| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MORNING STAR AL #4 | 941 GOINS ROAD PEMBROKE, NC 28372 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on 02/02/17, 02/06/17, and 02/07/17. | D 000 | | |
| D 074 | 10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to assure walls, ceilings, and floors were kept clean and in good repair for 2 of 3 common resident bathrooms, 5 of 6 residents' bedrooms, the hallway, and the dining room.<br><br>The findings are:<br><br>Observation of the dining room on 02/02/17 at 10:08 a.m. revealed the ceiling vent was rusted with a build-up of dust.<br><br>Observation of common bathroom B (tub, toilet and sink) on 02/02/17 at 11:18 a.m. revealed:<br>-The wall around the metal faucet on the tub had brown stains near the faucet.<br>-There was a small round hole in the wall behind the door where the door knob rested against the wall.<br><br>Observation of resident room #6 on 02/02/17 at 11:21 a.m. revealed: | D 074 | | |

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| D 074 | Continued From page 1<br>-There were multiple areas of rust stains all over the floor near all of the walls and underneath the legs of furniture throughout the room.<br>-There were 4 areas on the sheetrock walls that had been patched but needed painting.<br>-The baseboard on the wall around the left side of the room was dented in and had rust stains.<br><br>Interview with the Administrator on 02/02/17 at 11:35 a.m. revealed:<br>-She thought the rust stains had been caused by metal legs on furniture becoming rusted.<br>-They needed to do some painting.<br><br>Observation of common bathroom C (shower, toilet and sink) on 02/02/17 at 11:24 a.m. revealed:<br>-There was a cracked tile on the wall to the left of the shower.<br>-The floor of the shower had a build-up of light brown stains in the corner.<br><br>Interview with the Administrator on 02/02/17 at 11:50 a.m. revealed:<br>-She had tried to clean and re-grout the tile in the shower and some of the grout had come back up and the stains would not come up.<br>-The crack in the tile near the shower was caused when they removed a shower curtain holder.<br><br>Observation of the hallway on 02/02/17 at 11:24 a.m. revealed the ceiling vent outside of common bathroom C was missing a screw and hanging down on one side.<br><br>Observation of resident room #5 on 02/02/17 at 11:33 a.m. revealed:<br>-There was a brown water stain on the ceiling about 2 feet by 2 and ½ feet on the right side of the room. | D 074 | | |

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| D 074 | Continued From page 2<br>-There were multiple areas of rust stains all over the floor near the walls and underneath the legs of furniture throughout the room.<br><br>Interview with the Administrator on 02/02/17 at 11:35 a.m. revealed:<br>-There was a hurricane in October 2016 that blew some shingles off the roof, causing the leak in the ceiling in resident room #5.<br>-She had the maintenance staff person on the roof replacing the shingles today.<br>-They had to repaint the ceiling.<br>-The rust stains were caused by metal legs on furniture.<br><br>Observation of resident room #4 on 02/02/17 at 11:35 a.m. revealed:<br>-The floor had multiple scattered rust stains near the corners of the room.<br>-The floor had black stains in a circled pattern around the legs of the bed positioned against the outer wall.<br>-The left wall on the inner side of the room had scattered, scuffed gray and brown soiled areas over the wall's surface located just above the bed positioned against the wall.<br>-The walls throughout the room had a yellow fading paint color with multiple, scattered white, plaster-type painted sections.<br>-There was fading handwriting on the right inner wall.<br>-There was an indented area in the plaster type wall close to the floor, beside the bed positioned against the outer wall.<br><br>Review of an environmental inspection dated 01/13/17 revealed the facility received 3 demerits related to "All walls should be in good repair and thoroughly clean". | D 074 | | |

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| D 074 | Continued From page 3<br><br>Observation of resident room #3 on 02/02/17 at 11:37 a.m. revealed there was about a 4 inch scratch and indentation on the wall behind the door with missing paint.<br><br>Observation of resident room #2 on 02/02/17 at 11:40 a.m. revealed:<br>-There were areas of rust stains all over the floor near the walls and underneath the legs of furniture throughout the room.<br>-The baseboard around the left side of the room was lifting away from the wall and had rust stains.<br><br>Interview with the Administrator on 02/02/17 at 11:50 a.m. revealed:<br>-She was in the process of making repairs and improvements to this facility but she had been more focused on repairs to a sister facility.<br>-She had some painting to get done and they were going to work on the floors and the baseboards.<br>-She could have the floor stripped and buffed and that would remove the rust stains.<br>-It had been "a while" since the floors had been stripped but she would get it done.<br><br>Review of the facility's cleaning schedule posted in the kitchen revealed:<br>-1st shift: clean beds and change linens on Mondays and Thursdays; sweep and mop rooms; make beds; and dust.<br>-2nd shift: sweep, mop, and clean laundry room; and put up laundry.<br>-3rd shift: mop hall, living room, dining room, and all bathrooms; clean all bathrooms, dining room chairs, pictures in hall, exit signs, emergency lights, door frames, and laundry room; sweep and mop med room, and dust living room. | D 074 | | |

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| D 076 | Continued From page 4 | D 076 | | |
| D 076 | 10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings<br><br>10A NCAC 13F .0306 Housekeeping And Furnishings<br>(a) Adult care homes shall:<br>(3) have furniture clean and in good repair;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to have furniture in good repair in 4 residents' bedrooms including chest of drawers, night stands, dressers, chairs and kitchen cabinets/drawers.<br><br>The findings are:<br><br>Observation of resident room #6 on 02/02/17 at 11:21 a.m. revealed:<br>-There was a 4 drawer chest of drawers that was missing 4 of 8 knobs.<br>-There was another 4 drawer chest of drawers with scratches and missing stain on the wood.<br>-There was a straight back chair with wooden arms that had scratches and missing stain on the wood.<br>-There was a wooden night stand with scratches and missing stain.<br><br>Observation of resident room #5 on 02/02/17 at 11:33 a.m. revealed:<br>-There was a 4 drawer chest of drawers that was missing 3 of 10 knobs.<br>-The chest of drawer had scratches and was missing stain on the wood.<br><br>Observation of resident room #2 on 02/02/17 at 11:40 a.m. revealed: | D 076 | | |

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| D 076 | Continued From page 5<br>-There were two wooden night stands with scratches and missing stain on the wood and one was missing a knob.<br>-There were two large wooden dressers that were scratched with missing stain and pieces of chipped off wood at the bottom below the drawers.<br><br>Interviews with the Administrator on 02/02/17 at 11:35 a.m. and 11:50 a.m. revealed:<br>-She planned to refurbish the wooden furniture because it was good and sturdy.<br>-She had some knobs for replacements on the furniture and they had to get the knobs installed.<br><br>Observation of resident room #4 on 02/02/17 at 11:35 a.m. revealed:<br>-There was a chest of drawers against the wall to the left of the room.<br>-There was a section of the chest of drawers left corner base that was chipped and missing wood that exposed the under layer pressed board.<br>-The chipped and missing wood was approximately 12 inches long by 3 inches wide.<br>-There was a section of the chest of drawers right corner base that was chipped, splintered and had missing wood that exposed the under layer pressed board. The chipped and missing wood was approximately 4 inches long by 3 inches wide.<br>-There were scattered scuff marks over the lower portion of the front of the chest drawer that exposed the under layer wood color.<br><br>Interview with the Administrator on 02/02/17 at 4:27 p.m. revealed:<br>-The furniture in the facility was good.<br>-She had started re-staining the furniture in the resident rooms today.<br>-She would have all furniture repaired. | D 076 | | |

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| D 076 | Continued From page 6<br><br>Observation of the kitchen on 02/02/17 at 1:10 p.m. revealed:<br>-There was a four drawer kitchen cabinet with a drawer handle not secured in place and was hanging downward, a second drawer handle was missing and one of drawers was in a slanted upward position and would not close flush with the cabinet's base.<br>-There was a cabinet door over a section of the kitchen counter on the left of the room that had a missing handle and scattered areas of peeling chipped paint.<br>-The facility's repairman was in the kitchen working on a ceiling light fixture.<br><br>Interview with the Administrator on 02/02/17 at 4:20 p.m. revealed:<br>-She knew there were some needed repairs in the kitchen and was planning on starting on the repairs soon.<br>-The repairman would start in the kitchen today.<br><br>Observation of the kitchen cabinet on 02/07/16 at 1:10 p.m. revealed the cabinets and handles had been painted and repaired.<br><br>Review of an environmental inspection dated 01/13/17 revealed the facility received 4 demerits related to "Cabinets and drawers in the kitchen should be in good repair". | D 076 | | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and | D 079 | | |

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| D 079 | Continued From page 7<br>orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to assure the facility was maintained in a clean and orderly manner and free of hazards in 3 of 3 common resident bathrooms, resident bedrooms, and the dining room.<br><br>The findings are:<br><br>Observation in the dining room on 02/02/17 at 10:42 a.m. revealed:<br>-There was a water fountain on the wall to the right of the room.<br>-The water fountain electrical cord was unplugged laying on the floor underneath the base of the fountain.<br>-There was a plate missing on the front of the water fountain that exposed the electrical and mechanical parts of the fountain.<br><br>Interview with the Administrator on 02/02/17 at 4:27 p.m. revealed:<br>-The tape was placed on front of the fountain today to cover the mechanical and electrical parts.<br>-She would have the fountain repaired or removed.<br><br>A second observation in the dining room on 02/02/17 at 4:31 p.m. revealed:<br>-The water fountain electrical cord was unplugged laying on the floor underneath the base of the | D 079 | | |

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| D 079 | Continued From page 8 | D 079 | | |

fountain.
-There was gray duct tape applied to the front of the water fountain that covered the electrical and mechanical parts of the fountain.

