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	HAL026052	A. BUILDING: _____ B. WING _____	02/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY PINES ADULT CARE	2521 MURIEL DRIVE FAYETTEVILLE, NC 28306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 02/23/16 - 02/25/16.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls and floors for 4 of 4 common bathroom/shower rooms and the hallway on the long hall and 1 of 2 shared resident bathrooms on the short hall were kept clean and in good repair. The findings are: 1. Observation on 02/23/16 of the hallway on the long hall at 12:48 p.m. revealed: - Floor vent in front of the exit door was rusty with dark brown stains. Observations on 02/23/16 of the shower room located between Rooms #8 and #12 on the long hall at 12:50 p.m. revealed: - There were dark, dirty scuff marks along the bottom third of the walls to the entrance of the shower room. - Paint was chipped and peeling on the wall surrounding the main showerhead. - The tiles and grout under the main showerhead had scattered dark black brownish stains. - The lower wall next to the entrance of the rear shower had two round brown stains approximately 6 inches long.	D 074		

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D 074	Continued From page 1 - The paint was cracked and chipped along the wall next to the base of the tub. - Brown stains were seen along the white molding of the tub and on the walls surrounding the tub. - Two grayish black scuff marks approximately 3 feet long were on the lower wall behind the shower room door. - The left lower wall and door frame inside the entrance way of the shower room had chipped, peeling paint that was stained with blackish brown spots and rust. Observations on 02/23/16 of the shower room located between Rooms #6 and #8 on the long hall at 1:02 p.m. revealed: - The door to the shower had 2 black stains that extended across the width of the lower bottom of the door. - The base of the inside door frame and surrounding flooring had rust and dark brown stains. - The lower left wall located inside of the door had peeling white paint that was stained with dark brown spots. - The wall to the underside of the sink located next to the entrance door had chipped, peeling grayish paint with rust stains. - The floor vent located next to the shower was rusty with dark brown stains. - The paint was chipped and peeling around the wall surrounding the shower head. - The outside edge of the wall that was adjacent to the tub had peeling, chipped paint that extended 3 feet up from the base tile. - There was an area missing floor covering under the sink approximately 3 feet long and up to 6 inches wide with the cement subflooring exposed. Observations on 02/23/16 of the women's bathroom located between Rooms #5 and #7 on	D 074		

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D 074	Continued From page 2	D 074		

the long hall at 1:25 p.m. revealed:
- The bottom of the door had a large dark black mark that extended across the bottom width of the door.
- The wall and floor inside the entrance door had peeling paint and dark brown stains along the lower part of the wall.
- The wall baseboards were stained with black and brown spots in the grout area.
- The floor vent located across from the commode area was chipped with a brown spot covered approximately 1/3 of its length.
- The lower areas of the walls across from the commode area were covered with blackish gray scuff marks and chipped paint along the entire width of this area.
- There was a 3 foot area of chipped paint in the middle of the wall across from the commode.

Observation of the men's bathroom between Rooms #9 and #11 on the long hall on 02/23/16 at 12:59 p.m. revealed:
- There was black scuff marks and peeling paint at the bottom of the wall that expanded approximately 6 feet long.

Interview with the Administrator on 02/23/16 at 5:55 p.m. revealed:
- The area of missing floor covering under the bathroom sink had been that way since last year when the floor had to be cut to repair some leaking pipes.
- The area of missing floor covering in the hallway had been that way since he bought the building a few years ago.
- He thought it was an area of flooring that had to be removed to get to leaking pipes because it was an old building and the floors had cement underneath the covering.
- There were no current plans to repair the floor.

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D 074	Continued From page 3 - The missing paint and black scratch marks on the walls were caused by wheelchairs bumping into the walls. - They repair and paint the walls every so often every year. Interview with the Administrator on 02/24/16 at 8:50 a.m. revealed: - He just came in and had brought new floor vents. - He was going to start replacing the rusted floor vents with the new ones. - He stayed late at the facility last night and painted some of the walls in need of paint. Recheck of the shower / bathroom between Rooms #8 and #12 on the long hall on 02/24/16 at 1:25 p.m. revealed: - The rusted floor vent had been replaced with a new one. Recheck of the men's bathroom between Rooms #9 and #11 on the long hall on 02/24/16 at 1:27 p.m. revealed: - The area of the missing wall paint had been painted over. - The rusted floor vent had been replaced with a new one. Recheck of the hallway on the long hall on 02/24/16 at 1:29 p.m. revealed: - The rusted floor vent at the end of the hall near the door had not been replaced. - The area of missing floor tile was the same. Recheck of the shower / bathroom between Rooms #6 and #8 on 02/24/16 at 1:30 p.m. revealed: - The rusted floor vent had been replaced with a new one.	D 074		

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D 074	Continued From page 4 - The plaster on the wall at the bathtub had been repaired and painted. Recheck of the women's shower / bathroom between Rooms #5 and #7 on the long hall on 02/24/16 at 1:32 p.m. revealed: - The area of the missing wall paint had been painted over. - The rusted floor vent had been replaced with a new one. 2. Observation of the shared resident bathroom between Rooms #1 and #3 on the short hall revealed the floor vent cover was rusted and discolored. Interview with the Administrator on 02/25/16 at 5:25 p.m. revealed: -The Administrator acknowledged that the vent cover needed replacing. -The Administrator stated that he was in the process of replacing all floor vent covers that were in poor repair. Recheck of the shared resident bathroom between Rooms #1 and #3 on the short hall on 02/25/16 revealed the floor vent cover had not been replaced by the end of the survey.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.	D 076		

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D 076	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure 7 of 7 blue cloth chairs in the dining room used by residents were clean. The findings are: Observation of the dining room on 02/24/16 at 4:55 p.m. revealed: - There were 15 chairs at the dining room tables in the dining room. - Eight of the 15 chairs were made of black leather. - Seven of the 15 chairs were made of blue cloth material. - All 7 of the cloth chairs had multiple dark brown stains all over the seat and back cushions of the chairs. - All 7 of the cloth chairs had a brownish black build-up of dirt on the top of the back of the chair where one would grab the chair to pull it out or push it under the table. Confidential interview with a resident revealed: - The blue cloth chairs had always been stained to their knowledge. - The resident had not seen anyone clean the chairs. - It would be good to have new clean chairs to sit in for meals. Interview with the Administrator on 02/24/16 at 5:01 p.m. revealed: - The cloth chairs in the dining room have been cleaned at a carpet cleaning store in the past. - He could not recall when but stated it had been a while. - They clean the cloth dining room chairs "when they need it". - He would check on getting the chairs cleaned or replaced.	D 076		

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D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure 4 of 4 common bathroom/shower rooms on the long hall and 1 of 2 shared resident bathrooms on the short hall were maintained in a clean and orderly manner, free of all obstructions and hazards. The findings are: 1. Observations on 02/23/16 of the shower room located between Rooms #8 and #12 on the long hall at 12:50 p.m. revealed: - The showerhead was loose and extended from the wall base. - The handrail inside of the shower had a loose fitting where it was attached to the wall. - The soap dish inside of the shower was broken with jagged exposed edges. - The plastic covering of the shower curtain rod was partially stripped off the rod and this stripped covering hung down approximately 3 feet from the exposed shower rod. - The exposed area of the stripped shower rod was brown and rusty. - The inside of the tub had grayish stains on the inside of the tub and yellowish brown stains were scattered along the top ledge of the tub.	D 079		

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D 079	Continued From page 7 - The shower curtain surrounding the tub had a cloudy residue on it. Observations on 02/23/16 of the shower room located between Rooms #6 and #8 on the long hall at 1:02 p.m. revealed: - The underside of the sink located next to the door was covered with scattered rusty stains. - The sink had brownish yellow stains all over the top and inside of the sink. - The grout between the tiles inside of the tub/shower area had scattered black and brown stains. - The tile area to the left of the tub faucet was cracked. - The inside of the tub had grayish stains and yellowish brown stains were scattered along the top ledge of the tub. - The soap dish had a piece broken off exposing two jagged edges. - The lower third of the clear shower curtain had a light brown buildup of stains that spanned the width of the shower curtain. - The molding to the outside of the tub had several rust stains. Observations on 02/23/16 of the women's bathroom located between Rooms #5 and #7 on the long hall at 1:25 p.m. revealed: - The brackets to the handrails inside of both commode areas had rust stains. - The elevated toilet seat on the second commode had brown stains on its seat and back inner ledge area. - The second wall mounted light over the bathroom was not working. - The underside of the second sink located from the entrance door was covered with scattered rusty stains. - The side of the first sink located from the door	D 079		

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D 079	Continued From page 8	D 079		

was streaked with brown stains.
- The light switch cover was corroded with rust to its outer edges.

Observation of the men's bathroom between Rooms #9 and #11 on the long hall on 02/23/16 at 12:59 p.m. revealed:
- The light over the first sink was not working.
- The toilet seat near the window had an area about 8 inches long and 2 inches wide where the white coating on the seat was rubbed off.

Interview with a resident on 02/23/16 revealed:
- The soap dish has been broken off for a while in the shower.
- If you bump against it, it will cut you.
- The resident's arm was cut on the broken soap dish in July 2015.
- The resident's arm had healed now.

Recheck of the shower / bathroom between Rooms #8 and #12 on the long hall on 02/24/16 at 1:25 p.m. revealed:
- There was a new shower curtain hanging at the shower.
- The piece broken off the soap dish had been reattached and cracks could be seen where it was glued back together.

Recheck of the men's bathroom between Rooms #9 and #11 on the long hall on 02/24/16 at 1:27 p.m. revealed:
- The toilet seat had been replaced with a new one.

Recheck of the shower / bathroom between Rooms #6 and #8 on the long hall on 02/24/16 at 1:30 p.m. revealed:
- There was a new shower curtain hanging at the shower.

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D 079	Continued From page 9	D 079		

- The soap dish was still broken with rough, sharp edges.
- The tub was still dirty with the brownish stains and film covering the bottom and inside walls of the tub.

Recheck of the women's shower / bathroom between Rooms #5 and #7 on the long hall on 02/24/16 at 1:32 p.m. revealed:
- The side of the sink and the elevated toilet seat had been cleaned.

Interview with the Administrator on 02/23/16 at 5:55 p.m. revealed:
- They had tried to clean the tubs but the coating of stains will not come up.
- They had tried sanding and putting white bathtub paint on the tubs and sinks.
- They sanded and painted the tubs and sinks last year but it does not last.
- They do not have staff solely designated as a housekeeper.
- The personal care aide on first shift was the main housekeeper but she also worked as an aide at the same time.
- First shift staff cleans bathrooms every day including the tubs, toilets, and sinks.

Interview with the first shift personal care aide (PCA) on 02/24/16 at 11:40 a.m. revealed:
- She worked as a housekeeper and PCA when she was on duty Monday - Friday from 8am - 4pm.
- She detailed all rooms every other day by dusting, wiping down, and sweeping under furniture.
- She swept and mopped the floors in all rooms every day.
- She checked the bathrooms when she first came in to see if they needed cleaning and she

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D 079	Continued From page 10 detailed the bathrooms after lunch. Refer to the faclity's environmental health sanitation report dated 05/27/15. 2. Observations of the shared resident bathroom between Rooms #1 and #3 on the short hall on 02/23/16 at 1:05 p.m. revealed: -Both the tub and sink drains were encircled with rusty area approximately 4-5 inches in diameter. -Sharp, metal-like fragments could be felt around both drains in the rusted areas. -The tub caulking was discolored with a brownish, black substance. -The tub had brownish stains on the tub edge and grayish discoloration on the inside. -The hand hold on the soap dish mounted on the tile wall surrounding the tub was broken leaving 2 prongs extending outward from the wall. -The tub molding abutting the door jamb was broken at the base and missing a section approximately 8 inches long. -The commode leaked water at the base when flushed. -Paper towels were on the floor around the base of the commode. -The light switch for the overhead light on Room #1's side did not work. Interview with a resident who lived in Room #1 revealed: -The resident stated that the light from the outside security light shined through his closed window blind at night and provided some light in the bathroom. -The resident stated that he would cross the bathroom floor and turn the light on by using the switch on Room #3's side. -The resident was concerned about the content of the water leaking from the base of the commode	D 079		

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D 079	Continued From page 11 as well as the wet floor. Interview with the Resident Care Coordinator (RCC) on 02/25/16 at 4:10 p.m. revealed: -The RCC was unaware of the hazards in the bathroom shared by Rooms #1 and #3. -The RCC stated that she would try replacing the overhead light bulb in the bathroom to see if that would resolve the light switch problem. Interview with the Administrator on 02/25/16 at 5:25 p.m. revealed: -The Administrator had contacted a person who refinishes bath tubs, but he had refused to attempt the repair because the tubs are in an adult care facility. -The Administrator planned to make repairs as soon as possible. Refer to the faclity's environmental health sanitation report dated 05/27/15. Review of the facility's environmental health sanitation report dated 05/27/15 revealed: - The facility received a sanitation grade of 93.5 on 05/27/15. - The facility needed to replace all missing light bulbs throughout the facility. - The facility needed to thoroughly clean the tub and replace the moldy shower curtain in the bathroom in bedroom #4. - The facility needed to clean the tub or refinish the surface of the tub in the community bath only room and replace the shower curtain.	D 079		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of	D 164		

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D 164	Continued From page 12 Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 5 medication aides (C, D) sampled received training by a licensed health professional on the care of diabetic residents prior to administering insulin to residents. The findings are: 1. Review of Staff C's (medication aide) personnel file revealed: - Staff C was hired on 09/23/15 as a medication aide. - Staff C completed the Medication Aide Clinical Skills Validation Checklist on 10/01/15.	D 164		

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D 164	Continued From page 13	D 164		

- Staff C passed the written Medication Aide Exam on 01/17/13.
- Staff C had Medication Aide Employment Verification documented.
- There was no documentation of any diabetes training for Staff C.

Review of the facility's February 2016 medication administration records revealed Staff C administered insulin at least 14 out of 24 days from 02/01/16 - 02/24/16.

Interview with the Resident Care Coordinator (RCC) on 02/25/16 at 4:50 p.m. revealed:
- She did not recall if Staff C had completed any diabetes training.
- Staff C had always administered medications since she was hired.
- Staff C usually administered insulin to the residents when she was working as the medication aide.
- She would check to see if she could find any documentation of any diabetes training that Staff C may have completed.

No documentation of diabetes training for Staff C was provided.

Refer to interview with the RCC on 02/25/16 at 4:20 p.m.

