Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051024	A. BUILDING: _____ B. WING _____	R 01/13/2017

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BROOKDALE SMITHFIELD	830 BERKSHIRE ROAD SMITHFIELD, NC 27577

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 1/11/17 - 1/13/17.	D 000		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 6 staff sampled (B) who provided personal care to residents had successfully completed an 80-hour personal care training and competency evaluation program. The findings are:	D 150		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrew J Wheeler III — TITLE: Executive Director — (X6) DATE: 2/20/17

2/16/17 Renewed accepted KMiles.

Brookdale Smithfield
POC of 1/13/17
GNMI11

This Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

Tag 150 KM 10A NCAC 13F .0501 Personal Care Training and Competency

1. The Business Office Coordinator (BOC) or designee will review staff records to verify compliance with training and competency.
2. Health and Wellness Director (HWD).
3. The HWD will perform competency evaluations for the staff that do not have the documentation of training.
4. The BOC will maintain training records for the staff.
5. The Executive Director (ED) will monitor the training records for the staff monthly x3 months and then quarterly thereafter.
6. The date of correction for this standard deficiency will not exceed March 21, 2017.

Tag 270 E 10A NCAC 13F .0901(b) Personal Care and Supervision

1. Residents will be assessed for supervision needs. Residents needing increased supervision will be identified and increased supervision will be implemented as needed.
2. Interventions for residents with increased personal care and supervision needs will be implemented and addressed on the resident service plan and added to the assignment sheet. These interventions may include but are not limited to increased monitoring, PT/OT, medication reviews and consults with other providers.
3. Increased monitoring following a fall will be every 30 minutes for 24 hours, every 1 hour for 24 hours and every 2 hours for 24 hours times 72 hours. This will be recorded in the resident record each shift by the Medication Technician (MT). The HWD or Designee will monitor daily to verify compliance.
4. Residents who continue to have falls or need increased supervision beyond the 72 hours or who continue to have falls will be assessed by the physician for a higher level of care. When a resident requires one to one supervision, the appropriate legal representative and/or family members will be notified. A companion will be required for the resident until the resident has been discharged from the community or when the physician in coordination with the community believes one to one supervision is no longer necessary.
5. The date of correction for this Violation will not exceed February 27th, 2017.

Tag 280/K 10A NCAC 13F .0903 Licensed Health Profession Support

1. Current Residents will be assessed for LHPS needs.
2. HWD will complete the LHPSs and place on the chart audit tool for tracking.
3. The HWD or designee will review the chart audit tool on a monthly basis.
4. The ED will monitor the chart audit tool monthly for three months and then quarterly thereafter for compliance.
5. The date of correction for this standard deficiency will not exceed March 21, 2017

Tag 282/Km 10A NCAC 13F. 0904(a)(1) Nutrition and Food Service

1. Areas noted in the Statement of Deficiencies will be thoroughly cleaned.
2. The ED and the Dietary Manager will develop a cleaning schedule.
3. The cleaning schedule will be implemented.
4. The Dietary Manager or designee will monitor the kitchen for cleanliness on a daily basis.
5. The ED, Manager on Duty (MOD) or Designee will monitor the kitchen on a daily basis for 2 weeks for cleanliness.
6. The ED will then monitor the kitchen on a weekly basis for cleanliness.
7. This will be documented on the cleaning schedule.
8. The date of correction for this standard deficiency will not exceed March 21, 2017.

Tag 311/Km 10 A NCAC 13F. 0904(f)(1) Nutrition and Food Service

1. Residents will be assessed by the Clare Bridge Program Coordinator and the HWD for feeding assistance.
2. Trained staff to meet the needs of the residents will be provided at meal times for feeding assistance as needed.
3. Training will be provided by the HWD or designee to verify that staff members are aware of proper feeding techniques.
4. The HWD or designee will monitor the Clare Bridge (CB) dining room on a daily basis for one week on all shifts to verify adequate staffing.
5. The HWD or designee will monitor the CB dining room weekly on varying shifts to verify adequate staffing for feeding assistance.
6. The date of correction for this standard deficiency will not exceed March 21, 2017.

Tag 338 10A NCAC 13F .0909 Resident Rights

1. Staff is trained during associate foundations on Resident Rights.
2. The ED will verify that staff will be retrained on Resident Rights.

3. The BOC will maintain training logs.
4. The date of correction for this standard deficiency will not exceed March 21, 2017

Tag 468 10A NCAC 13F. 1306 Admission to the Special Care Unit

1. The HWD/Clare Bridge Program Coordinator/Resident Care Coordinator and Executive Director will be retrained regarding the requirement of the pre-admission assessment for CB residents.
2. New Residents will have the pre-admission screening tool completed prior to being accepted into the Memory Care Unit.
3. The forms will be maintained in the resident record with the original FL2.
4. The date of correction for this standard deficiency will not exceed February 27, 2017.

Tag 468 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training

1. The community has a plan in place to verify training requirements are met prior to staff working with residents.
2. The Community has in place a Foundations program with 8 hours of dementia related training that staff complete prior to beginning their resident contact.
3. Staff will receive a total of 20 hours of additional training in the first six months of employment in the Memory Care unit.
4. This training will be provided by the community and by outside providers.
5. The BOC will track the training in the staff training records.
6. The ED will monitor the staff training records for memory care training compliance on a monthly basis.
7. The date of correction for this standard deficiency will not exceed March 21, 2017.

Tag 912 G. S. 131D-21(2) Declaration of Resident Rights

Refer to plan of correction for Tag D270- 10A NCAC 13F .0901(b)

Tag 935 G.S. 131D-4.5B(b) Medication Aides: Training and Competency Evaluation Requirements

1. Staff training records will be reviewed by the BOC and ED.

2. Medication Technicians without the appropriate documentation will receive retraining and/or competency check offs completed by the HWD. Such staff will not be able to administer medications until the requirements are completed.

3. The BOC will maintain training records.

4. The ED will monitor staff training records on a monthly basis.

5. The date of correction for this standard deficiency will not exceed March 21, 2017.

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Review of the personnel record for Staff B revealed:
- Hire date of 6/09/16 as a medication aide.
- There was no documentation of personal care training.

Observation on 1/11/17 at 4:42 p.m. of residents in the memory care unit revealed:
- A resident had been seated at the table in the day room with other residents by Staff B.
- The resident was in a wheelchair and dressed in only plaid cloth boxer underwear and a shirt.

Interview on 1/11/17 at 4:42 p.m. with Staff B revealed:
- The resident had just awakened and she had brought him to the day room to wait for dinner to be served.
- The resident had been dressed in bed with plaid cloth boxer underwear with briefs underneath.
- Staff used the cloth plaid boxers for pajamas for the resident.
- The resident required incontinent care, dressing and staff assistance with the wheelchair.
- She asked if she should take the resident back to his room and change his clothes.

Interview on 1/13/17 at 6:35 p.m. with Staff B revealed:
- She provided personal care to residents and was a medication aide in the special care unit.
- She had taken a nursing assistant course, but had never taken the test.
- She had been trained in a previous facility to give personal care.
- She did not have any documentation of taking the personal care course at the previous facility.

