
-Her breakfast plate was of pureed consistency.
-She was given a fork to feed herself.

Observation, Interview and record review of Resident #1 revealed she was not able to be interviewed.

Interview with Resident #2 on 2/24/2016 at 8:47 AM revealed:
-He was always given a spoon to eat with.
-He had never been given a knife.
-He was able to feed himself with the spoon.

Interview with the Personal Care Aide (PCA) on 2/24/2016 at 8:42 AM revealed:
-All residents were given a fork or a spoon.
-There were only given both a fork and a spoon if they received cold cereal.
-She had never seen any resident given a knife at any meal.

Observation of the lunch meal on 2/24/2016 at

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D 287	Continued From page 11 12:45 PM revealed every resident in the large dining room was given a fork or a spoon to eat lunch. Interview with the Resident Care Coordinator on 2/24/2016 at 11:30 AM revealed he was not responsible for the kitchen staff. Interview with the Cook on 2/24/2016 at 9:00 AM revealed: -The kitchen staff would give the residents a fork or a spoon. -They had enough silverware to give each resident a fork, knife and spoon. -They did not give the residents a knife because there was nothing they needed to cut. -Some of the residents had behaviors and may not be safe with a knife. -He was trained by the previous cook that no longer worked there. -He had never been told he had to give each resident a fork, knife and spoon. Interview with the other Cook on 2/24/2016 at 9:10 AM revealed: -He was trained by the other cook. -He had only been working in the kitchen a few months (not specified). -There were only 2 cooks that worked in the kitchen. -They had not given out a fork, knife and spoon since he had worked in the kitchen. -He was not told he needed to give out a fork, knife and spoon at each meal. Interview with the Kitchen Supervisor on 2/24/2016 at 12:46 PM revealed: -He was not aware the resident's had to be given a fork, knife and spoon. -The kitchen had all 3 pieces of silverware	D 287		

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D 287	Continued From page 12 available but did not use them. -He would ensure all residents were given a fork, knife and spoon at each meal. Interview with the Administrator on 2/24/2016 at 2:00 PM revealed: -She was not aware the residents should be given a fork, knife and spoon at each meal. -She would ensure that all residents would be given all 3 pieces of silverware starting today (2/24/2016). Confidential interview with 3 residents in the dining room on 2/25/2016 at 8:00 AM revealed: -They had all lived at the facility for about 3 years. -They had never requested to have a fork, knife and spoon. -Today (2/25/2016) was the first day they were given a fork, knife and spoon at a meal.	D 287		
D 291	10A NCAC 13F .0904(c)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain menus for a regular, no added salt and a no concentrated sweets diet in the kitchen and identified as to the current menu day and cycle for guidance for the	D 291		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(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 291	Continued From page 13 food service staff. The findings are: Observation of the kitchen on 2/23/2016 at 11:00 AM revealed: -There was a facility generated menu dated 2/23/2016 posted on the wall. -There was no therapeutic cycle menu found in the kitchen. -There was a diet list posted which included individual resident's names and the type of diet they should receive. Interview with the cook on 2/23/2016 at 11:00 AM revealed: -He had been working in the kitchen a few months. -There were 2 cooks that worked in the kitchen. -He was trained by the second cook. -He had always used the facility generated menu that was given to him by the Kitchen Supervisor. -There was no menu in the kitchen that reflected the serving size for each diet on the diet list. -He remembered there was a menu book that was on the counter in the kitchen but it had been removed when they cleaned (time unknown). Interview with the Administrator on 2/23/2016 at 1:05 PM revealed she would have the Kitchen Supervisor provide me with the menus. Interview with the Kitchen Supervisor on 2/23/20016 at 4:00 PM revealed: -The therapeutic cycle menus were no longer kept in the kitchen. -They removed them from the kitchen when they started using new menus. -The food service provider had given the facility new menus on a USB drive.	D 291		

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D 291	Continued From page 14 -He was unsure of the date of the new menus. -The Administrative Assistant had the new menus from the food service company on a USB drive. -The Administrative Assistant had left for the day, so he did not have access to the spreadsheet/therapeutic menus. -The Administrative Assistant would go into the computer every week and transfer the menu onto a document. -The Administrative Assistant would give it to him (Kitchen Supervisor) for approval. -The kitchen staff was trained by the cook that had been working there the longest. -He was aware that there needed to be menus in the kitchen for staff to follow. -He thought the way they had been typing out the menus, it would make it easier for staff to follow. -He would ensure the menus from the food service provider were printed and placed in the kitchen tomorrow (2/24/2016) for staff quidance. Interview with the other Cook on 2/24/2016 at 7:15 AM revealed: -He was trained by the previous kitchen cook that no longer worked there. -He was responsible for training all new kitchen staff. -All serving sizes were the same. -He tried to give all the resident's a good portion size. -He had not measured the amount of food that was served. -There was no menu that told the kitchen staff how much to serve. Interview with the Administrative Assistant on 2/24/2016 at 9:15 AM revealed: -She was responsible for typing the facility generated menu. -She would print breakfast, lunch and dinner for	D 291		

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each day onto one sheet of paper.
-She would have a menu for every day during the week.
-She would give the menu to the Kitchen Supervisor for approval.
-The Kitchen Supervisor would make corrections and she would go back in to the computer and edit the menus.
-Once the menus were edited and approved, they would be given to the kitchen staff.