2. Review of Staff D's (Resident Care Coordinator) personnel file revealed:
- Staff D was hired on 02/21/11 as a medication aide / supervisor.
- Staff D completed the Medication Aide Clinical Skills Validation Checklist on 02/21/11.
- Staff D passed the written Medication Aide Exam on 02/08/11.
- There was no documentation of any diabetes

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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 164	Continued From page 14 training for Staff D. Review of the facility's February 2016 medication administration records revealed Staff D administered insulin at least 8 out of 24 days from 02/01/16 - 02/24/16. Interview with Staff D (RCC) on 02/25/16 at 4:50 p.m. revealed: - She did not recall if she had completed any diabetes training. - She had always administered medications since she was hired. - She usually administered insulin to the residents when she was working. - She would check to see if she could find any documentation of any diabetes training she may have completed in the past. No documentation of diabetes training for Staff C was provided. Refer to interview with the RCC on 02/25/16 at 4:20 p.m. _____ Interview with the RCC on 02/25/16 at 4:20 p.m. revealed: - She and the Administrator were responsible for maintaining the personnel files. - She thought diabetes training for all medication aides had been done but she was not sure.	D 164		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more	D 201		

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D 201	Continued From page 15 shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure adequate staffing for 3 of 6 shifts sampled on 02/19/16 and 02/20/16 when the facility's census was 21 residents. The findings are: Confidential interview with a staff person revealed: - The Administrator took all residents to any appointments himself.	D 201		

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D 201	Continued From page 16 - The Administrator lived next door to the facility and was in and out daily but not usually there from 8am - 4pm as indicated on the schedule. - The Administrator was usually at the facility daily for an average of about 2 to 3 hours and sometimes 5 to 6 hours depending on how many appointments the residents had each day. - There was usually one medication aide, one personal care aide, and one cook on first shift. - The medication aide and the personal care aide (PCA) on first shift were also responsible for cleaning and laundry. - The cook stayed strictly in the kitchen on first shift. - There was no cook on duty on second shift. - There was no separate housekeeping staff at the facility. - When the Resident Care Coordinator (RCC) left on second shift around 8pm or 9pm, there was usually only 1 staff person on duty until third shift staff person came in. - On Saturday and Sunday, there was usually only one staff person in the facility on each shift. - The staff person thought they needed more help at the facility because they had to do multiple tasks including housekeeping, laundry, and preparing meals in addition to taking care of the residents. Review of the facility's census report revealed: - The facility had a census of 21 residents on 02/19/16. - The facility had a census of 21 residents on 02/20/16. [According to the staffing chart, 16 hours of aide duty are required for first and second shifts and 8 hours of aide duty are required for third shift for 21 residents. In addition, the Administrator/Supervisor should be in the building	D 201		

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D 201	Continued From page 17 or within 500 feet and immediately available.] Review of personnel time sheets for 02/19/16 (Friday) revealed: - The facility had 13 hours and 53 minutes of aide duty on first shift but required 16 hours. - The facility had 13 hours and 43 minutes of aide duty on second shift but required 16 hours. Review of personnel time sheets for 02/20/16 (Saturday) revealed: - The facility had 15 hours and 4 minutes of aide duty on second shift but required 16 hours. Interview with the RCC on 02/25/16 at 5:05 p.m. revealed: - They usually had one medication aide, one personal care aide, one dietary staff, and the Administrator on first shift each day. - They usually had one medication aide and one personal care aide on second shift. - She usually worked as the medication aide on second shift. - They usually had one medication aide on duty on third shift. - The Administrator lived next door and was in and out of the facility at different times throughout the day. - The Administrator usually took all residents to their appointments. Interview with the Administrator on 02/25/16 at 6:00 p.m. revealed: - He lived next door to the facility and was at the facility all the time. - He was at the facility every day. - He did not clock in when he was at the facility so he did not have a time sheet. - He was usually in the facility except when he took residents to appointments.	D 201		

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D 201	Continued From page 18 - He usually took residents to all appointments. - He was aware the facility was short staffed and he was in the process of trying to hire more help. Review of the staff schedule for the week of 02/21/16 - 02/27/16 revealed: - First shift for Monday through Friday included: one medication aide/supervisor 7am - 3pm; one aide 8am - 4pm; Administrator 8am - 4pm; and a cook 7am - 3pm. - First shift for Saturday and Sunday included: one medication aide/supervisor 7am - 3pm; one aide 8am - 3pm or 8am - 4pm. - Second shift for Sunday through Saturday included: one medication aide/supervisor for 3pm - 10:30pm and one aide for 3pm - 9pm or 4pm - 9 pm. - Third shift for Sunday through Saturday included: one medication aide/supervisor for 10:30pm - 8am.	D 201		
D 206	10A NCAC 13F .0604 (2--b) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staff The following describes the nature of the aide's duties, including allowances and limitations: (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. This Rule is not met as evidenced by:	D 206		

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D 206	Continued From page 19 Based on observation, interview, and record review, the facility failed to assure any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. were limited to occasional, non-routine tasks for medication aides and personal care aides working in the facility. The findings are: Review of the facility's resident roster on 02/23/16 revealed: - The resident had 22 residents listed on the report but 1 resident was currently in the hospital. - The facility's current census was 21 residents. Review of the staff schedule for the week of 02/21/16 - 02/27/16 revealed: - First shift for Monday through Friday included: one medication aide/supervisor 7am - 3pm; one aide 8am - 4pm; Administrator 8am - 4pm; and a cook 7am - 3pm. - First shift for Saturday and Sunday included: one medication aide/supervisor 7am - 3pm; one aide 8am - 3pm or 8am - 4pm. - Second shift for Sunday through Saturday included: one medication aide/supervisor for 3pm - 10:30pm and one aide for 3pm - 9pm or 4pm - 9 pm. - Third shift for Sunday through Saturday included: one medication aide/supervisor for 10:30pm - 8am. - The only titles listed on the schedule were medication aides, aides, cook and supervisor. - There was no staff listed as housekeepers. Observation of facility staff on 02/23/16 revealed: - At 9:25 a.m., the personal care aide (PCA) was mopping the floors in the common areas. - At 2:00 p.m., the medication aide was mopping the kitchen and dining room floors.	D 206		

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D 206	Continued From page 20 Interview with the Administrator on 02/23/16 at 5:55 p.m. revealed: - They do not have staff solely designated as a housekeeper. - The personal care aide on first shift was the main housekeeper, but she also worked as an aide at the same time. - All staff helped with housekeeping duties. - First shift staff cleaned every day including the bathrooms and common areas. - First shift staff cleaned the tubs, toilets, sinks, floors. - First shift staff mopped the floors several times a day. - When the PCA was doing housekeeping duties, the medication aide watched the residents and the Administrator administered the medications. Review of the February 2016 medication administration records revealed: - The Administrator had documented he administered medications on 2 days from 02/01/16 - 02/23/16. - He documented he administered medications at 8:00 a.m. on 02/04/16 and 02/13/16. Observation of facility staff on 02/24/16 revealed: - At 9:18 a.m., the PCA took clothes out of washing machine in one laundry room and took the clothes across the hall to another laundry room and put them in the dryer. - At 9:25 a.m., the PCA took out the trash in the common living room area and put a new trash bag in the trash can near the vending machines. - At 10:50 a.m., the PCA swept the floor on the short hall near the laundry room, the long hall, the dining room, and the common living room. - At 11:14 a.m., the PCA was in the laundry room and checked clothes in the dryer and then left the laundry room.	D 206		

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D 206	Continued From page 21 - At 11:59 a.m., the PCA came out of the laundry room with a basket of clothes. - At 12:20 p.m., the PCA had the housekeeping cart in the hallway outside of the staff bathroom and she was mopping the floor in the bathroom. The medication aide was in the medication room / office with a resident. The Administrator was in the medication room / office looking through a notebook. The cook was in the kitchen. There was no other staff on duty at that time. - At 3:00 p.m., the PCA had the mop in her hand and stated she had just finished mopping the floors on the long hallway and the short hallway. - At 3:18 p.m., the PCA had the housekeeping cart on the short hall and was inside a resident room cleaning the room. - At 5:04 p.m., the PCA was coming out of the laundry room carrying a basket of clean clothes. Interview with the first shift PCA on 02/24/16 at 11:40 a.m. revealed: - She worked as a housekeeper and PCA when she was on duty Monday - Friday from 8am - 4pm. - There was usually 2 staff physically in the facility on first shift. - The Administrator was usually at the facility Monday through Friday but left to take residents to appointments. - The Administrator was usually at the facility about 5 to 6 hours a day depending on residents' appointments. - She detailed all rooms every other day by dusting, wiping down, and sweeping under furniture. - She swept and mopped the floors in all rooms every day. - She checked the bathrooms when she first came in to see if they needed cleaning and she detailed the bathrooms after lunch.	D 206		

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D 206	Continued From page 22 - They also did laundry while on duty as well. - The residents have assigned days for laundry so they averaged about 3 to 5 loads per day during her shift. - She spent about half of her shift performing housekeeping and laundry duties. - She also helped with activities. - When she was doing housekeeping duties, the medication aide usually took over providing care to the residents. Observation of a PCA on 02/25/16 at 9:35 a.m. revealed: -PCA had the cleaning cart in a resident's room. - PCA cleaned the resident's bathroom and then mopped the resident's bathroom and the floor of the resident's bedroom. Confidential interview with a resident revealed: - The PCAs at the facility did all of the housekeeping. - The PCAs did the all the laundry, swept, mopped, and did all of the cleaning to all of the residents' rooms and bathrooms. Observation of facility staff on 02/25/16 revealed: - At 1:45 p.m., the PCA was pushing the housekeeping cart down the short hall to "clean toilets" . Observation and interview with the first shift PCA on 02/25/16 at 2:25 p.m. revealed: - The PCA was walking down the long hall of the facility with the housekeeping cart. - She reported she usually mopped the hallways and other common areas of the facility daily after lunch.	D 206		

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D 209	Continued From page 23	D 209		
D 209	10A NCAC 13F .0604 (2-e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care Other Staffing The following describes the nature of the aide's duties, including allowances and limitations (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medication aides and personal care aides were not assigned food service duties such as preparing meals. The findings are: Observation on 02/23/16 at 10:40 a.m. revealed the medication aide (MA) was clearing glasses away from dining area. Observation on 02/23/16 at 4:30 p.m. revealed the personal care aide (PCA) and the MA were in the kitchen cooking pasta sauce, elbow macaroni, as well as chopping lettuce. Review of the staff schedule for the week of 02/21/16 - 02/27/16 revealed: - First shift for Monday through Friday included: one medication aide/supervisor 7am - 3pm; one aide 8am - 4pm; Administrator 8am - 4pm; and a cook 7am - 3pm. - First shift for Saturday and Sunday included: one medication aide/supervisor 7am - 3pm; one	D 209		

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aide 8am - 3pm or 8am - 4pm.
- Second shift for Sunday through Saturday included: one medication aide/supervisor for 3pm - 10:30pm and one aide for 3pm - 9pm or 4pm - 9 pm.
- Third shift for Sunday through Saturday included: one medication aide/supervisor for 10:30pm - 8am.
- The only titles listed on the schedule were medication aides, aides, cook and supervisor.
- The only cook staff scheduled daily was from 7am - 3pm.

Interview with the Administrator on 02/24/16 at 5:30 p.m. revealed:
- The first shift cook usually cooked the supper meal and labeled it.
- All staff on second shift helped warm the food, plate the food, and serve the food.
- There was no cook on duty on second shift.
- The food for tonight's supper should be labeled and stored in the kitchen.

Observation on 02/24/16 at 5:50 p.m. revealed the Administrator was observed collecting uncooked food items from freezers and pantry for supper.

Interview with the Kitchen Manager / Cook on 02/25/16 at 9:10 a.m. revealed:
- She normally cooked 3 meals a day but since the supper menu for 02/24/16 included items that must be served hot (sausage, hash browns, mixed vegetables, bran muffins, and apple crisp) she could not prepared the meal before she left at 2:00 p.m. yesterday.
- When she does not prepare supper, either the PCA or MA would cook.

Interview with the PCA on 02/25/16 at 2:30 p.m.

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D 209	Continued From page 25 revealed: - There was no dietary staff to prepare dinner for the residents for supper. - The PCAs had to finish preparing dinner every day for residents. - The PCAs went in the kitchen for dinner and they usually had to heat up the main entrée dish. - They prepared the side dishes for the main entrée. - They prepared plates and beverages for all the residents and then the PCAs served the dinner. Observation on 02/25/16 at 6:00 p.m. revealed: - The Resident Care Coordinator was in the kitchen preparing sandwiches for the supper meal. - The MA was in the kitchen preparing sandwiches for the supper meal.	D 209		
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: TYPE B VIOLATION Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#2, #3) as related to failure to obtain oxygen as ordered by the hospitalist (#2), failure to coordinate nephrology appointment (#2), failure to notify the physician of refusals of breathing treatments (#2), failure to	D 273		

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obtain mental health services for a resident with behaviors (#3), failure to discuss abnormal thyroid labwork with the primary care physician (#3), and a missed cardiology appointment (#3). The findings are:

1. Review of Resident #2's current FL-2 dated 10/21/15 revealed:
- The resident's diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure, heart failure, and heart disease. -
Resident #2 was admitted to the facility on 10/19/15.
A. Review of Hospital Discharge Instructions for Resident #2 dated 12/28/15 revealed: - Resident #2 was hospitalized from 12/26/15 to 12/28/15 with diagnoses of acute chronic obstructive pulmonary disease exacerbation, diabetes, debility, hypertension, kidney failure, and left leg cellulitis.
- There was physician's order for Resident #2 to continue to have oxygen at night.

Review of a Physician's Order for Resident #2 dated 12/29/2015 revealed:
- An order was written for the pulmonology office to contact Durable Medical Equipment (DME) service about oxygen for Resident #2.

Interview with Resident #2 at 8:35 a.m. on 02/24/16 revealed:
- Resident #2 complained to the staff that she felt like she couldn't catch her breath and she wanted some oxygen.
- Resident #2 said she had used oxygen at night and had an order for oxygen as needed when she was at another facility.
- She wore oxygen at night when she was in the hospital for pneumonia in December 2015.

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D 273	Continued From page 27 - The medication aide (MA) told Resident #2 that she did not have an order for oxygen but asked if the resident would like to go to the emergency room. - Resident #2 did not feel she needed to go to the emergency room but she needed to have some oxygen. - The MA told Resident #2 that she did not get her oxygen yet because the resident had not completed the overnight pulse oximetry test yet. - The MA reminded Resident #2 that she had refused to have the test done on 02/19/16. - Resident #2 responded she did not refuse to have the overnight pulse oximetry test done on 02/19/16 and that staff never woke her up to put the monitor on her. Interview with the MA on 02/24/16 at 10:00a.m. revealed: - Resident #2 had refused to have testing done two times in recent months to see if the resident needed oxygen. - Resident #2 had refused to have the overnight pulse oximetry done on 02/19/16. - Resident #2 liked to play games because the resident wanted attention and that was why the resident was complaining of being short of breath earlier this morning. - The Administrator had taken Resident #2 for an appointment with the pulmonologist on 02/22/16 but the resident had been sent back because Resident #2 had refused to have the overnight pulse oximetry done on 02/19/16. - The resident had not been on oxygen since she had come to this facility. - She was not aware of any orders for Resident #2 regarding oxygen. - She did not get to see any new orders for the residents of the facility. - All new orders are handled by either the	D 273		

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Resident Care Coordinator (RCC) or the Administrator.
- She only saw new orders if there were changes on the medication administration record.
- The Administrator usually took all the residents to their doctor's appointments.

Review of shift notes for Resident #2 revealed:
- Resident #2 refused her oxygen tester on 02/19/16.
- There was no documentation of what time Resident #2 refused the oxygen testing.
- There was no signature of who documented that Resident #2 refused the oxygen testing

Interview with the RCC on 02/24/16 at 4:55 p.m. revealed:
- She served in the role of medication aide and RCC for the facility.
- She usually followed up with the providers for any new orders for residents.
- She knew the resident was supposed to have gone to the pulmonologist.
- The pulmonologist had ordered overnight pulse oximetry to be done to see if the resident needed oxygen.
- Resident #2 had not gotten any oxygen because the resident had refused to do the overnight pulse oximetry twice.
- She did not know the shift note dated 02/19/16 did not have a documented time that Resident #2 refused or a staff signature but she could find out what time it was and she knew the handwriting of the staff on the shift notes for the facility.
- No other refusal for pulse oximetry for Resident #2 was documented in shift notes.
- She would review the orders and contact the pulmonologist again regarding Resident #2.