Interview on 1/13/17 at 5:45 p.m. with the Interim

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D 150	Continued From page 2 Executive Director (ED) revealed: - She had filled in at this facility on occasion and expected that all personal care staff had personal care training and were "CNAs" (Certified Nursing Assistants). - All training was in the personnel folders or in one of the training notebooks. - The ED would be responsible for ensuring training was completed. - She would ensure the current ED knew about the staff training documentation issue.	D 150		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide increased supervision for 1 of 4 sampled residents (#4) residing in the special care unit known to have multiple falls with injuries. The findings are: Review of Resident #4's current FL-2 dated 3/15/2016 revealed a diagnoses of included closed fracture of pelvis, difficulty walking, muscle weakness, dysphagia, and oropharyngeal leukocytosis. Review of the Resident Register revealed an	D 270		

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D 270	Continued From page 3 admission date of 4/22/15. Review of Resident #4's Progress Notes and Care Plan revealed: -Resident #4 had 15 falls from 7/16/16 to 1/4/17. Review of the Incident Reports revealed: -On 7/16/16 at 5:30 a.m., the unwitnessed fall occurred in the resident's room resulting in injury to the right hand and skull requiring Emergency Room (ER) treatment. -Initial actions taken by staff were contact 911, check for injury, notified emergency contact, notified Nurse. -The physician was notified by fax. -There was no documentation staff increased supervision in response to Resident #4 falls. -On 8/7/16 at 2:55 a.m., the unwitnessed fall occurred in the resident's room resulting in no apparent injury. -Initial actions taken by staff were vital signs, check for injury, notified emergency contact, notified Nurse. -The physician was notified by fax. -The Physician signed the fax on 8/7/16 with no recommendations documented. -There was no documentation staff increased supervision in response to Resident #4 falls. -On 8/30/16 at 2:45 p.m., the unwitnessed fall occurred in the resident's bathroom resulting in no apparent injury. -Initial actions taken by staff were check for injury, notified emergency contact, notified Nurse. -Staff spoke with the physician by phone. -There was no documentation staff increased supervision in response to Resident #4 falls. -On 9/1/16 at 10:45 a.m.,the unwitnessed fall occurred in the resident's bathroom resulting in no apparent injury. -Initial actions taken by staff were vital signs,	D 270		

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check for injury, notified emergency contact, notified Nurse.
-The physician was notified by fax.
-There was no documentation staff increased supervision in response to Resident #4 falls.
-On 9/4/16 at 11:25 a.m., the unwitnessed fall occurred in the resident's bathroom resulting in no apparent injury.
-Initial actions taken by staff were vital signs, check for injury, notified emergency contact, notified Nurse.
-A voice message was left with the physician.
-There was no documentation staff increased supervision in response to Resident #4 falls.
-On 10/31/16 at 10:00 a.m., the unwitnessed fall occurred in the resident's bathroom resulting in no apparent injury.
-Initial actions taken by staff were check for injury, notified emergency contact, notified Nurse.
-The physician was notified by fax.
-"Resident will be continuing to be encouraged to use call bell system to ask for help and use assistive device. Staff will monitor resident closely".
-On 11/28/16 at 3:00 p.m., the unwitnessed fall related to "resident to resident alleged aggressive behavior" in the resident's room resulting in no apparent injury.
-Initial actions taken by staff were check for injury, notified emergency contact, notified Nurse.
-A voice message was left with he physician.
-There was no documentation staff increased supervision in response to Resident #4 falls.
-On 12/12/16 at 2:30 p.m., the unwitnessed fall occurred in the resident's bathroom resulting in no apparent injury.
-Initial actions taken by staff were vital signs, check for injury, notified emergency contact, notified Nurse.
-Staff spoke with the physician by phone.

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D 270	Continued From page 5 -"Body Part(s) Injured: Pelvis". -There was no documentation staff increased supervision in response to Resident #4 falls. -On 1/1/17 at 9:40 a.m.,the unwitnessed fall occurred in the hallway resulting in injury to the head requiring ER treatment. -Initial actions taken by staff were vital signs, check for injury, notified emergency contact, notified Nurse. -A voice message was left with the physician. -There was no documentation staff increased supervision in response to Resident #4 falls. -On 1/4/17 at 10:30 a.m., the unwitnessed fall occurred in the resident's bathroom resulting in a laceration to the left side of the face requiring ER treatment. -Initial actions taken by staff were vital signs, check for injury, notified emergency contact, notified Nurse. -A voice message was left with the physician. -There was no documentation staff increased supervision in response to Resident #4 falls. Review of the Fall and Pain Assessment dated 7/18/16 revealed: -This was the only Fall and Pain Assessment completed for Resident #4. -"The patient was started on Tramadol by Emergency Department. No pain today and per staff patient with no complaints of pain. There was no as needed Tramadol received. Discontinued 7/18/16". (Tramadol is used to help relieve moderate to moderately severe pain). Based on observations, interviews and record reviews, Resident #4 was not interviewable. Interview with a Medication Aide/Supervisor (MA/Supervisor) on 1/12/17 at 2:48 p.m. revealed:	D 270		

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D 270	Continued From page 6 -She had worked at the facility for 1 year. -Resident #4 had a condition change in the past couple of weeks. -The resident needs help by staff with toileting, personal care and showers. -The resident transfers self in the bathroom. -The resident used to be independent, but staff is helping more with transferring in the last couple of weeks. -The resident had fallen within the past month. -Resident #4 had fallen multiple times. -He had quite a few falls in the past week. -"I have never witnessed any falls". The resident yells "Help I'm falling". -The resident's last fall occurred on 11/28/16 when another resident was pushing him in the wheelchair. The resident was heard yelling and stated the other resident pushed him head first out of the wheelchair. Resident #4 was sent to the Emergency Room. -Resident #4 returned to the facility with bruising and a Band-Aid to his forehead. -Staff supervised the resident by watching him and keeping him in the activity room. -"I keep him in my view and make 30 minute checks while he is lying in bed". -Resident is in the activity room when he is out of bed. -When the resident falls, he was assessed, vitals were taken and we "see if he's ok". -The staff completes an incident report, "watch and evaluate", get him up and "if something is wrong call EMS". -The family member, Health Wellness Director (HWD) and physician are notified. -She did not recall any broken bones from Resident #4's falls. Interview with a Personal Care Aide (PCA) on 1/12/17 at 4:50 p.m. revealed:	D 270		

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-She had worked at facility for 4 years.
-She had not worked in the Memory Unit in a while.
-Resident #4 tries to get out of bed and hollers for help every 30 minutes to an hour.
-The resident is in pain now because he had fallen.
-The resident fell out of bed "the week before last" on 2nd shift.
-The resident was found by another staff between 10 p.m. - 11 p.m.
-He was found on the floor bedside of the bed and was calling for help.
-The resident was sent to the Emergency Room.
-The HWD told staff "to keep an eye on him" and monitor the resident closely which meant taking the residnt to the activity room with staff at all times.
-She was aware of other falls by the resident when the staff communicated other falls during each oncoming shift change.
-The resident had skin tears from falls.

Observation of Resident #4 on 1/12/17 on 2 p.m. revealed the resident was sleeping in bed.

Observation of Resident #4 on 1/13/17 at 11 a.m. revealed the resident was in the Activity Room sitting at a table.

Observation of Resident #4 on 1/11/17 revealed:
-At 10 a.m., the resident was in bed.
-The resident was observed in bed again at 2 p.m.
-The resident was observed coming to the Dining Room for the dinner meal at 4:30 p.m. in a wheelchair assisted by the staff.

