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D 000	Initial Comments The Adult Care Licensure Section and the Chowan Department of Social Services conducted an annual survey on March 1-2, 2017.	D 000		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider of the acute health care needs of 1 of 5 residents (#1) sampled as evidenced by the facility failing to notify the primary care provider of a fall that resulted in a resident's injury, changes in the resident's level of consciousness with decreased oral intake for 3 to 4 days, and failing to schedule a follow-up appointment related to the resident's fall and injury. The findings are: Review of Resident #1's current FL-2 dated 01/05/17 revealed: -Diagnoses included hypertension, senile dementia, and cellulitis both lower extremities. -Resident #1 was ambulatory and was intermittently disoriented. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 01/18/16.	D 273		

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D 273	Continued From page 1 Review of Resident #1's Care Plan dated 02/16/17 revealed: -Resident #1 used a walker for ambulation and required extensive assistance for toileting, bathing, dressing, grooming, and transferring. -Resident #1 required limited assistance for eating and supervision for ambulation. -Resident #1 liked to be around people, watch television, and dance. Review of the emergency room discharge instructions for Resident #1 dated 02/23/17 revealed: -Resident #1 was diagnosed with a closed left rib fracture. -Resident #1 was to follow-up in 1 week with his primary care provider. -Resident #1 should seek medical care for increased pain or difficulty breathing. -Tramadol 50mg was prescribed every 4 hours as needed for pain. Review of a facility incident report for Resident #1 dated 02/23/17 at 4:00pm revealed: -Resident #1 was found on the floor in room on 02/23/17 at 4:00pm. -Resident #1's left rib was injured. -Resident #1 was taken to the emergency room but was not admitted to the hospital. -Staff applied ice to the left rib fracture area per emergency room discharge instructions. -Resident #1 was to follow-up with the primary care provider in 1 week. -Resident #1's primary care provider was not notified of fall. Interview on 03/01/17 at 3:40pm with the medication aide who completed the incident report revealed:	D 273		

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-She was the Supervisor on the afternoon when staff found Resident #1 on the floor in his room.
-Resident #1 was sent to the emergency room because he complained of pain to his left rib area.
-She completed the incident report for Resident #1's fall on 02/23/17 but she did not notify the primary care provider.
-The Resident Care Coordinator (RCC) usually notified the primary care provider when a resident had a fall.
-Resident #1's condition changed considerably since he returned from the emergency room on 02/23/17.
-Resident #1 was active, walked around the facility using his walker, and was talkative with staff and other residents at the facility before his fall.
-Resident #1 had stayed in bed since he came back from the emergency room on 02/23/17 and seemed really sleepy since then.
-Resident #1 had been hard to wake up sometimes since 02/23/17.
-She had noticed Resident #1 was not eating or drinking since his fall.
-She told the RCC about Resident #1's decreased oral intake and his sleepiness on 02/28/17.
-She did not know if the RCC had called Resident #1's primary care provider.

Review of Care Notes for Resident #1 revealed:
-On 02/25/17 on the 3:00pm - 11:00pm shift, Resident #1 could not be wakened for his supper, and staff could only wake up Resident #1 long enough to take his medications.
-On 02/26/17 on the 7:00am - 3:00pm shift, Resident #1's status had not changed and Resident #1 refused all food except for ice cream.
-On 02/26/17 on the 3:00pm - 11:00pm shift, Resident #1 had a low-grade fever of 99.8

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degrees Fahrenheit, refused to eat supper, and staff had difficulty getting Resident #1 to take his medications.
-On 02/27/17 on the 7:00am - 3:00pm shift, Resident #1 had a low-grade fever of 99.5 degrees Fahrenheit; he slept all day and refused to eat; but the staff gave him a nutritional supplement.
-On 02/27/17 on the 3:00pm - 11:00pm shift, Resident #1 would not eat supper; he refused his nutritional supplement; and he slept the entire shift.
-On 02/28/17 on the 7:00am - 3:00pm shift, Resident #1 refused his breakfast, ate approximately 10% of his lunch and seemed to be in a lot of pain.
-On 03/01/17 on the 7:00am - 3:00pm shift, Resident #1 refused all food and liquids and took his medications with applesauce.
-It was documented on 03/01/17 with no time specified, Resident #1 was sent to the emergency room for not eating in 3 to 4 days, coughing up mucus, and not being able to be turned in bed.
-There was a late entry for 02/28/17 for the 7:00am - 3:00pm shift documented in the Care Notes after staff had sent Resident #1 to the emergency room on 03/01/17.
-The entry documented that staff had spoken with the nurse at primary care provider for Resident #1 on 02/28/17 and reported to the nurse that Resident #1 wasn't eating and complained of pain.
-There was no documentation that staff notified the primary care provider that Resident #1 fell on 02/23/17.
-There was no documentation staff made an appointment for Resident #1 with his primary care provider for follow-up per emergency room discharge instructions related to left rib fracture.
-There was no documentation that staff notified