Interview with the Administrator on 02/24/16 at

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D 273	Continued From page 29 5:10 p.m revealed: - He was not aware of the hospital discharge orders for Resident #2 to have oxygen. - The facility staff did not call to follow up with the 12/28/15 hospital discharge orders for Resident #2 after she was discharged from the hospital. - The RCC usually checks all new orders for the residents. - Resident #2 was scheduled for a pulmonology appointment by the hospital discharge planner after she was discharged from the hospital. - The pulmonologist had ordered overnight pulse oximetry to be done to see if the resident needed oxygen. - Resident #2 had been going to her pulmonology appointments but she did not get any oxygen yet because the resident had refused the overnight pulse oximetry 2 times this year. - He would have the RCC to call the pulmonologist to find out what needed to be done for the oxygen order for Resident #2. Interview with the Administrator on 02/25/16 at 9:30 a.m. revealed: - He contacted the pulmonologist to get clarification of the oxygen order for Resident #2 from her hospital discharge in December 2015 after he was made aware of this order on 02/24/16. - Resident #2 had not gotten oxygen yet because it had not be proven she needed it medically. - Resident #2's appointment for the pulmonologist on 01/28/16 had to be rescheduled because the brakes on the van for resident transportation had to be fixed. - It had been reported to him on 02/22/16 that Resident #2 had refused the pulse oximetry test on 02/19/16 but he would have the RCC to follow-up to see if can be done again and get the resident to the follow-up appointment.	D 273		

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D 273	Continued From page 30 - The facility did not notify the physican on 02/19/16 regarding Resident #2's refusal of the overnight pulse oximetry. Review of faxed summary letter from pulmonologist on 02/25/16 revealed: - The summary letter was faxed to the facility on 02/25/16. - Resident #2 was seen for consultation on 12/29/15 and it was ordered for the resident to have an overnight pulse oximetry done to see if the resident qualified for nocturnal oxygen. - The overnight pulse oximetry was done on 01/06/16 and follow-up appointment was set up for Resident #2 on 01/28/16. - Results of the pulse oximetry done on 01/06/16 were not documented in the summary letter. - When the pulmonology office contacted the facility to confirm the January 2016 appointment, the facility informed their office that the facility did not have transportation for Resident #2 and the facility rescheduled the appointment for 02/22/16. - Per Medicare guidelines, the face-to-face appointment after the pulse oximetry has to be done within 30 days of the written physician orders. - The pulmonology office advised the facility that the new appointment was outside of the 30 day window and Resident #2 would have to have new physician orders and have to re-do the overnight pulse oximetry test again. - The office was informed on 02/21/16 that Resident #2 had refused the overnight pulse oximetry test. Refer to the interview with the Administrator on 02/24/16 at 4:50 p.m. Refer to the interview with the Administrator on 02/24/16 at 5:35 p.m.	D 273		

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D 273	Continued From page 31 B. Review of Hospital Discharge Instructions for Resident #2 dated 12/28/15 revealed: - Resident #2 was hospitalized from 12/26/15 to 12/28/15 with diagnoses of acute chronic obstructive pulmonary disease exacerbation, diabetes, debility, hypertension, kidney failure, and left leg cellulitis. - There was physician's order for Resident #2 to have nephrology consult 3-4 weeks after hospital discharge. Interview with the medication aide (MA) on 02/24/16 at 10:00a.m. revealed: - She was not aware of any orders for Resident #2 regarding a nephrology consult. - She did not get to see any new orders for the residents of the facility. - She said all new orders are handled by either the Resident Care Coordinator (RCC) or the Administrator of the facility. - She only saw new orders if there were changes on the medication administration record. Interview with Resident #2 on 02/24/16 at 10:05 a.m. revealed: - She was not aware that a nephrology consult needed to be done since she was discharged from the hospital in December 2015. - She had not seen a nephrologist since she was discharged from the hospital in December 2015. Interview with the RCC on 02/24/16 at 4:55 p.m. revealed: - Resident #2 had not had a nephrology consult since the resident was discharged from the hospital in December 2015. - She had not notified the primary physician for Resident #2 regarding the hospital discharge orders from 12/28/15.	D 273		

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D 273	Continued From page 32 - She would review the orders and follow-up on the nephrology consult. Telephone interview with a nurse at the nephrology office for Resident #2 on 02/24/16 at 4:57 p.m. revealed: - The nephrology office had received the referral for nephrology consult from the hospital discharge planner for Resident #2 in December 2015. - Resident #2 had previously been a patient at this nephrologist's office but had not been since 2008. - Resident #2 had missed the first nephrology appointment scheduled by the hospital discharge planner for 02/01/16. - The nephrology office rescheduled for Resident #2 to to have an appointment on 02/15/16. - Resident #2 missed the appointment scheduled on 02/15/16. - No one from the facility had contacted them regarding the follow-up for the nephrology consult. - The facility can call and make another appointment for consult for Resident #2. Interview with the Administrator on 02/24/16 at 5:10 p.m. revealed: - He was not aware of the hospital discharge orders for Resident #2 to have a nephrology consult. - The hospital usually told the facility when a resident was scheduled for a follow-up appointment but he doesn't remember it being done for this hospital discharge for Resident #2 for the nephrology consult. - Resident #2 had not had a nephrology consult since she was discharged from the hospital in December 2015.	D 273		

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Interview with the RCC on 02/25/16 at 4:05 p.m. revealed:
- She had called and made an appointment for Resident #2 to have a nephrology consult on 03/18/16 at 3:45 p.m.

Refer to the interview with the Administrator on 02/24/16 at 4:50 p.m.

Refer to the interview with the Administrator on 02/24/16 at 5:35 p.m.

C. Review of a Physician's order for Resident #2 dated 12/29/15 revealed:
- There was a physician's order for Resident #2 to have Albuterol 0.083% nebulizer treatments every 6 hours (Albuterol inhalation solution is a used to treat airway narrowing relaxing airway muscles to increase air flow in the lungs. It is used to treat certain breathing problems asthma and other obstructive airway disease).

Review of the December 2015 medication administration record (MAR) for Resident #2 revealed:
- There was an entry for Albuterol Nebulizer .0.083% solution to be given, 1 treatment via nebulizer every 6 hours.
- Administration times were scheduled for 6:00 a.m., 12:00p.m., and 6:00p.m.
- No administration times were printed for a 12:00 a.m. Albuterol nebulizer dose.
- Resident #2 started Albuterol nebulizer treatments on 12/31/15 at 12:00 p.m. and received a second dose of Albuterol nebulizer treatment at 6:00 p.m.
- No refusals of the Albuterol nebulizer treatment were documented on 12/31/15 for Resident #2.
- There was no documentation that a 12:00 a.m. dose of Albuterol nebulizer was scheduled or

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administered to Resident #2.

Review of the January 2016 MAR for Resident #2 revealed:
- There was an entry for Albuterol Nebulizer .0.083% solution to be given, 1 treatment via nebulizer every 6 hours.
- Administration times were scheduled for 6:00 a.m., 12:00 p.m., and 6:00 p.m.
- No administration times were printed for a 12:00 a.m. Albuterol nebulizer dose.
- Resident #2's refusal of 27 Albuterol nebulizer treatments scheduled for 6:00 a.m. were documented on the notes section of the MAR.
- Resident #2's refusal of 28 Albuterol nebulizer treatments scheduled for 12:00 p.m. were documented on the notes section of the MAR.
- Resident #2's refusal of 11 Albuterol nebulizer treatments scheduled for 6:00 p.m. were documented on the notes section of the MAR.
- There was no documentation that a 12:00 a.m. dose of Albuterol nebulizer was scheduled or administered to Resident #2.

Review of the February 2016 MAR for Resident #2 dated 02/01/16 - 02/23/16 revealed:
- There was an entry for Albuterol Nebulizer .0.083% solution to be given, 1 treatment via nebulizer every 6 hours.
- Administration times were scheduled for 6:00 a.m., 12:00 p.m., and 6:00 p.m.
- Resident #2 received Albuterol nebulizer treatment on 02/13/16 at 6:00 a.m.
- Resident #2's refusal of 22 Albuterol nebulizer treatments doses scheduled for 6:00a.m. were documented on the notes section of the MAR.
- Resident #2's refusal of 23 Albuterol nebulizer treatments doses scheduled at 12:00 p.m. were documented on the notes section of the MAR.
- Resident #2's refusal of 23 Albuterol nebulizer

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treatments doses scheduled at 6:00 p.m. were documented on the notes section of the MAR.
- There was no documentation that a 12:00 a.m. dose of Albuterol nebulizer was scheduled or administered to Resident #2.

Interview with the medication aide (MA) on 02/24/16 at 10:00a.m. revealed:
- Resident #2 had a medication order for Albuterol nebulizer treatments to be given every 6 hours but she had not noticed there was no time slot printed for the fourth nebulizer treatment on the electronic MAR.
- Resident #2 had been refusing the Albuterol nebulizer treatments for a while now and the Resident Care Coordinator was aware.
- She did not know if the primary physician was aware Resident #2 was refusing her Albuterol nebulizer treatment.

Interview with Resident #2 on 02/24/16 at 11:55a.m. revealed:
- She never got a midnight dose of the Albuterol nebulizer treatment.
- She used the Albuterol nebulizer treatments when she first got out of the hospital because she had a lot of shortness of breath.
- She did not like the Albuterol nebulizer treatments because they made her feel nervous.
- She could not recall the last time she had been offered the Albuterol nebulizer treatments by the staff at the facility.
- She had told the medication aides she did not like taking the Albuterol nebulizer treatments.
- She would like to have the Albuterol inhaler instead of the Albuterol nebulizer treatments.

Interview with the Resident Care Coordinator (RCC) on 02/24/16 at 4:55 p.m. revealed:
- Resident #2 had been refusing the Albuterol

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nebulizer treatments but she was unsure of how often.
- She had not notified the primary physician regarding Resident #2 refusing the Albuterol nebulizer treatments but she would call the primary physician to inform them now.
- She would contact the primary physician to see if the Albuterol nebulizer treatment could be changed to Albuterol inhaler.

Telephone interview with a Nurse at the Pulmonologist's office for Resident #2 on 02/25/16 at 11:35 a.m. revealed:
- They were not aware Albuterol nebulizer treatments were not being administered every 6 hours as ordered.
- They were unaware Resident #2 was refusing her scheduled Albuterol nebulizer treatments.
- The nurse would notify the pulmonologist to make him aware of the Albuterol nebulizer not being administered every 6 hours as ordered and that Resident #2 was refusing the Albuterol nebulizer treatment.

Telephone interview with a Nurse for the Primary Physician for Resident #2 on 02/25/16 at 11:55 a.m. revealed:
- They were unaware Resident #2 was refusing her scheduled Albuterol nebulizer treatments and that the treatments were not being given as ordered.
- The nurse would notify the primary physician to make him aware that Resident #2 was refusing the Albuterol treatments and that the treatments were not being given as ordered.

Interview with the RCC on 02/25/16 at 3:40 p.m. revealed:
- She had not contacted the primary physician yet to let them know that Resident #2 had been

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D 273	Continued From page 37 refusing her Albuterol nebulizer treatment. - The facility did not normally call the primary physician when a resident refused medications or treatments. - The facility did not have a policy addressing medication refusal by the residents. - She normally sent the MAR with the resident to their next physician's appointment to let the physician know the resident had refused the medication or treatments. - No care note or care summary was sent to physician's office to go with the MAR. - She did not follow up with the physician to check if he understood that a resident had refused treatment or medications. - The facility did not have a policy regarding how or when to notify the physician when a resident refused medication or treatment. Refer to the interview with the Administrator on 02/24/16 at 4:50 p.m. Refer to the interview with the Administrator on 02/24/16 at 5:35 p.m. _____ Interview with the Administrator on 02/24/16 at 4:50 p.m. revealed: - It was the responsibility of the RCC to review new orders and follow-ups from providers for all residents. - It was the responsibility of the RCC to review all orders for the residents and to make sure that orders were done correctly. - Sometimes he faxed medication orders to the pharmacy to try to help out. Interview with the Administrator on 02/24/16 at 5:35 p.m. revealed: - New orders and consults were usually handled	D 273		

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by the RCC.
- The RCC usually checks all new orders for the residents.
- The new orders for Resident #2 did not get done in December 2015 because the orders were in the hospital discharge paperwork.
- No staff at the facility saw the new orders and that was why there was no follow up for Resident #2.

2. Review of Resident #3's current FL-2 dated 01/11/16 revealed:
- The resident's diagnoses included mild mental retardation, hypertension, coronary artery disease, hyperlipidemia, anxiety, migraine, and gastroesophageal reflux disease.
- The resident was not documented as disoriented or as having inappropriate behavior.

A. Review of the February 2016 medication administration records (MARs) revealed:
- Resident #3 was receiving at least 5 medications used to treat heart / blood pressure conditions.
- He was receiving Aspirin 325mg at 8am. (Aspirin is used to prevent heart disease.)
- He was receiving Atorvastatin 40mg at 8am. (Atorvastatin helps lower cholesterol to prevent heart disease.)
- He was receiving Isosorbide Mononitrate 60mg ER at 8am. (Isosorbide Mononitrate is used to prevent chest pains and lowers blood pressure.)
- He was receiving Losartan/HCTZ 50/12.5mg at 8am. (Losartan/HCTZ lowers blood pressure.)
- He was receiving Ranexa 500mg at 8am and 8pm. (Ranexa is used to treat chronic chest pain.)
- The resident's blood pressure was taken daily at 8am and ranged from 100/69 - 132/67 from 02/01/16 - 02/23/16.

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Review of Resident #3's cardiology visit form dated 09/15/15 revealed:
- The cardiologist ordered to change the resident's blood pressure checks to morning.
- The resident was to follow up with the cardiologist in 3 months.

Review of Resident #3's record revealed no documentation of a follow-up visit with the cardiologist.

Telephone interview with the cardiology medical assistant on 02/24/16 at 3:30 p.m. revealed:
- Resident #3 had a scheduled appointment with the cardiologist on 12/15/15.
- The resident did not show up for the appointment.
- No one called to cancel the appointment or to let them know the resident would not be coming to the appointment.
- No one had called to reschedule the missed appointment.
- The resident had a DNA test during his last appointment to help determine if his medications were working for him.
- The purpose of the follow up appointment on 12/15/15 was to review the results of the DNA test and determine if any of his medications needed changing.
- The cardiologist was currently working at the hospital and unavailable for interview.

Interview with the Administrator on 02/24/16 at 4:35 p.m. revealed:
- He was unsure about a cardiology appointment for Resident #3 but he would check the appointment book.
- There was documentation of a cardiology appointment for Resident #3 in the appointment

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book but no documentation about why the resident did not go to the appointment.
- He did not know why Resident #3 did not go to the scheduled cardiology appointment.
- He would contact the cardiology office to reschedule the appointment.

Interview with the Administrator on 02/25/16 at 9:32 a.m. revealed he scheduled an appointment for Resident #3 to see the cardiologist on the next day, 02/26/16 at 1:00 p.m.

B. Review of Resident #3's neurology visit form dated 08/06/15 revealed:
- The resident had abnormal blood tests.
- Neurologist noted the primary care physician (PCP) had report on these.
- Neurologist wrote a note for the facility to talk with the resident's PCP about his thyroid labs being abnormal.