Interview with a second PCA on 1/13/17 at 11:21 a.m. revealed:

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D 270	Continued From page 8 -She had been employed at the facility for 11 years. -The resident requires assistance to get into bed or go to the bathroom. -The resident needs more help than what is given by staff when getting into bed and going to the bathroom. -He had two falls within the past 3 months. -She had not witnessed any falls. -She last worked in the Memory Unit a week ago. -The policy for falls was to notify the Medication Aide. The Medication Aide would then check the vitals of the resident, help the resident stand up and complete the paper work for the fall. -The PCA was the staff assigned to the resident when the falls occurred on 8/30/16, 10/31/16, 12/12/16 and 1/1/17. Interview with a third PCA on 1/13/17 at 11:51 a.m. revealed: -She had been employed for one month. -The resident needs to be monitored when going to the bathroom and getting in and out of bed. -The resident "had had two falls since I've been here". -"I know that the resident had a fall when I get the report during the oncoming shift change". -She monitors the resident by leaving the bedroom door open during the shift. "I then ask the resident if he needs anything every couple of hours". -The PCA tries not to let the resident wander around the unit by himself. -She is "Not sure if he has fallen on my shift". -The policy for falls is to call the Medication Aide. -The Medication Aide checks for cuts, bleeding, bruising and does an assessment. -The Medication Aide calls the HWD, and notifies the family and physician. -The PCA stays with the resident until the HWD	D 270		

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comes or an ambulance is called.
-"One more person would help a lot for the whole shift".

Interview with Program Coordinator on 1/13/17 at 4:32 p.m. revealed:
-She had worked in the Memory Unit for almost a year.
-Resident #4 "has had a couple of falls and needs increased supervision for falls", which meant bringing the resident to the Activity Room and keeping the resident out of his room.
-He needed more assistance over the past week and a half.
-When the resident started having falls the resident was diagnosed and treated for a Urinary Tract Infection (UTI).
-The physician had been monitoring the resident's falls and visited the resident on 1/13/17.
-The staff monitors the resident every 15-20 minutes.
-If the resident is in his room, someone checks on him. We have done this for a few weeks.
-Before the resident had falls he was monitored every 30-45 minutes.
-This was no documentation of the monitoring in Resident #4's record.
-The HWD and the Resident Care Coordinator (RCC) communicates to staff at stand up meetings about resident falls.
-When we monitor the resident, I walk in the room and talk to him to see if he needs anything. I ask if he's ok or if he needs to go to the bathroom.
-The staff keeps the resdient out of his room as much as possible and encourage him to come to the activity table with a snack.
-By the afternoon he wants to go to bed.
-Resident #4 has not had therapy. The family member denied Physical and Occupational Therapy.

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D 270	Continued From page 10 Interview with a Supervisor on 1/13/17 at 3:30 p.m. revealed: -She had worked at the facility for 7 months. -Resident #4 needs 24 hour supervision. -The resident had been told to call for help and use the call bell. -Resident #4 had fallen 5 times. -Resident #4 had a fall on her shift, 3 p.m. -11 p.m. -He was found on the floor between the bed and the chair sitting on his bottom. -She asked the resident if he hit his head and checked his body for bruising or swelling. -The incident was reported to the on call HWD and the family member. -The resident was moved to a wheelchair by the Supervisor and PCA on shift and took his vital signs. -The procedure for falls is to leave a message for the physician. -She was told by the HWD to monitor the resident and bring to the activity room and place him at the activity table with a snack. -The resident usually falls during a UTI or when he is sick. He is now getting over a bad UTI. -The resident had been declining for 2-3 weeks. -A supervision plan was put into place by the HWD on 1/3/17. -Staff were told to check the resident every 30 minutes and bring him to the activity room and give snacks. -The monitoring was not documented in Resident #4's record. -Staff were to complete resident notes when he falls for 3 days in a row or a condition change. -"It is hard to pass meds and do personal care with two staff". Interview with the Health and Wellness Director	D 270		

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D 270	Continued From page 11 (HWD) on 1/13/17 at 4:02 p.m. revealed: -The procedure for reporting falls is in the facility policy. -Falls without injury are only monitored. -Interventions are put in place for other falls by contacting physical therapy, removing and identifying obstacles, document change in condition and review medications with any fall. -All falls are added to the Personal Service Plan with fall interventions. -New orders are reviewed in the stand-up meetings with staff and twice a day on 1st and 2nd shift during shift change. -The Hot Box list is used by the facility to list all the resident falls and is the responsibility of the Medication Aide to update. -Medication Aides are also responsible for updating the 24 hour chart book that is kept on the medication cart. -She was aware that Resident #4 had multiple falls. -She told staff to monitor the resident closely for falls. -Staff were told to bring the resident to the Activity Room and offer him snacks to supervise him. -There were no other interventions put in place. Interview with the Interim Executive Director on 1/13/17 at 4:20 p.m. revealed: -The acting Executive Director was not available for interview. -The staff training on falls is in the Core Foundations new hire training that is completed upon hire. -The training is completed annually between January and December. -The HWD and RCC is responsible for notifying staff of resident falls, contacting the family, the physician and other referrals. -The facility policy should be to reach out to the	D 270		

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physician for other lab work and additional interventions.
-When a resident falls, staff must decide if the resident is safe and if 1:1 supervision is needed during the times the resident had fallen.

Review of the 24 hour report book on 1/13/17 at 4:18 p.m. revealed:
-January 2017 was the only month available for Resident #4.
-There was no interventions documented for falls or supervision on the documented dates where the falls occurred on 1/1/17 and 1/4/17.

Interview with Resident #4's family member on 1/13/17 at 1:10 p.m. revealed:
-The resident had falls out of the chair and bed in his room.
-Every time he falls, the facility sends him to the hospital.
-One time, the resident fell over the course of 4 days. He could not recall the dates.
-The resident had fallen numerous times within the past 2 months.
-He had not been told anything had been put into place for Resident #4's falls.
-The resident is starting to decline again.
-The family member had declined therapy because it will be of no benefit to the resident.

Review of the facility's Fall Management Policy on 1/13/17 revealed:
-"A fall is defined as any drop, collapse, or tumble. Any witnessed or reported unwitnessed fall with or without injury is reported in the reporting system. Resident who sustain a fall should have a post fall investigation completed with interventions identified to reduce the potential for future falls and injury".
-The ED and HWD are responsible for verifying

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D 270	Continued From page 13 that associates have completed the training. -Resident falls are noted in the Resident Record and entered into the reporting system. -A post fall investigation is completed after a resident fall and individualized interventions are included in the service plan. -When a fall occurs, staff should assist the resident and provide first aid or call 911. -Notify the HWD/designee and ED. -Notify the physician for evaluation, care and treatment. -Notify the family/responsible party and document in the record. -Document the resident fall/injuries, resident response and interventions taken in the resident record. -" Review the fall in the morning standup meeting to verify that the post fall investigation is underway". -Discuss resident falls at the next care review meeting. -"Additional interventions should be noted on the resident service plan if recurrent falls occur". -The facility could not provide documented interventions for post fall investigations completed for the identified 15 falls the resident had from 7/16/16 to 1/4/17. -No interventions were documented on the resident service plan dated 11/4/16. _____ The facility failed to provide supervision for 1 of 4 (#4) sampled residents residing in the special care unit, with falls in accordance to the resident's assessed needs, care plan and current symptoms. There were 15 falls from 7/16/16 to 1/4/17, which resulted in scrapes and abrasions on the face and hand and injury to the pelvis. The failure of the facility results in the detriment to the health, safety, and welfare of the resident which constitutes a Type B Violation.	D 270		