Review of the facility generated menu dated 2/24/2016 posted in the hallway revealed:
-Breakfast was to include: cereal, eggs, link sausage, toast/jelly, water/juice/coffee.
-Lunch was to include: baked chicken, mashed potatoes, peas, corn bread, beverage.
-Dinner was to include: taco salad, Spanish rice, corn, beverage.
-Alternate was managers choice.

Observation of the breakfast meal on 2/24/2016 at 8:30 AM revealed:
-All residents were served water, juice and coffee upon request.
-Some residents were served scrambled eggs and others a hardboiled egg.
-All residents were served 1 piece of link sausage.
-All residents were served a biscuit.
-Kitchen staff came out with packages of non-sugar free jelly and passed it out to any resident that requested.

Continued interview with the second Cook on 2/24/2016 at 9:45 AM revealed:
-All residents were served grits, eggs, 1 sausage link, 1 biscuit and beverage of choice.
-He gave anyone jelly that requested it.

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D 292	Continued From page 16	D 292		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to assure any substitutions made in the menu to be of equal nutritional value, appropriate for therapeutic diets (no concentrated sweets, no added salt, and pureed diets) and documented to indicate the foods actually served to the residents. The findings are: Observation of the kitchen on 2/23/2016 at 11:00 AM revealed: -There was a facility generated menu for 2/23/2016 posted on the wall. -There was no therapeutic menu found in the kitchen. -There was a diet list posted which included individual resident's names and the type of diet they should receive. Interview with the cook on 2/23/2016 at 11:00 AM revealed: -He had been working in the kitchen a few months. -There were 2 cooks that worked in the kitchen. -He was trained by the second cook. -He had always used the typed and printed menu that was given to him by the Kitchen Supervisor.	D 292		

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D 292	Continued From page 17 -He was not aware if there was a substitution book. Review of the substitution log on 2/24/2016 at 9:45 AM revealed the most recent entry was dated 9/15/2015. Interview with a second Cook on 2/24/2016 at 9:45 AM revealed: -He was trained by the previous cook that was no longer employed there. -He trained the new cook. -There was a substitution book kept in the kitchen. -The kitchen staff used the substitution book when they needed to substitute a menu item for something else. -The kitchen staff rarely had to use the substitution book because the Kitchen Supervisor ordered the food using the menu he provided for the kitchen to use. Review of the facility generated menu dated 2/24/2016 typed posted in the hallway revealed: -Breakfast was to include: cereal, eggs, link sausage, toast/jelly, water/juice/coffee. -Lunch was to include: baked chicken, mashed potatoes, peas, corn bread, and beverage. -Dinner was to include: taco salad, Spanish rice, corn, beverage. -Alternate was manager's choice. Observation of the breakfast meal on 2/24/2016 at 8:30 AM revealed: -All residents were served water, juice and coffee upon request. -Some residents were served scrambled eggs and others a hardboiled egg. -All residents were served 1 piece of link sausage.	D 292		

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D 292	Continued From page 18 -All residents were served a biscuit. -There was no milk served. -Kitchen staff came out with packages of non-sugar free jelly and passed it out to any resident that requested. Continued interview with the second Cook on 2/24/2016 at 9:45 AM revealed: -He decided to serve biscuits instead of toast that morning for breakfast. -He made scrambled eggs using real liquid eggs in a carton because he did not have enough fresh eggs. -He boiled what he had of fresh eggs and served those when he ran out of the scrambled eggs. -He did not document this in the substitution book. Review of Weekly Menu for Fall/Winter 2015-2016 - Week 1 that was provided on 2/24/2016 revealed: -Breakfast should have included: orange juice, cereal, eggs, breakfast meat, biscuit, jelly and 2% milk. -Lunch should have included: glazed pork chop, baked potato half, greens, chocolate revel bar and cornbread. Observation on the lunch meal on 2/24/2016 at 12:30 PM revealed residents were served baked chicken, mashed potatoes, peas, cornbread and beverage of choice. Interview with the Kitchen Supervisor on 2/24/20016 at 12:46 PM revealed: -The kitchen staff was trained by the cook that had been working there the longest. -He would make the menus each week using the food service approved menus that were on the USB drive.	D 292		

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D 292	Continued From page 19 -He would change some of the menus because of cost effectiveness and resident preferences. -The kitchen staff would utilize a substitution book in the kitchen if they were not able to serve what was on the menu. -He was not aware there needed to be entries for the substitutions when he altered the menu. -He would ensure that he and the kitchen staff utilized a substitution book for every substitution made from now on. Review of the substitution log on 2/25/2016 at 8:00 AM revealed the most recent entry was dated 9/15/2015.	D 292		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 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: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, interviews and record review; the facility failed to offer 8 ounces of milk twice a day to 7 of 7 (#1,#2,#4,#5,#8,#9,#10) sampled residents that were to have received milk. The findings are:	D 299		