Observation of common bathroom A (toilet and sink only) on 02/02/17 at 11:12 a.m. revealed:
-The metal toilet paper holder was rusted.
-The toilet seat had yellow stains and the white covering was rubbed off in several areas exposing brown material under the cover.
-The toilet lid had liquid stains running down and the white covering was rubbed off in several areas exposing brown material under the cover.

Observation of common bathroom B (tub, toilet and sink) on 02/02/17 at 11:18 a.m. revealed:
-The toilet seat had brown stains on the seat and running down the front of the toilet.
-There was urine inside the toilet bowl.

Observation of resident room #6 on 02/02/17 at 11:21 a.m. revealed there were broken slats in the mini blind hanging in the window.

Review of an environmental inspection dated 01/13/17 revealed the facility received 2 demerits that included the facility's blinds needed to be maintained in good repair.

Observation of common bathroom C (shower, toilet and sink) on 02/02/17 at 11:24 a.m. revealed:
-There was a white athletic sock tied around the metal pipe connected to the shower head.
-The sock was wet and discolored with reddish orange stains.
-Water leaked around the sock and shower head when the water was turned on.
-The metal faucet on the sink was loose.

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| D 079 | Continued From page 9 | D 079 | | |

-There was a dirty wet wipe with light brown stains on the back of the toilet.
-The metal toilet paper holder was rusted.
-The toilet seat had brown stains scattered on the seat.

Observation of resident room #2 on 02/02/17 at 11:40 a.m. revealed there was an electrical outlet near the window with a broken face plate exposing a hole in the middle of the outlet.

Interview with the Administrator on 02/02/17 at 11:50 a.m. revealed:
-She was in the process of making repairs and improvements to this facility but she had been more focused on repairs to a sister facility.
-She replaced the shower head in the common bathroom (C) less than a year ago.
-She did not realize it was leaking or that a socked had been wrapped around it.
-She was not aware the bathroom sink faucet was loose but she would get it tightened.
-She would have the electrical outlet replaced.
-Staff on duty were supposed to clean every day on their shift, including the bathrooms.
-She would have the toilet seats cleaned and/or replaced.

Interview with the personal care aide (PCA) on 02/02/17 at 1:17 p.m. revealed:
-She usually worked on first shift.
-They have cleaning assignments and she usually tried to clean 3 resident rooms on first shift.
-Second shift staff was supposed to clean 3 resident rooms.
-Third shift staff was supposed to clean the bathrooms, hallways, and living room.
-They had new staff on third shift and she thought they were still in the process of learning their duties and may have overlooked cleaning the

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| D 079 | Continued From page 10<br>bathrooms.<br><br>Review of the facility's cleaning schedule posted in the kitchen revealed:<br>-1st shift: clean beds and change linens on Mondays and Thursdays; sweep and mop rooms; make beds; and dust.<br>-2nd shift: sweep, mop, and clean laundry room; and put up laundry.<br>-3rd shift: mop hall, living room, dining room, and all bathrooms; clean all bathrooms, dining room chairs, pictures in hall, exit signs, emergency lights, door frames, and laundry room; sweep and mop med room, and dust living room. | D 079 | | |
| D 269 | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to provide incontinence care according to facility procedures of every two hours for 3 of 4 resident's (Resident #2, #4, #5) who required total assistance with toileting resulting in skin irritation and redness for two residents. | D 269 | | |

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| D 269 | Continued From page 11<br>The findings are:<br><br>1. Review of Resident #4's current FL-2 dated 04/05/16 revealed:<br>-Diagnoses included dementia in other diseases classified elsewhere with behavioral disturbances, altered mental status unspecified, unspecified bacterial pneumonia, other skin changes, and Type 2 diabetes mellitus without complications.<br>-The resident was constantly disoriented and semi-ambulatory.<br>-The resident was incontinent of bowel and bladder.<br><br>Review of Resident #4's Resident Register revealed an admission date of 07/15/14.<br><br>Review of Resident #4's Personal Care Plan dated 07/14/16 revealed:<br>-The resident had daily incontinence of bowel and bladder.<br>-The resident required total assistance from staff with toileting/incontinent care every 2 hours and as needed.<br>-The primary care provider signed the care plan on 07/06/16.<br><br>Observation of Resident #4 on 02/02/17 at 10:45 a.m. revealed:<br>-The resident was in the television/living room with the other residents.<br>-The Medication Aide (MA) told the resident it was time for her to check her blood sugar.<br>-The resident walked with the MA out of the television room.<br><br>Observation of Resident #4 on 02/02/17 at 10:50 a.m. revealed she was sitting in the television/living room with other residents. | D 269 | | |

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| D 269 | Continued From page 12<br><br>Observation of Resident #4 on 02/02/17 at 12:13 p.m. revealed:<br>-The resident came out of the television/living room into the dining room.<br>-The resident sat at a dining room table to eat lunch.<br><br>Observation of Resident #4 and the MA in the resident's bedroom on 02/02/17 at 2:00 p.m. revealed:<br>-The MA removed Resident #4's lower clothing and incontinent brief.<br>-Resident #4's incontinent brief was not soiled.<br>-The MA used a wet incontinent wipe to clean Resident #4's perineum and buttocks.<br>-Resident #4's buttocks was red, scaly and rough in appearance.<br><br>Interview with the MA on 02/02/17 at 2:05 p.m. revealed:<br>-She was not aware that Resident #4's skin on her buttocks was red, scaly and rough.<br>-That was the first time she had changed Resident #2's incontinent brief since she had been working in the building today but the other aide had changed her.<br><br>Observation of Resident #4 on 02/02/17 revealed it had been greater than 2 hours since incontinent care had been provided.<br><br>Observation on 02/02/17 at 4:45 p.m. revealed:<br>-The PCA removed Resident #4's lower clothes and incontinent brief while the resident was in a standing position.<br>-Resident #4 began to breathe heavily.<br>-The incontinent brief was soiled heavily with urine.<br>-The residents buttocks was red, scaly and rough | D 269 | | |

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|---|---|
| MORNING STAR AL #4 | 941 GOINS ROAD PEMBROKE, NC 28372 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 269 | Continued From page 13 | D 269 | | |

in appearance.
-The inner portion of the residents thighs were red.
-The PCA opened Resident #4's top clothes drawer and stated there were "no wipes".
-The PCA applied a barrier cream to Resident #4's buttocks and inner thighs without cleaning the urine from the resident's buttocks, perineum and inner thighs, then applied a clean incontinent brief and assisted the resident to reapply her lower clothing.

Interview with the PCA observed providing incontinent care on 02/02/17 at 4:51 p.m. revealed:
-She had not noticed that Resident #4 had a red scaly rash on her buttocks and the redness on her upper inner thighs prior to today.
-The PCA usually cleaned the resident's skin with wipes with each brief change.
-Wipes should have been in Resident #4's room.
-She did not think about using soap, water and a wash cloth to cleanse Resident #4's skin.

