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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
	HAL065035	A. BUILDING: _____ B. WING _____	02/24/2017

PRINTED: 03/15/2017
FORM APPROVED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and New Hanover Department of Social Services conducted an annual survey from 02/21/17 through 02/24/17.	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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the physician of the acute and chronic health care needs of 2 of 5 residents sampled (#1, #3) as evidenced failing to notify the physician of elevated finger stick blood sugar results outside of the ordered parameters (results ranging from 364-532) for a diabetic resident (#3) for 9 of 13 opportunities in February 2017; failing to monitor and notify the physician of non-compliance with continuous oxygen therapy (#3); failing to notify the physician for acute changes in a resident's condition and complaints of weakness, shortness of breath, coughing, and not feeling well for several days (#3); and failing to schedule a speech consult for a resident known to pocket food in his mouth while eating (#1). The findings are: Review of Resident #3's current, hospital generated FL-2 dated 01/26/17 revealed	D 273	D273 Resident Care Coordinator will review and coordinate referrals and orders with appropriate staff and outside medical personnel and support staff to ensure referral and follow-up for residents' orders and related needs. Staff training and review of procedure and protocol will be provided for ○ Blood sugar test results, evaluation, and follow up. ○ How to monitor and document compliance with O2 orders and usage ○ Observation and documentation of any change in resident status and conditions These items were implemented on or before March 26, 2017.	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] [signature]		4-4-17

STATE FORM 6899 10ZD11 If continuation sheet 1 of 58

* The Plan of Correction with addendum was reviewed and accepted on 05/02/17. Refer to addendum pages 2, 26, 28, 30, 31, 39, 43, 47, 48, 54, 55 of this Statement of deficiencies.

[signature] 05/02/17

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D 273	Continued From page 1 diagnoses included pneumonia and schizophrenia. Review of Resident #3's previous FL-2 dated 12/13/16 revealed diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes, obstructive sleep apnea, and dependence on supplemental oxygen. A. Interview with Resident #3 on 02/21/17 at 10:05am revealed: -He was a diabetic and received sliding scale insulin (SSI) as needed. -Staff checked Resident #3's FSBS four times daily. Review of the physician's orders for Resident #3 dated 01/25/17 revealed an order for finger stick blood sugar (FSBS) testing before each meal and at bedtime daily with Humalog sliding scale insulin (SSI) as follows: for FSBS results of 150-180, give 1 unit of Humalog; FSBS 181-210, give 2 units; FSBS 211-240, give 3 units; FSBS 241-270, give 3 units; FSBS 271-300, give 4 units; FSBS 300 and greater, give 5 units. Call physician for FSBS greater than 350. (Humalog is a fast acting insulin that lowers blood sugar levels.) Review of Resident #3's February 2017 Medication Administration Records (MARs) revealed: -There was a computer generated entry for "check blood sugar before meals and at bedtime followed by Humalog SSI: 150-180=1u (unit); 181-210=2u; 211-240=3u; 241-270=3u; 271-300=4u; 300 + (plus) =5u. If > (greater than) 350 call MD (physician)" with administration times of 7:30am, 11:30am, 5:30pm, and 8pm. -There was handwritten documentation beside	D 273 D273	Addendum Per telephone with Mr. Hugh Campbell On 05/02/17. The nurse consultant will Perform chart audits (Between 3-5 charts per week) to assure referrals, orders, follow ups routine and acute care health care needs of residents are met. Staff training was provided by the Facilities nurse consultant, contracted pharmacy provider, Local management entity and an outside provider specializing in gerontology. Staff training will be done yearly and will be incorporated into orientation training for newly hired staff. Staff training included education related to recognizing and reporting changes in a residents condition and signs and symptoms to report. Quinn H. LPN	

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D 273	Continued From page 2 the computer generated entry which read "document on flow sheet." -There was no documentation that Resident #3's physician was notified on any date on the MAR. Review of Resident #3's "Diabetic Flow Sheet" for February 2017 revealed: -The physician order for SSI coverage and parameters to contact the physician for FSBS greater than 350 was a handwritten on the flow sheet.. -From 02/01/17-02/23/17 at 7:45am, Resident #3's FSBS results was documented greater than 350 one time: 449 on 02/10/17. -From 02/01/17-02/23/17 at 11:45am, Resident #3's FSBS results were documented below the ordered parameter (350) on all dates. -From 02/01/17-02/23/17 at 5:50pm, Resident #3's FSBS results were documented greater than 350 six times: 395 on 02/01/17; 392 on 02/03/17; 378 on 02/12/17; 436 on 02/15/17; 422 on 02/17/17; and 366 on 02/18/17. -From 02/01/17-02/23/17 at 9:00pm, Resident #3's FSBS results were documented greater than 350 six times: 532 on 02/03/17; 357 on 02/04/17; 364 on 02/07/17; 595 on 02/15/17; 437 on 02/16/16; and 405 on 02/17/17. Interview with the Administrator on 02/24/17 at 11:30am revealed documentation of the physician being notified for FSBS results outside of the ordered parameters would be found in the resident records in the Nurses Notes, fax notifications to the physician, or on the resident MARs. Review of the "Nurse's Notes" for Resident #3 revealed: -On 2/15/17, there was documentation that Resident #3's physician on call was notified by	D 273		