Review of labwork for Resident #3 dated 02/04/16 revealed:
- The resident's TSH (thyroid stimulating hormone) level was 7.950 (reference range was 0.358 - 3.740).
- There was a handwritten note that the lab results form was faxed to the PCP on 02/08/16.

Review of Resident #3's record revealed the resident did not have any orders for medications used to treat thyroid conditions.

Interview with the Administrator on 02/24/16 at 4:35 p.m. revealed:
- He was aware Resident #3 had some labwork recently because he took the residents to all appointments.
- He never talked with Resident #3's primary care physician (PCP) about the thyroid labwork

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because he had not noticed the neurologist's instructions on the visit form for the facility to discuss it with the PCP.
- The neurologist did not go over it verbally with him and he just did not see it on the form.
- He usually reviewed the paperwork received from residents' appointments.
- He would go to the PCP office in the morning to review the information with the PCP.

Interview with the Administrator on 02/25/16 at 9:32 a.m. revealed:
- He took Resident #3 to the PCP this morning to discuss the thyroid labs and behaviors with the PCP.
- The PCP did not want to treat the thyroid issues because the resident was not exhibiting any symptoms.
- The PCP also addressed the resident's behaviors.
- He forgot to get a copy of the paperwork from the visit but he planned to go back to the PCP's office in a few minutes to get a copy for the facility's records.

Review of a physician's request form dated 02/25/16 for Resident #3 revealed:
- Facility staff wrote in the problem section of the form: neurologist wanted you to be notified that the residents' thyroid levels are outside normal range. Also, the resident has had behavioral outburst.
- Physician response section of the form noted: the resident had recent labs suggesting subclinical hypothyroid. No treatment necessary secondary no symptoms. Continue to follow with lab.

Attempts to contact Resident #3's PCP were unsuccessful during the survey.

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Attempts to contact Resident #3's neurologist were unsuccessful during the survey.

C. Review of charting notes for Resident #3 revealed:
- 01/22/15 (8:11 p.m.): Resident #3 began calling staff names, "b----es", "black wh---" and making verbal threats that he'll beat staff's "a--". Staff intervened because another resident went over to hit Resident #3. Staff prompted Resident #3 to be quiet but resident did not comply and resident "swung on staff". "Staff therapeutic restrained resident and called 911."
- 01/28/16 (5:26 p.m.): Resident #3 seems to be agitated. Staff asked the resident several times if he was eating this evening but the resident would not respond. He looked at staff and then turned around.
- 02/19/16 (8:14 p.m.): Resident #3 was asked to be excused for a minute while staff was trying to clean under the chair he was sitting in. The resident complied and went to receive his medications. Resident #3 heard another resident calling staff names then Resident #3 joined in. Resident #3 followed staff down the hallway saying things. Staff continued to ignore the resident. Resident #3 then walked in staff's personal space. Staff asked the resident to step back but the resident refused and tried to "swing on staff". Staff blocked the hit then "therapeutically escorted" Resident #3 to his room while resident was "swinging on staff". Resident #3's roommate went to grab the resident but staff redirected the roommate and called the Administrator. The Administrator arrived and talked to the resident.

Review of the December 2015 - February 2016 medication administration records (MARs)

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revealed:
- There was an entry for Alprazolam 1mg every 12 hours as needed for anxiety.
- Alprazolam was documented as administered on 3 occasions in December 2015 (12/01/15, 12/02/15, and 12/03/15).
- Alprazolam was documented as administered on 4 occasions in January 2016 (01/22/16, 01/23/16, 01/24/16, and 01/28/16).
- Alprazolam was documented as administered on 2 occasions in February 2016 (02/04/16 and 02/20/16).

Interview with the Administrator on 02/24/16 at 5:18 p.m. revealed:
- They had tried to get Resident #3 in to see a mental health provider.
- He took the resident to a mental health provider appointment last month but they would not see the resident because the resident had no current ID and no original insurance card.
- He just recently got the resident's birth certificate so they could take him to get a current identification (ID) card.
- He was not sure when the appointment was and he did not see it documented in the appointment book.
- He had not rescheduled the appointment yet because he was waiting on the insurance card and he had to take the resident to the Division of Motor Vehicles to get a current photo ID.
- He was not sure if the resident's primary care physician (PCP) was aware of the behaviors.
- There was no documentation of the PCP being notified of Resident #3's behaviors.

Telephone interview with office staff at the mental health provider's office on 02/25/16 at 12:45 p.m. revealed:
- Resident #3 had an appointment with the

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mental health provider on 12/01/15.
- The resident could not be seen because he did not have a current valid photo ID.
- The appointment had not been rescheduled.

Review of a physician's request form to the PCP dated 02/25/16 for Resident #3 revealed:
- Facility staff wrote in the problem section of the form: The resident has had behavioral outburst.
- Physician response section of the form noted: Complaint of behavioral outburst likely related to dementia or psych issue. Resident to follow with psychiatrist and neurologist.

Attempts to contact Resident #3's PCP for interview were unsuccessful during the survey.

Attempts to contact Resident #3's neurologist were unsuccessful during the survey.

Review of the facility's plan of protection dated 02/23/16 revealed:
- For identified residents, all referrals shall be scheduled immediately.
- Primary care providers (PCP) shall be notified of any changes in residents' conditions.
- All residents' records shall be reviewed to ensure all appointments are kept and orders are being followed.
- The Administrator shall review all orders to ensure they are complete and being followed.
- Record reviews shall continue on an ongoing basis.
- The facility shall resume using a facility consultant to review records quarterly.
- The Administrator or designee shall be responsible for scheduling appointments.
- The Resident Care Coordinator (RCC) will follow up to ensure that residents make it to all

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D 273	Continued From page 45 appointments weekly. - The supervisor on duty will notify PCP of any changes in condition of residents and then notify the Administrator. - RCC shall follow up to ensure appointment is made or that any orders given are followed. - Notification will be documented in chart note for the residents' records. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2016.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure food being served to 1 of 5 residents sampled (#5) was protected from contamination for a resident being fed by staff. The findings are: Observation on 02/24/16 at 12:55 p.m. revealed: - The medication aide (MA) was in the dining room feeding Resident #5. - The MA was not wearing gloves. - A visitor brought in a bag of food from a fast food restaurant and gave it to the MA. - The MA took the food out of the bag and opened the wrapper of a fish sandwich. - The MA tore the fish sandwich in half with her	D 283		

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D 283	Continued From page 46 bare hands and put half of the sandwich on Resident #5's plate. - The MA took a container of French fries and put a handful of the fries on Resident #5's plate with her bare hands. - The MA then ate a few French fries with her fingers and her fingers touched her lips. - The MA then picked up some French fries in Resident #5's plate with the same hand she used to feed herself and fed the fries to Resident #5 with her bare hands. - The MA continued to feed the resident while she ate her own lunch without wearing gloves or washing or sanitizing her hands. Interview with the MA on 02/25/16 at 10:27 a.m. revealed: -Resident #5 had been losing weight recently and the MA was encouraging the resident to eat. -The MA knew the resident would eat the fish sandwich and French fries. -The MA had not thought about the possibility of contaminating the fast food with her saliva as she ate with her bare hands and shared the food with the resident. Interview with the Administrator on 02/25/16 at 5:25 p.m. revealed: -He saw the MA sharing the fast food with the resident. -He had told the MA that she could not give fast food to the resident. -He acknowledged the possibility of the exchange of body fluids between the resident and MA in the manner the food was shared.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 47 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 observations, interviews and record reviews, the facility failed to assure that therapeutic diets including 1800 calorie, no concentrated sweets, no added salt and fluid restrictions were served as ordered for 4 of 5 residents (#2, #3, #4, #5) observed. The findings are: 1. Review of Resident #2's current FL-2 dated 10/21/15 revealed: - The resident's diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure, heart failure, and heart disease. - The diet order for Resident #2 was No Concentrated Sweets. Review of Hospital Discharge Instructions for Resident #2 dated 12/28/15 revealed: - Resident #2 was hospitalized from 12/26/15 to 12/28/15 with diagnoses of acute chronic obstructive pulmonary disease exacerbation, diabetes, debility, hypertension, kidney failure, and left leg cellulitis. - There was physician's order for Resident #2 to have a low sodium, 1800 calorie diabetic, and low potassium diet with 1500 milliliter daily fluid restriction. Review of the facility's therapeutic diet list revealed:	D 310		

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D 310	Continued From page 48 - Resident #2's diet was listed as 1800 calories/ No Added Salt. - There was no documentation of fluid restriction. Interview with the medication aide (MA) on 02/24/16 at 10:00 a.m. revealed: - She was not aware of any orders for Resident #2 regarding a new diet order with the fluid restriction. - She did not get to see any new orders for the residents of the facility. - All new orders were handled by either the Resident Care Coordinator (RCC) or the Administrator of the facility. - She only saw new orders if there were changes on the medication administration record. Interview with Resident #2 on 02/24/16 at 10:05 a.m. revealed: - She was not aware of any new diet order since she was discharged from the hospital in December 2015. - She was on a diet since she was diabetic but she did know the kind of diet. - She had been told by a doctor previously that her diet should have no added salt. Review of the 1800 calorie menu for lunch on 02/24/16 revealed Mexican lasagna made with 3 ounces of ground turkey, 1-6 inch flour tortilla, 1 cup of tossed salad greens with 2 tablespoons of oil and vinegar dressing, ½ cup of sugar free cocktail and 1 cup of 2% milk. Observation of the Kitchen Manager (KM) preparing plates to serve for lunch on 02/24/16 at 12:40 p.m. revealed: -A heaping 6 ounce scoop of the ground turkey mixture was placed on every plate. -The appropriate amount of salad was placed on	D 310		

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each plate but the dressing was measured with a soup spoon.
-Fruit cocktail in syrup was measured correctly onto several plates before the KM remembered the diabetics required sugar free fruit cocktail.
-The KM put some of the fruit cocktail in a colander and rinsed under cold water.
-The rinsed fruit cocktail was served to Resident #2.

Interview with the Administrator on 02/24/16 at 4:50 p.m. revealed:
- It was the responsibility of the Resident Care Coordinator (RCC) to review new orders and follow-ups from providers for all residents.
- It was the responsibility of the RCC to make sure that orders were done correctly.
- Sometimes he faxed medication orders to the pharmacy to try to help out.

Interview with the RCC on 02/24/16 at 4:55 p.m. revealed:
- She was not aware of the new orders for the diet with fluid restrictions for Resident #2.
- She had not notified the primary physician for Resident #2 regarding the hospital discharge orders from 12/28/15.
- She would review the orders and follow-up with Resident #2's primary physician for the diet order and fluid restrictions.

Interview with the Administrator on 02/24/16 at 5:10 p.m. revealed:
- He was not aware of the hospital discharge orders for Resident #2 on 12/28/15 with the diet order which included fluid restrictions.
- The facility staff did not call to follow up with the 12/28/15 hospital discharge orders for Resident #2 after she was discharged from the hospital.
- He would check with the RCC to make sure the

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D 310	Continued From page 50 12/28/15 hospital discharge orders are reported to the primary physician. Interview with the Administrator on 02/24/16 at 5:35 p.m. revealed: - New orders and consults are usually handled by the RCC. - The new orders for Resident #2 did not get done in December 2015 because the orders were in the hospital discharge paperwork. - No staff at the facility saw the new orders and that is why there was no follow up for Resident #2 for the diet order. - Diets should be served as ordered by the physician and staff should follow the menu. Interview with Resident #2 on 02/24/16 at 5:55 p.m. revealed: - The doctor had told her to restrict her fluid intake but she was unsure when she was told to do so. - Staff at the facility did not monitor what she drank but she knew what to do. - She normally drank from a plastic coffee mug that held approximately 16 ounces of fluid. - She normally drank about a half of cup before breakfast and then she drank whatever the facility provided with breakfast. - She normally got a glass of water with breakfast. - The facility served her orange juice and coffee with breakfast. - She filled her coffee mug with ice and she ate the ice chips until lunch and then she drank whatever the facility gave her with lunch. - She filled her coffee mug again with ice after lunch and she ate on the ice chips until supper and then she drank whatever came with dinner which was usually milk and unsweetened ice tea. - She filled her coffee mug again with ice after	D 310		

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supper and she ate about 2 coffee mugs of ice between supper and breakfast the next morning.

Telephone interview with a Nurse for the Primary Physician for Resident #2 on 02/25/16 at 11:55 a.m. revealed:
- They were unaware of the hospital discharge orders written for Resident #2 on 12/28/15.
- They became aware of these orders when the facility Administrator called them about 10:00 a.m. on 02/25/16 to request clarification of the dietary orders and the fluid restrictions.
- The physician had not had time yet to review the chart or the orders but they would try to get the orders to the facility today.

Observation of Resident #2 on 02/25/16 at 12:10 p.m. revealed:
- Resident #2 took a sip of water from a 4 ounce cup when she was given medicine by the MA.

Interview with Resident #2 on 02/25/16 at 12:10 p.m. revealed:
- Resident #2 normally drank water with her medication administration of approximately 2 ounces.

Review of the February 2016 Medication Administration Records for Resident #2 revealed:
- Resident #2 received oral medications 4 times a day at 8:00a.m., 12:00p.m., 5:00p.m, and 8:00p.m.

Observation of Resident #2 on 02/25/16 at 12:40 p.m. revealed:
- Resident #2 was in the dining room for lunch.
- Resident #2 was served 8 ounces of milk and 16 ounces of unsweetened tea with her lunch.
- Resident #2 brought her personal coffee mug that was filled with ice and unknown drink that

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was dark in color.
- Resident #2 drank approximately 4 ounces of milk and 8 ounces of unsweetened tea.
- She drank approximately 1/3 of the fluid from her personal coffee mug which was approximately 5 ounces.
- Total observed fluid intake during lunch was approximately 17 ounces.

Interview with the RCC on 02/25/16 at 3:45 p.m. revealed:
- She had followed up with the primary physician for Resident #2 regarding the fluid restrictions.
- The primary doctor ordered that Resident #2's fluid intake be restricted to 1500 milliliter daily and their office would fax over the order for fluid restrictions either today or tomorrow morning.

Review of a faxed Physician's Orders dated 02/26/16 for Resident #2 revealed:
- A new order for Resident #2 to have an 1800 calorie ADA/low sodium diet with a 1500 milliliter fluid restriction.

Refer to interview with the Administrator on 02/24/16 at 4:30 p.m.

2. Review of Resident #3's current FL-2 dated 01/11/16 revealed:
- The resident's diagnoses included mild mental retardation, hypertension, coronary artery disease, hyperlipidemia, anxiety, migraine, and gastroesophageal reflux disease.
- There was no diet order listed on the FL-2.

Review of a diet order sheet dated 01/11/16 for Resident #3 revealed an order for an 1800 calorie diet.