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D 270	Continued From page 14 The facility submitted a Plan of Protection, as follows: -Immediately, all resident will be assessed for supervision needs. -Residents needing increased supervision will be identified and increased supervision will be implemented. -The interventions for residents with increased personal care and supervision needs will be implemented and entered on the Resident Service Plan. -The interventions may include but not limited to physical therapy, occupational therapy, medication review and consulting with providers. -Increased monitoring following a fall will be every 30 minutes for 24 hours, every hour for 24 hours and every 2 hours for 24-72 hours. This will be recorded in the residents record each shift by the Medication Aide. -The Health Wellness Director or Designee will monitor daily to ensure the monitoring was completed. -Residents who continue to have falls or who have a need for increased supervision beyond the 72 hours, will be assessed by the physician for a higher level of care. -Residents determined to need one to one supervision for any reason, will be notified by the family and a "companion" will be required to monitor the resident until the resident was discharged from the facility or "deemed" by the physician to no longer need one to one supervision. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 27, 2016	D 270		

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D 280	Continued From page 15	D 280		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (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 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: (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; (2) evaluating the resident's progress to care being provided; (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 (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure Licensed Health Professional Support (LHPS) reviews of residents' health status, care plan and care provided were completed within 30 days of the onset of the development of the tasks/orders and the quarterly reviews for 1 of 2 sampled residents (#2) with LHPS tasks of assistance with a wheelchair, use of suppositories, physical	D 280		

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therapy, use of anti-embolic stockings, feeding assistance with dysphagia, and transfers. The findings are:

Review of the current FL-2 dated 6/29/16 for Resident #2 revealed:
- Diagnoses included hypertension and hearing loss.
- The resident was listed as non-ambulatory with no assistive device marked on the FL-2.
- Medication orders included, Acetaminophen 650 mg suppositories as needed for fever of 101 degrees Fahrenheit.

Review of the Resident Register for Resident #2 revealed an admission date of 9/19/13.

Review of hospice nurse notes for Resident #2 dated 5/20/16 revealed a physical therapy evaluation for balance and fall recovery including functional transfers.

Review of the record for Resident #2 revealed the physician order for the physical therapy was not in the record.

Review of hospice notes dated 5/24/16 included the resident had a recent stroke and fall with left sided weakness, was non-ambulatory and required maximum assistance with transfers.

Review of physician notes dated 5/24/16 for Resident #2 revealed a recent CVA, (cerebrovascular accident - stroke) with left side weakness, recent dysphagia with a soft diet and thick liquids, limited range of motion required maximum assistance with transfer and was non-ambulatory.

Review of home health hospice nurse notes

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dated 6/15/16 included Resident #2 required a wheelchair and had edema in the lower extremities.

Orders dated 7/13/16 for anti-embolic support stockings to prevent accumulation of lower extremity fluid retention and to promote blood flow. They were to be put on in the a.m. and to be removed in the p.m.

Review of the most current assessment and care plan dated 7/20/16 provided by the facility included:
- Resident did not require assistance with dressing, grooming, bathing, bathroom assistance and transfers.
- Family or sitter assisted with these.
- A sitter helped with feeding the resident.
- The resident was independent with a walker as a mobility aid and a manual wheelchair.
- Another entry listed the sitter and family helped with these tasks.

Review of a LHPS reviews for Resident #2 revealed:
- There was no LHPS review in the resident's record since 12/31/15 until 11/11/16.
- The LHPS review dated 11/11/16 included tasks of anti-embolic support hose for edema, rectal suppositories, assistance with the wheelchair and transfers.
- There was no LHPS review within 30 days of the onset/order nor was a review completed quarterly with the tasks of assistance with an assistive device, transfers, anti-embolic support hose, physical therapy, and feeding techniques with dysphagia and use of suppositories.

Interview on 1/12/17 at 11:20 a.m. with the Health and Wellness Director (HWD), a registered nurse

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revealed:
- She was not very familiar with residents as yet.
- She had recently started working in the facility a few weeks ago.
- The HWD was to complete LHPS reviews within the 30 days from onset of tasks and the subsequent reviews.
- She did not know why LHPS reviews had not been completed for Resident #2 by the previous HWD.
- The previous HWD would have been responsible for ensuring they were completed.

Interview on 1/13/17 at 12:15 p.m. with Resident #2's sitter revealed:
- Resident #2 had been unable to be independent with the walker and wheelchair, transfers, and feeding since a stroke about May 2016 or June 2016.
- She had been assisting the resident with transfers when able to be up in wheelchair, feed the resident, and assist with other care.
- The resident had anti-embolic stockings for swelling.
- Facility staff were to assist with the anti-embolic stockings.

Interview on 1/13/17 at 1:07 p.m. with a medication aide revealed:
- Resident #2 had a decline in her abilities to be independent.
- She had not been able to transfer, walk, or be independent with the walker and wheel chair since around June 2016.
- The resident had one fall when the stroke was discovered.
- The resident broke her wrist and had a cast and a sling.
- The resident had physical therapy after that.
- She wore anti-embolic hose to help with edema

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D 280	Continued From page 19 since early last year and needed assistance with feeding.	D 280		
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 kitchen's walls, floors, the shelves and floors in the walk-in-cooler, walk-in-freezer, pantry and the beverage station were cleaned. The findings are: Observation of the dining room on 1/11/17 at 11:20 a.m. revealed the area of the floor in front of the beverage station, which was in front of the double doors that led to the kitchen, had brown dried crumbs and dried brown cereal around the black floor mat. Observation of the kitchen on 1/11/17 at 11:21 a.m. revealed: -The center of the double doors at the entrance of the kitchen had peeled paint. -The center of the wall where the double doors were located had brown dried food stains. -The lower part of the wall on the side of the ice cream freezer had dried gray stains. -The floor throughout the kitchen had dried brown crumbs, orange and white food substances on the floor. -Sixteen of Sixteen shelves in the walk-in cooler	D 282		

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had brown and white dry stains. There was an open loaf of bread in the cooler and a gallon of milk with a red sticky substance on the outside of the milk carton.
-One fourth of the floor in the walk-in-freezer had solid ice under the shelves with pieces of frozen carrots and pieces of a green leafy vegetable on the floor.
-The outside of the ice machine and the edges of the ice machine underneath the lid had built-up white residue.
-The inside of the ice cream freezer had ice on all four walls. The top of the ice cream freezer had a dirty apron with white and brown, dried stains. The two glass lids covering the ice cream freezer had built-up dry brown crumbs and two paper clips in the corner of the freezer's lid. The vent cover on the left side of the freezer had built-up dust.
-The floor in the pantry had a potato under the shelf and a white dry substance on the floor.

Observation of the dining room on 1/11/17 at 4:36 p.m. revealed the floor around the beverage station had not been cleaned.

Observation in the kitchen on 1/11/17 at 4:36 p.m. revealed:
-The walls in the kitchen were cleaned.
-The entrance door in the kitchen and the pantry floor had been cleaned.
-The floors in the kitchen, walk-in cooler and walk-in freezer, the shelves in the walk-in cooler, the ice machine and the ice cream freezer had not been cleaned.
-The loaf of bread had been closed.
-The red sticky liquid on the gallon of milk had not been cleaned.

Observation of the beverage station in the dining

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room revealed the mat on the floor in front of the station had dried brown cereal crumbs around the mat.