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D 273	Continued From page 3 telephone for FSBS of 595 at 8:00pm; a new verbal order was received for additional units of insulin. –On 02/17/17, there was documentation that Resident #3's physician was notified by telephone for FSBS of 422 at 5:00pm and 405 at 8:00pm; new verbal orders were received. -There was no other documentation in the Nurses Notes of the physician being notified. Review of the untitled documents for Resident #3 identified by a Medication Aide (MA) as the forms used by the facilty to notify and communicate with the physician revealed: -On 02/15/17, there was documentation of physician notification and receipt of a verbal order for Resident #3's FSBS result of 595. -On 02/17/17, there was documentation of physician notification and receipt of verbal orders for Resident #3's FSBS results of 422 and 405. -There was no other documentation of physician notification or communication. Interview with a MA and the Administrator on 02/24/17 at 2:38pm revealed the MA had notified Resident #3's physician of a FSBS result of 449 on the morning of 02/10/17 using her personal cell phone, but she did not document the notification. Observation of the call history in the personal cell telephone of the MA on 02/24/17 at 2:38pm revealed there was a record of a telephone call to Resident #3's physician's office on 02/10/17 at 8:05am. Interview with Resident #3 on 02/24/17 at 9:20am revealed: -He always received his insulin on time. -His FSBSs were high "sometimes" but he had	D 273		

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D 273	Continued From page 4 not noticed any problems or changes when his FSBS was high. -He did not know if the facility notified his physician when his FSBS was high. Telephone interview with a second MA on 02/24/17 at 1:50pm revealed: -Physician orders with parameters were supposed to be followed as written. -When a resident had a FSBS outside of the ordered parameter, the physician was supposed to be notified. -Documentation of the physician notification and any insulin coverage or other orders were supposed to be documented in the resident's record. Interview with a third MA on 02/24/17 at 3:35pm revealed: -The MA acknowledged initialing Resident #3's "Diabetic Flow Sheet" on 02/01/17, 02/03/17, 02/12/17, and 02/15/17-02/17/17 when the FSBS results were greater than 350. -When FSBS results were greater than the ordered parameter, she contacted the physician and documented the notification and orders in the resident's record. -If there was no documentation in Resident #3's record that the physician was notified, she "probably forgot" to document that she called the physician. Attempt to interview a fourth MA who initialed Resident #3's February 2017 "Diabetic Flow Sheet" by telephone on 02/24/17 at 2:00pm was unsuccessful. Interview with the Assisted Living Manager /Medication Aide on 02/24/17 at 1:20pm revealed: -When FSBS results were outside of the ordered	D 273		

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D 273	Continued From page 5 parameters, the MA was supposed to notify the physician by telephone or fax and document the notification and orders in the resident's record. -The MAs documented the physician notification on the Nurse's Notes. -Sometimes after hours and on weekends, there was no physician available, so the MA faxed the notification to the physician's office and documented the notification in the Nurse's Notes; the fax notifications were retained in the resident's record. Interview with the Executive Director (ED) on 02/24/17 at 12:00 revealed: -Any physicain orders with parameters were expected to be followed. -The Medication Aides were expected to notify the physician for FSBS results outside of the ordered parameters. Telephone interview with the Medical Assistant at Resident #3's physician's office on 02/24/17 at 3:55pm revealed: -The Medical Assistant checked the documentation on file in Resident #3's record in the "correspondence file", "communication", and "telephone calls section" and did not locate any correspondence or notification from the facility of Resident #3's FSBS results greater than 350 on 02/01/17, 02/03/17, 02/04/17, 02/07/17, 02/12/17, or 02/16/17. -The physician expected orders to be implemented as written and would expect to be notified if Resident #3's FSBS results were outside of the ordered parameters. Interview with the Administrator on 02/24/17 at 3:00pm revealed the Administrator expected the physician to be notified by telephone and/or fax when FSBS results were greater than the	D 273		

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D 273	Continued From page 6 parameters in the order. B. Observation of Resident #3 on 02/21/17 at 10:05am revealed: -He was sitting on the porch with his rollator walker beside him. -There was a portable oxygen canister with nasal cannula tubing hanging on the rollator walker; he was not wearing the oxygen -He exhibited labored breathing with nasal flaring intermittently. -He had a red and purple colored periorbital bruise around his left eye and sutures over his left eye in the brow area. Interview with Resident #3 on 02/21/17 at 10:05am revealed: -He was oriented to time, place, self, and situation. -He "blacked out" two days ago when he began coughing; he fell and injured his head. -He was supposed to wear his oxygen all of the time, but did not wear his oxygen all of the time; he wore the oxygen when "I need it." -He had been wearing oxygen since "around Thanksgiving" (November 2016) when he was hospitalized for pneumonia and "respiratory failure." -After being hospitalized in November 2016, he was discharged to a rehab facility for two weeks then returned to the facility before Christmas (in December 2016). Review of the "Emergency Department Encounter" for Resident #3 dated 02/18/17 revealed: -The "chief complaint" was documented as "fall, head injury without loss of consciousness, and facial laceration." -Resident #3 was walking with his walker that	D 273		