Review of a physician's order sheet dated

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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 310	Continued From page 53 01/11/16 for Resident #3 revealed an order for an 1800 diabetic calorie/no added salt diet. Review of the facility's diet list revealed Resident #3 was listed as an 1800 diabetic calorie/no added salt diet. Review of the 1800 calorie menu for lunch on 02/24/16 revealed Mexican lasagna made with 3 ounces of ground turkey, 1-6 inch flour tortilla, 1 cup of tossed salad greens with 2 tablespoons of oil and vinegar dressing, ½ cup of sugar free cocktail and 1 cup of 2% milk. Observation of Kitchen Manager (KM) on 02/25/16 at 12:40 p.m. preparing plates to serve revealed: -A heaping 6 ounce scoop of the ground turkey mixture was placed on every plate. -The appropriate amount of salad was placed on each plate but the dressing was measured with a soup spoon. -Fruit cocktail in syrup was measured correctly onto several plates before the KM remembered the diabetics required sugar free fruit cocktail. -The KM put some of the fruit cocktail in a colander and rinsed under cold water. -The rinsed fruit cocktail was served to Resident #3. Review of an order faxed by the physician and dated 02/25/16 revealed: - The physician changed Resident #3's diet order to a regular diet. Refer to interview with the Administrator on 02/24/16 at 4:30 p.m. 3. Review of Resident #4's current FL-2 dated 09/08/15 revealed:	D 310		

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D 310	Continued From page 54 -The resident's diagnoses included type II diabetes mellitus, mixed hyperlipidemia, hypertension, and moderate mental retardation. -The resident was constantly disoriented. -The diet order section was blank. Review of Resident #4's record revealed a diet order sheet signed by the physician on 01/11/16 for an 1800 calorie diet. Observation of the kitchen on 02/24/16 at 12:45 p.m. revealed: -A copy of the facility's 'diet orders' was posted on the door of the refrigerator. -Copies of weekly diet sheets from the dietary manual were on the window seal partially covered by other paperwork. Review of the facility's diet list revealed Resident #4 was listed as an 1800 calorie diet. Review of the 1800 calorie menu for lunch on 02/24/16 revealed Mexican lasagna made with 3 ounces of ground turkey, 1-6 inch flour tortilla, 1 cup of tossed salad greens with 2 tablespoons of oil and vinegar dressing, ½ cup of sugar free cocktail and 1 cup of 2% milk. Observation of Kitchen Manager (KM) on 02/25/16 at 12:40 p.m. preparing plates to serve revealed: -A heaping 6 ounce scoop of the ground turkey mixture was placed on every plate. -The appropriate amount of salad was placed on each plate but the dressing was measured with a soup spoon. -Fruit cocktail in syrup was measured correctly onto several plates before the KM remembered the diabetics required sugar free fruit cocktail. -The KM put some of the fruit cocktail in a	D 310		

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D 310	Continued From page 55 colander and rinsed under cold water. -The rinsed fruit cocktail was served to Resident #4. Refer to interview with the Administrator on 02/24/16 at 4:30 p.m. Interview with the Administrator on 02/24/16 at 4:30 p.m. revealed: -He purchased the food for the facility. -He purchased "no added sugar" fruit cocktail. -He did not know why the KM did not serve the sugar free fruit cocktail to the residents as indicated on the menu. -He did not comment on the heaping 6 ounce scoop of Mexican lasagna served to each resident at lunch. -He stated he would review the diet sheets from their dietary manual with the KM. 4. Review of Resident #5's current FL-2 dated 02/23/16 revealed: -The resident's diagnoses were mental retardation with behaviors and diabetes [unspecified]. -The diet order section was blank. -Resident #5 did not have an order to allow fast food. Review of Resident #5's record revealed a diet order sheet signed by the physician on 02/23/16 for a no added salt (NAS) diet. Review of the facility's diet list revealed Resident #5 was listed as a no added salt diet. Observations on 02/24/16 at 12:55 p.m. revealed: -A medication aide (MA) was sitting with Resident #5, assisting the resident to eat her facility prepared meal.	D 310		

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D 310	Continued From page 56 -Other residents were in the dining area eating lunch. -A visitor came in and handed the MA a fast food restaurant bag. -The MA opened the fast food bag and began eating French fries and a fish sandwich. -The MA tore the sandwich in half and put it in Resident #5's plate of food served by the facility. -The MA also shared her French fries with Resident #5. -Resident #5 ate the fish sandwich and the french fries. Interview with the MA on 02/25/16 at 10:27 a.m. revealed: -Resident #5 had been losing weight recently and the MA was encouraging the resident to eat. -She knew Resident #5 would eat the fish sandwich and French fries. -She knew Resident #5 was on a NAS diet. Interview with the Administrator on 02/25/16 at 05:25 p.m. revealed: -He had seen the MA sharing the fast food with the resident. -He had told the MA that she could not give fast food to the resident. Review of the facility's weight book revealed: -Resident #5's admission weight on 03/03/15 was 138.6 pounds. -Resident #5's recorded weight for January 2016 was 136 pounds. -Resident #5's recorded weight for February 2016 was 139 pounds.	D 310		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program	D 316		

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D 316	Continued From page 57 (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a monthly calendar of planned group activities which was easily readable with large print was posted in a prominent location by the first day of each month	D 316		

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and updated when there was any changes. The findings are:

Confidential resident interview revealed:
- They used to have an activity calendar posted on the wall beside the office / medication room.
- The resident had not seen an activity calendar in a few months.
- They had some activities at the facility.
- The resident did not usually know when they had activities or what the activity was going to be because there was no calendar posted.

Confidential interview with a second resident revealed:
- They played games at 3:00 p.m. on some days.
- The resident was not sure which days they played.
- The resident did not know if they had activities scheduled at other times.

Confidential interview with a third resident revealed:
- They had some activities at the facility.
- The resident did not know when they usually had activities.
- The resident did not like the activities they had at the facility.

Confidential interview with a fourth resident revealed:
- They played bingo once in a while.
- The resident was not sure which days they played.
- The resident did not know if they had other activities or when they were scheduled

Review of the facility's February 2016 Activity Calendar revealed:
- The calendar was printed on an 8 ½ by 11

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piece of paper with handwritten entries in the daily blocks.
- There was 14 - 14.5 hours listed weekly.
- Activities included current events, bingo, puzzles, checkers, art, music and coloring, board games, dance and exercise, church, pick a favorite magazine, word search, reminiscing, Valentine social and popcorn social.
- The activity calendar was stored in a notebook in the office / medication room.

Interview with the medication aide on 02/25/16 at 12:14 p.m. revealed:
- The Resident Care Coordinator (RCC) was the Activity Director.
- They had an activity calendar hanging on the wall near the office in December 2015.
- One of the residents kept taking the calendar off the wall and taking it to his room.
- They kept the activity calendar in a notebook in the office/medication room.

Interview with the RCC / Activities Director on 02/25/16 at 4:55 p.m. revealed:
- She was aware an activity calendar was supposed to be hanging up in the facility for the residents to see.
- She could not explain why there was no activity calendar posted in the facility.
- She could not say when an activity calendar was last posted.
- It was her responsibility to post the calendar but she had not done it.
- They did not document changes in the activities on the calendar.

Observation on 02/24/16 at 10:25 a.m. revealed there was a church service being held in the common living room.

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D 316	Continued From page 60 Review of the February 2016 activity calendar revealed: - The activity listed for 02/24/16 from 10am - 11am was puzzles. - There was no church activity listed on the calendar for 02/24/16. - There was no documentation the calendar was updated to reflect the change.	D 316		
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 A2 VIOLATION Based on observation, record review and interview, the facility failed to assure 1 of 3 sampled residents (#3) was free from physical and mental abuse relating to verbal and physical mistreatment of the resident by Staff A. The findings are: Review of Resident #3's current FL-2 dated 01/11/16 revealed: - The resident's diagnoses included mild mental retardation, hypertension, coronary artery disease, hyperlipidemia, anxiety, migraine, and gastroesophageal reflux disease. - The resident was ambulatory and continent of bowel and bladder. - The resident was not documented as disoriented or as having inappropriate behavior. - No personal care assistance was documented	D 338		

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as needed by the resident.

Review of Resident #3's Resident Register revealed he was admitted to the facility on 11/14/13.

Review of Resident #3's assessment and care plan dated 01/11/16 revealed:
- The resident was ambulatory and independent with all activities of daily living.
- The resident was sometimes disoriented, forgetful and needed reminders.
- The resident could be verbally and physically abusive (mostly toward women).

Review of charting notes for Resident #3 revealed:
- 01/22/15 (8:11 p.m.): Resident #3 began calling staff names, "b----es", black wh---" and making verbal threats that he'll beat staff's "a--". Staff intervened because another resident went over to hit Resident #3. Staff prompted Resident #3 to be quiet but resident did not comply and resident "swung on staff". "Staff therapeutic restrained resident and called 911."
- 02/19/16 (8:14 p.m.): Resident #3 was asked to be excused for a minute while staff was trying to clean under the chair he was sitting in. The resident complied and went to receive his medications. Resident #3 heard another resident calling staff names the Resident #3 joined in. Resident #3 followed staff down the hallway saying things. Staff continued to ignore the resident. Resident #3 then walked in staff's personal space. Staff asked the resident to step back but the resident refused and tried to "swing on staff". Staff blocked the hit then "therapeutically escorted" Resident #3 to his room while resident was "swinging on staff". Resident #3's roommate went to grab the resident but staff

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redirected the roommate and called the Administrator. The Administrator arrived and talked to the resident.

Confidential staff interview revealed:
- A resident reported to the staff person that Resident #3 was cursing at Staff A (medication aide/personal care aide) one day over the past weekend.
- The resident overheard Staff A say she's had it with him (referring to Resident #3).
- The resident observed Staff A grab Resident #3 and drag Resident #3 to his room.
- Resident #3 was a small resident and only weighed about 116 pounds.
- Resident #3 also reported the incident to the staff person.
- Resident #3 stated his roommate saw the incident.
- The incident occurred on Friday (02/19/16).
- Resident #3 reported Staff A dragged him in his room, threw him on the bed, and then threw him on the floor.
- Resident #3 hurt his arm when Staff A threw him on the floor.
- The resident still had a bruise/abrasion on his elbow.
- Resident #3 reported it to the Administrator but the Administrator told the resident it was the resident's fault because of the way the resident talks.
- There was another incident in January 2016 when Staff A said "something smart" (meaning sarcastic) to Resident #3 and Resident #3 called Staff A's family member a "b----".
- 911 was called in January 2016 during this incident.
- The staff person had not observed Resident #3 make any verbal threats to any staff.
- Resident #3 would just curse and go to his

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room and lay down.
- The staff person had not observed Resident #3 swing at any staff.
- Resident #3 was usually quiet and sat in the tv room with friends most of the time.
- Resident #3 got agitated when Staff A worked.
- Staff A worked at a sister facility and just worked at this facility on third shift about 3 to 4 times a week.
- Staff A sometimes worked other shifts to fill in.

Confidential resident interview revealed:
- Resident #3 was hit and treated bad [sic] by a "redheaded staff member" about 2 days ago.
- The resident did not know the staff member's name but stated the staff member worked at another facility and only worked at this facility at night.
- The staff member pushed Resident #3 down and dragged him across the floor.
- Resident #3 was then thrown on his bed and choked by the staff member.
- The staff member looked at this resident while she was choking Resident #3 and asked if this resident "wanted some of this".
- Resident #3's left elbow was hurt and bled [sic] when he was pushed down by staff member.
- Resident #3 told the Administrator about the incident.

Confidential interview with a second resident revealed:
- Resident #3 has a problem with African-Americans.
- The resident could hear Resident #3 cursing and calling Staff A vulgar names.
- The resident heard Staff A saying that she was tired of Resident #3 calling her vulgar names and Staff A was going to put Resident #3 to bed.
- Staff A tried to push Resident #3 into his

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bedroom.
- Staff A and Resident #3 started to wrestle in the hallway.
- Staff A picked up Resident #3 and put him on his bed.
- The resident saw Staff A kneeling down and holding Resident #3 down on the bed.

Interview with Resident #3 on 02/23/16 at 2:50 p.m. revealed:
- A red headed woman that worked at the facility part time started fussing at him all the time.
- He identified the staff person as Staff A.
- Staff A called him all kinds of names and cursed at him.
- Staff A used to do the same thing when he lived at the sister facility.
- Every time Staff A worked, she cursed at him and other residents.
- An incident with Staff A occurred over this past weekend.
- He was unsure which day but it was getting dark outside.
- He was sitting on the couch watching tv and Staff A told him to move so she could sweep under the couch.
- He got up and did not say anything.
- The medication aide called him to get his medication so he went around the corner to get his medications and water.
- Staff A started cursing him and calling him names like "son of a b----", "bast---", and a racial slur.
- He was in the hall outside his bedroom door when Staff A grabbed him by the shirt and back of the neck and drug him in his room.
- Staff A threw him on the bed, got on top of him and started choking him with both hands.
- Staff A also beat him in the chest with her fist.
- Resident #3 lifted his shirt to show his chest.

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D 338	Continued From page 65 - The resident had an old healed surgical scar running down the middle of his chest about 12 inches long but no bruises were observed. - He told Staff A to get off of him. - Staff A stood up and left the room but came back a few minutes later. - He was sitting on the bed and was wearing a hoodie. - Staff A grabbed him by the shirt and threw him on the floor. - He hurt his elbow. - He held up his elbow which had a reddish brown scab about 1 inch in diameter. - He told Staff A to leave him alone. - He called Staff A names like "son of a b----" and a racial slur. - The Administrator came to the building right after the incident and bandaged the resident's arm. - The Administrator told the resident that the resident caused all that trouble. - He had not seen Staff A since the incident this past weekend. - About a month ago, he was in the dining room at the table and he got up to walk down the hall. - Staff A pushed him against the handrail on the wall and grabbed him under the chin with her hand. - Another staff person was in the office when it happened and told Staff A to keep her hands off the resident. - The Administrator knew about both incidents but told the resident it was the resident's fault. Interview with Resident #3's roommate on 02/23/16 at 3:14 p.m. revealed: - Staff A worked part time at the facility and worked this past weekend. - While Staff A was working in the evening after supper, she dragged Resident #3 into their	D 338		

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bedroom.
- Staff A was pulling Resident #3 by one leg and one arm and dragging him across the floor and then Staff A put her arms around him and threw him on the bed.
- Staff A got on top of the resident on the bed by strattling her body on top of his.
- He could not see what she was doing with her hands while she was on top of Resident #3.
- Resident #3 stood up to defend himself and Staff A thought Resident #3 was going to hit her.
- Staff A then pushed Resident #3's chest with both hands and he fell back on the bed.
- Staff A realized she was missing an earring so she picked up Resident #3 and threw him on the floor so Staff A could search his bed for her earring.
- Resident #3 landed about 6 feet across the room in front of a laundry basket.
- Staff A and Resident #3 were cursing at each other.
- Staff A was all "hyped up with adrenaline".
- No other staff were in the room or came to the room during the incident.
- The roommate stayed on his bed during the incident and did not get up.
- Staff A left the room on her own.
- Staff A also cursed at another resident in the hallway and that resident cursed back at Staff A.
- The Administrator came after the incident and bandaged Resident #3's arm.
- Staff A worked a little while longer after the incident but she had not been back to the facility since then to his knowledge.
- No one interviewed the roommate about what he witnessed.
- He was okay with staff knowing what he was reporting because staff knew that he witnessed the incident.
- About a month ago, Staff A had cursed at

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D 338	Continued From page 67 Resident #3. - Resident #3 called Staff A a "wh---" and Staff A cursed back at Resident #3. Interview with the Administrator on 02/23/16 at 3:42 p.m. revealed: - On 02/19/16, Staff A called him and told him to come to the facility and get Resident #3. - Staff A told the Administrator that Resident #3 had "done got started with her". - He lived next door to the facility so he came over as soon as she called. - He went to Resident #3's room and Resident #3 told him that Staff A "started messing with me". - Resident #3 was not specific and did not give details - He spoke with the other resident who was yelling and he was not specific about the incident. - Resident #3 had a scratch on his elbow. - The resident did not say what happened to his elbow. - Staff A did not report any physical altercation with the resident. - He did not know how the resident physically got the abrasion on his elbow. - Resident #3 was moved from his previous facility for slapping a female resident. - It is a "female thing" with Resident #3. - He interviewed 3 other residents including Resident #3's roommate, Staff A, Resident #3 and the other staff person on duty. - The other residents told him that Staff A did not do anything and Resident #3 started on Staff A. -Staff A was a medication aide / personal care aide and she worked part time at the facility on second or third shifts about 3 nights a week and some weekends. - Staff A had worked at the facility for many years. - He had not noticed Staff A documented in the	D 338		

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charting note on 02/19/16 that she "therapeutically escorted" Resident #3 to his room.
- He did not know what that phrase meant.
- Some of the staff have had training on therapeutic holds but that had not been done to any residents at the facility to his knowledge.
- Other staff have complained about Resident #3 being verbal with them but not physical.