Review of "Two Hour Diaper Check" forms dated 01/15/17 through 02/02/17 for Resident #4 revealed:
-First shift times included 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., and 2:00 p.m.
-No incontinence checks were documented on first shift on 01/15/17, 01/24/17, and 01/27/17 - 02/02/17.
-Second shift times included 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m.
-No incontinence checks were documented on second shift on 01/20/17 and 02/02/17.
-Third shift times included 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m.
-No incontinence checks were documented on third shift on 01/17/17, 01/19/17, 01/22/17, and

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| D 269 | Continued From page 14<br>02/01/17.<br><br>Interview with the Head Supervisor on 02/02/17 at 5:20 p.m. revealed:<br>-All PCAs should clean resident's skin with wipes and or soap / water with each brief change.<br>-All incontinent resident's rooms should be stocked with incontinent wipes.<br>-The Head Supervisor would check each resident room to assure wipes were readily available.<br>-Staff had not reported Resident #4 had skin redness or irritation.<br><br>Interview with the Administrator on 02/02/17 at 5:20 p.m. revealed:<br>-She expected staff to always provide skin care by properly cleaning residents' skin with incontinent wipes and or soap/water during incontinent care.<br>-She would expect staff to gather all needed items prior to starting care for residents to assure all needed items were available.<br>-Resident #4's primary care physician would be contacted regarding the rash/redness on Resident #4's buttocks and upper inner thighs.<br><br>Review of Resident #4's charting notes revealed:<br>-Resident #4's primary care provider was contacted on 02/03/17, the office was closed but would call again 02/06/17, "Will do proper personal care on her in the meantime".<br>-There was a charting note dated 02/06/17 that an appointment was made for the resident with the primary care provider for 02/07/17 at 4:00 p.m. related to "her bottom".<br>-There was a charting note dated 02/07/17 that Resident #4 was seen by the primary care provider and no new orders were given for the redness on her buttocks. | D 269 | | |

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| D 269 | Continued From page 15<br>Attempted call to Resident #4's primary care provider was unsuccessful on 02/07/17 at 5:10 p.m.<br><br>Refer to the interview with the Administrator on 02/02/17 at 10:24 a.m.<br><br>Refer to the interview with the MA on 02/02/17 at 1:48 p.m.<br><br>Refer to the interview with the Administrator on 02/02/17 at 5:20 p.m.<br><br>Refer to the interview with the Head Supervisor on 02/02/17 at 5:20 p.m.<br><br>2. Review of Resident #2's current FL-2 dated 01/20/17 revealed:<br>-The resident's diagnoses included dementia and hypertension.<br>-The resident was non-ambulatory and constantly disoriented.<br>-The resident was incontinent of bowel and bladder.<br>-The resident required total personal care assistance.<br><br>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/06/10.<br><br>Review of Resident #2's current plan of care dated 01/20/17 revealed:<br>-The resident was always disoriented and had significant memory loss.<br>-The resident was non-ambulatory.<br>-The resident had daily incontinence of bowel and bladder.<br>-The resident was totally dependent in toileting, "staff change resident". | D 269 | | |

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| D 269 | Continued From page 16<br><br>Observation during the initial tour on 02/02/17 at 10:45 a.m. to 12:10 p.m. revealed:<br>-Resident #2 was seated in a reclined Geri chair, in the television/living room with other residents.<br>-Staff did not transfer Resident #2 out of the television/living room.<br><br>Observation in the dining room on 02/02/17 at 12:11 p.m. revealed staff transferred Resident #2 from the television/living room into the dining room.<br><br>Observation of Resident #2 on 02/02/17 revealed it had been greater than 2 hours since incontinent care had been provided.<br><br>Observation on 02/02/17 at 1:40 p.m. revealed:<br>-The Medication Aide (MA) used a Hoyer lift to transfer Resident #2 from the Geri chair to the bed.<br>-The MA positioned Resident #2 on his side to change his adult incontinent brief.<br>-Resident #2's incontinent brief was soiled with a large bowel movement at 1:42 p.m.<br>-The MA cleaned Resident #2's perineal and buttock area with wet incontinent wipes.<br>-Resident #2's skin was red around the sacral portion of his buttocks. The redness was approximately 6 inches in length by 4 inches in width. Scattered redness was noted in the resident's groin area.<br>-The MA applied Resident #2's clean incontinent brief and positioned the resident on the right side.<br><br>Review of "Two Hour Diaper Check" forms dated 01/15/17 - 02/02/17 for Resident #2 revealed:<br>-First shift times included 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., and 2:00 p.m.<br>-No incontinence checks were documented on | D 269 | | |

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| D 269 | Continued From page 17<br>first shift on 01/15/17, 01/18/17, 01/20/17, 01/23/17 - 01/25/17, and 01/27/17 - 02/02/17.<br>-Second shift times included 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m.<br>-Second shift checks were documented as done from 01/15/17 - 02/01/17.<br>-Third shift times included 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m.<br>-No incontinence checks were documented on third shift on 01/21/17, 01/22/17, and 02/01/17.<br><br>Interview with the MA on 02/02/17 at 1:48 p.m. revealed:<br>-Resident #2 had not had any open sores.<br>-Resident #2's skin was sensitive.<br>-This was the first time she had changed Resident #2's brief since she had been working in the building today but the other aide had changed him.<br>-The MA always tried to allow the residents to sit up for a little while after eating a meal before she would lay them down in order to change their incontinent briefs.<br>-The MA would leave Resident #2 in the bed until the next 2 hour brief change.<br><br>Interview with a Personal Care Aide (PCA) on 02/02/17 at 4:51 p.m. revealed the PCA had already changed Resident #2 "20 minutes ago".<br><br>Interview with the Administrator on 02/02/17 at 5:20 p.m. revealed Resident #2's primary care physician would be contacted regarding the redness on the residents' buttocks and groin.<br><br>Review of Resident #2's primary care provider's physician note dated 02/03/17 revealed:<br>-Some redness noted to the resident's groin and buttocks secondary to urinary and bowel incontinence. | D 269 | | |

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| D 269 | Continued From page 18<br>-There was an order for fanny cream (a skin barrier to protect the skin) to perineum and buttocks with incontinence change.<br><br>Refer to the interview with the Administrator on 02/02/17 at 10:24 a.m.<br><br>Refer to the interview with the MA on 02/02/17 at 1:48 p.m.<br><br>Refer to the interview with the Administrator on 02/02/17 at 5:20 p.m.<br><br>Refer to the interview with the Head Supervisor on 02/02/17 at 5:20 p.m.<br><br>3. Review of the current FL-2 dated 12/12/16 for Resident #5 revealed:<br>-The resident's diagnoses included Alzheimer's dementia, altered mental status, cerebrovascular accident, diabetes mellitus type 2, hypertension, peripheral vascular disease, Vitamin B12 deficiency, and gastroesophageal reflux disease.<br>-The resident was constantly disoriented and non-ambulatory.<br>-The resident was incontinent of bowel and bladder.<br>-The resident's skin was noted to be normal.<br>-The resident required total assistance with personal care including bathing, feeding, and dressing.<br><br>Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 08/31/10.<br><br>Review of Resident #5's current Personal Care Plan dated 05/11/16 revealed:<br>-The resident was always disoriented and had significant memory loss. | D 269 | | |

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| D 269 | Continued From page 19<br>-The resident was non-ambulatory and used a geri-chair.<br>-The resident had daily incontinence of bowel and bladder.<br>-The resident required total assistance from staff with toileting/incontinent care every 2 hours and as needed.<br>-The primary care provider signed the care plan on 05/18/16.<br><br>Review of Resident #5's Memory Care Individual Program review form dated 01/07/17 revealed:<br>-Staff goal was to maintain the resident's skin integrity.<br>-Staff would change the resident every 2 hours as needed.<br>-Staff would make sure the resident maintained clean and dry skin.<br><br>Observation during the initial tour on 02/02/17 from 10:45 a.m. to 12:10 p.m. revealed:<br>-Resident #5 was seated in a reclined Geri chair, in the television/living room with other residents.<br>-Staff did not transfer Resident #2 out of the television/living room.<br><br>Observation in the dining room on 02/02/17 at 12:11 p.m. revealed staff transferred Resident #5 from the television/living room into the dining room.<br><br>Observation of Resident #5 on 02/02/17 revealed it had been greater than 2 hours since incontinent care had been provided.<br><br>Interview with the Medication Aide on 02/02/17 at 2:24 p.m. revealed:<br>-She had just changed Resident #5's incontinent brief.<br>-Resident #5 received hospice care and they had | D 269 | | |

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| D 269 | Continued From page 20 | D 269 | | |

changed the resident's incontinent brief when they visited today as well.

Review of "Two Hour Diaper Check" forms dated 01/15/17 - 02/02/17 for Resident #5 revealed:
-First shift times included 6:00 a.m., 8:00 a.m., 10:00 a.m., 12:00 p.m., and 2:00 p.m.
-No incontinence checks were documented on first shift on 01/24/17 and 01/29/17 - 02/02/17.
-Second shift times included 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m.
-Second shift checks were documented as done from 01/15/17 - 02/01/17.
-Third shift times included 10:00 p.m., 12:00 a.m., 2:00 a.m., 4:00 a.m., and 6:00 a.m.
-No incontinence checks were documented on third shift on 01/17/17, 01/19/17, and 02/01/17.