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D 299	Continued From page 20 Review of Resident's #1,#2,#4,#5,#8,#9,#10 diet orders revealed each resident should have received milk twice a day. Observation of the refrigerator on 2/24/16 at 7:30 AM revealed there were 5 gallons of milk. Observation of the breakfast meal on 2/24/2016 at 8:30 AM revealed 7 of 7 sampled residents were not served or offered milk. Three confidential resident interviews revealed: -There was no milk offered for breakfast today (2/24/2016). -The residents were only given milk if they asked for it. -The residents only received milk if they had cold cereal. -Cold cereal was not served today (2/24/2016) unless you requested it. -Not all residents knew they could ask for milk. -The residents were served coffee, orange juice and water at breakfast. Review of the 2/24/16 breakfast menu revealed 8 ounces of 2% milk were to be served to all residents. Observation of the lunch meal on 2/24/2016 at 12:30 PM revealed no milk was served to the residents. Confidential staff interview on 2/24/2016 at 8:35 AM revealed: -There was milk on hand at the facility and residents could have milk anytime they requested it. -The facility never served milk unless a resident requested it.	D 299		

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D 299	Continued From page 21 Interview with a Cook on 2/24/2016 at 8:05 AM revealed: -He was trained by the previous cook that no longer worked at the facility. -Milk was served if there was a doctor's order. -Milk was given upon request by the resident only. -He was not aware the facility must offer milk to all resident's twice a day. Interview with the Kitchen Supervisor on 2/24/2016 at 8:10 AM revealed: -The facility always had milk available. -Some resident's would ask for milk. -All residents knew they could ask for milk and receive it. Interview with the Resident Care Coordinator on 2/24/2016 at 11:30 AM revealed: -He was responsible for obtaining diet orders from the primary care provider. -He would provide a diet list for the kitchen staff to follow. -He was not responsible for any menus or what was being served by the kitchen. -The Kitchen Supervisor and Administrator was responsible for kitchen staff. Interview with the Administrator on 2/24/2016 at 2:00 PM revealed: -The Kitchen Supervisor was responsible for the kitchen and the kitchen staff. -She was not aware milk must be offered to each resident, not just upon request. -There was milk available in the kitchen for the resident's. -She would ensure all residents were offered milk per the menu.	D 299		

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D 299	Continued From page 22 Confidential interview with 3 residents in the dining room on 2/25/2016 at 8:00 AM revealed: -They had lived at the facility for about 3 years. -Today (2/25/2016) was the first day they were offered milk without having to ask for it.	D 299		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 14 hours of a variety of planned group activities per week for residents residing at the facility. The findings are: Review of the wall calendar and dry erase board revealed: -Seven sheets of paper with red marker hand writing was posted on the wall bulletin board in the hallway outside of the activity room.	D 317		

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D 317	Continued From page 23 -The first hand written sheet of paper noted Saturday, 2/20/16 as " Free Day " (resident ' s choice of activities) and the second sheet of paper noted for Sunday, 2/21/16 " Church worship service " at 10:00 a.m. -The third hand written sheet of paper noted Monday, 2/22/16 as follows: 9:30 a.m. " Morning Check-In, " 10:00 a.m. " Bingo, " 11:00 a.m. " Arts & Crafts, " 1:15 p.m. " Remember When, " and 2:15 p.m. " Trivia. " -The fourth hand written sheet of paper noted Tuesday, 2/23/16 as follows: 9:30 a.m. " Morning Check-In, " 10:00 a.m. " Tabletop Games, " 11:00 a.m. " Po-Ke-No, " 1:15 p.m. " Arts & Crafts, " and 2:15 p.m. " Hot Potato. " -The fifth hand written sheet of paper noted Wednesday, 2/24/16 as follows: 9:30 a.m. " Morning Check-In, " 10:00 a.m. " Games, " and 1:30 p.m. " Resident Counsel. " -The sixth hand written sheet of paper noted Thursday, 2/25/16 as follows:9:30 a.m. " Morning Check-In, " 10:00 a.m. " Tabletop Games, " 11:00 a.m. " Shuffle Board, " and 1:15 p.m. " Surprise Party. " -The seventh hand written sheet of paper noted Friday, 2/26/16 as follows: 10:00 a.m. " Arts & Crafts - Birthday Cards, " 11:00 a.m. " Prep for Birthday Party, " and 1:20 p.m. " Shopping Trip. " -No end times were specified for any of the activities noted on the seven hand written sheets of paper posted. -A small dry erase board with black marker handwriting was posted on the lower half of the activity door. -Activities for the entire month of February 2016 were written on the dry erase board. -The activities written on the dry erase board for the seven days posted on the wall bulletin board were exactly the same for those five days. -The dry erase board did not have end times	D 317		

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specified for the activities noted for the entire month of February 2016.
-Fourteen hours or more of a variety of planned activities were not noted on the seven hand written sheets of paper of activities on the wall bulletin board or on the hand written dry erase board of activities for the month of February.

Observation of the facility activity room on 2/23/16 at 2:21 p.m. revealed:
-No scheduled activities were occurring as noted on the seven day wall calendar and month at a glance dry erase board.
-The activity room was empty.
-The scheduled activity for that day beginning at 2:15 p.m. was noted on both calendars as " Hot Potato. "

Second observation of the facility activity room on 2/23/16 at 3:37 p.m. revealed:
-No activities were occurring.
-The activity room door was closed.
-No activities were scheduled.