Observation of the kitchen on 1/13/17 at 3:25 p.m. revealed:
-The floor had cooked fries, brown crumbs, plastic paper, white unknown substance throughout the floor.
-The ice machine had been cleaned.
-The shelves in the walk-in-cooler had not been cleaned.
-The floor in the walk-in-cooler and walk-in-freezer had not been cleaned.
-The apron on the ice cream freezer had been removed. The inside and outside of the freezer was the same and had not been cleaned.
-The floor in the pantry had been cleaned.

Interview with the Dietary Supervisor on 1/11/17 at 11:20 a.m. revealed:
-Lunch was served to the residents at 12:00 p.m.
-Staff had to catch up with the cleaning in the kitchen, because two days ago a water pipe had broken in the facility due to the snow storm.
-The water was turned off.
-The water just came back on yesterday (1/10/17).
-Dietary was trying to catch-up with the cleaning in the kitchen.

Interview with the Dietary Supervisor on 1/13/17 at 3:35 p.m. revealed:
-He had been working at the facility for one month.
-He was responsible for making sure dietary staff cleaned the kitchen.
-The facility had a written cleaning schedule, but it had not been completed.
-There was no assigned person to clean the

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D 282	Continued From page 22 kitchen. Whichever staff worked that day cleaned the kitchen. -The floors in the kitchen were swept at the end of the day and mopped as needed. -The floor in the kitchen should have been swept the night of 1/12/17. -The walk-in-cooler was swept daily and mopped every other day. -The shelves in the walk-in-cooler had not been cleaned since he had been working at the facility. -The walk-in-freezer's ice started building up on 1/7/17. It needed to get repaired. -He last cleaned the ice cream freezer the week of 1/1-1/7/17. He wiped the freezer. He could not remember if the ice cream freezer had built-up ice in it when he last cleaned it or not. Review of a written weekly cleaning schedule revealed the schedule was not documented and there was no written cleaning schedule for the concerned areas. Interview with the Interim Executive Director on 1/13/17 at 6:36 p.m. revealed: -The facility's Executive Director managed the Dietary Supervisor. -She did not know the facility's dietary cleaning schedule. -She does not know the facility's Executive Director's expectation in reference to the cleanliness of the kitchen.	D 282		
D 311	10A NCAC 13F .0904(f)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (1) Sufficient staff shall be available for individual	D 311		

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D 311	Continued From page 23 feeding assistance as needed. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure sufficient staff was available to feed 3 of 3 residents (#4, #6, #7) residing in the special care unit requiring feeding assistance. The findings are: 1. Review of Resident #4's record revealed a diet order of ground with nectar thick liquids. Review of the Resident Register for Resident #4 revealed an admission date of 4/22/15. Review of Resident #4's "Resident Service Plan" revealed total assistance needed with feeding. Based on observations, interviews and record review, Resident #4 was not interviewable. Observation of the dinner meal on 1/11/17 at 5:00 p.m. revealed: -There were 15 residents in the dining room. -There were 2 staff serving meals, beverages and preparing to assist other residents with their meals. -At 5:10 p.m., Resident #4 was attempting to feed self a cup of soup. -At 5:11 p.m., the surveyor asked the staff to assist the resident before the soup spilled on him. -Staff removed the cup of soup away from Resident #4. -At 5:15 p.m., the resident attempted a second time and pulled the cup of soup closer to himself to eat. -At 5:17 p.m., a second staff removed the cup of soup from the resident and stated they would	D 311		

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help soon.
-At 5:20 p.m., the resident attempted a third time to feed himself and the surveyor intervened before the cup of soup spilled on the resident.
-At 5:21 p.m., the staff removed the items from the resident and began to assist resident with feeding.

Interview with the Supervisor on 1/11/17 at 5:50 p.m. revealed:
-There was usually only 2 staff in the memory unit on 2nd shift to help with feeding.
-"It is not enough people".
- She had told Management since June 2015 that more staff was needed to help feed residents.

Observation of the dinner meal on 1/11/17 at 5:56 p.m. to 6:15 p.m. revealed:
-No staff was available to assist Resident #4 that required feeding assistance.
-Staff left the table to begin serving dessert and helping other residents away from the dining room to the activity room.
-At 5:58 p.m., Resident #4 knocked over the plate reaching for food.
-Staff assisted with cleaning him up and put a plate guard on his plate.
-At 6:00 p.m., Resident #4 attempted to feed self with spoon against plate guard and dropped the spoon into his food.
-At 6:01 p.m., Resident #4's plate was taken by staff for cleanup.

Observation of the breakfast meal on 1/12/17 at 8:00 a.m. to 9:20 a.m. revealed:
-There were 14 residents in the dining room.
-There were 3 staff serving meals, beverages and preparing to assist other residents with feeding.
-At 8:11 a.m., Resident # 4 was attempting to drink water from a glass and began to spill the

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glass of water.
-At 8:11 a.m., the surveyor notified the Program Coordinator, that Resident #4 was spilling his water.
-At 8:12 a.m., the Program Coordinator sat in an empty chair beside the resident to begin feeding him.

Interview with the Program Coordinator on 1/12/17 at 8:22 a.m. revealed:
-There are usually 2 people assisting those residents that need help with meals.
-"We are running behind".
-We need more help during meals since the recent decline of the residents.
-Resident #4 needs assistance with meals.

Interview with another Personal Care Aide (PCA) at 11:51 a.m. on 1/13/17 revealed:
-Resident #4 needs help with eating.
-The resident cannot complete a meal without assistance by staff.
-Staff rotates feeding residents during meal times.
-She received training when she was hired on how to assist the residents with feeding.
-There are 3 staff in the dining room during breakfast and lunch to help with feeding.
-You have to walk away from feeding residents to help other residents.
-All residents that need help during meals do not eat at the same time.
-We reheat the food sometimes.
-"If the resident isn't chewing, I'll go warm it up".

Interview with Program Coordinator on 1/13/17 at 4:32 p.m. revealed:
-She was trained to sit next to the resident when assisting with meals.
-She will remind staff if they forget to sit next to

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residents during meals.
-She is here for breakfast and lunch meals.
-There are 3 staff at all times in the memory unit; Medication Aide, Personal Care Aide and the Program Coordinator.
-The need to increase staff had been brought to the attention of Management under the facility's serve alignment guidelines.
-She was not sure of the timeframe that she brought this to the attention of Management.
-Resident assistance during meals had been brought to Management's attention by families and the Regional Manager.
-There had been family member concerns about staffing during meals within the past 6 months.
-Staff are responsible for serving food, drinks, rolling silverware and place settings.
-All staff bring residents to the dining room.
-She was told by Management that dinner is a lighter meal and is easier, so they do not need as much staff.

Interview with the Supervisor on 1/13/17 at 3:30 p.m. revealed:
-She did not receive any training on feeding residents when hired.
-She knows to sit beside the resident and not stand up.
-Resident #4 needs help with meals now that he had declined.
-There are residents that get up during the meal and won't sit down.
-Resident #4 was feeding himself until "I returned to work on 1/3/17".

Refer to interview with the Interim Executive Director on 1/13/17 at 6:36 p.m.

2. Review of Resident #6's current FL-2 dated 7/18/16 revealed the resident's diagnoses

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included dementia and hypothyroidism. The resident had a history of a transischemic attack and was intermittently disoriented.

Review of the Resident Register revealed the resident was admitted to the facility on 4/10/15.

Review of Resident #6's "Resident Service Plan" dated 7/18/16 revealed the resident was totally dependent with feeding.