Interview with a Personal Care Aide (PCA) on 02/02/17 at 4:51 p.m. revealed the PCA had already changed Resident #5 "20 minutes ago".

Observation on 02/02/17 at 6:20 p.m. revealed:
-Resident #5's incontinent brief was soiled with urine.
-The PCA cleaned Resident #5's perineum and buttocks with a wet incontinent wipe and reapplied an incontinent brief.
-Resident #5 had no redness, irritation, or open skin areas on her perineum or buttocks.

Interview with a hospice aide on 02/06/17 at 1:55 p.m. revealed:
-She worked with Resident #5 for the first time on Friday, 02/03/17.
-A different hospice aide worked with Resident #5 prior to 02/03/17.
-She worked with Resident #5 daily since 02/03/17.
-She noticed the resident's buttocks had a little

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| D 269 | Continued From page 21<br>redness on Friday, 02/03/17 and fanny cream was put on the resident.<br>-She did not see any skin breakdown on Resident #5, just the redness.<br>-Facility staff had not reported any concerns about Resident #5 to her.<br><br>Refer to the interview with the Administrator on 02/02/17 at 10:24 a.m.<br><br>Refer to the interview with the MA on 02/02/17 at 1:48 p.m.<br><br>Refer to the interview with the Administrator on 02/02/17 at 5:20 p.m.<br><br>Refer to the interview with the Head Supervisor on 02/02/17 at 5:20 p.m.<br><br>_____<br><br>Interview with the Administrator on 02/02/17 at 10:24 a.m. revealed there were no residents with skin breakdown at the facility.<br><br>Interview with the MA on 02/02/17 at 1:48 p.m. revealed the staff follow the facility's timed, every 2 hour schedule change for the incontinent residents.<br><br>Interview with the Head Supervisor on 02/02/17 at 5:20 p.m. revealed:<br>-She was not aware that brief changes were exceeding the facility's established procedure for every 2 hour incontinent brief changes.<br>-She was not aware staff were not recording brief changes every 2 hours.<br>-It was expected for staff to report any skin changes to her or the MA so the primary care provider could be notified. | D 269 | | |

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| D 269 | Continued From page 22<br><br>Interview with the Administrator on 02/02/17 at 5:20 p.m. revealed:<br>-All staff were aware that all incontinent residents must receive incontinent care every 2 hours.<br>-There were posted signs in the facility to remind staff of the every 2 hour incontinent brief checks.<br>-She was not aware that brief changes were exceeding the facility's established procedure for every 2 hour incontinent brief changes.<br>-Staff should be providing incontinent brief changes every 2 hours and documenting those brief changes on the facility's "Two Hour Diaper Check" log.<br>-She was not aware staff were not recording brief changes every 2 hours.<br><br>The facility's failure to provide incontinence care in accordance to established every two hour procedure resulted in 2 of 3 residents having skin redness and irritation. The failure of the facility to assure a system for appropriate incontinence care directly impacted the health and safety of the residents, which constitutes a Type B Violation.<br><br>Review of the facility's plan of protection submitted on 02/02/17 revealed:<br>-The Administrator would place wipes in each persons room that required incontinence brief changes.<br>-Each resident would be checked by two people every two hours to ensure the person was dry and clean.<br>-The employees would document results.<br>-The RCC and the Administrator would spot check incontinence brief changes and skin.<br>-Two people would be present to change residents and documented by each person. | D 269 | | |

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| D 269 | Continued From page 23<br>-The employee would place initials, date and time on the incontinence briefs to ensure residents were changed within the two hour time period.<br>-The MD would be called about the two residents.<br>-The RCC and Administrator would monitor this area daily to ensure compliance.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 24, 2017. | D 269 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 3 residents (#1, #2) sampled as related to failure to have Resident #1 follow-up with a nephrologist after a hospitalization for acute renal failure requiring temporary dialysis followed by the resident being readmitted to the hospital in intensive care for end stage renal disease then requiring permanent hemodialysis and failure to notify Resident #2's primary care provider of a recent hospitalization and subsequent recommendations for recurrent urinary tract infections and urosepsis.<br><br>The findings are: | D 273 | | |

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1. Review of Resident #1's current FL-2 dated 02/03/17 revealed:
-Diagnoses included dementia, schizophrenia, hypertension, chronic obstructive pulmonary disease, chronic kidney disease and history of diastolic heart failure.
-The resident was intermittently disoriented.

Review of Resident #1's Resident Register revealed an admission date of 09/21/16.

Review of Resident #1's Special Care Unit Resident Profile dated 01/07/17 revealed:
-Resident #1's memory recall included "room" and names.
-Resident #1's cognitive skills for daily decision making was severely impaired and he was unable to make decisions.
-Resident #1's comprehension was slow.

Interview with the Administrator on 02/02/17 at 10:24 a.m. revealed Resident #1 was new to dialysis.

Review of Resident #1's hospital discharge information signed by a physician dated 09/21/16 from a local hospital revealed:
-The resident was admitted from 09/09/16 to 09/21/16.
-The primary discharge diagnoses included acute renal failure, hypertensive disorder and hyponatremia.
-The resident was admitted to the hospital from the facility due to medication refusals, not eating, bathing, or sleeping for an unreported amount of time.
-The resident refused voluntary medical interventions and was brought to the emergency room under involuntary commitment.
-The resident's hospital course consisted of

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treatment for his worsened kidney function with dialysis and correcting his electrolytes per nephrology recommendations.
-The resident was being discharged back to the facility to maintain his current medical treatment and to follow up as an outpatient with his primary care physician and Nephrology.

Review of Resident #1's surgical procedure note from a local hospital dated 09/20/16 revealed:
-The resident underwent a surgical procedure to remove a vascular catheter.
-Indications for the procedure noted the resident no longer needed hemodialysis.

Review of Resident #1's discharge instructions from a local hospital dated 09/21/16 revealed:
-Follow-up appointments included for the facility to make a follow-up appointment to see nephrology within one week of discharge and with the primary care provider in one week.
-Both of the follow up appointments had been highlighted in yellow.
-There was an unsigned handwritten entry beside the instructions for the follow up appointment with nephrology "did will mail appointment".

Review of Resident #1's Resident Note dated 09/21/16 revealed:
- (A named nephrologist) was called to make an appointment, they would mail an appointment but it would not be in one week.
-The note was signed by the Special Care Coordinator (SCC).

Review of Resident #1's Resident Note dated 11/18/16 revealed:
-An appointment was made with (a named surgical group/gastrointestinal) for 12/15/16 at 11:00 a.m.

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| D 273 | Continued From page 26<br>-The note was signed by the SCC.<br><br>Review of Resident #1's medical care visit notes, primary care orders, and Resident Notes did not reflect a follow-up appointment with a Nephrologist after 09/21/16.<br><br>Review of Resident #1's Resident Note dated 01/16/17 revealed:<br>-The resident was admitted to a local hospital related to wheezing, coughing and difficulty breathing.<br>-The note was signed by the SCC.<br><br>Review of Resident #1's hospital discharge summary from a different local hospital dated 01/22/17 revealed:<br>-The resident was admitted from 01/16/17 through 01/23/17.<br>-The resident was initially admitted to an intensive care unit.<br>-The resident's admitting diagnoses included end stage renal disease, acute anemia on anemia end stage renal disease, NSTEMI (non-ST-elevation myocardial infarction which is a medical term for a type of heart attack).<br>-The resident's discharge diagnoses included end stage renal disease and hemodialysis dependent.<br>-The resident's follow up appointments included home health, follow up with the primary care provider and Nephrology in one week.<br>-The resident was scheduled and set up with outpatient dialysis.<br>-Procedures performed during the hospital course included dialysis, 3 times per week, and permacath<br>(A catheter placed in the jugular vein for hemodialysis) placement by a vascular surgeon.<br><br>Review of a "provider rounding note" by a | D 273 | | |

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Nephrologist at a local outpatient hemodialysis clinic for Resident #1 dated 01/25/17 revealed assessment was completed and the resident was tolerating dialysis.

Interview with Resident #1's family member on 02/06/17 at 8:10 a.m. revealed:
-The family member tried to visit the resident at least weekly and last saw him on 02/05/17.
-The family member was not aware of any issues with the resident's medical appointments or issues with medications.
-Resident #1 moved to this facility in September 2016 from another facility on the same grounds.
-The family member felt the resident gets more attention in this facility and seemed happier.
-The family member went with Resident #1 for his first hemodialysis appointment a few weeks ago.