Interview with the Administrator on 2/23/16 at 4:03 p.m. revealed:
-The activity intern worked 10:00 a.m. - 1:00 p.m. and was not certified.
-The activity intern may arrive at 8:00 a.m. to prep the activity room area.
-The activity room was the primary area where activities were held daily.
-The activity director, who was certified, oversees the activity intern.
-Both the Activities Director and Activities Intern developed the activity schedules together.
-Activities end at 3:00 p.m. when the Activity Director left for the day.
-The Activities Intern had coordinated off campus trips.

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-Off campus activities occurred at least twice per month.
-The Activities Intern made announcements over the intercom when activities were about to start.
-The Activities Director and Activities Intern both have gone to the residents to encourage participation in activities.
-Assessments were completed on each resident to determine leisure interests by the Activities Director and Activities Intern were reviewed (by surveyor).

Interview with the Activities Intern on 2/24/16 at 9:08 a.m. revealed:
-She had been working with the residents at the facility since October 2015.
-Activities usually last about an hour with the exception of " Morning Check-In " which lasted about 30-minutes.
-She did not know that ending times for the activities needed to be listed.
-She was not aware that at least 14 hours of activities were to be scheduled weekly.
-She followed the schedule as posted " most of the time but the residents may vote to something different. "
-She made the hand written sheets posted outside of the activity room to provide the residents with a " week at a glance that was easier to read. "
-She wrote the handwritten month at a glance calendar on the dry erase board posted on the activity room door.
-She developed the monthly activity calendar with resident input.
-There were 10-12 residents at a time engaged in activities in the activity room.
-Each resident has the opportunity to take part in the activities offered.
-She made an announcement prior to starting

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT GREEN OF CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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activities to encourage participation.
-She talked with the residents to encourage participation in activities.
-Community outings were scheduled for all residents.
-A variety of activities were offered to residents with their input on the kinds of activities they preferred.
-She had a book of leisure assessments which were performed on each resident.
-The Activity Director completed the initial leisure assessments on the residents and she would complete the six month updates on each resident.
-These assessments included questions related to the residents ' activity preferences.

Interview with the Activity Director on 2/24/16 at 9:20 a.m. revealed:
-She had not seen the week at a glance on bulletin board or the monthly schedule created by the activities intern due to being assigned additional job responsibilities " up front. "
-She was not aware of the duration of each activity posted because she was " in the office more so now. "
-The Activities Intern was informed by her to ensure all activities had " start and end times. "
-She knew all activities required " start and end times " and should be " 14 hours minimum per week per her training and certification. "
-She would now make daily checks of the calendars and activity areas down the hall to ensure that activities have beginning and ending times.
-She expected the activities listed to occur as scheduled and " if a change was made, it should be reflected on the calendars. "
-The Activities Intern coordinated community outings at least once monthly for all residents.

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-Not all the residents chose to go on community outings but were encouraged by the Activities Intern as well as herself to participate.
-The Activities Intern completed the monthly activities schedule, but would keep her informed of any issues or concerns.
-She completed the initial leisure assessments on residents and would have the Activities Intern complete the follow-up six month updates.

Observation of activity room on 2/24/16 at 10:24 a.m. revealed:
-Seven residents were observed participating in Arts & Crafts assisted by the Activities Intern.
-The week at a glance (7 hand written sheets of paper) was gone and the bulletin board was empty.
-The hand written dry erase board remained as posted on the lower portion activity room door.
-The scheduled activity on the hand written dry erase board was " Games " at 10:00 a.m.
-A few of the seven residents were playing " cards " and not engaged in the Arts & Crafts " activity.

Second interview with the Administrator on 2/24/16 at 10:50 a.m. revealed:
-She was not aware that there were no end times noted for the activities written on the monthly activities calendar or week at a glance calendar.
-To her knowledge, more than 14 hours of activities occurred weekly " because there is always something happening down the hall down there in that room all day. "
-She was aware of the minimum 14 hour requirement for weekly scheduled activities offered to residents.
-She would ask the Activity Director to follow-up with the Activities Intern to correct the monthly and week at a glance calendars to reflect ending

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times for activities as well as to ensure the 14 hour requirement is met.
-She was not aware that activities were not occurring as posted on the calendars.
-She would follow-up with the Activity Director and Activities Intern to ensure that modifications were made to the calendar as needed daily to reflect resident choice or prefer changes.

Observation of announcement made over the intercom on 2/24/16 at 10:57 a.m. revealed:
-Residents were invited to attend Arts & Crafts in the activity room.
-The scheduled activity as noted on the dry erase board, month at a glance calendar, was " Games of Choice. "
- " Games of Choice " were scheduled to begin at 11:00 a.m.