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D 273	Continued From page 7 morning (02/18/17) when he had a "violent coughing spell;" he fell forward and hit his head on the floor. -Resident #3 had a 4cm laceration over his left eyebrow which was repaired with ten sutures. -The "Radiology CT Scan" showed no evidence of an "acute intracranial hemorrhage." Review of the "Hospitalist Discharge Summary" for Resident #3 dated 11/30/16 revealed: -Resident #3 was admitted to the hospital on 11/21/16 and discharged 11/30/16. - Resident #3 was "deconditioned and required SNF (skilled nursing facility) at discharge." -The "discharge diagnoses" included "acute hypoxic respiratory failure", COPD exacerbation, sepsis, diabetes mellitus, hypertension, and tobacco abuse. -Resident #3 required oxygen at discharge. Review of the Physician orders for Resident #3 dated 12/14/16 revealed: -"Discharge home 12/14/16 for ALF (assisted living facility)." -"Continuous O2 (oxygen) at 2 LPM (liters per minute) via NC (nasal cannula). Observation of Resident #3 on 02/21/17 at 2:04pm revealed he was sitting in his room on the side of his bed taking a nebulizer treatment. Interview with Resident #3 on 02/21/17 at 2:07pm revealed: -He was not wearing his oxygen earlier (on 02/21/17) and got short of breath. -He asked the Medication Aide for a breathing treatment to help with the shortness of breath. -The breathing treatments helped. -He had not been wearing his oxygen on 02/18/17 when he fell and hit his head, but he had his	D 273		

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D 273	Continued From page 8 oxygen with him. -He started coughing and "I was on the floor" before he knew it. -He did not know if the hospital was told he was not wearing his oxygen when he fell (on 02/18/17). Review of the "Nurse's Notes" dated 02/18/17 revealed: -Resident #3 was sitting on his rollator when he began to cough and "fell over head first." -Resident #3 was sent to the hospital and then he returned to the facility with sutures. -There was no documentation whether Resident #3 was wearing his oxygen when he fell. Review of the "Incident/Accident Report" dated 02/18/17 revealed: -"Resident was sitting on rollator, started coughing and fell forward." -Resident #3 was transported to the hospital for a "laceration." -Resident #3's physician was notified. Observation of Resident #3 on 02/21/17 at 5:20pm during the dinner meal revealed: -He was sitting at the dining table in the Assisted Living dining room. -He was not wearing his oxygen and did not have it with him. -His respirations were even and unlabored. Interview with the Executive Director (ED) on 02/21/17 at 6:04pm revealed the ED was unsure of the details of Resident #3's oxygen order but thought it should be at 2LPM, "I believe." Observation of Resident #3 on 02/22/17 at 7:50am revealed: -He was in his room without his oxygen on.	D 273		

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D 273	Continued From page 9 -His respirations were uneven and labored. Interview with Resident #3 on 02/22/17 at 7:50am revealed: -He was getting ready to go to breakfast. -He got short of breath "sometimes" and his breathing became labored "sometimes." -He put on his oxygen and rested when he became short of breath. Observation of Resident #3 on 02/22/17 at 8:30am during the breakfast meal revealed: -He was not wearing his oxygen. -His respirations were even and unlabored. Interview with the ED and Administrator on 02/22/17 at 9:45am revealed: -Resident #3 did not wear his oxygen all of the time. -Resident #3 became short of breath when walking and rested frequently when ambulating. -The Administrator gave the example that Resident #3 drove himself to most of his appointments. He parked his vehicle in the facility parking area in the parking spaces closest to the door. He got short of breath when walking the short distance from the parking area to the porch so he would stop and sit down on the porch to rest. He would sometimes rest again in the entryway of the facility before going to his room. Observation of Resident #3 on 02/22/17 at 1:30pm revealed: -Resident #3 was getting out of his vehicle in the facility parking lot. -Resident #3 was carrying his oxygen but was not wearing the oxygen. -Resident #3's respirations were labored and he sat down on a chair on the porch.	D 273		