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the primary care provider of Resident #1's increased sleepiness, decreased oral intake, difficulty taking medications, pain complaints, or productive cough prior to the late entry in the care notes on 02/28/17.

Observation of Resident #1 on 03/01/17 at 10:05am revealed:
-Resident #1 was lying in bed on his back with eyes closed, mouth open, and lips with dry, peeling, white skin.
-Both of Resident #1's arms were partially drawn across the front of his abdomen.
-An opened 8oz. can of vanilla Ensure with a straw in it was at his bedside table.
-Resident #1 did not respond when his name was called.

Interview with another resident on 03/01/17 at 10:07am revealed:
-Resident #1 was found on the floor next to his recliner on 02/23/17.
-Resident #1 was taken to the emergency room on 02/23/17 but he did not stay in the hospital.
-He believed Resident #1 had broken ribs because Resident #1 complained of pain to left rib area.
-Resident #1 had been in bed since he returned back from the emergency room.
-Resident #1 had been sleeping a lot since the weekend of 02/25/17.

Interview with the Resident Care Coordinator on 03/01/17 at 11:30am revealed:
-Resident #1 had not been eating or drinking normally since the weekend of 02/25/17.
-She had called Resident #1's primary care provider (PCP) and left a message with the nurse on 02/28/17 to report Resident #1 was not eating.
-She had not heard back from the PCP and she

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had not called them back after 02/28/17.
-She would follow-up with the PCP on 03/01/17 if Resident #1's condition did not improve.
-She was not sure if the PCP had been notified previously about Resident #1's fall on 02/23/17.
-She told the nurse at the PCP's office about Resident #1's fall when she called the PCP's office on 02/28/17.

Interview with a second Medication Aide (MA) on 03/01/17 at 11:45am revealed:
-Resident #1 was not eating or drinking and had become increasingly sleepy since the weekend of 02/25/17.
-Resident #1 refused his breakfast on 02/27/17 so she had given him a nutritional supplement instead.
-Resident #1 slept all of the 7-3 shift on 02/27/17 and 02/28/17.
-It was hard to wake Resident #1 up to take his medications since 02/25/17.
-She thought the RCC had called Resident #1's primary care provider on 02/28/17 but the facility had not received any new orders.

Interview with a Personal Care Aide (PCA) on 03/01/17 at 12:23pm revealed:
-Resident #1 had fallen sometimes around the end of the week of 02/24/17 but she wasn't sure exactly when.
-Resident #1 was ambulatory and talkative before he fell.
-Resident #1 walked the halls of the facility using his walker, participated in line dancing activities, and talked with residents at the facility before he fell on 02/23/17.
-Resident #1 had been in bed since he returned from the emergency room after he fell.
-Resident #1 had been increasingly sleepy and had not been eating or drinking much since the

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weekend of 02/25/17.
-It was hard keeping Resident #1 awake long enough for him to eat or drink.
-She had offered Resident #1 a nutritional supplement on 03/01/17 because she could not get Resident #1 to eat his breakfast because he was so groggy.
-Resident #1 only drank one or two sips of the nutritional supplement.
-She could not get Resident #1 to drink because he was too sleepy.
-She could not get Resident #1 to stay awake.
-Resident #1 complained of pain to his left rib area whenever staff tried to reposition him in bed.
-She just tried to make him comfortable with pillows when she repositioned him, but tried to move Resident #1 as little as possible once he was repositioned in bed.
-Staff turned and repositioned Resident #1 every 2 hours since he had been in bed.
-She had not reported anything to the Resident Care Coordinator (RCC) because the RCC already knew about Resident #1's condition.

Interview with RCC on 03/01/17 at 2:40pm revealed Resident #1 had been sent to the emergency room for further evaluation due to Resident #1 not eating in the last 3 or 4 day, coughing up green mucus, and staff was not able to turn and reposition Resident #1 due to his left rib pain.