Observation of bulletin board outside of activity room on 2/24/16 at 11:34 a.m. revealed:
-Five typed sheets of paper on the bulletin board outside the activity room with start and end times for all activities listed from Wednesday through Sunday.
-The five typed sheets on bulletin board noted Arts & Crafts to begin at 11:05 a.m. and to end at 12:05 p.m.
-The hand written dry erase board on the activity room door had " Games of Choice " scheduled for 11:00 a.m.
-The month at a glance dry erase board do not have specified end times for activities listed.
-The Activities Intern came out, removed the dry erase board, and said that she would update the month at a glance board and possibly type it later.
-At least fourteen hours were specified on the five day typed calendar of scheduled activities.
-Unable to determine fourteen hours of scheduled activities from the hand written dry erase board

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D 317	Continued From page 29 for the month of February 2016 activities due to no specified ending times. Interviews with six residents regarding activities revealed: -A variety of activities were not offered. -They were asked what their preferences were by the Activities Intern but these were not offered. -The same activities such as " Bingo " and " Card Playing " occurred most of the time. -The residents would like more variety or activity choices.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of 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 observations, interviews, and record review the facility failed to assure staff implemented severe weather conditions procedures in accordance to the facilities emergency procedures guide. The findings are: Record review of the facility license revealed: -The facility capacity was 120 residents. -On 2/24/16 the facility census was 83 residents. Review of emergency broadcast alert system on 2/24/16 revealed:	D 338		

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-A tornado warning had been declared for the area at 3:38pm until 4:15pm. Instructions were given to take shelter now.
-A second tornado warning had been declared for the area at 4:14 pm until 5:00pm. Instructions were given to take shelter now.
- A third tornado warning had been declared for the area at 4:15 am until 5:00pm. Instructions were given to take shelter now.

Observation on 2/24/16 at 3:40 pm through 4:45pm revealed:
-The Administrator instructed staff to take residents' into the dining room.
-The Administrator instructed a staff member to stop buffing the middle hallway floor.
-The Resident Care Coordinator (RCC) was working in her office.
-The Business manager was working in her office.
-Personal Care Aides where assisting residents into the dining room.
-The Medication Aide pushed two medication carts into the dining room.
- The dining room had 5 large windows on each side of the dining room which included a glass pane exit door.
- Residents were placed at tables next to the windows on each side of the room.
- Residents were move into the center hallway at 4:45pm (The tornado warning expired at 5:00pm)

Review of the facilities current emergency procedures guide dated 8/06 revealed:
- A heading titled " Tornado " .
-If a tornado warning is declared, move all residents into the center hall.
-Stay away from windows and doors.
-Place blanket over any door that has glass in it.
-When the threat is over, assess all residents and

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then return them to their rooms.

Interview with the RCC on 2/25/16 at 10:59 am revealed:
-He was trained on inclement weather about a year ago.
-When there was a tornado warning, staff should get resident in a closed space away from windows, have them protect their heads and face in a crotched position.
-Remove residents away from windows.
-It's a team effort to get residents in place. "The medication aides and personal care aides monitor the resident until the end of the warning or event".

Interview with the Medication Aide on 2/25/16 at 11:06 am revealed:
-Staff had been trained on fire drill, the medication aide did not remember being training on tornado preparedness " I could have been off that day " .
-Keep residents away from all windows.
-Account for residents and inform the residents what is going on.
-"Normally, residents meet in the dining room for emergencies".

Interview with a Personal Care Aide (PCA) on 2/25/16 at 11:17 am revealed:
-They had just started work at the facility about one month ago.
-She had been trained on emergency drills, fire alarms, storms on the second day of employment.
-The PCA had not been trained on what to do in the event of a tornado.
-The PCA was instructed "if an emergency occurs put residents in the hall for fires, storms and emergencies".

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D 338	Continued From page 32 Interview with another Medication Aide/Personal Care Aide (MA/PCA) on 2/25/16 at 11:20am revealed: -It was her third day of employment and had not had training for emergencies. -The MA/PCA had training at her previous employment and was trained to go into all rooms, pull privacy curtain, make sure residents were covered with blankets, also pull window to make sure no glass hit the residents. -Line residents up on one side of the hall and close all the fire doors, make sure staff had blankets to cover residents. -The MA/PCA was not sure what the procedures were at the facility, but that was what she had learned at a previous facility. Interview with another PCA on 2/25/16 at 11:28 am revealed: -She had received training for emergencies with a previous employer. - In case of emergency read the fire evacuation plan. -If something happened "I would rely on previous training" and get the non-ambulatory residents first. - The PCA was not sure if there were emergency directions posted at the facility. -In case of an emergency "I would follow the directions of the Administrator". Interview with a Cook on 2/25/16 at 11:48 am revealed: -He had not received training for emergencies related to weather conditions. -The cook would implement what he had learned at other places in case an emergency occurred at the facility.	D 338		

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D 338	Continued From page 33 Interview with another Cook on 2/25/16 at 11:50 am revealed: -"I had not had training for tornados". -"Yesterday, was the first experience of a tornado procedures". - "I had training for what to do if it was a fire but nothing with tornados or other weather events". Interview with the Administrator on 2/25/16 at 10:45am revealed: -Residents were taken into the dining room on 2/24/16 to get a head count of residents prior to instructing the resident to go into the hallway. -The emergency procedures guide had been effective for about 10 years. - "We had never had tornado before, we are used to hurricane warnings". -"Staff were trained on yesterday on what to do. "I instructed them to take residents to the dining room so we could account for each resident". The facility submitted a Plan of protection on 2/25/16 as follows: -In the event of the threat of a natural disaster. All residents will be moved to a central location to be accounted for and relocated to the safest area to avoid harm. -All staff will be in-serviced on natural disasters and residents will be located to a safe area. -Staff will be in- serviced on the threat of natural disasters. -All staff will know locations that are deemed safe for residents until the threat is resolved. -Staff will be in serviced quarterly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 26,2016.	D 338		