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D 273	Continued From page 10 Observation of Resident #3 on 02/22/17 at 5:17pm revealed: -He was ambulating in the hallway with his rollator. -He was wearing his oxygen at 2.5LPM. Observation of Resident #3 on 02/23/17 at 3:00pm revealed: -He was in his bathroom taking items out of the pockets of his pants. -His respirations were uneven and labored; he was not wearing his oxygen. -After he came out of the bathroom and sat down in the chair his room, his respirations were no longer uneven/labored. Interview with Resident #3 on 02/23/17 at 3:00pm revealed: -"I'm give out a little bit." -His physician did not know he did not wear his oxygen all of the time because he did not want to "lose" his oxygen. Observation and interview with Resident #3 on 02/24/17 at 9:20am revealed: -He was not wearing his oxygen and was breathing with pursed lips. -He made most of his own medical appointments. -Staff always printed his paperwork for him to take to his medical appointments. -He did not know if staff had notified his physician that he had not been wearing his oxygen all of the time but they probably hadn't because his physician thought he wore his oxygen all of the time. Interview with a Nurse Aide (NA) on 02/23/17 at 3:55pm revealed: -Resident #3 administered his own oxygen. -The NA thought Resident #3 was supposed to	D 273		

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D 273	Continued From page 11 wear his oxygen at 2LPM. -Resident #3's breathing would get labored; he would let staff know when this occurred. -When a resident was short of breath, the Medication Aide (MA) was notified; the resident was given breathing treatments by the MA, or the ambulance was called as needed. Interview with the Assistant Living Manager on 02/23/17 at 8:20am revealed: -Resident #3 was supposed to wear his oxygen all the time, but he didn't. -Resident #3 usually carried his oxygen with him but did not always have it on. -Staff did not monitor or document Resident #3's oxygen use. -The Assistant Living Manager did not know if Resident #3's physician was aware he was not wearing his oxygen all the time. -Resident #3's breathing did get labored at times. -She was on duty on 02/18/17 when Resident #3 fell. -Resident #3 was sitting on his walker near the nurse's desk; he was wearing his oxygen. -He asked her to check his oxygen; she checked the oxygen and told him the oxygen appeared to be working ok. -His breathing was labored, which was not unusual. -He started to cough; she asked him if he was ok, and he said he was ok. -He continued to cough and "blacked out"; she called 911 and he went to the hospital. Interview with the Administrator on 02/22/16 at 3:45pm revealed: -Resident #3 wore his oxygen "more times than not" and took it with him when he signed out. -When ambulating, Resident #3's had to rest frequently because he got tired and his breathing	D 273		

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D 273	Continued From page 12 became "labored." -Any documentation or notification to Resident #3's physician that he was not wearing his oxygen continuously would be in his record; the documentation would not be found in any other location. Review of the "Nurse's Notes" in Resident #3's record revealed there was no documentation of Resident #3 having any signs or symptoms of shortness of breath or labored breathing and no documentation that the physician was notified of Resident #3's labored breathing or shortness of breath and was not wearing his oxygen as ordered (continuously). Telephone interview with a Registered Nurse (RN) at Resident #3's Pulmonologist's office on 02/23/17 at 4:10pm revealed: -Resident #3 was last evaluated by the Pulmonologist on 02/15/17. -Resident #3 had "poorly controlled" COPD and was dependent on oxygen at 2LPM continuously. -At the last office visit on 02/15/17, a "walk test" was performed on Resident #3; his oxygen saturation was stable with his oxygen on continuously at 2LPM. -The Pulmonologist would expect the facility to monitor Resident #3's oxygen use and notify his primary physician if he was not compliant with the oxygen use. Interview with the Administrator on 02/23/17 at 8:50am revealed: -The Executive Director (ED) had made multiple attempts to contact Resident #3's primary physician by telephone on 02/21/17, 02/22/17, and again earlier that morning (02/23/17) to inquire about his oxygen orders and use; the physician had not returned any of the telephone	D 273		

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	HAL065035	A. BUILDING: _____ B. WING _____	02/24/2017

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D 273	Continued From page 13 calls. -Resident #3 had an appointment with his physician that day (02/23/17) at 12:30pm; the ED would send notification with Resident #3 to his physician's appointment requesting information related to his oxygen use. Review of an undated document on facility letter head identified by the Administrator as a note for Resident #3 to take to his primary physician during his appointment scheduled for 02/23/17 revealed: -Resident #3 "has an order for continuous oxygen (O2). However, [Resident #3's name] had been using the oxygen part-time (he does not use the O2 at all times). Please discuss with [Resident #3's name] the recommended utilization. If he is allowed flexibility, please revise the order to reflect the flexibility allowance." -"Thank you! [Executive Director's name]." Review of the physician orders for Resident #3 dated 02/23/17 revealed there was an order which read "may use O2 on PRN (as needed) basis." Telephone interview with a Medical Assistant at Resident #3's physician's office on 02/24/17 at 9:00am revealed: -The physician expected orders to be implemented as written and for any orders in question to be clarified with the physician. -There was no documentation on file dated prior to 02/23/17 of the facility notifying the physician that Resident #3 was not wearing his oxygen and was short of breath and tired on exertion. -On 02/23/17, Resident #3's oxygen order was changed to as needed. -The physician would expect to be notified of Resident #3's non-compliance with wearing his	D 273		