Interview with a third MA on 03/01/17 at 4:30pm revealed:
-She noticed Resident #1 was very groggy on 02/25/17 but she was able to get Resident #1 awake enough for him to take his medications on the 3-11 shift.
-Resident #1 started running a low-grade fever on 02/26/17.

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-Resident #1 refused to eat his supper on 02/26/17.
-It was very difficult for her to get him to stay awake to even take his medications.
-She gave Resident #1 some medication to reduce his fever and advised the next shift to monitor him.
-She did not notify the primary care provider about Resident #1's fever because she thought the fever may go away she thought the resident may have had just a virus.
-She thought that was the reason why the resident was not eating.
-There was still no change with Resident #1's condition on 02/27/17 Resident #1 slept through the entire 3-11shift on 02/27/17.
-Staff could not get Resident #1 to eat on the 3-11 shift on 02/27/17 he refused to drink any of the nutritional supplement when the staff offered it to him.
-She did report to the staff on the next shift on 02/27/17.
-She did not recall if she reported Resident #1's condition to the RCC.

Interview with the RCC on 03/02/17 at 9:20am revealed:
-Resident #1 had been sent out to the emergency room on 03/01/17 because he had not been eating or drinking very much in the last 3 or 4 days; he had productive cough; and he complained of left rib pain when staff had to reposition him in the bed.
-She was not aware if the facility had a policy regarding how soon staff should contact the primary care provider for changes in resident's health status.
-She had called Resident #1's primary care provider on 02/28/17 and spoke with the nurse in the primary care provider's office because she

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was concerned with Resident #1's sleepiness and not eating.
-The nurse from the primary care provider was supposed to contact the facility back; but the RCC had not heard back from his office.
-The RCC had not followed up with the primary care provider since the initial call made on 02/28/17.
-Sometimes, the medication aides helped the RCC to inform the primary care provider if a resident has a significant change in their health status when the RCC is not available.
-She was not sure if Resident #1's primary care provider had been notified on 02/23/17 when Resident #1 fell.
-The RCC did inform the nurse about the fall when she called the primary care provider on 02/28/17.
-She had planned to make a follow-up appointment with the primary care provider for Resident #1's post hospital visit.
-She never heard back from the nurse.
-She had not called the primary care provider earlier than 02/28/17 about Resident #1's increased sleepiness and not eating because she talked with a family member of Resident #1 on 02/27/17 and the family member did not want the primary care provider contacted at that time.
-The family member did not think Resident #1 needed to be seen by his primary care provider at that time.
-The family member told the RCC that she would come to check Resident #1 on 02/28/17; but, that family member never came to the facility.
-It was an unwritten policy of the facility to avoid conflict between the facility and the family.
-Staff did not notify the primary care provider if a family member or power of attorney asked the facility not to do so.
-The RCC called the primary care provider on

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02/28/17 because she did not know what else to do and Resident #1 did not seem to be getting any better.
-The RCC sent Resident #1 to the emergency room on 03/01/17 because Resident #1 was not getting any better and she had not seen or heard anything from Resident #1's family member.

Interview with the Administrator on 03/02/17 at 9:45am revealed:
-She was not aware of Resident #1's change in health status prior to 03/01/17.
-The RCC was responsible to notify the primary care provider when a resident had a fall or any other significant change in their health status.
-The facility did not have a policy that addressed how soon the primary care provider should be notified when a resident has a significant change in their health status.
-Sometimes, the staff at the facility contacted the resident's family member or other responsible party before they called resident's primary care provider.
-The staff allowed the family member to make the decision to contact the primary care provider for a resident to be evaluated medically.
-The facility was trying to avoid conflict with the family member and/or responsible party regarding medical decisions for the resident.
-She did recognize that it was still the facility's responsibility to communicate any significant changes in a resident's health to the resident's primary care provider.

Telephone interview with Resident #1's family member on 03/02/17 at 11:52am revealed:
-She knew Resident #1 had fallen on 02/23/17 and had a rib fracture because staff at the facility had notified her.
-She had talked with the RCC on 02/27/17 to

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check on Resident #1.
-The RCC told her that Resident #1 had some rib pain and maybe he needed more medical attention.
-The family member expected Resident #1 to have pain because of his rib fracture.
-She told the RCC she did not think Resident need any more medical attention.
-The facility staff had not made her aware that Resident #1 had increased sleepiness or he was not eating or drinking as usual since he fell on 02/23/17.
-She did not know if the facility had contacted Resident #1's primary care provider about his fall or any recent health changes.
-Resident #1 was alert, ambulatory, and talkative before his fall on 02/23/17.