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D911	Continued From page 34	D911		
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: The facility failed to assure full recognition of indiviuality and right to privacy for 1 resident (Resident #11), and respect, consideration and dignity for 1 resident (Resident #1) related to pureed diet preparation. The findings are: 1.Review of Resident #11's FL-2 dated 2/12/2015 revealed diagnoses of seizure disorder, severe mental retardation, psoriasis and psychosocial stressors. Interview with Resident #11 on 1/19/2016 at 12:18 PM revealed: -He and Resident #12 kissed but went no further and Resident #12 enjoyed the kiss. -The two of them would have meals together and he considered Resident #12 as his girlfriend. -Resident #12 would come to his room and he would go to her private room. -They communicated by writing notes. -Staff told him in the beginning of January 2016 to stay away from Resident #12, and staff had been trying to keep them apart. -He ended the relationship with Resident #12 because of all the hassel from staff. Review of facility security system for 1/15/2016 at 8:37 PM revealed:	D911		

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D911	Continued From page 35 -The medication aide (MA) was making rounds on the 200 hallway. -Resident #11 was on the 200 hallway and waited for the med aide to leave the hall then sneaked into Resident #12's room. -Resident #11 entered Resident #12's room at 8:38 PM and was found in the room by the MA at 10:33 PM -Resident #11 did not leave the room until the MA found him in the room. Interview with Medication Aide on 1/19/2016 at 2:58 PM revealed: -On 1/15/2016 he found Resident #11 in Resident #12's room when making rounds -Upon entering the room Resident #11 was sitting in his wheelchair in front of Resident #12's bed (Resident #12 was sitting on her bed). -Resident #12 seemed upset the other resident was in the room and she was motioning to the MA that she did not want him in the room (pointing at Resident #11 with her hands in the air pointing at the door and motioned to med aide she was trying to sleep). -The MA told Resident #11 to leave the room. Confidential interview with a Resident revealed: -Resident #11 has been harassing Resident #12 since November of 2015. -On 11/25/2015 Resident #11 tried to kiss Resident # 12 in the television room. -On 1/16/2016 Resident #11 was "kicked out" of Resident #12's room. -On 1/17/2016 Resident #11 attempted to enter Resident #12's room, when he noticed who was in the room he left. Confidential Interview with an Employee on 1/19/2016 revealed: -Resident #11 had been after Resident #12 since	D911		

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D911	Continued From page 36 11/20/2015. -Several staff had talked with Resident #11 explaining to him he had to leave Resident #12 alone. -The Administrator talked to Resident #11 before he went home for the Christmas holidays and informed him to leave Resident #12 alone. -Resident #11 would try to sit beside Resident #12 in the dining hall, Resident #12 would raise her hand asking to move or to have Resident #11 moved away from her. -Resident #11 continually asked questions about Resident #12. -Resident #12 could not lock her door and had no way to signal if she was in danger. Confidential interview with a second Resident on 1/19/2016 revealed: -Resident #11 had been bothering Resident #12, trying to sit next to her in the television room and dining room. -Resident #12 becamed upset when Resident #11 came around because he always bothered her and was always trying to go to her room. Interview with Administrator on 2/25/2016 at 9:25 AM revealed: -Resident #11 was informed on 12/24/2015 to refrain from pursuing a Resident #12. -Resident #12 was too young for Resident #11 to hang around with and Resident #12's guardian was informed at admittance to the facility she would be kept safe at the facility. -The relationship between Resident #11 and Resident #12 had made the Administrator uncomfortable because Resident #11 was paying to much attention to Resident #12.	D911		

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D911	Continued From page 37 2. Review of Resident #1's current FL-2 dated 4/15/15 revealed: -Diagnoses included congestive heart failure, hypothyroidism, chronic obstructive pulmonary disease, atrial fibrillation, dementia, coronary artery disease, hypertension, cardiac failure, osteoporosis and history of falls. Review of the Resident Register revealed Resident #1 was admitted to the facility 4/16/14. Review of the facility diet list (no date) revealed Resident #1 was on a pureed diet. Interview with the Kitchen Supervisor on 2/23/2016 at 4:00 PM revealed: -He was responsible for the kitchen. -The cook that had been there the longest was responsible for training all new kitchen staff. -The cook that did the training was instructed by the previous cook that was no longer employed at the facility. -He was not familiar with exactly how the kitchen prepared the food. Observation in the kitchen on 2/24/2016 at 8:30 AM revealed: -The kitchen staff was preparing a pureed diet for Resident #1. -The cook added 1 scoop of grits, 1 scoop of scrambled eggs and 1 link of sausage into the food processor and blended it all together. -Once the food was blended together, it was scooped out of the food processor into the large section of a divided plate. -The plate was given to a Personal Care Assistant (PCA) to serve to Resident #1. Interview with a Personal Care Assistant (PCA)	D911		