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D 273	Continued From page 14 oxygen or changes in status such as shortness of breath. Interview with the Administrator on 02/22/16 at 3:45pm revealed: -The facility did not currently have a system in place to monitor residents' use of oxygen. -The facility would implement a system for monitoring residents' oxygen. C. Interview with Resident #3 on 02/21/17 at 10:05am revealed: -He was alert and oriented to time, place, self, and situation. -He had been hospitalized in January 2017 for ten days for "breathing problems" and pneumonia. Review of the "Emergency Department Encounter" for Resident #3 dated 01/16/17 revealed: -The "chief complaint" was "shortness of breath." -"Patient had worsening fevers, cough, congestion, and respiratory distress at home." Review of the hospital "History and Physical" dated 01/16/17 revealed "Patient reports that he noticed increased shortness of breath about a week ago, progressively worse, associated with increased cough..." fever "101.1 this morning" and sore throat. Review of the "Hospitalist Discharge Summary" for Resident #3 dated 01/26/17 revealed: -Resident #3 was hospitalized from 01/16/17-01/26/17. -Discharge diagnoses included acute hypoxic respiratory failure. Interview with a Medication Aide (MA) and the Assisted Living Manager on 02/24/17 at 11:45am	D 273		

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D 273	Continued From page 15 revealed: -When resident had a health or medical complaint or change in status, it was supposed to be documented in the Nurse's Notes in the resident's record by the staff who was notified or observed the change. -The changes were also supposed to be documented on the "24 Hour Report" for the next shift. -The physician was supposed to be notified of any changes. -The Executive Director was also notified as needed. Interview with Resident #3 on 02/24/17 at 9:20am revealed: -He was hospitalized for 10 days in January 2017 (01/16/17-01/26/17) for "pneumonia." -Prior to his hospitalization in January 2017, he was "feeling bad a couple of days." -He was "coughing," and was "weak" and "run down." -He took his nebulizer treatments, but he did not get any better. -In the few days before he was hospitalized (on 01/16/17), he told the Medication Aides (MAs) about his symptoms and that he "was not feeling good." -He could not remember which MAs he told, but he told "several." -He always told staff when he did not feel good or he was going to the doctor. -On 01/16/17, he knew "something was wrong" so he told the MA on duty that he was going to "Quick Care" then he signed out and went. -The physician at "Quick Care" did a chest x-ray and told him he had pneumonia and needed to be put in the hospital. -He could not recall if he had asked the MAs to check his temperature during the days prior to the	D 273		

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D 273	Continued From page 16 January 2017 hospitalization; he does ask the MAs to check his temperature "sometimes" and they always do. -He did not know if the MAs notified his physician of his symptoms (in the days prior to his January 2017 hopitalization). Review of the "Nurse's Notes" for Resident #3 revealed: -On 01/16/17 at 8:30am: "Resident told the Med Tech (Medication Aide) he had a doctor appointment this morning because he has been feeling weak for a few days and just not feeling well." The Medication Aide (MA) "asked the resident has he let any other Med Tech know how he has been feeling and he stated 'I told someone, just can't remember.' Resident left facility after having breakfast to go to his appointment." -There was no other documentation found in the Nurse's Notes related to Resident #3's complaints of weakness, feeling "run down", or "coughing" and no documentation of the physician being notified. Interview with a MA on 02/24/17 at 11:47am revealed: -The MA acknowledged writing the documentation on the "Nurse's Note" on 01/16/17 at 8:30am after Resident #3 told her he did not feel well. -The MA recalled that Resident #3 said he had been feeling bad for a "few days" so she asked him if he had told any other staff (because it was the first she had heard anything about it) and there was nothing on the shift report about it. -She documented that Resident #3 said he felt weak and was going to the appointment because it was supposed to be documented. -She documented that he was hospitalized that	D 273		

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D 273	Continued From page 17 day (01/16/17) on the shift report. Interview with the Assisted Living Manager on 02/23/17 at 3:25pm revealed: -Resident #3 would alert staff of any issues he was having such as shortness of breath. -Staff monitored Resident #3 for any signs of changes in his condition. Interview with a Nurse Aide (NA) on 02/23/17 at 3:55pm revealed Resident #3 always communicated his needs to staff. Telephone interview with a second MA on 02/24/17 at 1:50pm revealed: -The physician was supposed to be notified of any status changes; the notification was supposed to be documented in the resident's record on the Nurse's Notes and also documented on the shift report. -The MA did not recall Resident #3 complaining of "feeling bad" in the days prior to his hospitalization from 01/16/17-01/26/17. Interview with the Assisted Living Manager on 02/24/17 at 11:49am revealed any changes in resident status were supposed to be documented and communicated with the physician. Review of the "24 Hour Shift Reports" revealed: -On 01/13/17 and 01/14/16, "n/c" (no change) was documented for Resident #3 on first and second shifts; there was no documentation for third shift. -On 01/15/17, "no change" was documented for Resident #3 on first, second, and third shifts. -On 01/16/17, "admitted in the hospital' was documented for Resident #3 on first shift. Review of the "Daily Care Notes" for Resident #3	D 273		