Interview with the Primary Care Provider (PCP) for Resident #1 on 03/02/17 at 1:35pm revealed:
-His office had received a call from the facility on 02/28/17 that Resident #1 had fallen on 02/23/17 and had fractured rib.
-The facility did not report any changes in Resident #1's health status (sleepiness or decreased oral intake).
-The facility did not report to his office that Resident #1 was sent to the emergency room on 03/01/17.
-The facility had not made an appointment with his office for the 1 week follow-up from Resident #1's emergency room visit on 02/23/17.
-If he had known about the changes in Resident #1 health status since his fall on 02/23/17, he would have seen Resident #1 in his office or at least had the facility to send Resident #1 to the emergency room sooner.
-He had concerns that the facility failed to notify to him when Resident #1 had changes in his health status or bring the resident in for follow-up

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appointments.
-Resident #1 was seen in his office on 08/09/16 and was supposed come back for a follow-up appointment in 4 weeks.
-The facility staff usually scheduled the appointments for Resident #1.
-The facility did not schedule the 4 week follow-up appointment for Resident #1 and did not bring Resident #1 to his office again until 12/22/16.

Telephone interview with Resident #1's hospital nurse on 03/02/17 at 11:10am revealed:
-Resident #1 had been diagnosed with dehydration and pneumonia.
-Resident #1 had failed his swallowing test and needed further evaluation.
-Further medical treatment would be discussed with Resident #1's family.

The facility failed to notify the primary care provider of Resident #1 who experienced changes in the resident's level of consciousness with decreased oral intake for 3 to 4 days. The failure to provide the services necessary to maintain the physical and mental well-being of Resident #1 constitutes a Type A1 Violation.

Review of the Plan of Protection dated 03/02/17 revealed:
-The Administrator/designee will review resident records to assure referrals and follow-ups are being scheduled and followed through with, in order to meet the routine and acute health care needs of the residents.
-Training with the staff, to be provided by the Administrator and Regional Director on understanding and reporting change of status in resident's condition.
-As new residents are admitted or change of status are completed with care plan,

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D 273	Continued From page 12 Administrator or designee will train staff, within 2 days, on the care plan needs of the resident. -For two weeks and randomly thereafter, the Administrator or designee will check on the residents each shift to ensure staff were addressing needs as identified on the resident care plan. -Regional Director/designee will randomly check on residents to ensure staff are addressing needs as identified on the care plan. -Administrator/Regional Director/designee will randomly interview residents to ensure staff are addressing needs as identified on the care plan. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 1, 2017.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the stand-alone cooler, walk-in freezer, kitchen storage areas, and floors in the kitchen areas were cleaned, in good repair and free of contamination. The findings are: Observation of the stand-alone cooler on 3/01/17 at 12:05 p.m. revealed:	D 282		

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	HAL021008	A. BUILDING: _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

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D 282	Continued From page 13 -The door of the stand-alone cooler had a white, sticky substance from the top of the door to the bottom front of the door. -The door seal was loose and hanging from the bottom of the door. -The door seals from top to bottom had a white, sticky substance on it. Observation of the walk-in freezer on 03/01/17 at 12:10 p.m. revealed: -The floor of the walk-in freezer had several dark brown and black stained areas. -The floor had dark brown rust stains on all four corners and around the base of the poles of the metal shelves. Observation of the storage unit in the kitchen area on 3/01/17 at 12:17 p.m. revealed: -Five of five metal shelves had dried food particles and were covered in grime. -Several small white plates and cups on the shelves were dirty, covered in grime, and had dried food particles. (Those small plates and cups were being used by the residents for food service). Interview with the Dietary Aide on 3/01/17 at 12:25 p.m. revealed: -The kitchen storage areas were cleaned as needed daily by the end of their shifts. -There was a daily cleaning schedule kitchen staff initialed and followed. -She was not aware of how long the door seal of the stand-alone cooler had been loose and hanging. The door seal had been that way for quite some time. -She was unaware of how long the floor of the walk-in cooler had been in that condition. -She had not reported any repairs to maintenance or to the dietary manager.	D 282		