Based on observations, interviews and record review, Resident #6 was not interviewable.

Interview with the Supervisor on 1/11/17 at 5:50 p.m. revealed:
-There is usually only 2 staff in the memory unit on 2nd shift to help with feeding.
-"It is not enough people".
-Had told Management since June 2015 that more staff is need to help feed residents.

Observation of the breakfast meal on 1/12/17 at 8:00 a.m. to 9:20 a.m. revealed:
-There were 14 residents in the dining room.
-There were 3 staff serving meals, beverages and preparing to assist other residents with feeding.
-At 8:12 a.m., the Program Coordinator sat in an empty chair beside the resident to begin feeding him.
-There was no staff available to assist Resident #6 with feeding.
-Resident #6 was served at 8:26 a.m.
-Resident #6 did not attempt to feed herself.
-At 8:34 a.m., the Medication Aide prompted resident #6 to wake up.
-At 8:36 am, the Medication Aide left the table and went in the Activity Room.
-At 8:37 am, the Resident Care Coordinator (RCC) came to the dining room and began

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assisting Resident #6 with feeding.
-Resident #6 was observed sleeping with her right hand in her eggs.
-At 8:51 a.m., the RCC asked the Program Coordinator where the Medication Aide was to help with feeding.
-The Medication Aide returned to the table and began feeding resident #6 at 8:54 am.

Interview with the Program Coordinator on 1/12/17 at 8:22 am revealed:
-There are usually 2 people assisting those residents that need help with meals.
-"We are running behind".
-We need more help during meals since the recent decline of the residents.
-Resident's #6 needs assistance with meals sometimes.

Observation of the breakfast meal on 1/12/17 at 8:26 am revealed:
-The Medication Aide returned to the dining room.
-Resident #6 was served.
-The Medication Aide assisted Resident #6 with feeding.
-The Medication Aide stopped feeding the resident at 8:36 am.
-The Resident Care coordinator (RCC) came to the table to assist Resident #6.
-Resident #6 was observed sleeping with her hand in the food.
-The RCC asked where the Medication Aide was.
-The Medication Aide returned to the table to assist Resident #6 with feeding.

Observation of the dinner meal on 1/12/17 at 5:33 p.m. revealed one staff was feeding Resident #6 while standing.

Interview with a Personal Care Aide (PCA) at 5:52

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D 311	Continued From page 29 p.m. on 1/12/17 revealed: -She had been assisting resident #6 with meals for about a month. -She was not trained to stand while assisting residents with meals. -She preferred to stand while assisting residents with feeding. Interview with another PCA at 11:51 a.m. on 1/13/17 revealed: -Staff rotates feeding residents during meal times. -She received training when she was hired on how to assist the residents with feeding. -There are 3 staff in the dining room during breakfast and lunch. -You have to walk away from feeding residents to help other residents. -All residents that need help during meals do not eat at the same time. -We reheat the food sometimes. -"If the resident isn't chewing, I'll go warm it up". -May have to reheat meals at least once for Resident #6. Interview with Program Coordinator on 1/13/17 at 4:32 p.m. revealed: -She was trained to sit next to the resident when assisting with meals. -She will remind staff if they forget to sit next to residents during meals. -She is here for breakfast and lunch meals. -There are 3 staff at all times in the memory unit; Medication Aide, Personal Care Aide and the Program Coordinator. -They need to increase staff had been brought to the attention of Management under the facility's serve alignment guidelines. -She was not sure of the timeframe that she brought this to the attention of Management.	D 311		

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-Resident assistance during meals had been brought to Management's attention by families and the Regional Manager.
-There have been family member concerns about staffing during meals within the past 6 months.
-Staff are responsible for serving food, drinks, rolling silverware and place settings.
-All staff bring residents to the dining room.
-She was told by Management that dinner is a lighter meal and is easier, so they do not need as much staff.

Interview with the Supervisor on 1/13/17 at 3:30 p.m. revealed:
-She did not receive any training on feeding residents when hired.
-She knows to sit beside the resident and not stand up when feeding.
-Resident #6 needs help with meals now that she had declined.
-There are residents that get up during the meal and won't sit down.
-We have to reheat plates twice for Resident #6 for most dinner meals.

Refer to interview with the Interim Executive Director on 1/13/17 at 6:36 p.m.

3. Review of Resident #7's current FL-2 dated 11/16/16 revealed:
-The resident's diagnoses included Alzheimer's dementia, coronary artery disease and osteoporosis.
-The resident was constantly disoriented.

Review of Resident #7's "Resident Service Plan" dated 7/18/16 revealed the resident was totally dependent with feeding.

Based on observations, interviews and record

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D 311	Continued From page 31 review, Resident #7 was not interviewable. Interview with the Supervisor on 1/11/17 at 5:50 p.m revealed: -There is usually only 2 staff in the memory unit on 2nd shift to help with feeding. -"It is not enough people". -She had told Management since June 2015 that more staff is need to help feed residents. Observation of the breakfast meal on 1/12/17 at 8:00 a.m. to 9:20 a.m. revealed: -There were 14 residents in the dining room. -There were 3 staff serving meals, beverages and preparing to assist other residents with feeding. -Resident #7 was served at 8:15 a.m. -Resident #7 did not attempt to feed herself. -At 8:26 am, Resident #7's plate was reheated and served to the resident. -At 8:30 am, the Medication Aide began to feed Resident #7. -At 8:34 am, the Medication Aide continued feeding Resident #7. -At 8:36 am, The Medication Aide left the table and went in the Activity Room. -At 8:37 am, the Resident Care Coordinator (RCC) came to the dining room and began assisting Resident #7 with feeding. -The Medication Aide returned to the table and began feeding Resident #7 at 8:54 a.m. Interview with the Program Coordinator on 1/12/17 at 8:22 a.m. revealed: -There are usually 2 people assisting those residents that need help with meals. -"We are running behind". -We need more help during meals since the recent decline of the residents. -Resident #7 needs assistance with meals sometimes.	D 311		

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D 311	Continued From page 32 Observation of the dinner meal on 1/12/17 at 5:33 p.m. revealed: -One staff was feeding Resident #7 while standing. Interview with another Personal Care Aide at 11:51 a.m. on 1/13/17 revealed: -Staff rotates feeding residents during meal times. -She received training when she was hired on how to assist the residents with feeding. -There are 3 staff in the dining room during breakfast and lunch. -You have to walk away from feeding residents to help other residents. -All residents that need help during meals do not eat at the same time. -We reheat the food sometimes. -"If the resident isn't chewing, I'll go warm it up". -May have to reheat meals at least once for Resident #7. Interview with Program Coordinator on 1/13/17 at 4:32 p.m. revealed: -She was trained to sit next to the resident when assisting with meals. -She will remind staff if they forget to sit next to residents during meals. -She is here for breakfast and lunch meals. -There are 3 staff at all times in the memory unit; Medication Aide, Personal Care Aide and the Program Coordinator. -The need to increase staff had been brought to the attention of Management under the facility's serve alignment guidelines. -She was not sure of the timeframe that she brought this to the attention of Management. -Resident assistance during meals had been brought to Management's attention by families	D 311		