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D911	Continued From page 38 on 2/24/2016 at 8:38 AM revealed: -Resident #1's breakfast was always pureed together and put into the large section of the divided plate. -Resident #1 usually ate most of all her meals. Observation of Resident #1 during the breakfast meal on 2/24/2016 at 8:40 AM revealed: -The resident was served a divided plate with 3 sections at 8:40 AM. -The large section of the plate had an unidentifiable beige colored food of pureed consistency. -Resident consumed 100% of food by 8:52 AM. Observation, Interview and record review of Resident #1 revealed she was not able to be interviewed. Observation in the kitchen on 2/25/2016 at 8:35 AM revealed: -The kitchen staff was preparing a pureed diet for Resident #1. -The cook added 1 scoop of grits, 1 waffle, 1 slice of country ham, 2 tablespoons of pancake syrup and a small amount of milk into the food processor and blended. -Once the food was blended together, it was scooped out of the food processor into the large section of a divided plate. -The plate was given to a PCA to serve to Resident #1. Interview with a Cook on 2/25/2016 at 8:35 AM revealed: -The other cook had trained him. -He had worked there a few month. -He had always prepared the pureed meal by adding all food items to the food processor and blending together.	D911		

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D911	Continued From page 39 -He did not know you should pureed the items separately and utilize the 3 sections of the divided plate. Interview with the second Cook on 2/25/2016 at 8:35 AM revealed: -He was trained by the previous cook that was no longer employed there. -He had always prepared the pureed meal by adding all food items to the food processor and blending together. -He did not know you should pureed the items separately and utilize the 3 sections of the divided plate. Interview with a second PCA on 2/25/2016 at 8:45 AM revealed: -The kitchen always served pureed meals by putting all the food together. -Resident #1 ' s breakfast, lunch and dinner always was mixed together and served in the large section of the divided plate. Interview with the Administrator on 2/25/2016 at 9:00 AM revealed: -The Kitchen Supervisor was responsible for the kitchen. -When the kitchen prepared a pureed diet, they added all the food items into the food processor and blended together. -The kitchen staff would add thickener, milk or water to achieve the correct consistency. -She was unsure of how long the kitchen staff had been serving a pureed diet that way.	D911		
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:	D912		

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	HAL068024	A. BUILDING: _____ B. WING _____	C 02/25/2016

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D912	Continued From page 40 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure resident received care and services which are adequate related to supervision of residents with falls and implementation of emergency procedures in accordance to facility policy during and active tornado declaration. The findings are: 1. Based on observations, interviews, and record review the facility failed to provided supervision for 1 of 4 sampled residents(#1) who had falls and sustained injury. [Refer to Tag 270, 10A NCAC 13F .0901 (b) (Type A2 Violation)] 2. Based on observations, interviews, and record review the facility failed to assure staff implemented severe weather conditions procedures in accordance to the facilities emergency procedures guide. [Refer to Tag 338, 10A NCAC 13F .0909 (Type B Violation)].	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care	D935		

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D935	Continued From page 41 home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by:	D935		

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D935	Continued From page 42 TYPE B VIOLATION Based on record review and interview, the facility failed to assure 1 out of 5 sampled staff (Staff D) had completed Medication Aide written exam, medication competency validation, and completed 5,10, and 15 hour Medication Aide training. The findings are: Review of Staff D's Personnel File revealed: -Staff D had a medication clinical skills checklist dated for 08/14/2015. -There was no documentation that Staff D had medication training. -There was no documentation that Staff D had taken the state medication exam. Review of a resident's February 2016 Medication Administration Record (MAR) revealed on 02/24/2016 Staff D documented he administered 50 milligrams of Tramadol (a narcotic used for moderate to severe pain) at 6:00 AM. Review of a second resident's February 2016 Medication Administration Record (MAR) revealed on 02/24/2016 Staff D documented he administered 20 milligrams of Opana extended release (a narcotic used for severe pain) at 6:00 AM. Review of a third resident's February 2016 Medication Administration Record (MAR) revealed: -On 02/24/2016 Staff D documented he administered 2 units of Humalog Insulin (a fast acting insulin) at 8:00 AM in the resident's left arm. -He also documented the finger stick blood sugar result was 234.	D935		

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D935	Continued From page 43 Review of a fourth resident's February 2016 Medication Administration Record (MAR) revealed on 02/09/2016 and 02/24/2016 Staff D documented he administered 112 micrograms of Synthroid (a replacement therapy for hormones normally produced by the thyroid gland) at 6:00 AM. Review of a fifth resident's February 2016 Medication Administration Record (MAR) revealed: -On 02/09/2016 Staff D documented he administered 12 units of Humalog Insulin (a fast acting insulin) per sliding scale at 8:00 AM in the right arm. -He also documented the finger stick blood sugar result was 275. Review of a sixth resident's February 2016 Medication Administration Record (MAR) revealed on 02/09/2016 and 02/24/2016 Staff D documented he administered 975 milligrams (1 Tab=325 milligrams) of Tylenol (a pain reliever and fever reducer) at 11:00 PM. Review of a seventh resident's February 2016 Medication Administration Record (MAR) revealed on 02/09/2016, 02/15/2016, and 02/24/2016 Staff D documented he administered 25 micrograms of Synthroid (a replacement therapy for hormones normally produced by the thyroid gland) at 6:00 AM. Review of an Eighth resident's February 2016 Medication Administration Record (MAR) revealed on 02/09/2016 and 02/24/2016 Staff D documented he administered 25 micrograms of Synthroid (a replacement therapy for hormones normally produced by the thyroid gland) at 6:00	D935		