Interview with the Resident Care Coordinator (RCC) on 02/23/16 at 3:42 p.m. revealed:
- Resident #3 and another resident "feed off" each other when they get upset.
- She was not working on 02/19/16 but came to the facility to drop something off.
- Resident #3 was agitated that day because the resident was about to eat and he was cursing at her.
- He called staff names like "wh--- and b----".

Telephone interview with Staff A on 02/23/16 at 4:21 p.m. revealed:
- She was working at the facility on Friday night, 02/19/16.
- She was cleaning in the living room and asked a resident to get up.
- The resident started calling her racial slurs and saying other profanity.
- Resident #3 came down the hall and joined in with the other resident calling her names too.
- Two female residents got upset with the male residents and told the male residents they were always disrespecting females.
- She told Resident #3 to go to his room and she started cleaning a common bathroom in the hallway.
- Resident #3 started yelling and walked up on her.
- She told Resident #3 to get out of her personal

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space.
- Resident #3 told Staff A that he would knock her out and he called her a "little black wh---".
- She told Resident #3 not to touch her.
- She started mopping in the hallway outside of Resident #3's room.
- Resident #3 swung his fist toward her face so she blocked the hit by throwing up her arm in an L-shape.
- This blocked the hit but the resident was still trying to fight.
- Staff A said she wasn't going to use the word "grabbed" because it did not sound good.
- She put her arm under Resident #3's arm and walked him fast to his room and stood by the bed.
- Resident #3 was ready to fight and she left the room to get the phone.
- The resident stayed in the room but he was still talking out loud.
- She thought Resident #3's roommate came in the room during the incident but she was not sure.
- The only other staff person working was administering medications and did not witness the incident.
- She called the Administrator and asked him to come to the facility.
- She did not know the resident had pulled her earring out until another resident told her later that her earring was missing.
- Her earring was in the hallway.
- She told the Administrator what happened and asked the Administrator to de-escalate the problem.
- The Administrator talked to Resident #3 and a couple more residents.
- Resident #3 stayed in his room the rest of the night.
- She was not aware there was an injury to Resident 3#'s elbow.

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D 338	Continued From page 70 - When she wrote the charting note she could not think of other words to describe how she got the resident in the room besides "therapeutically escorted". - She did not want someone to read the note and think she "abused" the resident. - When she got up under his arm, Resident #3 tried to pull away so he could swing at her so she walked him into the room fast and then she left the room. - She stated she was a "big girl" (physically) and "if there had been an altercation, it would have been really ugly". - She had to call the police a couple of months ago because Resident #3 was swinging at her and calling her racial slurs and profanities. - During the incident on 01/22/16, she therapeutically restrained Resident #3 by jumping between Resident #3 and another resident. - She restrained Resident #3 by blocking the hit. - She was "quick to always block". - She had worked at the facility for 4 to 5 years part time. - Resident #3's behavior had just recently become physical in January 2016. - Prior to that, his behavior was verbal. Interview with a medication aide (MA) on 02/23/16 at 4:20 p.m. revealed: - She was called in to work as the MA on 2nd shift on 02/19/16. - The MA had started to do her 7:00 p.m. medication pass from the medication room - Staff A was sweeping and mopping the common dining area. - A resident started arguing with Staff A when Staff A asked that resident and Resident #3 to move so she could finish cleaning in the common area. - Resident #3 moved from the area and came for	D 338		

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his medication administration.
- Resident #3 went down the hallway toward his bedroom after he received his medication.
- The other resident started down the hallway going to his bedroom and flicked off the light switch by the medication room.
- This light switch controlled the lights to the common dining area.
- The other resident and Staff A started arguing because the resident cut off the lights.
- The MA was in the medication room but she could hear that the other resident and Resident #3 were arguing with Staff A and calling Staff vulgar names.
- Resident #3 said to Staff A that he didn't say anything to Staff A.
- Staff A told Resident #3 and the other resident to go on down to their room.
- The MA told Resident #3 and the other resident to stay calm and go to bed.
- The MA observed that Resident #3 was getting really agitated.
- The MA saw Staff A and the other resident by the light switch located by the medication room and they were still arguing.
- The MA administered medication to the other resident.
- Resident #3 and the other resident were both going down the hallway toward their bedrooms.
- Staff A followed Resident #3 and the other resident down the hallway.
- The MA closed the door to the medication room and went down the hallway toward Resident's #3 bedroom.
- The MA observed Staff A restraining Resident #3 with his arms across the front side of his body.
- The MA told Staff A to come out of Resident #3's room.
- Staff A told the MA that Resident #3 swung on her and that Resident #3 was going to call the

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police.
- The MA saw the Administrator was in the building when she got back down the end of the hallway.
- The MA said the Administrator did not ask her what happened with this incident.

Interview with Resident #3's roommate on 02/24/16 at 8:58 a.m. revealed:
- The roommate stated he did not want to get any staff in trouble.
- He was concerned that a report would be written on Staff A related to the incident with Resident #3.
- He wanted to talk with the surveyor again about the incident with Staff A and Resident #3.
- No one had threatened him or asked him to change his story.
- He was just trying to be supportive to his roommate yesterday when he told the surveyor about the incident.
- During the incident, Resident #3 came in the room and tripped over the laundry basket.
- Staff A picked up Resident #3 by an arm and a leg and "dropped" him on the bed and Resident #3 tried to hit Staff A.
- Staff A's earring fell out and she told Resident #3 to scoot over and Staff A found the earring.
- Resident #3 tried to hit Staff A and called her names like "wh--- and b----".
- Staff A told Resident #3 that he was the "wh--- and b----".
- The roommate reported he was in bed during the incident and rolled over to face the wall and put in his earplugs.
- When asked how he knew what happened during the incident if he was facing the wall with his earplugs in, the roommate hesitated and then said he "saw a little bit".
- He wanted the surveyor to let the Administrator

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D 338	Continued From page 73 know he had talked to the surveyor again about the incident. - He felt safe at the facility and was not afraid of anyone at the facility. Interview with the Administrator on 02/25/16 at 9:35 a.m. revealed: - He had started interviewing residents and staff about the incident for his investigation. - He had not talked with the roommate. - The residents know if a staff person did not do their job, they would get written up. - He thought that might be what the roommate was referring to. - He had not told any residents that Staff A was going to be reported or written up. Review of the facility's plan of protection dated 02/23/16 revealed: - Staff A shall be suspended from working until investigation is completed. - The Adult Home Specialist has been notified and reports shall be sent to the Health Care Personnel Registry. - If allegations are substantiated, Staff A will be terminated. - There will be no consequence to any resident who may have witnessed alleged incident. - Any staff attempting to violate residents' rights shall be reported and incident report filled out and submitted along with suspension from work. - Ombudsman will be contacted for residents' right training for all staff. - The Administrator shall monitor staff to ensure residents' rights are not being violated. - The Administrator will interview residents ongoing to ensure they have no complaints or have witnessed any residents' rights violations at least 3 times a week and anytime the	D 338		

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D 338	Continued From page 74 Administrator is in the facility. CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2016.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 1 of 3 residents (#6) observed during the medication passes, including errors with insulin and 1 of 3 residents (#2) sampled for record review including an error with a medication for breathing treatments. The findings are: 1. The medication error rate was 6% as evidenced by the observation of 2 errors out of 32 opportunities during the 8:30 a.m./9:00 a.m. and 12:00 p.m./12:30 p.m. medication passes on 02/24/16. A. Review of Resident #6's current FL-2 dated 08/03/15 revealed: - The resident's diagnoses included mental	D 358		

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retardation, hypertension, hip fracture, severe constipation, dementia, insulin-dependent diabetes mellitus, psychosis, and osteoarthritis.
- There was an order to administer Humalog insulin three times a day and at bedtimes using the following sliding scale: 0-70 = Call MD & Resident to drink orange juice, 71-150 = 0 units, 151- 200 = 2 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, 401 or greater = 12 units, call physician if blood sugar is > 401. (Humalog is rapid-acting insulin used to lower blood sugar.)

Review of a Physician's order for Resident #6 dated 02/24/16 revealed:
- There was a medication order for finger stick blood sugars (FSBS) before meals and to administer Humalog insulin before meals according to the following scale: 0-70 = Call MD & Resident to drink orange juice, 71-150 = 0 units, 151- 200 = 2 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, 401 or greater = 12 units, call physician if blood sugar is > 401. (Humalog is rapid-acting insulin used to lower blood sugar.)

[According to the Humalog KwikPen manufacturer, the pen should be primed before each injection. A dose of 2 units should be dialed up and hold the pen with the needle pointing up and tap reservoir gently to move air bubbles to the top of needle. Press the push button on the syringe as far as it will go until a stream of insulin appears coming out the needle tip. This removes air bubbles and ensures the pen and needle are working properly. (Air bubbles displace the amount of insulin in the syringe and prevents the full dose from being administered.)]

[According to the Humalog KwikPen

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manufacturer, while holding down the dose knob of the Humalog KwikPen, the needle of the Humalog KwikPen should be held in the skin for at least 5 seconds after the insulin injection to ensure the full dose of insulin has been administered.]

Review of the February 2016 medication administration record (MAR) for Resident #6 revealed:
- Resident #6's blood sugar was 167 at 7:30 a.m. on 02/24/16.
- Resident #6's blood sugars ranged from 104 to 274 from 02/01/16 - 02/24/16.

Observation of the 8:30 a.m. medication pass on 02/24/16 revealed:
- Resident #6 was observed eating her breakfast in the dining room at 8:35 a.m. and had finished eating her breakfast by 8:45 a.m.
- The medication aide (MA) brought Resident #6 into the medication room at 8:58 a.m.
- The MA dialed up 2 units of insulin using the Humalog KwikPen and injected the insulin into the right upper arm of Resident #6 at 9:00 a.m. and immediately removed the needle from the resident's right upper arm after the insulin injection.
- The needle of the Humalog KwikPen was not held in the skin for at least 5 seconds after the insulin was injected.
- The MA did not prime the Humalog KwikPen with a 2 unit air shot prior to dialing up the 2 units of Humalog ordered per sliding scale.
- Resident #6 was administered Humalog insulin 15 minutes after she had finished eating instead of before the meal as ordered.

Review of the facility's medication administration policy and procedure book on 02/24/16 revealed:

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D 358	Continued From page 77 - There were no policies or procedures regarding insulin administration or the use of insulin pens. Interview with the MA on 02/24/16 at 11:10 a.m. revealed: - She usually gave Resident #6 Humalog insulin about 15 to 30 minutes after the resident had finished eating. - She was not aware the insulin needed to be given prior to Resident #6 eating. - She was unaware of the medication order to give the sliding scale prior to meals but she made sure the resident had eaten something. - She recalled having insulin pen training but she was unsure of when she completed the training. - She primed the Humalog KwikPen with 1 unit air shot prior to insulin administration for Resident #6. - She did not remember being trained to use the 2 unit air shot to prime the needle prior to insulin pen administration. - She was aware she needed to hold the needle in the skin for a while after she administered the insulin using the Humalog KwikPen but she just got busy this morning with her morning medication pass. - She had diabetes training at this facility sometime during 2014 but she was unsure of what month. - She did not know if the facility had a policy regarding the administration of insulin or the use of insulin pens. Interview with the Administrator on 02/24/16 at 11:20 a.m. revealed: - He wasn't sure about the insulin order for Resident #6 and that he would have to review it to make sure that the MAs were giving the insulin as ordered. - He knew that all medication aides and staff had	D 358		

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diabetes training but he was unsure of when that training was done.
- He did not know insulin pens had to be primed prior to insulin administration and the needle had to remain in the skin to complete the insulin administration.
- He was unsure if administration of insulin using insulin pens was covered in the diabetes training.
- He was not sure if the insulin administration was covered in the medication administration procedure book for this facility.
- He would make sure the medication aides were educated on reviewing MARs to make sure all medications were being administered as ordered.
- He would make sure the medication aides were educated again on the administration of insulin using insulin pens.
- He would work with the medication aides to make sure they understood the medication orders and insulin was being administered at the correct times using the correct administration procedures.

Interview with the same MA on 02/24/16 at 11:40 a.m. revealed:
- There was no policy in the facility medication administration procedure book to regarding insulin administration.
- She would make sure to review the medication orders for insulin and make sure that all residents received their insulin are ordered by the doctor.

Interview with Resident Care Coordinator/Medication Aide on 02/24/16 at 5:00 p.m. revealed:
- She normally tried to give Resident #6 her insulin when the resident started to eat.
- She was not sure what the orders were for Resident #6's insulin administration.
- She would have to review the medication orders

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for Resident #6 regarding her insulin administration.
- She did not prime insulin pens prior to insulin administration.
- She had not been holding the needle in the skin for at least 5 seconds after insulin pen administration.
- She was unsure if the facility had a policy about insulin administration. -
She could not recall any training regarding the administration of insulin using insulin pens being done at the facility.
- She was unsure when diabetes training had been done at the facility but she believed that all staff had been through diabetes training.
- She would work with the Administrator to help educate other staff to understand the medication orders and that insulin needed to be administered as ordered.

B. Review of Resident #6's current FL-2 dated 08/03/15 revealed:
- The resident's diagnoses included mental retardation, hypertension, hip fracture, severe constipation, dementia, insulin-dependent diabetes mellitus, psychosis, and osteoarthritis.
- There was an order to administer Humalog insulin three times a day and at bedtimes using the following sliding scale: 0-70 = Call MD & Resident to drink orange juice, 71-150 = 0 units, 151- 200 = 2 units, 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, 401 or greater = 12 units, call physician if blood sugar is > 401. (Humalog is rapid-acting insulin used to lower blood sugar.)

Observation of the 12:00/12:30 p.m. medication pass on 02/24/16 revealed:
- Resident #6's blood sugar reading was 186.
- The medication aide (MA) dialed up 1 unit of

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Humalog and performed an air shot while holding the Humalog KwikPen at approximately a 60 degree angle.
- The MA dialed up 2 units of insulin using the Humalog KwikPen and injected the insulin into the left upper arm of Resident #6 at 12:26 p.m. and held the needle in the skin for approximately 5 seconds.
- The MA did not prime the Humalog KwikPen with a 2 unit air shot prior to dialing up the 2 units of Humalog ordered per sliding.
- Resident #6 was taken to the dining area at 12:30 p.m. and Resident #6 immediately began eating her lunch.