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D 273	Continued From page 18 revealed: -On 01/13/17 "no concerns" was documented for first shift; "no change" was documented for second and third shifts. -On 01/14/17 and 01/15/17, "no change" was documented on first, second, and third shifts. -On 01/16/17, there was documentation on first shift that Resident #3 was out of the facility at the hospital. Interview with the Executive Director (ED) and Administrator on 02/22/17 at 9:45am revealed: -On 01/16/17, Resident #3 drove himself to a local urgent care facility and was later transferred from the urgent care to the hospital that same day (01/16/17). -The ED was "surprised" when she received notification from the urgent care that Resident #3 would require hospital admission on 01/16/17. -Prior to that date (01/16/17), Resident #3 had not displayed any changes in his condition. -Resident #3 always coughed because he had COPD. Interview with the ED and Administrator on 02/24/17 at 12:00pm revealed: -Changes in patient status were supposed to be reported to the MA/Supervisor and documented on the shift report. -"Depending on severity," changes or complaints would be documented elsewhere such as the Nurse's Notes. -Staff should notify the resident's physician of "acute changes depending on the severity." Telephone interview with a Medical Assistant at Resident #3's physician's office on 02/24/17 at 9:00am revealed: -There was no documentation on file from the facility notifying the physician of Resident #3's	D 273		

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D 273	Continued From page 19 feeling weak, run down, or coughing in January 2017. -The last notification on file from the facility for any changes in Resident #3's condition was dated 11/22/16 when the facility notified the physician that Resident #3 had been admitted to the hospital. -The physician expected to be notified of any changes in Resident #3's status or condition. 2. Review of Resident #1's current FL-2 dated 06/28/16 revealed: -Diagnoses included dementia, Alzheimer's type, hypothyroidism, and hyperlipidemia. -The resident was constantly disoriented. Review of Resident #1's Resident Register revealed an admission date of 07/01/16. Review of an unsigned/untitled facility document identified by a Medication Aide (MA) as the forms used by the facility to notify and communicate with the physician for Resident #1 located in the resident record, dated 01/24/17 revealed: -The resident had lost 4 pounds. -The facility would like to give double portions, a 206 cookie three times per day (The manufacturer's instructions revealed a 206 cookie contained 200 calories and 6 grams of protein used for involuntary weight loss interventions). -A swallow evaluation was requested due to the resident starting to pocket food in his mouth. -The resident would be placed on weekly weights. -The section for the physician's signature and date was blank. Review of a copy of the untitled facility document dated 01/24/17 that was provided by the Executive Director (ED) on 02/24/17 for Resident #1 revealed:	D 273		

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D 273	Continued From page 20 -The form had 2 separate faxed dates and times with the name of the physician's practice and fax number dated 02/24/17 at 6:24 p.m., and a second on 01/24/17 at 5:04 p.m. located at the bottom of the form. -The form had a fax date and time with the facility's name and fax number dated 01/24/17 at 10:47 a.m. at the top of the form. -There was a handwritten entry signed by the physician's Registered Nurse (RN) dated 01/24/17 that she had spoken with the facility's Resident Care Coordinator (RCC) and the Special Care Unit Coordinator (SCUC) on 01/24/17 regarding the resident's diet and weight. -There was a separate handwritten entry by the physician's RN dated 01/24/17 that she had spoken with the RCC who was told to order a swallow evaluation. -The Physician had signed the faxed form with a date of 01/28/17. Interview with the SCUC on 02/24/17 at 11:35 a.m. revealed: -The RCC and the SCUC were responsible for follow up needs of the residents. -The SCUC received a call from the RN at the physician's office related to a swallow evaluation for Resident #1 in January 2017 but she transferred the call to the RCC. -All orders were received in writing and orders could also be received by a fax. -The RCC was not supposed to take a verbal order over the telephone. A telephone interview with the RCC on 02/24/16 at 2:45 p.m. revealed: -The RCC was a nurse. -The RCC did speak with the RN at the Physician's office in January 2017 regarding a swallow evaluation for Resident #1.	D 273		

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D 273	Continued From page 21 -The RCC did not receive a telephone order from the Physician's RN. -Typically, Resident #1's physician would not order anything until the physician evaluated the resident. -The RCC understood that the Physician would want a swallow evaluation before any changes were done for Resident #1. -An upcoming appointment was made for Resident #1 (April 2017), but the RCC had made several follow up calls to the physician's office in hopes Resident #1 could be evaluated earlier by the physician. -The facility received the signed order yesterday (02/23/17). -The RCC had called the physician's office yesterday to see if they had an original fax confirmation with the signed order however was told they did not have a received confirmation for the January 2017 order. -The facility had implemented a quality assurance program a few months ago related to weight loss and weight gain and Resident #1 was "at the top of the list". -It was against the facility's policy to accept telephone orders, unless it was an emergent situation. -If the order was received "we" would not have waited to get a swallow evaluation done for Resident #1. -The RCC may have documented the telephone conversation on her "old calendar" but did not document the conversation in Resident #1's record. Telephone interview with the Social Worker at the Physician's office on 02/24/17 at 3:11 p.m. revealed: -The Physician's RN was not there today. -The computer system showed that the	D 273		