Interview with the Nurse Manager at the hemodialysis center on 02/06/17 at 9:29 a.m. revealed:
-Resident #1 was new to dialysis.
-There had been no issues of missed dialysis appointments or late arrivals for Resident #1.
-Resident #1 was transported to dialysis by a local transport provider.

Interview with the Administrator on 02/02/17 at 6:45 p.m. revealed the SCC was responsible for all follow up appointments for the residents and the SCC would be able to give additional information regarding Resident #1's follow up appointments.

Interview with the Administrator on 02/06/17 at 3:31 p.m. revealed the SCC would look for additional information regarding Resident #1's follow up with a Nephrologist.

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| D 273 | Continued From page 28<br><br>Interview with the SCC on 02/06/17 at 5:53 p.m. revealed:<br>-She had documented on the discharge instructions from the hospital dated 09/21/16 indicating that she had called and an appointment would be mailed.<br>-The facility never received the appointment card in the mail so she made an appointment with the previous nephrologist.<br>-She called and scheduled an appointment for 12/15/16 with Resident #1's previous physician after no appointment was received in the mail from the Nephrologist called on 09/21/16.<br><br>Review of a card provided by the SCC revealed a list of providers under a surgical and gastrointestinal group.<br><br>Telephone interview with the surgical and gastrointestinal group for Resident #1 on 02/07/17 at 9:40 a.m. revealed:<br>-The resident was last seen 12/15/16 in the clinic.<br>-The physician was a general surgeon.<br>-The clinic did not provide any nephrology services.<br><br>Telephone interview on 02/07/17 at 10:14 a.m. with a nurse at a nephrology clinic that worked with the named Nephrologist in the Resident #1's Resident Note written by the SCC on 09/21/16 revealed:<br>-There was an appointment made for Resident #1 on 11/09/16 at 3:15 p.m. however the resident was listed as a no show and no reschedule.<br>-There were no calls regarding the no show and no reschedule from the facility that she was aware of or could see in the system.<br>-The appointment was mailed to the facility's address (the nurse verified the correct mailing address for the facility) and the clinic had an | D 273 | | |

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automated system that called the facility one day prior to the appointment for an appointment reminder (the nurse verified the correct contact telephone number for the facility).
-The resident had never been seen at the clinic.
- Follow-up needs could have included regular monitoring and tracking of kidney functions and if indicated, an ongoing need for dialysis treatments.
-In general, failure to follow up with a nephrologist could pose serious health risks especially for a person who had a known kidney disease and had received temporary dialysis treatments.

Attempt to interview Resident #1's primary care provider on 02/07/17 was unsuccessful.

Interview with the SCC on 02/07/17 at 2:53 p.m. revealed:
-She had continued to look for information related to a nephrology appointment for Resident #1.
-She needed to find her old resident appointment book.
-She never received a nephrology appointment through mail for Resident #1 so she called his previous doctor he had seen.
-Resident #1 refused to go to the appointment with the nephrologist.
-When asked to clarify how could Resident #1 refuse an appointment if the appointment was never received in the mail, the SCC could not give a reply.

A second interview with the SCC on 02/07/16 at 3:03 p.m. revealed:
-Resident #1 had refused a "bunch' of medical appointments.
-She did not see where she had written Resident #1 had refused to go to the nephrologist appointment but thought he refused.

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-She normally had residents to sign when they refused medical care.
-The facility may have received the card from the nephrologist's office but she was unsure if she had attempted to call and reschedule another appointment for Resident #1.

Interview with the Administrator on 02/07/16 at 3:50 p.m. revealed:
-She expected all resident follow-up appointments to be scheduled and if needed rescheduled.
-The SCC was responsible to follow up with all of the residents' medical appointments.

2. Review of Resident #2's current FL-2 dated 01/20/17 revealed the resident's diagnoses included dementia and hypertension.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/06/10.

Review of Resident #2's current assessment and care plan dated 01/20/17 revealed:
-The resident was non-ambulatory and had limited eye-hand coordination.
-The resident was incontinent of bowel and bladder.
-The resident was always disoriented and had significant memory loss.
-The resident was totally dependent for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of hospital emergency room forms dated 10/21/16 revealed:
-Resident #2 was treated for a urinary tract infection and given an antibiotic.
-The discharge instructions indicated for the

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resident to follow-up with the primary care provider (PCP) in 2 days.

Review of a visit note from the former primary care physician (PCP) dated 10/26/16 for Resident #2 revealed:
-The PCP ordered to have home health evaluate and hospice for urosepsis - recurrent.
-The PCP noted the urosepsis had been present for the last two weeks.

Review of Resident #2's provider visit notes revealed:
-There was no documentation the resident followed up with home health or hospice regarding the resident's recurrent urosepsis.

Interview with the Administrator on 02/02/17 at 6:30 p.m. revealed:
-Resident #2's family had refused hospice services.
-She did not document the refusal.

Interview with a hospice representative on 02/07/17 at 2:50 p.m. revealed Resident #2's family refused hospice care on 10/26/16.

Attempt to interview Resident #2's family member was unsuccessful.

Review of hospital discharge papers dated 01/05/17 for Resident #2 revealed:
-The resident was admitted with diagnoses of acute encephalopathy suspected due to urinary tract infection and dehydration with mild acute renal failure.
-The resident's discharge diagnoses included acute encephalopathy - resolved and urinary tract infection.
-The resident was to follow-up with PCP in 2 to 4

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days and "consider repeat urinalysis in 4 weeks and BNP to monitor normal renal function and urine test of cure".

Interview with the Special Care Coordinator (SCC) on 02/07/17 at 5:55 p.m. revealed:
-She did not recall seeing the information about getting a repeat urinalysis and lab work on the hospital discharge forms for Resident #2.
-The resident did not have a urinalysis or any labwork done because she overlooked the instructions on the discharge paperwork.
-She did not see the orders to follow-up with the PCP for the hospitalization so she had not set up a follow-up appointment.
-The resident had been seen by the previous and new PCPs since the hospitalization for a routine visit.
-She had not reported the hospitalization to either PCP.
-She did not know if either PCP was aware of the resident's hospitalization in 01/2017.

Review of Resident #2's physician visit notes and lab reports revealed:
-There was no documentation the resident followed up with the PCP in 2 to 4 days regarding the hospitalization on 01/05/17.
-There was no documentation of a repeat urinalysis or BNP lab work being done.

Review of a visit note from the new PCP dated 01/20/17 for Resident #2 revealed:
-This was a routine visit.
-The resident was incontinent of bowel and bladder, continue skin care protocol.
-There was no documentation the PCP was made aware of resident's hospitalization on 01/05/17 for urinary tract infection.

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Review of a visit note by the new PCP dated 02/03/17 for Resident #2 revealed:
-The resident had an ongoing physical and mental decline.
-The resident was reliant on staff for all activities of daily living.
-The PCP noted some redness of buttocks and groin secondary to incontinence of bowel and bladder.
-The PCP wrote an order to apply fanny cream to peri-area / buttocks with incontinence changing.
-There was no documentation the new PCP was made aware of the resident's hospitalization on 01/05/17 for urinary tract infection.

Interview with the Administrator on 02/07/17 at 2:40 p.m. revealed:
-She had just spoken with the home health agency the facility used and they did not receive any referrals on Resident #2 to evaluate for urosepsis or to get any labwork.
-She did not know why referrals were not sent to the home health agency.
-She did not know why the hospitalization was not reported to the PCPs.

Interview with the Administrator on 02/07/17 at 3:50 p.m. revealed:
-The SCC was responsible for reviewing hospital discharge paperwork and implementing any orders or setting up any follow-up appointments or referrals.
-The hospital discharge with order for home health referral should have been faxed to the home health agency.
-The home health agency would have come to the facility to provide services if they had received the orders.
-The new NP was not aware of Resident #2's hospitalization or orders.