Interview with the MA on 02/24/16 at 12:45 p.m. revealed: -
She knew she was supposed to do the 2 unit air shot when using the insulin pen but she just forgot and did the 1 unit air shot out of habit.
- She would make sure that she did the 2 unit air shot and hold the insulin pen at a 90 degree angle from now on when she did the air shots.

2. Review of Resident #2's current FL-2 dated 10/21/15 revealed:
- The resident's diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure, heart failure, and heart disease.

Review of Hospital Discharge Instructions for Resident #2 dated 12/28/15 revealed:
- Resident #2 was hospitalized from 12/26/15 to 12/28/15 with diagnoses of acute chronic obstructive pulmonary disease exacerbation, diabetes, debility, hypertension, kidney failure, and left leg cellulitis.

Review of a Physician's order for Resident #2

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D 358	Continued From page 81 dated 12/29/15 revealed: - There was a physician's order for Resident #2 to have Albuterol 0.083% nebulizer treatments every 6 hours (Albuterol inhalation solution 0.083% is a medication used to treat airway narrowing relaxing airway muscles to increase air flow in the lungs. It is used to treat certain breathing problems such as asthma and other obstructive airway disease). Review of medication on hand on 02/24/16 revealed: - The instructions on the label for the Albuterol inhalation solution was to be administered via nebulizer every 6 hours. Review of the December 2015, January 2016, February 2016 medication administration records (MARs) for Resident #2 revealed: - There was computer generated entry for Albuterol Neb. 0.083% - give 1 treatment via nebulizer every 6 hours. - Administration times were 6a.m., 12p.m., and 6p.m. - Albuterol 0.083% nebulizer treatments were documented as administered at 6a.m., 12p.m., and 6p.m. instead of 6 hours as ordered from 12/31/15 through 02/24/16. Interview with the medication aide (MA) on 02/24/16 at 10:00 a.m. revealed: - She knew Resident #2 had a medication order for Albuterol nebulizer treatments to be given every 6 hours but she had not noticed there was no time slot printed for the fourth nebulizer treatment on the electronic MAR. - She knew if the Albuterol nebulizer treatment was not printed with the fourth dose listed on the electronic MAR then the resident didn't get it. - She did not get to see any new orders for the	D 358		

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residents of the facility.
- All new orders were handled by either the Resident Care Coordinator (RCC) or the Administrator.
- She only saw new orders if there were changes on the electronic MARs for the residents.
- Resident #2 had been refusing the Albuterol nebulizer treatments for a while now and the RCC was aware.
- She did not believe Resident #2 had any Albuterol nebulizer treatments so far in February 2016.

Interview with Resident #2 on 02/24/16 at 11:55 a.m. revealed:
- She never got a midnight dose of the Albuterol nebulizer treatment.
- She used the Albuterol nebulizer treatments when she first got out of the hospital because she had a lot of shortness of breath.
- She did not like the Albuterol nebulizer treatments because they made her feel nervous.
- She could not recall the last time that she had been offered the Albuterol nebulizer treatments by the staff at the facility.
- She had told the MAs that she did not like taking the Albuterol nebulizer treatments.
- She would like to have the Albuterol inhaler instead of the Albuterol nebulizer treatments.

Interview with the Administrator on 02/24/16 at 4:50 p.m. revealed:
- It was the responsibility of the RCC to review new orders and follow-ups from providers for all residents and to make sure orders were done correctly.
- Sometimes he faxed medication orders to the pharmacy to try to help out.

Interview with the RCC on 02/24/16 at 4:55 p.m.

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D 358	Continued From page 83 revealed: - She had served in the role of medication aide and RCC for the facility. - She usually followed up with the providers for any new orders for residents of the facility. - The pharmacy entered the new orders on the electronic MARs for the residents. - She checked the electronic MARs to make sure they are correct. - She missed seeing the Albuterol nebulizer treatments were not scheduled on the electronic MAR every 6 hours for Resident #2. - There was no system in place to compare the written orders against the electronic MARs to make sure that orders were entered correctly. Interview with the Nurse at the Pulmonologist of Resident #2 on 02/25/16 at 11:35 a.m. revealed: - Their office was not aware Albuterol nebulizer treatments were not being administered every 6 hours as ordered. - The nurse would notify the pulmonologist to make him aware of the Albuterol nebulizer were not being administered every 6 hours ordered.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observation, interview, and record	D 371		

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review, the facility failed to assure medications were administered in accordance with infection control measures to prevent the development and transmission of disease or infection for 2 of 2 residents (#2, #6) observed during the medication passes on 02/24/16. The findings are:

1. Review of Resident #6's current FL-2 dated 08/03/15 revealed:
- The resident's diagnoses included mental retardation, hypertension, hip fracture, severe constipation, dementia, insulin-dependent diabetes mellitus, psychosis, and osteoarthritis.

Review of a Physician's order for Resident #6 dated 02/24/16 revealed:
- There was a physician's order for Resident #2 to have finger stick blood sugars (FSBS) before meals and to administer Humalog insulin per sliding scale before meals. (Humalog is rapid-acting insulin used to lower blood sugar.)

Observation of the medication aide (MA) during the 8:30 a.m. medication pass on 02/24/16 revealed:
- The MA brought Resident #6 into the medication room at 8:58 a.m.
- She noted Resident #6's blood sugar was 167 at 7:30 a.m. on 02/24/16 and was to receive 2 units of Humalog per sliding scale order.
- The MA sanitized her hands using hand sanitizer.
- The MA wiped off the right upper arm of Resident #6 with an alcohol pad to prepare for insulin administration.
- The MA injected 2 units of insulin using a Humalog KwikPen into the right upper arm of Resident #6 at 9:00 a.m.
- She disposed the needle from the Humalog

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KwikPen in the sharps container.
- The MA sanitized her hands using hand sanitizer after the needle disposal.
- The MA did not wear gloves during the insulin administration of Resident #6.
- She did not wear gloves during the needle disposal after the insulin injection of Resident #6.

Review of the facility's medication administration policy and procedure book on 02/24/16 revealed:
- There was an infection control policy that staff should wear gloves when performing any resident care that involves the potential exposure to blood or bodily fluids.

Refer to interview with the medication aide on 02/24/16 at 11:10 a.m.

Refer to Interview with the Administrator on 02/24/16 at 11:20 a.m.

Refer to Interview with the Resident Care Coordinator / Medication Aide on 02/24/16 at 5:00 p.m.

2. Review of Resident #2's current FL-2 dated 10/21/15 revealed:
- The resident's diagnoses included chronic obstructive pulmonary disease with acute exacerbation, chronic respiratory failure, heart failure, and heart disease.

Review of a Physician's order for Resident #2 dated 02/24/16 revealed:
- There was a physician's order for finger stick blood sugars (FSBS) 2 hours after meals and at bedtime.

Observation of the medication aide (MA) during the 10:30 a.m. medication pass on 02/24/16

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revealed:
- The MA brought Resident #2 into the medication room at 10:30 a.m. to check her blood sugar as ordered.
- The MA sanitized her hands using hand sanitizer.
- The MA used a lancet and pricked the right index finger of Resident #2.
- The MA squeezed the finger to obtain the blood sample and applied the blood sample to the blood sugar strip of the glucometer for Resident #2.
- She noted the blood sugar reading of 238 for Resident #2.
- She removed the used blood sugar strip from the glucometer and put it in the sharps container.
- She disposed of the used lancet in the sharps container.
- She sanitized her hands using hand sanitizer after she performed the finger stick.
- The MA did not wear gloves during the finger stick procedure.

Review of the facility's medication administration policy and procedure book on 02/24/16 revealed:
- There was an infection control policy that staff should wear gloves when performing any resident care that involves the potential exposure to blood or bodily fluids.

Interview with Resident #2 on 02/24/16 revealed:
- Resident stated that she really did not pay attention if staff used gloves when she got her finger sticks or insulin injections.
- She saw the staff use gloves when they had to clean up though.

Refer to interview with the medication aide on 02/24/16 at 11:10 a.m.

Refer to interview with the Administrator on

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D 371	Continued From page 87 02/24/16 at 11:20 a.m. Refer to Interview with the Resident Care Coordinator / Medication Aide on 02/24/16 at 5:00 p.m. Interview with the medication aide on 02/24/16 at 11:10 a.m. revealed: - She did not use gloves with the insulin injection or the finger stick because she did not see how she was being exposed to blood or bodily fluids. - She was aware the facility had an infection control policy that all staff were to wear gloves when performing resident care when there was a risk of exposure to blood or bodily fluids. - She would use gloves from now on when she did the insulin injections, finger sticks, or if there was risk of contact with blood or bodily fluids. Interview with the Administrator on 02/24/16 at 11:20 a.m. revealed: - He was not aware the medication aide was not using gloves when she performed insulin injections and finger sticks. - The facility had a policy that staff was supposed to wear gloves when performing resident care when there was a potential for contact with blood or other bodily fluid. - He would make sure the infection control policy was re-emphasized with all staff. Interview with the Resident Care Coordinator / Medication Aide (MA) on 02/24/16 at 5:00 p.m. revealed: - The facility had a policy that staff was supposed to wear gloves when performing resident care when there was a potential for contact with blood or other bodily fluid. - She always wore gloves when she did insulin	D 371		

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D 371	Continued From page 88 injections, finger sticks, and any other resident care where there was potential risk of being exposed to blood or bodily fluids. - She was not aware the MA was not using gloves when she performed insulin injections and finger sticks - She had not observed other staff not using gloves when there was a potential for contact with blood or other bodily fluids. - She would remind all staff of the infection control policy regarding wearing gloves when performing resident care and when there may be a risk of exposure to blood or other bodily fluids.	D 371		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure action was taken in response to medication reviews and documented for 2 of 3 residents (#1, #7) sampled for review related to recommendations to discontinue a steroid topical cream due to refusals (#7) and changing the times of administration for a thyroid medication and a calcium supplement to prevent a drug-binding interaction (#1). The findings are: 1.Review of Resident #1's current FL-2 dated 03/03/15 revealed the resident's diagnoses included organic brain syndrome, spinoceberalla ataxia type [sic], osteoarthritis, [a thyroid condition	D 406		

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D 406	Continued From page 89 was not included on FL-2]. Review of the Resident Register revealed Resident #1 was admitted to the facility on 02/26/15. Review of Resident #1's medication administration record (MAR) for the month of December 2015 revealed: -Levothyroxine sodium [a man-made thyroid hormone replacement] 100 micrograms (mcg) to be given at 8:00 a.m. -Doses of Levothyroxine sodium 100mcgs had been documented as given every day at 8:00 a.m. from December 1st until December 31st . -Oyster Shell Tab (a calcium supplement) 500mg to be given twice a day at 8:00 a.m. and 8:00 p.m. -Doses of Oyster Shell Tab had been documented as given daily at 8:00 a.m. and 8:00 p.m. from December 1st until December 31st. Review of Resident #1's MAR for the month of January 2016 revealed: -Doses of Levothyroxine sodium 100mcgs had been documented as given every day at 8:00 a.m. from January 1st until January 31st . -Oyster Shell Tab 500mg had been documented as given daily 8:00 a.m. and 8:00 p.m. from January 1st until January 31st. Review of Resident #1's MAR for the month of February 2016 revealed: -Doses of Levothyroxine sodium 100mcgs had been documented as given every day at 8:00 a.m. from February 1st until February 24th. -Oyster Shell Tab 500mg had been documented as given daily 8:00 a.m. and 8:00 p.m. from February 1st until February 24th. Review of Pharmacist's Medication Regimen	D 406		

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D 406	Continued From page 90 Review dated 07/06/15 revealed: -It was recommended that the resident's thyroid medication and the calcium supplement should be separated by 4 hours to prevent a drug-binding [the calcium could prevent the thyroid medication from being absorbed properly] interaction. -The pharmacist documented that a memo was sent to the pharmacy to change calcium time to 2:00 PM and 8:00 PM. The Pharmacist's Medication Regimen Review dated 10/06/15 repeated the same recommendation. The Pharmacist's Medication Regime Review dated 01/11/16 did not address the Levothyroxine sodium/calcium issue. Interview with the medication aide (MA) on 02/25/16 at 10:00 a.m. revealed: -The Resident Care Coordinator (RCC) or Administrator were responsible for following up with the Pharmacist's recommendations. -The MA stated that she did not have access to the Pharmacist's Medication Regimen Review results. Telephone interview with the providing pharmacy on 02/25/16 at 10:05 a.m. revealed: -The pharmacy had received both of the memos from the pharmacist performing the medication review. -The pharmacy could not explain why the change was not made. -The pharmacy would change the times for the calcium administration on the MAR immediately. Telephone interview with Resident #1's primary care provider's office on 02/25/16 at 11:26 a.m.	D 406		

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revealed:
-Resident #1 was scheduled for an annual physical on 3/03/16.
-Laboratory tests will be performed at that time to monitor thyroid function.

Refer to interview with the Resident Care Coordinator (RCC) on 02/25/16 at 3:40 p.m.

Refer to interview with the Consultant Pharmacist (CP) on 02/24/16 at 12:14 p.m.

2. Review of Resident #7's current FL-2 dated 10/19/15 revealed:
- The resident's diagnoses included seizures / epilepsy, hypertension, major depressive disorder, history of traumatic brain injury, subdural hematoma with neuropsychiatric impairment, history of suicide / self-inflicted injury.
- There was an order for Clobetasol Cream topical twice daily. (Clobetasol cream is a topical steroid used to reduce swelling, itching, and redness associated with many skin conditions.)

Review of a physician's order for Resident #7 dated 01/05/16 revealed:
- There was an order for Clobetasol cream 0.05% apply a small amount to the affected area twice daily - apply to callous on toe for fungus.

Review of Resident #7's most recent medication regimen review dated 01/11/16 revealed:
- The pharmacist noted the resident no longer used Clobetasol cream due to refusals.
- The pharmacist recommend the order for Clobetasol be discontinued due to the refusals.

Review of Resident #7's record revealed no documentation the medication review recommendations had been followed up.

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D 406	Continued From page 92 Review of Resident #7's February 2016 medication administration record (MAR) revealed: - There was an entry for Clobetasol Cream 0.05% apply a small amount to affected area twice daily - apply to callous on toes for fungus. - Clobetasol cream was scheduled to be administered at 8:00 a.m. and 8:00 p.m. - Clobetasol cream was documented as refused from 02/01/16 - 02/11/16 and 02/16/16 - 02/24/16. - Clobetasol was documented as administered 3 times in February 2016 on 02/07/16 at 8:00 p.m., 02/20/16 at 8:00 p.m. and 02/21/16 at 8:00 a.m. - The resident was documented as being on a home visit from the evening of 02/11/16 through the morning of 02/16/16. Interview with the medication aide on 02/25/16 at 10:10 a.m. revealed: - The pharmacy entered the medication orders on the MARs. - She did not know if the medication reviews had been followed up. - The Resident Care Coordinator (RCC) handled the medication reviews. Based on observation and interview, Resident #7 was unavailable for interview on 02/25/16 due to being at a medical appointment. Interview with the RCC on 02/25/16 at 3:40 p.m. revealed: - Resident #7 had a hard callous on the outer edge of his pinky toe. - There was no redness or open area on Resident #7's foot the last time she saw it a couple of days ago. Attempts to contact Resident #7's physician during the survey were unsuccessful.	D 406		

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D 406	Continued From page 93 Refer to interview with the Resident Care Coordinator (RCC) on 02/25/16 at 3:40 p.m. Refer to interview with the Consultant Pharmacist (CP) on 02/24/16 at 12:14 p.m. Interview with the RCC on 02/25/16 at 3:40 p.m. revealed: - She was responsible for following up on any medication review recommendations. - The Consultant Pharmacist gave her a copy of the recommendations the same day she did the reviews before she left the facility. - The RCC faxed the recommendations to the physicians on that same day. - She usually checked with the physicians if she does not get a response in a few days. - She must have overlooked the recommendations that had not been done. Telephone interview with the Consultant Pharmacist (CP) on 02/24/16 at 12:14 p.m. revealed: - The facility was given copies of the medication review recommendations when she completed the reviews on 01/11/16 - She did not recall any issues with the facility not following up on medication reviews in the past.	D 406		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record review and interviews, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .1001 and .1002 by not reporting known allegations of abuse of a resident (#3) by a staff person (Staff A) or an injury of unknown origin to a resident (#3) to the Health Care Personnel Registry. The findings are:

Review of Resident #3's current FL-2 dated 01/11/16 revealed:
- The resident's diagnoses included mild mental retardation, hypertension, coronary artery disease, hyperlipidemia, anxiety, migraine, and gastroesophageal reflux disease.
- The resident was not documented as disoriented or as having inappropriate behavior.