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D 311	Continued From page 33 and the Regional Manager. -There have been family member concerns about staffing during meals within the past 6 months. -Staff are responsible for serving food, drinks, rolling silverware and place settings. -All staff bring residents to the dining room. -She was told by Management that dinner is a lighter meal and is easier, so they do not need as much staff. Interview with the Supervisor on 1/13/17 at 3:30 p.m. revealed: -She did not receive any training on feeding residents when hired. -She knows to sit beside the resident and not stand up when feeding. -Resident #7 needs help with meals now that the resident had declined. -There are residents that get up during the meal and would not sit down. -We have to reheat plates twice for Resident #7 for most dinner meals. Refer to interview with the Interim Executive Director on 1/13/17 at 6:36 p.m. Interview with the Interim Executive Director on 1/13/17 at 6:36 p.m. revealed: -The feeders are fed last per company's policy. -If a resident was a total feeder, staff should sit down at the table to feed the resident and alternate beverages between bites until the resident had completed the meal. -The residents should not be rushed while eating. -The residents requiring feeding assistance in the Special Care Unit had increased. -She was not sure if staffing had increased. -She was unsure of the timeframe that feeding assistance had increased.	D 311		

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observation interview and record review, the facility failed to assure a resident's rights of respect and dignity were maintained related to a resident (#4) wearing bed clothes in the in the common areas of the Special Care Unit (SCU) and treatment received during a meal in the dining room by staff. The findings are: A. Observation on 1/11/14 at 4:42 p.m., of Resident #4 in SCU revealed: - He was sitting at a group table with other residents in the day room. - The resident was in a wheelchair and was dressed in red plaid cloth boxer underware and a shirt. Interview on 1/11/17 at 4:42 p.m. with a medication aide (MA)/Resident Assistant (RA) revealed: - The resident had just awakened and had been brought to the day room to wait for the dinner to be served in the dining room. - The resident had been dressed in bed with red plaid cloth boxer underware with protective briefs underneath. - Staff used the plaid cloth boxers for pajamas for the resident when he was in bed. - The resident required incontinent care,	D 338		

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dressing, transfers and assistance with the wheelchair.
- The MA/RA asked if she should change his clothes now.

Interview with the Health and Wellness Director on 1/13/17 at 6:57 p.m. revealed:
- Residents should be dressed appropriately when they go to the dining room.
- The residents should not be dressed in boxer shorts when they go to the dining room.
- She did not know why Resident #4 was dressed in boxer shorts when he went to the dining room.

Interview with the visiting Executive Director on 1/13/17 at 7:31 p.m. revealed:
-Staff should make sure residents are not dressed in underwear and pajamas when they come to the dining room.
-The residents should be treated with dignity and respect.

B. Observation of dinner meal at 5:22 p.m. on 1/12/17 revealed:
- Resident #4 was drinking from a glass with straw with the assistance of the Supervisor.
- The Health Wellness Director (HWD) came into dining room from the kitchen looked for Resident #4 and took the resident's glass out of his hand while he was drinking from the glass.
-The HWD did not ask Resident #4 for the glass.
- The HWD began checking the consistency of the nectar thick water by stirring the contents with the resident's straw.
- The HWD would stir content of the glass and hold the straw in the air and let it drop back into the glass over the table where other residents were eating.
- The HWD stated to the Supervisor that "it should be the consistency of what you feed a

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hummingbird" and left the dining room with the resident's glass.
- The resident did not have any beverages at the table to drink.
- Residents, staff and surveyor's were present in the dining room.

Interview with the Supervisor at 5:32 p.m. on 1/12/17 revealed:
- The surveyor asked the Supervisor who removed the glass from the resident's hand while he was drinking.
- The Supervisor stated it was the HWD.

Interview with HWD in the kitchen at 5:33 p.m. on 1/12/17 revealed:
- She wanted to check the consistency of Resident #4's water.
- "It should be nectar thick, the consistency of what you feed a hummingbird".
- "The longer it sits the thicker it gets".
- She had educated the staff on how to measure and what the consistency of Resident #4's liquids should be.

Observation of dinner meal on 1/12/17 at 5:44 p.m. revealed:
- Resident #4 was drinking tea with the assistance of the Supervisor
- The HWD was asked by the surveyor to bring Resident #4 a glass of water that she had removed for the remainder of his meal.
- She returned with glass of nectar thick water and gave to the staff that was feeding Resident #4.

Interview with a Personal Care Aide on 1/13/17 at 11:21 a.m. revealed:
- If a resident is given the wrong item at a meal, inform the resident.

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D 338	Continued From page 37 - Then apologize to the resident and give them the right item. Interview with another Personal Care Aide on 1/13/17 at 11:51 a.m. revealed, if the wrong food was given to a resident, we were trained to apologize, remove the wrong item and bring a new item to the resident. Interview with the HDW on 1/13/17 at 6:57 p.m. revealed: - If a resident had something in their hand and staff needed to remove it from them, staff should ask the resident for whatever it was in the resident's hand to remove it. - When she had gone in the dining room to check on Resident #4's thickened liquids, the resident had drank a sip of the thickened water and put the glass down and then she moved the glass from the table. - She did not take the glass out of the resident's hand. Interview with the Interim Executive Director on 1/13/17 at 7:31 p.m. revealed: - If a resident had something in their hand and was not supposed to, staff should ask the resident for whatever was in the resident's hand. - If the Health Wellness Director had taken the thickened beverage out of the resident's hand, it would be a dignity concern. - All residents should be treated with dignity.	D 338		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified	D 463		

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D 463	Continued From page 38 in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure documentation of a pre-admission screening to evaluate appropriate admissions for 3 of 3 sampled residents (#4, #5, #6) in the special care unit. The findngs are: 1. Review of Resident #4's current FL-2 dated 3/15/16 revealed: -The resident's diagnoses were closed fracture of pelvis, difficulty walking, muscle weakness, dysphagia, and oropharyngeal leukocytosis. -The resident was intermittently disoriented and a wanderer. -The resident's current and recommended level of care was the "Memory Care." Review of the Resident Register revealed Resident #4 was admitted to the facility on 4/22/15.	D 463		

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D 463	Continued From page 39 Review of Resident #4's "Resident Service Plan" dated 6/7/16 revealed: -The assessment type was listed as Alzheimer's. -The resident needed help to participate in community activities. -The resident was not always oriented to person, place or time. -The resident was totally dependent on staff with eating, toileting, bathing, dressing and grooming. -The resident required extensive assistance with transferring and required limited assistance with ambulation with a wheel chair. Review of Resident #4's record revealed there was no documentation of a Memory Care pre-admission screening. Refer to interview with the Special Care Unit Coordinator on 1/11/17 at 10:30 a.m. Refer to interview with the Interim Executive Director on 1/12/17 at 2:33 p.m. 2. Review of Resident #6's current FL-2 dated 7/18/16 revealed: -The resident's diagnoses included dementia and hyperthyroidism. -The resident was intermittently disoriented. -The resident's current and recommended level of care was the "Memory Care." Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 4/10/15. Review of Resident #6's "Personal Service Plan" dated 7/18/16 revealed: -The assessment type was listed as Alzheimer's. -The resident wandered and required redirection.	D 463		

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-The resident was not always oriented to person, place or time.
-The resident needed help to participate in activities, because of the resident ' s memory loss.
-The resident was total dependent by staff with eating, the resident required extensive assistance with toileting, bathing and dressing and the resident was independent with transferring and ambulation.

Review of Resident #6's record revealed there was no documentation of a Memory Care pre-admission screening.

Refer to interview with the Special Care Unit Coordinator on 1/11/17 at 10:30 a.m.