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| D 273 | Continued From page 34<br>-She would contact the new NP and let her know about the hospitalization and the orders that had not been implemented.<br><br>Interview with the new PCP on 02/07/17 at 5:35 p.m. revealed:<br>-She had noticed a decline in Resident #2 when she was at the facility on Friday, 02/03/17, from when she had treated him in the past.<br>-She was not aware of the resident's hospitalization for urinary tract infection in 01/2017.<br><br>Attempt to interview Resident #2' former PCP was unsuccessful.<br><br>---<br><br>The facility failed to have Resident #1 follow-up with a nephrologist after a hospitalization for acute renal failure that required temporary dialysis and the resident being readmitted to the hospital in intensive care for end stage renal disease requiring perrmanent renal dialysis for renal failure and the facility failed to notify Resident #2's PCP of a recent hospitalization and recommendations for a history of recurrent urinary tract infections and urosepsis. The failure of the facility to assure a system for the coordination of health care for the safety and well-being of the residents resulted in risk of serious physical harm to two residents and constitutes a Type A2 Violation.<br><br>---<br><br>Review of the facilities plan of protection dated 02/06/17 revealed:<br>-The facility would contact home health agency about any labs, physical therapy, occupational therapy, and any other needed follow-up and orders to be completed. | D 273 | | |

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| D 273 | Continued From page 35<br>-This would be documented in the residents' records.<br>-The physician would be contacted and informed that the orders were not done but would be completed.<br>-Forms have been developed to track labs and any follow-up orders given by hospital or physician.<br>-These forms would be completed by the SCC and monitored by the Administrator upon each visit to the hospital or physician's office.<br>-All labs, follow-up orders from the hospital and physician's office would be faxed to the agency requested and documented in the resident's record.<br>-A form for tracking labs and follow-up appointments has been developed and would be completed when orders were given.<br>-The SCC and Administrator would monitor these areas monthly and as needed to ensure compliance.<br>-Transportation person would be responsible for taking residents to appointments and would document in the residents' records that they have been taken.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 9, 2017. | D 273 | | |
| D 280 | 10A NCAC 13F .0903(c) Licensed Health Professional Support<br><br>10A NCAC 13F .0903 Licensed Health Professional Support<br>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care | D 280 | | |

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| D 280 | Continued From page 36<br>plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:<br>(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;<br>(2) evaluating the resident's progress to care being provided;<br>(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and<br>(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and evaluation within 30 days of admission and quarterly thereafter for 3 of 3 residents (#1, #2, #6) sampled by performing a physical assessment for required tasks of ambulation with assistive device that requires physical assistance, transferring semi-ambulatory and non-ambulatory residents, a prosthetic device, and colostomy care.<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated 01/20/17 revealed:<br>-The resident's diagnoses included dementia and | D 280 | | |

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hypertension.
-The resident was non-ambulatory and constantly disoriented.
-The resident required total personal care assistance.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/06/10.

Review of Resident #2's current assessment and care plan dated 01/20/17 revealed:
-The resident was non-ambulatory and used a geri-chair.
-The resident was totally dependent for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation during the initial tour on 02/02/17 at 10:45 a.m. from 12:10 p.m. revealed Resident #2 was seated in a reclined Geri chair, in the living room with other residents.

Observation in the dining room on 02/02/17 at 12:11 p.m. revealed staff pushed Resident #2 from the living room into the dining room in his geri-chair.

Observation in Resident #2's bedroom on 02/02/17 at 1:40 p.m. revealed:
-The medication aide / personal care aide (MA/PCA) used a Hoyer lift to transfer Resident #2 from the geri-chair to the bed.
-The MA /PCA positioned Resident #2 on his side to change his adult incontinence brief.
-The MA/PCA applied Resident #2's clean incontinence brief and positioned the resident on the right side.

Review of Resident #2's licensed health

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professional support (LHPS) review dated 10/27/16 revealed:
-The only LHPS tasks documented on the form was home health nurse for labs.
-The nurse noted the resident was alert and oriented and the resident was non-ambulatory.
-The nurse noted assessment was complete and the resident's vital signs were within normal limits.
-The nurse noted the resident required assistance with activities of daily living (ADLs) and no skin breakdown was noted.
-No problems were noted and the nurse made no recommendations.
-The LHPS review did not include an assessment for the tasks of ambulation using assistive devices (geri-chair) or transferring for non-ambulatory status.

Review of Resident #2's current LHPS review dated 01/27/17 by the same nurse revealed:
-The only LHPS tasks documented on the form was home health nurse for labs.
-The nurse noted the resident was alert and oriented x3 and the resident was ambulatory without assistive device.
-The nurse noted assessment was complete and the resident's vital signs were within normal limits.
-The nurse noted the resident required assistance with ADLs.
-No problems were noted and the nurse made no recommendations.
-The LHPS review did not include an assessment for the tasks of ambulation using assistive devices (geri-chair) or transferring for non-ambulatory status.

Interview with the Administrator on 02/07/17 at 1:35 p.m. revealed:
-Resident #2's health declined about 6 months ago and he became totally dependent with all

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ADLs.
-The resident had a geri-chair and staff used a hoyer lift for transfers.
-She did not know why the LHPS nurse assesed the resident as alert and oriented or ambulatory.

Refer to interview with the Administrator on 02/07/17 at 1:35 p.m.

Refer to interview with the LHPS nurse on 02/07/16 at 1:46 p.m.

2. Review of Resident #6's current FL-2 dated 06/09/16 revealed:
-The resident's diagnoses included dementia secondary to cerebrovascular accident, mood disorder, coronary artery disease, history of cerebrovascular accident, hypertension, and left above knee amputation.
-The resident was semi-ambulatory and constantly disoriented.
-The resident was incontinent of bowel and bladder.
-The resident required total care with bathing, feeding, and dressing.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 07/08/14.

Review of Resident #6's current assessment and care plan dated 07/15/16 revealed:
-The resident was ambulatory with use of a geri-chair by staff.
-The resident had a left leg amputation.
-The resident had limited arm range of motion.
-The resident had daily incontinence of bowel and bladder.
-The resident was always disoriented and had significant memory loss.

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| D 280 | Continued From page 40<br>-The resident required limited assistance with eating.<br>-The resident was totally dependent with ambulation (geri-chair by staff), bathing, dressing, grooming, and transferring.<br><br>Review of a primary care provider (PCP) visit dated 12/30/15 for Resident #6 revealed:<br>-The resident needed a geri-chair and hoyer lift for debility, difficulty walking, and worsening arthritis.<br>-These were needed for positioning that the resident could not do due to severe arthritis and muscle weakness and due to left above knee amputation.<br><br>Observation of Resident #6 on 02/02/17 at 10:50 a.m. revealed:<br>-The resident was sitting in a geri-chair in the living room.<br>-The resident had left above knee amputation and he was not wearing a prosthetic device.<br><br>Observation on 02/02/17 at 12:11 p.m. revealed staff pushed Resident #6 into the dining room in his geri-chair.<br><br>Review of physician's order dated 01/13/16 for Resident #6 revealed an order for referral for a prosthetic leg.<br><br>Review of a progress note for Resident #6 dated 03/31/16 revealed the resident's prosthetic leg got fitted today but he would need therapy.<br><br>Review of a physical therapy (PT) discharge note dated 08/05/16 for Resident #6 revealed:<br>-The resident began PT on 04/15/16 but maximum benefit had been achieved and the resident would be discharge from PT. | D 280 | | |

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| D 280 | Continued From page 41<br>-The resident remained non-ambulatory.<br><br>Interview with a medication aide / personal care aide (MA/PCA) on 02/06/17 at 1:30 p.m. revealed:<br>-Resident #6 had physical therapy but the resident was not willing to do the therapy.<br>-The resident did not use the prosthetic leg.<br>-The resident had a wheelchair a while ago but he did not have one now.<br>-The resident used a geri-chair now and has had it for a long time.<br>-The resident could not transfer by himself and staff used a hoyer lift to transfer the resident.<br><br>Interview with the Special Care Coordinator (SCC) on 02/06/17 at 1:36 p.m. revealed:<br>-Resident #6 had a prosthetic leg and worked with PT for a while.<br>-The resident was unable to use the prosthetic leg because of his dementia.<br>-The resident continued to use a geri-chair and had the geri-chair for "a long time".<br>-The resident had a wheelchair at one time but it had been over a year since he was switched to the geri-chair.<br>-Staff used the hoyer lift to transfer Resident #6.<br>-The resident could propel and transfer from the geri-chair at times but it was not safe for him to transfer by himself.<br><br>Interview with the physical therapist (PT) on 02/07/17 at 10:20 a.m. revealed:<br>-He had worked with Resident #6 on physical therapy with using the prosthetic leg and transfers from April 2016 - August 2016.<br>-The resident was unable to use the prosthetic leg because of his cognitive status.<br>-The resident used a geri-chair when he worked with him. | D 280 | | |

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| D 280 | Continued From page 42<br>-The resident could not propel the geri-chair himself or safely transfer from the geri-chair.<br>-Facility staff used a hoyer lift to transfer the resident.<br><br>Review of Resident #6's licensed health professional support (LHPS) review dated 10/27/16 revealed:<br>-The required LHPS tasks listed on the form included ambulation with assistive device (wheelchair) and one person transfer.<br>-The nurse noted the resident was alert and oriented and the resident was ambulatory with assistive device, a wheelchair.<br>-The nurse noted assessment was complete and the resident's vital signs were within normal limits.<br>-The nurse noted the resident required assistance with activities of daily living (ADLs) and no skin breakdown was noted.<br>-No problems were noted and the nurse made no recommendations.<br>-The LHPS review did not include any information about the resident's use of geri-chair or the use of hoyer lift for transfers.<br>-There was no documentation on the LHPS form regarding Resident #6's ability to use or non-use of his prosthetic leg.<br><br>Review of Resident #6's current LHPS review dated 01/27/17 revealed:<br>-The required LHPS tasks listed on the form included ambulation with assistive device (wheelchair) and one person transfer.<br>-The nurse noted the resident was alert and oriented and the resident was ambulatory with assistive device, a wheelchair.<br>-The nurse noted assessment was complete and the resident's vital signs were within normal limits.<br>-The nurse noted the resident required minimal assistance with ADLs. | D 280 | | |

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-No problems were noted and the nurse made no recommendations.
-The LHPS review did not include any information about the resident's use of geri-chair or the use of hoyer lift for transfers.
-There was no documentation on the LHPS form regarding Resident #6's ability to use or non-use of his prosthetic leg.