Review of Resident #3's assessment and care plan dated 01/11/16 revealed:
- The resident was ambulatory and independent with all activities of daily living.
- The resident was sometimes disoriented, forgetful and needed reminders.
- The resident could be verbally and physically abusive (mostly toward women).

Review of charting notes for Resident #3 revealed:
- 01/22/15 (8:11 p.m.): Resident #3 began calling staff names, "b----es", black wh---" and making verbal threats that he'll beat staff's "a--". Staff intervened because another resident went over to hit Resident #3. Staff prompted Resident

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D 438	Continued From page 95 #3 to be quiet but resident did not comply and resident "swung on staff". "Staff therapeutic restrained resident and called 911." - 02/19/16 (8:14 p.m.): Resident #3 was asked to be excused for a minute while staff was trying to clean under the chair he was sitting in. The resident complied and went to receive his medications. Resident #3 heard another resident calling staff names the Resident #3 joined in. Resident #3 followed staff down the hallway saying things. Staff continued to ignore the resident. Resident #3 then walked in staff's personal space. Staff asked the resident to step back but the resident refused and tried to "swing on staff". Staff blocked the hit then "therapeutically escorted" Resident #3 to his room while resident was "swinging on staff". Resident #3's roommate went to grab the resident but staff redirected the roommate and called the Administrator. The Administrator arrived and talked to the resident. Confidential staff interview revealed: - A resident reported to the staff person that Resident #3 was cursing at Staff A one day over the past weekend. - The resident observed Staff A grab Resident #3 and drag Resident #3 to his room. - Resident #3 also reported the incident to the staff person. - Resident #3 stated his roommate saw the incident. - The incident occurred on Friday (02/19/16). - Resident #3 reported Staff A dragged him in his room, threw him on the bed, and then threw him on the floor. - Resident #3 hurt his arm when Staff A threw him on the floor. - The resident still had a bruise/abrasion on his elbow.	D 438		

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D 438	Continued From page 96 - Resident #3 reported it to the Administrator but the Administrator told the resident it was the resident's fault because of the way the resident talks. - Staff were supposed to report any allegations of abuse to the Resident Care Coordinator (RCC) or the Administrator. - The staff person did not report it to the Administrator because Staff A had reported the incident already to the RCC. - The Administrator was aware of the incident because Staff A called him to come to the facility right after the incident. - There was another incident in January 2016 when Staff A said "something smart" (meaning sarcastic) to Resident #3 and Resident #3 called Staff A's family member a "b----". - 911 was called in January 2016 during this incident. Confidential resident interview revealed: - Resident #3 was hit and treated bad [sic] by a "redheaded staff member" about 2 days ago. - The staff member pushed Resident #3 down and dragged him across the floor. - Resident #3 was then thrown on his bed and choked by the staff member. - The staff member looked at this resident while she was choking Resident #3 and asked if this resident "wanted some of this". - Resident #3's left elbow was hurt and bled [sic] when he was pushed down by staff member. - Resident #3 told the Administrator about the incident. Confidential interview with a second resident revealed: - The resident could hear Resident #3 cursing and calling Staff A vulgar names. - The resident heard Staff A saying that she was	D 438		

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D 438	Continued From page 97 tired of Resident #3 calling her vulgar names and Staff A was going to put Resident #3 to bed. - Staff A tried to push Resident #3 into his bedroom. - Staff A and Resident #3 started to wrestle in the hallway. - Staff picked up Resident #3 and put him on his bed. - The resident saw Staff A kneeling down and holding Resident #3 down on the bed. Interview with Resident #3 on 02/23/16 at 2:50 p.m. revealed: - Staff A called him all kinds of names and cursed at him. - An incident with Staff A occurred over this past weekend. - Staff A started cursing him and calling him names like "son of a b----", "bast---", and a racial slur. - He was in the hall outside his bedroom door when Staff A grabbed him by the shirt and back of the neck and drug him in his room. - Staff A threw him on the bed, got on top of him and started choking him with both hands. - Staff A also beat him in the chest with her fist. - He told Staff A to get off of him. - Staff A stood up and left the room but came back a few minutes later. - He was sitting on the bed and was wearing a hoodie. - Staff A grabbed him by the shirt and threw him on the floor. - He hurt his elbow. - The resident held up his arm and there was a reddish brown scab on his elbow about 1 inch in diameter. - He told Staff A to leave him alone. - He called Staff A names like "son of a b----" and a racial slur.	D 438		

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- The Administrator came to the building right after the incident and bandaged the resident's arm.
- The Administrator told the resident that the resident caused all that trouble.
- About a month ago, he was in the dining room at the table and he got up to walk down the hall.
- Staff A pushed him against the handrail on the wall and grabbed him under the chin with her hand.
- Another staff person was in the office when it happened and told Staff A to keep her hands off the resident.
- The Administrator knew about both incidents but told the resident it was the resident's fault.

Interview with Resident #3's roommate on 02/23/16 at 3:14 p.m. revealed:
- While Staff A was working in the evening after supper, she drug Resident #3 into their bedroom.
- Staff A was pulling Resident #3 by one leg and one arm and dragging him across the floor and then Staff A put her arms around him and threw him on the bed.
- Staff A got on top of the resident on the bed by strattling her body on top of his.
- Resident #3 stood up to defend himself and Staff A thought Resident #3 was going to hit her.
- Staff A then pushed Resident #3's chest with both hands and he fell back on the bed.
- Staff A realized she was missing an earring so she picked up Resident #3 and threw him on the floor so Staff A could search his bed for her earring.
- Resident #3 landed about 6 feet across the room in front of a laundry basket.
- Staff A and Resident #3 were cursing at each other.
- Staff A was all "hyped up with adrenaline".
- The Administrator came after the incident and

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bandaged Resident #3's arm.
- No one interviewed the roommate about what he witnessed.

Interview with the Administrator on 02/23/16 at 3:42 p.m. revealed:
- On 02/19/16, Staff A called him and told him to come to the facility and get Resident #3.
- Staff A told the Administrator that Resident #3 had "done got started with her".
- He went to Resident #3's room and Resident #3 told him that Staff A "started messing with me".
- Resident #3 was not specific and did not give details
- He spoke with the other resident who was yelling and he was not specific about the incident.
- Resident #3 had a scratch on his elbow.
- When asked if the Administrator asked the resident how he injured his elbow, the Administrator stated the resident did not say what happened to his elbow.
- Staff A did not report any physical altercation with the resident.
- He did not know there was anything physical during the incident between Staff A and Resident #3.
- He did not know how the resident physically got the abrasion on his elbow.
- The facility's policy was to report something physical to the Adult Home Specialist and the Health Care Personnel Registry (HCPR).
- He interviewed 3 other residents including Resident #3's roommate, Staff A, Resident #3 and the other staff person on duty.
- The other residents told him that Staff A did not do anything and Resident #3 started on Staff A.
- No one reported the alleged physical altercation to him so he did not report it to the HCPR.
- He was aware of the injury to Resident #3's elbow but he did not know what caused the injury.

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D 438	Continued From page 100 - He did not ask Staff A about the injury to Resident #3's elbow. - He did not report the injury of unknown origin to the HCPR because he was not aware he was supposed to report it. - Staff A was a medication aide / personal care aide and she worked part time at the facility on second or third shifts about 3 nights a week and some weekends. - Staff A had worked at the facility for many years. - He had not noticed Staff A documented in the charting note on 02/19/16 that she "therapeutically escorted" Resident #3 to his room. - He did not know what that phrase meant. - Some of the staff have had training on therapeutic holds but that had not been done to any residents at the facility to his knowledge. Telephone interview with Staff A on 02/23/16 at 4:21 p.m. revealed: - She was working at the facility on Friday night, 02/19/16. - A resident started calling her racial slurs and saying other profanity. - Resident #3 came down the hall and joined in with the other resident calling her names too. - She told Resident #3 to go to his room and she started cleaning a common bathroom in the hallway. - Resident #3 started yelling and walked up on her. - She told Resident #3 to get out of her personal space. - Resident #3 told Staff A that he would knock her out and he called her a "little black wh---". - She told Resident #3 not to touch her. - She started mopping in the hallway outside of Resident #3's room.	D 438		

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D 438	Continued From page 101 - Resident #3 swung his fist toward her face so she blocked the hit by throwing up her arm in an L-shape. - This blocked the hit but the resident was still trying to fight. - She put her arm under Resident #3's arm and walked him fast to his room and stood by the bed. - Resident #3 was ready to fight and she left the room to get the phone. - The resident stayed in the room but he was still talking out loud. - She called the Administrator and asked him to come to the facility. - She told the Administrator what happened and asked the Administrator to de-escalate the problem. - She told the Administrator the same information she was reporting to the surveyor, including the information related to Staff A putting her arm under Resident #3's arm. - The Administrator talked to Resident #3 and a couple more residents. - Resident #3 stayed in his room the rest of the night. - She was not aware there was an injury to Resident 3#'s elbow. - When she wrote the charting note she could not think of other words to describe how she got the resident in the room besides "therapeutically escorted". - She did not want someone to read the note and think she abused the resident. - When Staff A got up under his arm, Resident #3 tried to pull away so he could swing at her so Staff A walked him into the room fast and then she left the room. - She stated she was a "big girl" (physically) and "if there had been an altercation, it would have been really ugly". - She had to call the police a couple of months	D 438		

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ago because Resident #3 was swinging at her and calling her racial slurs and profanities.
- During the incident on 01/22/16, she therapeutically restrained Resident #3 by jumping between Resident #3 and another resident.
- She restrained Resident #3 by blocking the hit.
- She was "quick to always block".

Interview with a medication aide (MA) on 02/23/16 at 4:20 p.m. revealed:
- She was called in to work as the MA on 2nd shift on 02/19/16.
- A resident started arguing with Staff A when Staff A asked that resident and Resident #3 to move so she could finish cleaning in the common area.
- Resident #3 moved from the area and came for his medication administration.
- Resident #3 went down the hallway toward his bedroom after he received his medication.
- The MA was in the medication room but she could hear that the other resident and Resident #3 were arguing with Staff A and calling her vulgar names.
- Resident #3 told Staff A that he didn't say anything to her.
- Staff A told Resident #3 and the other resident to go on down to their room.
- She told Resident #3 and the other resident to stay calm and go to bed.
- She observed that Resident #3 was getting really agitated.
- Staff A followed Resident #3 and the other resident down the hallway.
- The MA closed the door to the medication room and went down the hallway toward Resident #3's bedroom.
- The MA observed Staff A restraining Resident #3 with his arms across the front side of his body.
- The MA told Staff A to come out of Resident #3's

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room.
- Staff A told the MA that Resident #3 swung on her and that Resident #3 was going to call the police.
- The MA saw the Administrator was in the building when she got back down the end of the hallway.
- The Administrator did not ask the MA what happened with this incident.

Interview with Resident #3's roommate on 02/24/16 at 8:58 a.m. revealed:
- The roommate stated he did not want to get any staff in trouble.
- He was concerned that a report would be written on Staff A related to the incident with Resident #3.
- He wanted to talk about the incident with Staff A and Resident #3.
- No one had threatened him or asked him to change his story.
- He was just trying to be supportive to his roommate yesterday when he told the surveyor about the incident.
- During the incident, Resident #3 came in the room and tripped over the laundry basket.
- Staff A picked up Resident #3 by an arm and a leg and "dropped" him on the bed and Resident #3 tried to hit Staff A.
- Staff A's earring fell out and she told Resident #3 to scoot over and Staff A found the earring.
- Resident #3 tried to hit Staff A and called her names like "wh--- and b----".
- Staff A told Resident #3 that he was the "wh--- and b----".

Interview with the Administrator on 02/23/16 at 5:26 p.m. revealed:
- Staff should report any allegations of abuse the supervisor on duty or the Administrator.

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D 438	Continued From page 104 - The supervisor should report any allegations of abuse to the Administrator. - He would be responsible for reporting allegations of abuse to the HCPR. Review of a copy of a HCPR 24 hour initial report provided by the Administrator on 02/24/16 revealed: - The 24 hour report was faxed to the HCPR on 02/23/16 at 7:03 p.m. - An allegation of resident abuse was checked on the form with description of injury as abrasion on elbow. - The date and time of incident was noted as 02/19/16 at 7:30 p.m. - Staff A was listed as the accused individual. - Reasonable suspicion of a crime was marked as "no" and there was no serious bodily injury. Review of the facility's plan of protection dated 02/23/16 revealed: - The 24 hour report to the Health Care Personnel Registry (HCPR) shall be completed immediately and the 5 day report shall be completed within the time frame and both forms will be faxed to the HCPR. - Staff A is suspended from working until outcome of the investigation. - If substantiated, Staff A will be terminated. - Residents' rights training shall be scheduled through the Ombudsman. - Notifications of abuse, neglect, unknown injury, or exploitation shall be reported to the supervisor on duty or the Administrator. - If the Administrator is not present, staff will report to the Administrator as soon as possible to ensure the HCPR is notified as required. CORRECTION DATE FOR THE TYPE B	D 438		

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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 438	Continued From page 105 VIOLATION SHALL NOT EXCEED APRIL 10, 2016.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care and health care personnel registry. The findings are: 1. Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#2, #3) as related to failure to obtain oxygen as ordered by the hospitalist (#2), failure to coordinate nephrology appointment (#2), failure to notify the physician of refusals of breathing treatments (#2), failure to obtain mental health services for a resident with behaviors (#3), failure to discuss abnormal thyroid labwork with the primary care physician (#3), and a missed cardiology appointment (#3). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026052	A. BUILDING: _____ B. WING _____	02/25/2016

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D912	Continued From page 106 2. Based on record review and interviews, the facility failed to comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .1001 and .1002 by not reporting known allegations of abuse of a resident (#3) by a staff person (Staff A) or an injury of unknown origin to a resident (#3) to the Health Care Personnel Registry. [Refer to Tag D438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure a resident (#3) was free of mental and physical abuse related to the resident being verbally and physically mistreated by Staff A. The findings are: Based on observation, record review and interview, the facility failed to assure 1 of 3 sampled residents (#3) was free from physical and mental abuse relating to verbal and physical mistreatment of the resident by Staff A. [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).]	D914		