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D 282	Continued From page 14 Review of the Daily Cleaning Schedule dated for January and February 2017 revealed: -The cleaning schedule for January and February 2017 had several blank spaces. -The storage areas and refrigerators were to be cleaned on a weekly basis. -The lines for the cleaning of the storage areas and refrigerators were left blank and were not dated or initialed by staff for January and February 2017. Interview with the Dietary Manager on 3/01/17 at 12:40 p.m. revealed: -The stand-alone cooler and the five shelves of the kitchen storage unit with small kitchen items were to be cleaned daily or as needed by kitchen staff. -She was not sure of how long the seal had been loose and hanging from the door of the stand-alone cooler. -She was unaware the door of the stand-alone cooler was dirty. -The small plates and other kitchen items on the storage unit were cleaned as needed daily. -She was not aware the small plates and the five shelves of the storage unit were dirty. -She had not contacted anyone regarding the loose and hanging door seal of the stand-alone cooler or the floor of the walk-in cooler. -She monitored the cleaning of the kitchen areas on a weekly basis. -She was unaware if maintenance was going to repair or replace the floor in the walk-in freezer. Interview with the Maintenance Worker on 3/02/17 at 11:55 a.m. revealed: -He had not been informed of the loose and hanging door seal of the stand-alone cooler. -He was not aware of the condition of the floor in	D 282		

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D 282	Continued From page 15 the walk-in freezer. -He was unaware of any needed repairs. Interview with the Administrator on 3/02/17 at 12:00 p.m. revealed: -The dietary manager was responsible for ensuring the dining and kitchen areas were cleaned and were in working order. -She expected to be informed of any issues by the kitchen staff and/or dietary manager. -Cleaning of the kitchen storage areas should occur every day as needed. -Maintenance had repaired the loose and hanging door seal of the stand-alone cooler on 3/02/17. -She was not aware of any problems with the cleanliness or any needed repairs for the kitchen storage areas, stand-alone cooler, and walk-in freezer areas.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure residents were offered snacks three times per day. The findings are: Observations in the facility from 10:06 a.m.	D 298		

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D 298	Continued From page 16	D 298		

through 11:55 a.m. on 3/01/17 revealed no snacks were offered to the residents.

Interview with Dietary Aide on 3/01/17 at 12:25 p.m. revealed:
-Snacks were offered three times a day but some residents ate their own snacks and did not want one.
-Snack times were usually after meals at 10:00 a.m., 3:00 p.m. and 8:00 p.m.

Observations in the facility from 2:55 p.m. through 4:50 p.m. on 3/01/17 revealed no snacks were offered to the residents.

Confidential Interviews with eight residents on 3/01/17 and three residents on 3/02/17 revealed:
-They were only offered a snack maybe twice a day.
-Snacks were mostly offered at night before bedtime.
-Eight residents had not been served or offered snacks after breakfast or lunch on 3/01/17.
-Three residents had not been offered snacks after breakfast on 3/02/17.
-If they wanted a snack, they would eat one of their own.
-The residents asked for a snack at times but did not want to be a bother.

Interview with the Dietary Manager on 3/01/17 at 12:40 p.m. revealed:
-Snacks were offered three times each day to all residents but most of the residents refused a snack.
-Some residents preferred to eat their own snacks instead of those supplied by the facility.
-She did not prepare a snack for those residents she knew would probably eat their own snacks.

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D 298	Continued From page 17 Observations in the facility from 9:55 a.m. through 11:50 a.m. on 3/02/17 revealed no snacks were offered to the residents. Two residents were observed in there rooms eating their own snacks. Interview with the Administrator on 3/02/17 at 12:00 a.m. revealed: -She was not aware that the residents were not offered three snacks each day. -No resident had complained to her about not receiving a snack. -She thought that some residents did eat their own snacks. -She expected all residents to be offered three snacks each day and allow them to decline one but staff should offer snacks to the residents.	D 298		
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 observations, interviews and record review, the facility failed to assure all residents received services necessary to maintain the residents' physical health. The findings are: Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider of the acute health care needs of 1 of 5 residents (#1) sampled as evidenced by the facility failing to notify the primary care provider of a fall that resulted in a resident's injury, changes in the resident's level of consciousness with decreased oral intake for 3 to 4 days, and failing to schedule a follow-up appointment related to	D914		

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D914	Continued From page 18 the resident's fall and injury. [Refer to Tag D273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)]. Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider of the acute health care needs of 1 of 5 residents (#1) sampled as evidenced by the facility failing to notify the primary care provider of a fall that resulted in a resident's injury, changes in the resident's level of consciousness with decreased oral intake for 3 to 4 days, and failing to schedule a follow-up appointment related to the resident's fall and injury.	D914		