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D 273	Continued From page 22 physician's office received a fax from the facility on 01/24/17. -There was documentation in Resident #1's charting notes at the physician's office that a verbal order was given to the RCC on 01/24/17. -The Physician's office was unaware that the facility had a policy against verbal orders and the facility should have made this known. -The physician had written a new speech evaluation to a home health agency since the original order given on 01/24/17 had expired. Review of a "Patient Message" titled "Swallow eval" from Resident #1's physician's office revealed: -The form was dated 01/24/17 at 4:02 p.m. -The RN had spoken with the RCC for the facility regarding the resident's weight. -The RCC reported to the RN that for the past 2 weeks the resident was pocketing food in his mouth and the staff had to manually remove the food. -Per the physician, a swallow evaluation may be done. The facility will order. Observation of Resident #1 during the supper meal on 02/21/17 at 5:01 p.m. revealed: -The resident was served a pureed meal. -The resident did not have any coughing or gagging during the meal. Observation of Resident #1 during the breakfast meal on 02/22/17 at 8:00 a.m. revealed: -The resident was served a pureed meal. -The resident did not have any coughing or gagging during the meal. Interview with the Administrator on 02/24/17 at 3:40 p.m. revealed: -The signed order was received yesterday for the	D 273		

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D 273	Continued From page 23 swallow evaluation. -The facility was not aware of the signed order for the swallow evaluation until 02/23/17. -The facility's policy did not allow staff to receive telephone orders. -The Administrator would have expected for the RCC to document any notes related to communication and follow up information regarding Resident #1. _____ The facility's failure to notify the physician of elevated blood sugars outside of the ordered parameters, non-compliance with oxygen use, and changes in condition to include complaints of weakness, coughing, and shortness of breath for Resident #3 who had a documented history of diabetes, COPD, respiratory failure, and dependence on supplemental oxygen resulted in substantial risk for serious physical harm. This non-compliance constitutes a TYPE A2 Violation. _____ Review of the facility's plan of protection dated 02/23/17 with an addendum dated 02/24/17 revealed: -Effective immediately, the facility would designate one person (the RCC or designee in the RCC's absence) to receive, review, direct the implementation, and monitor the compliance of all referrals and follow-ups for residents that experience a change of condition or behavior. -Staff observations and notes from the residents' charts and other notes related to the need for referrals and follow-ups would be reported to the RCC or designee for the determination of a proper course of action and to include communication with the health care provider as needed.	D 273		

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D 273	Continued From page 24 -The Executive Director would schedule training for all direct care staff designed to help the staff recognize changes in the condition and behaviors that warrant the referral and follow up process and the proper documentation process. -To ensure compliance and follow through of this change, the facility would designate the contracted nurse consultant to perform regular and recurring monthly chart audits (at least 5 charts monthly) starting 03/15/17. -Physician directed monitoring and reporting requirements would be listed on the MAR. The Medication Aides would document the performance of monitoring and documentation on the MAR (or other designated form). -Required notifications to health care providers would be performed and documented in the resident's chart by the Medication Aide. -Additional training for direct care staff related to physician directed monitoring and reporting requirements would be conducted by 03/15/17. THE CORRECTION DATE OF THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2017.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the Personal	D 283	D283 The Executive Director will schedule training for all staff to review feeding issues involving dementia residents. This practice will be implemented on or before April 10, 2017.	