Interview with the LHPS nurse on 02/07/16 at 1:46 p.m. revealed:
-She was not sure why she documented Resident #6 was in a wheelchair.
-She thought she documented the resident required assistance with transfers.

Refer to interview with the Administrator on 02/07/17 at 1:35 p.m.

Refer to interview with the LHPS nurse on 02/07/16 at 1:46 p.m.

3. Review of Resident #1's current FL-2 dated 02/03/17 revealed:
-Diagnoses included dementia, schizophrenia, hypertension, chronic obstructive pulmonary disease, chronic kidney disease and history of diastolic heart failure.
-The resident was intermittently disoriented.
-The resident was incontinent of urine.
-The resident's bowel needs included a colostomy.

Review of Resident #1's Resident Register revealed an admission date of 09/21/16.

Review of Resident #1's surgical history from a hospital admission dated 09/09/16 revealed the resident underwent an ileostomy operation however no procedure date was documented.

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| D 280 | Continued From page 44<br><br>Review of Resident #1's current assessment and care plan dated 02/03/17 revealed:<br>-The resident was ambulatory with a wheelchair.<br>-The resident was sometimes disoriented and needed redirection at times.<br>-The resident was totally dependent in toileting needs and colostomy care.<br><br>Review of Resident #1's licensed health professional support (LHPS) review dated 01/27/17 revealed:<br>-The required LHPS tasks documented on the form included care of a well-established colostomy.<br>-The nurse noted the resident was alert and oriented and the resident was ambulatory with assistive device (wheelchair).<br>-The nurse noted assessment was complete and the resident's vital signs were within normal limits.<br>-No problems were noted and the nurse made no recommendations.<br>-The LHPS assessment did not include an assessment of the colostomy site.<br>-The LHPS nurse did not include how often the resident required colostomy care in the assessment.<br><br>Review of Resident #1's prior assessment and care plan dated 09/27/16 revealed:<br>-The resident was ambulatory with a wheelchair.<br>-The resident was sometimes disoriented.<br>-The resident was totally dependent in toileting needs and colostomy care.<br><br>Review of Resident #1's LHPS review dated 10/27/16 revealed:<br>-The required LHPS tasks documented on the form included care of a well-established colostomy. | D 280 | | |

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| D 280 | Continued From page 45<br>-The nurse noted the resident was alert and oriented and the resident was ambulatory with assistive device (wheelchair).<br>-The nurse noted assessment was complete and the resident's vital signs were within normal limits.<br>-No problems were noted and the nurse made no recommendations.<br>-The LHPS assessment did not include an assessment of the colostomy site.<br>-The LHPS nurse did not include how often the resident required colostomy care in the assessment.<br><br>Interview with the Medication Aide (MA) on 02/02/17 at 11:28 a.m. revealed Resident #1 was dependent on staff to provide care for the colostomy.<br><br>Observation of the MA and Resident #1 on 02/02/17 at 11:28 a.m. revealed:<br>-The MA told the resident it was time to check his colostomy.<br>-The resident entered the bathroom independently by wheeling himself in a wheelchair into the bathroom.<br>-The resident transferred himself from the wheelchair to the toilet with the MA providing stand by assistance.<br>-The MA emptied the resident's colostomy bag in the toilet.<br>-The MA informed the resident that the colostomy wafer needed to be changed.<br>-The MA assisted the resident to pull up his lower clothing.<br>-The MA provided stand by assistance while the resident transferred from the toilet back to the wheelchair.<br>-The resident wheeled himself into his bedroom and transferred to the bed with the MA providing stand by assistance. | D 280 | | |

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| D 280 | Continued From page 46<br>-The MA removed the colostomy wafer and colostomy bag from the stoma site (a surgically created opening on the surface of the abdomen to divert the flow of feces) located on the residents right lower abdomen.<br>-The stoma site was beefy red (A stoma should be a beefy red or pink color).<br>-The skin around the stoma site was intact with no redness or irritation.<br>-The MA applied a new colostomy wafer around the stoma site and connected the colostomy drainage bag.<br><br>Interview with the LHPS nurse on 02/07/16 at 1:46 p.m. revealed:<br>-She would "eye ball" Resident #1's colostomy site to make sure it was actively red and contents were going into the bag.<br>-She looked at Resident #1's colostomy bag during her last visit in 01/2017.<br>-The colostomy bag was on and intact and beefy red (A stoma should be a beefy red or pink color).<br><br>Refer to interview with the Administrator on 02/07/17 at 1:35 p.m.<br><br>Refer to interview with the LHPS nurse on 02/07/16 at 1:46 p.m.<br><br>---<br><br>Interview with the Administrator on 02/07/17 at 1:35 p.m. revealed:<br>-She had a friend who was a registered nurse that did the facility's LHPS reviews.<br>-She had not noticed the LHPS reviews were incomplete and had some inaccurate information about the residents.<br><br>Interview with the LHPS nurse on 02/07/16 at 1:46 p.m. revealed: | D 280 | | |

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| D 280 | Continued From page 47<br>-She went on-site to the facility to do the LHPS reviews.<br>-She tried to go around and see all of the residents and review their records.<br>-Staff was able to tell her about any skin issues since staff bathed the residents.<br>-She would ask staff if there had been any changes with residents and she would try to look at the residents herself.<br>-She checked resident's vital signs.<br>-She would try to document what type of assistive devices residents used or if they used the hoyer lift for transfers.<br>-She did not realize she had omitted required tasks for some of the residents.<br>-She would make sure to document complete physical assessment and include all required tasks for future LHPS reviews. | D 280 | | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to assure the walls, the cabinet floor, food storage bins, and the refrigerator were maintained in a clean manner and protected food from contamination.<br><br>The findings are:<br><br>Observation of the kitchen on 02/02/17 at 1:10 | D 282 | | |

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| D 282 | Continued From page 48<br>p.m. revealed:<br>-There was a cabinet door over a section of the kitchens bar on the left that had peeling and chipped paint.<br>-The wall behind the kitchen's sink had a large area of peeling white paint.<br>-The facility's repairman was in the kitchen working on a ceiling light fixture.<br><br>Observation of the refrigerator in the kitchen on 02/02/17 at 1:38 p.m. revealed:<br>-There was a peeled tangerine in a plastic bag that was not labeled in the door's second storage bin.<br>-There were scattered loose, brown and black debris, a small area of a sticky brown substance and a small, dead insect in the bottom of the door's second storage bin.<br>- In the 4th storage bin of the door there was 4 hamburger buns wrapped in a plastic covering and a dead fly laying in the corner of the bin.<br>-There were scattered brown colored stains on the lower floor of the refrigerator.<br><br>Confidential interview with a staff members revealed:<br>-Third shift staff was responsible for the cleaning of the snack cabinet and the refrigerator.<br>-The staff member at one time cleaned the refrigerator on her shift but she got tired of doing third shifts work, "You saw how the refrigerator looked".<br><br>Observation of the "snack cabinet" on 02/02/17 at 1:04 p.m. revealed:<br>-There was a plastic re-sealable bag of cereal that was not labeled.<br>-There was a 7.75 ounce bag of opened potato chips with a "guaranteed fresh date" until "January 12th". | D 282 | | |