Refer to interview with the Interim Executive Director on 1/12/17 at 2:33 p.m.
3. Review of the current FL-2 dated 2/01/16 for Resident #5 revealed:
- Diagnoses included Alzheimer's Dementia with behaviors, stroke, depression, osteoarthritis, falls, and history of subdural hematoma.
- Level of care was listed as "memory care".
- No date of admission was listed on the current FL-2.

Review of the Resident Register revealed:
- There was no date listed for admission.
- The Resident Register was signed by the resident's power of attorney on 1/16/15.

Review of a facility "Move-in Report" revealed the resident was admitted to the special care unit on 1/16/15 at 15:52 p.m.

Review of the resident's record revealed there was no documentation of completion of

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D 463	Continued From page 41 prescreening for admission to the special care unit. Review of the most recent assessment and care plan dated 2/16/16 for Resident #5 revealed the resident required total assistance with all activities of daily living. Review of the most recent resident assessment dated 7/01/16 revealed - The type of admission was listed as "Alzheimer's". - Independent with ambulation with a walker, transfers and eating. - The resident required assistance with showering and bathing, including assistance in and out of the shower washing the back, and any other areas needed. - Assistance with bathroom help to ensure clothing out of the way and help with hygiene and changing protective garments. - No behavior problems were listed. - Has cognitive impairments and needs help with structure, attention to accomplish daily routines due to memory loss or cognitive impairments. - Redirecting wandering. Refer to interview with the Special Care Unit Coordinator on 1/11/17 at 10:30 a.m. Refer to interview with the Interim Executive Director on 1/12/17 at 2:33 p.m. _____ Interview with the Special Care Unit Coordinator on 1/11/17 at 10:30 a.m. revealed: - The residents in the special care unit had memory care concerns. - She was not aware of the admission prescreening form process.	D 463		

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D 463	Continued From page 42 - The Health and Wellness Director would be responsible for all assessments. Interview on 1/12/17 at 2:33 p.m. with the Interim Executive Director (ED) revealed: - She was filing in for the current ED who was unavailable during the survey. - She checked to see if the facility's memory care unit's prescreen tool for admission was being completed and had just discovered the facility was not using the prescreen tool available for use. - She would ensure the current ED was informed about the prescreening tool forms not being completed.	D 463		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff	D 468		

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responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to assure 4 of 4 sampled staff (A, B, C, D) assigned to perform duties in the special care unit (SCU) had completed six hours of orientation within the first week of employment on the nature and needs of the residents and/or within six months of employment, had completed 20 hours of training specific to the population being served. The findings are:

1. Review of the personnel record for Staff A revealed:
- Hired 11/23/15 as a Resident Care Associate.
- There was 6 hours of SCU orientation training in the record upon hire.
- There was no documentation of completing a further 20 hours of SCU training specific to the population served within 6 months of hire in the personnel files.

Interview on 1/13/17 at 1:25 p.m. with Staff A revealed:
- She was a medication aide and had been working in the SCU since hire in 2015.
- She was sure she had all of the required

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training for the SCU. There had been a great deal of training upon hire.
- She was not sure the specific training titles for the the SCU.

Observation on 1/13/17 at 1:34 p.m. revealed:
- Staff A was administering medications to residents in the SCU day room.
- She was observed redirecting a resident to another area in the day room.

No further SCU training for the 20 hours was provided by the end of the survey.

Refer to the interview with the Interim ED on 1/13/17 at 3:20 p.m.

2. Review of the personnel record for Staff B revealed:
- Hired 6/09/16 as a Medication Aide
- There was no documentation of 6 hour orientation training to the SCU in the first week of hire nor of a further 20 hours of SCU training specific to the population served within 6 months of hire in the personnel files.

Observation on 1/12/17 at 5:35 p.m. revealed Staff B was working with residents in the SCU at dinner time.

Interview on 1/13/17 at 6:35 p.m. with Staff B revealed:
- Staff B provided personal care to residents and was a medication aide in the special care unit.
- She thought she must have had all of the SCU training as there was a lot of computer videos reviewed when she started work.
- She was not sure the videos were specific to the SCU or not.
- She did not know if there was 6 hours in the

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first week nor about the 20 hours SCU training required.

No further training for the SCU was provided by the end of the survey.

Refer to the interview with the Interim ED on 1/13/17 at 3:20 p.m.

3. Review of the personnel record for Staff C revealed:
- Hired 12/06/13 as a Medication Aide.
- There was no documentation of 6 hour orientation training to the SCU in the first week of hire nor of a further 20 hours of SCU training specific to the population served within 6 months of hire in the personnel files.

Observation on 1/11/17 at 5:05 p.m. revealed Staff C was working with residents in the SCU.

Staff C was not available for interview.

The current ED was not available for interview.

No further training for the SCU was provided by the end of the survey.

Refer to the interview with the Interim ED on 11/13/17 at 3:20 p.m.

4. Review of the personnel record for Staff D revealed:
- Hired 10/03/16 as a resident Care Associate.
- There was no documentation of 6 hour orientation training to the SCU in the first week of hire in the personnel files.

Review of the facility's work schedules for 1/11/17, 1/12/17 and 1/13/17 revealed Staff D

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D 468	Continued From page 46 was scheduled for work on those days on either the second or third shifts. Staff D was not available for interview. No further training for the SCU was provided by the end of the survey. Refer to the interview with the Interim ED on 11/13/17 at 3:20 p.m. _____ Interview on 1/13/17 at 3:20 p.m. with the Interim Executive Director (ED) revealed: - She was filling in for the current ED who was not available during the survey. - She was sure the staff in the SCU had all of their training based on company policy per orientation and training videos. - She did not know for sure if the training had been completed at this facility as she did not usually work here. - She would check for further staff training. - If the training was not in the training notebooks or the staff personnel record she did not know where it would be located.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and regulations. This Rule is not met as evidenced by:	D912		

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D912	Continued From page 47 Based on observation, interview and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide increased supervision for 1 of 4 sampled residents (#4) residing in the special care unit known to have multiple falls with injuries. [Refer to Tag D270, 10A NCAC 13F.0901 (b). (Type B Violation)]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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D935	Continued From page 48 (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 5 sampled medication aides (MA), (Staff C), hired on or after October 1, 2013 had a medication administration competency validation completed, had been verified as working as a medication aide during the previous 24 months in an adult care home or had successfully completed the 15 hour medication aide training prior to administering medications. The findings are: Review of the employee record for Staff C revealed: - A hire date of 12/06/13. - Hired as a supervisor and medication aide (MA). - There was documentation of passing a written medication administration written examination on 3/06/2001.	D935		

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D935	Continued From page 49 - There was no documentation of completing a medication administration clinical skills competency validation. - There was no documentation of verification of working as a medication aide during the previous 24 month of hire. - There was no documentation of the 15 hour medication administration training. Review of the three days of the survey facility schedule revealed Staff C was listed as the MA on 1/11/17 and 1/13/17 on the 2nd shift in the special care unit. Observation on 1/11/17 at 4 p.m. revealed Staff C administered medications to residents in the special care unit. Interview on 1/13/17 at 5:20 p.m. with the Interim ED revealed: - She had worked in this facility on occasion and thought all trainings and validations were in the personnel folders and in the training notebooks. - Training for medication aides was completed by the HWD (registered nurse), or the pharmacist. - She would look for the training and competency validations for Staff C. - She was not aware if there had been a verification of working as a medication aide within 24 months of hire for Staff C. Staff C was not available for interview. No documentation of the 15 hour training, competency validations or previous medication administration verification was provided by the end of the survey.	D935		