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D935	Continued From page 44 AM. Review of a ninth resident's February 2016 Medication Administration Record (MAR) revealed on 02/24/2016 Staff D documented he administered 150 micrograms of Synthroid (a replacement therapy for hormones normally produced by the thyroid gland) at 6:00 AM. Review of a tenth resident's February 2016 Medication Administration Record (MAR) revealed on 02/15/2016 Staff D documented he administered 50 milligrams (1/2 Tab) of Tramadol (a narcotic used for moderate to severe pain) at 12:30 AM. Interview with a Medication Aide on 02/25/2016 at 9:42 AM revealed: -Staff D was hired to work as a cook. -Staff D now works as a personal care aide. -Staff D started training to be a medication aide sometime last year, but he was not sure when. -He took training courses with Staff D. -Staff D had not taken his state medication exam. -Staff D was pulled off the medication cart and put back on the floor as a personal care aide. -He was not sure of when the last time that Staff D worked on the medication cart was. -He was not aware of any issues that occurred while Staff D was passing medications. Telephone interview with Staff D on 02/25/2016 at 9:53 AM revealed: -He had been working at the facility for a little more than a year. -He worked the first 6 months as a cook. -Currently working as a personal care aide for the facility. -He had some training for being a medication aide sometime in December of 2015.	D935		

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D935	Continued From page 45 -He was not sure of how many times since his training he worked on the medication cart. -He did receive the 5 and 10 hour training that was required by the state but he was not sure when he did that training. -He was not sure of who provided the 5 and 10 hour training to him. -All the training that he had received to be a medication aide was done at the facility. -He did have some training on passing medications that was done by two of the medication aides that worked at the facility. -He had never taken the state medication exam. -He plans to take it in the next week or two. -The last time that he worked on the medication cart was on 02/24/2016 from 11:00 PM to 7:00 AM. -He passed some medications during that shift. -He did not pass any other medications. Confidential interview with a resident on 02/25/2016 revealed: -Staff D had passed medications to the resident. -Staff D worked third shift as a medication aide. -Staff D checked the resident's finger stick blood sugar. -Staff D had administered insulin to the resident a few times. -The last time Staff D did the resident's medications was one day last week. Confidential interview with a second resident on 02/25/2016 revealed: -Staff D had passed medications to the resident. -Staff D checks the resident's finger stick blood sugar. -Staff D usually did the residents morning insulin dose. -The resident said Staff D passed their medications on 02/25/16.	D935		

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D935	Continued From page 46 -Staff D also gave the resident a PRN (as needed medication) Tramadol (a medications used for moderate to severe pain) this morning. Interview with the Resident Care Coordinator (RCC) on 02/25/2016 at 10:35 AM revealed: -Staff D started out working in dietary as a cook. -Staff D was currently in the process of getting his training to be a medication aide. -He was not sure when Staff D started his training to be a medication aide. -Staff D had been working as a personal care aide lately. -He was not sure if Staff D had taken his state medication exam. -It was the Administrators responsibility to make sure staff received their training. -The Administrator made the schedules for all staff. Interview with the Administrator on 02/25/2016 at 12:32 PM revealed: -Staff D had received his medication aide training. -Staff D's medication clinical skills check off competency was done sometime in August of 2015. -She was not sure when Staff D did his 5 hour training. -She was not sure where his documentation for his training was at. -She did contact the nurse who did the training but was unable to get up with the nurse in regards to the training. -She pulled Staff D off the medication cart in November 2015 because he has not been to take his Medication Aide exam. -He had not worked as a medication aide since she pulled him off the medication cart. -She did let Staff D hold the keys on 02/24/16 but only because she was in the building.	D935		

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D935	Continued From page 47 -She had no other choice but to let him hold the keys due to recently letting an employee from third shift go and she did not have anyone else to work. -Staff D was only to check in the medication brought in by the pharmacy or if he needed to get something out of the medication room for a resident. -Staff D was not passing any medications while he was holding the keys. -There are no medication passes done on the 11:00 PM to 7:00 AM shift. -There are some 6:00 AM medication passes but when Staff D worked she brought in the first shift person early to pass those medications. -Staff D was allowed to pass out any PRN (as needed medications) medications that residents might need while he was holding the keys. -She was not aware of Staff D passing out any medications while he was working. -She was responsible for keeping up with staff training and did staff schedules. The facility provided a plan of protection as follows: -No staff will administer medications without proper training and qualifications. -All staff will have medication training and validations prior to administering medications. -The Administrator will ensure complete compliance. -All staff records will be reviewed and any training will be done immediately to avoid harm or create safety issues while administering medications. -All training requirements will be met prior to medications administration by any individual.	D935		

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D935	Continued From page 48 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2016.	D935		