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| D 282 | Continued From page 49<br>-There was a 14 ounce bag of opened cheese balls with a use by date of 10/19/16.<br>-There was an 11.5 ounce bag of opened cheese corn snacks with a "guaranteed fresh" date until December 15th".<br>-There were 2 plastic storage bins that had scattered pieces of crumbs and food debris in the bottom of the containers.<br><br>Interview with the Medication Aide (MA) on 02/02/17 at 1:06 p.m. revealed:<br>-The snacks in the cabinet were currently being used for the residents at the facility.<br>-The opened potato chips belonged to a resident that no longer lived at the facility but the family left the chips for the other residents to have.<br><br>Interview with the Head Supervisor on 02/02/17 at 1:08 p.m. revealed:<br>-Third shift was responsible to throw away all snacks that were out of date.<br>-There were more snacks in an outside building for the residents.<br>-There was a posted list of housekeeping tasks for staff in the kitchen.<br><br>Interview with the Personal Care Aide (PCA) on 02/02/17 at 1:11 p.m. revealed:<br>-Third shift staff were responsible for cleaning all areas of the kitchen.<br>-She had served cheese balls as a snack a few days ago, but not today.<br>-Third shift staff were responsible for checking all of the dates on the snacks and if out of date they were required to throw it away.<br>-The PCA was aware that all foods placed in a plastic bag must be labeled.<br><br>Observation of the snack cabinet on 02/02/17 at 4:15 p.m. revealed: | D 282 | | |

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| MORNING STAR AL #4 | 941 GOINS ROAD PEMBROKE, NC 28372 |

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| D 282 | Continued From page 50<br>-The cabinet had been restocked with new snacks.<br>-The potato 7.75 ounce bag of opened potato chips with a guaranteed fresh date until "January 12th" was not in the cabinet.<br>-The 14 ounce bag of opened cheese balls with a use by date of 10/19/16 was not in the cabinet.<br>-The 11.5 ounce bag of opened cheese corn snacks with a guaranteed fresh date until "December 15th" was not in the cabinet.<br><br>Interview with the Administrator on 02/02/17 at 4:20 p.m.<br>-She knew there were some needed repairs in the kitchen and was planning on starting on the repairs soon.<br>-The repairman would start in the kitchen today.<br>-The Administrator was not aware the refrigerator needed cleaning.<br>-The Administrator was not aware snack foods in the snack cabinet were out of date.<br>-Today, the Administrator had disposed of the food in the refrigerator that was not labeled.<br>-She had replaced the out dated snacks today.<br>-Third shift staff members were responsible for cleaning the refrigerator each shift.<br>-Third shift staff members were responsible for purging out dated foods and cleaning the snack cabinet.<br>-She would start monitoring the kitchen more often to assure staff had cleaned the refrigerator, checked the snack foods for expiration dates, kept food bins clean, and cleaned the walls and floors.<br><br>Observation of the "snack cabinet" in the kitchen on 02/07/17 at 1:06 p.m. revealed:<br>-There was brown build-up dirt and food debris on the cabinet's floor.<br>-There was a small blue block of rat bait in the | D 282 | | |

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| D 282 | Continued From page 51<br>corner of the lower cabinet.<br>-The walls on the lower section of the cabinet had scattered splatters and streaks of a thick, sticky yellow substance.<br><br>Observation of the kitchen cabinet on 02/07/16 at 1:10 p.m. revealed the cabinets had been painted.<br><br>Observation of the refrigerator in the kitchen revealed on 02/07/17 at 1:10 p.m. revealed:<br>-The doors storage bins had been cleaned.<br>-The floor of the refrigerator had been cleaned.<br>-There were no re-sealable, undated bags of food in the refrigerator.<br><br>Review of a cleaning list for third shift that was posted in the kitchen revealed the cleaning of the refrigerator, checking the snack foods for expiration dates and keeping food bins clean was not listed.<br><br>Interview with the Head Supervisor on 02/07/17 at 1:12 p.m. revealed there was a list posted in the kitchen that listed cleaning the refrigerator and keeping the bins for snacks clean but it must have got pulled down when the cabinets were painted.<br><br>Interview with the Administrator on 02/07/17 at 1:28 p.m. revealed:<br>-She expected third shift to do all cleaning tasks in the kitchen including wiping down the walls in the cabinets and cleaning the floors of the kitchen.<br>-She would review the cleaning needs with third shift staff again. | D 282 | | |

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| D 310 | Continued From page 52 | D 310 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to follow a physician ordered renal lib diet by not following the indicated portion sizes on the dietary menus for 1 of 5 sampled residents (Resident #1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 02/03/17 revealed:<br>-Diagnoses included dementia, schizophrenia, hypertension, chronic obstructive pulmonary disease, chronic kidney disease and history of diastolic heart failure.<br>-The resident was intermittently disoriented.<br>-The resident was on a "renal lib" diet.<br><br>Observation of Resident #1's lunch meal on 02/02/17 at 12:13 p.m. revealed:<br>-The resident was served approximately 1 cup of macaroni with beef, ¼ cup of pudding, one slice of bread, ½ cup of corn, and 8 ounces of water.<br>-The resident ate all of the macaroni and beef and asked the Medication Aide (MA) for more.<br>-At 12:23 p.m. the MA gave the resident approximately 1 ½ cups of macaroni and beef.<br>-The resident ate all of the macaroni and beef and the remainder of the food on his plate at 1:00 | D 310 | | |

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| D 310 | Continued From page 53<br>p.m.<br><br>Review of "Week 2, Day 4" lunch for the renal lib diet menu revealed Resident #1 should have received 4 ounces of meatloaf, ½ cup of noodles.<br><br>Review of a menu substitution log for the lunch meal on 02/02/17 revealed meatloaf and noodles was replaced with goulash (The same as macaroni and beef).<br><br>Interview with the Medication Aide (MA) on 02/02/17 at 12:23 p.m. revealed:<br>-Resident #1 had a good appetite.<br>-Resident #1 had been placed on a medication to increase his appetite.<br>-Resident #1 usually asked for and received second helpings of food.<br><br>Review of "Week 2, Day 4" supper for the renal lib diet menu revealed Resident #1 should have received 4x6 square of vegetable quiche.<br><br>Review of a menu substitution log for the supper meal on 02/02/17 revealed lasagna replaced the vegetable quiche.<br><br>Observation of Resident #1's supper meal on 02/02/17 at 5:28 p.m. revealed:<br>-The resident was served approximately 1 ½ cups of macaroni and beef, ½ cup slaw, ½ cup of applesauce, and 6 ounces of water.<br>-At 5:55 p.m. the resident asked for more food.<br>-The Personal Care Aide gave Resident #1 ½ cup of pears.<br>-The resident ate all of the food on the plate at 5:59pm.<br><br>Interview with the Administrator on 02/02/17 at 6:45 p.m. revealed she was not aware of any | D 310 | | |

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| D 310 | Continued From page 54<br>portion sizes for Resident #1.<br><br>Interview with the Cook on 02/07/17 at 1:16 p.m. revealed:<br>-Resident #1 was on a renal diet.<br>-She knew that portion sizes were important for Resident #1.<br>-She did not plate any food for the residents.<br>-She prepared the food in a separate building and placed the residents' food in containers and staff in the facility would plate the food for the residents.<br>-She always sent extra food in case the residents requested a second serving.<br><br>Interview with a Personal Care Aide (PCA) on 02/07/17 at 1:00 p.m. revealed:<br>-Some of the residents eat more than others.<br>-There was no menu in the facility to guide the PCAs and MAs on portion sizes.<br>-The PCA prepared Resident #1's plate in the same way she prepared her own plate.<br>-The facility used extra-large serving spoons when plating the residents' food.<br>-She was not aware diets included exact portion sizes since there were no menus in the facility to follow.<br><br>Confidential interview with a staff member revealed staff had no way of knowing what portion sizes are needed for residents because the menus are not kept in the building.<br><br>Interview with the Administrator on 02/07/17 at revealed:<br>-The menus were not kept in the building to guide staff when preparing the residents plates.<br>-Menus would be kept in the facility for staff use when preparing the residents plates at mealtime. | D 310 | | |

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| D912 | Continued From page 55 | D912 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, 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 personal care and health care.<br><br>The findings are:<br><br>1. Based on observations, interviews and record reviews, the facility failed to provide incontinence care according to facility procedures of every two hours for 3 of 4 resident's (Resident #2, #4, #5) who required total assistance with toileting resulting in skin irritation and redness for two residents. [Refer to Tag D269 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation).]<br><br>2. Based on observations, record reviews, and interviews, the facility failed to meet the health care needs for 2 of 3 residents (#1, #2) sampled as related to failure to have Resident #1 follow-up with a nephrologist after a hospitalization for acute renal failure requiring temporary dialysis followed by the resident being readmitted to the hospital in intensive care for end stage renal | D912 | | |

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| D912 | Continued From page 56<br>disease then requiring permanent hemodialysis and failure to notify Resident #2's primary care provider of a recent hospitalization and subsequent recommendations for recurrent urinary tract infections and urosepsis. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] | D912 | | |