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D 283	Continued From page 25 Care Aide (PCA) followed sanitation guidelines while providing feeding assistance for 2 residents (Resident #6, #7) who required assistance with eating in the Special Care Unit (SCU). The Findings are: Observation of the supper meal on 02/21/17 at 5:02 p.m. revealed: -Resident #6 was sitting at the end of the dining room table. -The PCA was sitting between Resident #6 and Resident #7. -The PCA was wearing gloves. -The PCA was feeding Resident #6. - While the PCA was feeding Resident #6, the PCA picked up a sandwich that Resident #7 had taken bites from, handed the sandwich back to Resident #7 and fed Resident #6 while wearing the soiled gloves. -At 5:06 p.m. the tomato soup spilled into the PCA's gloved hand from Resident #6's spoon, the PCA wiped the soup from the gloved hand with a napkin and with the same napkin, wiped Resident #6's mouth while wearing the same soiled gloves. -At 5:15 p.m., the PCA tore Resident #6's sandwich into smaller pieces while wearing the soiled gloves. -At 5:25 p.m. the PCA picked up Resident #6's beverage glass by the top of the glass while wearing the same soiled gloves and assisted Resident #6 to drink the beverage. -The PCA never changed the gloves she was wearing while assisting the 2 residents during the meal. -At 5:19 p.m. another PCA sat down at the table to assist Resident #7. -At 5:24 p.m. Resident #7 had completed her meal and left the table.	D 283 D283	Addendum Per telephone with Mr. Hugh Campbell on 05/10/17. The Executive Director and the Nurse Consultant provided the training related to feeding issues involving dementia residents that included education related to feeding techniques to avoid cross contamination. This staff training will be provided to staff annually and will be incorporated into infection control training for all hands on staff. This area will be monitored by the Special Care Unit Coordinator, the Resident Care Coordinator, Executive Director and the Dietary manager. The Special Care Unit Coordinator and the Dietary manager will physically monitor staff assisting residents during meals by observation daily and the Resident Care Coordinator and Executive Director will physically observe staff assisting residents during meals randomly to assure no issues are identified Hugh H. [illegible] RN	

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D 283	Continued From page 26 Interview with the PCA that assisted Resident #6 and Resident #7 with the supper meal on 02/21/17 at 5:37 p.m. revealed: -The PCA had worked at the facility for 2 years. -The PCA had received in-service training related to feeding assistance when she first started working at the facility. -The PCA was also trained by another worker in feeding assistance. -Usually she would not feed two residents at the same time, usually she fed only one resident at a time. -Resident #7 could usually feed herself but at times needed help to eat her meal. -The PCA did not have extra gloves in her pocket during the supper meal but always tried to keep extra gloves with her. - The PCA was trained to change gloves and wash her hands between residents. Interview with the Special Care Unit Coordinator (SCUC) on 02/22/17 at 5:45 p.m. revealed: -The PCA should not feed 2 residents at the same time. -The PCA should have changed gloves. -The Resident Care Coordinator (RCC) had trained staff in feeding assistance. Interview with the Executive Director (ED) on 02/21/17 at 6:20 p.m. revealed: -The facility had a in-service scheduled in February 2017 related to identifying feeding issues needed with dementia however the in-service had to be rescheduled. -The ED expected staff to always change gloves between resident care or anytime gloves become soiled.	D 283		

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D 306	Continued From page 27	D 306		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served to residents in the Assisted Living (AL) dining room for 2 of 2 meals observed. The findings are: Observation of the dinner meal in the AL dining room on 02/21/17 from 5:00pm-5:35pm revealed nineteen of nineteen residents were not served water. Interview with a resident on 02/21/17 at 5:28pm revealed: -Water was not usually served at meals, but was available and served on request. -If the resident had been served water on the table, the resident probably would have drank some of the water. Interview with a second resident on 02/21/17 at 5:33pm revealed: -Water was not routinely served at meals. -If the resident requested water, staff would bring water to the resident. Interview with the Dietary Manager (DM) on 02/21/17 at 5:25pm revealed:	D 306	D306 The dietary manager will communicate to all dietary that water is to be served to each resident at every meal. This practice will be implemented on or before April 10, 2017. This area will be monitored by the Special Care Unit Coordinator, Resident Care Coordinator, Executive Director and the Dietary manager. The Special Care Unit Coordinator and the Dietary Manager will physically observe meals daily and the Resident Care Coordinator and the Executive Director will physically observe meals randomly to assure water is served to each resident at each meal in addition to other beverages. Addendum Per telephone with Mr. Hugh Campbell on 05/02/17 D306	

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D 306	Continued From page 28 -Water was routinely served at meals in the Special Care Unit (SCU) but was not routinely served at meals in the AL dining room because the residents in AL were alert and oriented and could tell staff their choice of beverage. -Water was available on the counter at all meals in the AL dining room and served at the residents' request. -Staff asked residents what they wanted to drink; most residents did not like to drink water. Observation of the breakfast meal in the AL dining room on 02/22/17 from 8:11am-8:48am revealed: -Twenty one of twenty one residents were not served water. -There were two pitchers of water on the counter. -There were five staff serving food and beverages to residents to include one Dietary Aide, one Medication Aide/Nurse Aide, one Personal Care Aide, one Activity Director, and one Dietary Manager. -None of the residents were offered water by staff. Interview with the Administrator on 02/22/17 at 9:45am revealed he thought the facility was in compliance with the rule area if water was readily visible at meals and served to residents upon request.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 29 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure therapeutic diets were served to 2 of 4 residents sampled (#1, #3) with orders for mechanical soft diets. The findings are: 1. Review of Resident #1's current FL-2 dated 06/28/16 revealed: -Diagnoses included dementia, Alzheimer's type, hypothyroidism, and hyperlipidemia. -The resident was constantly disoriented. -There was an order for a mechanical soft, chopped diet. Observation of the supper meal on 02/21/17 at 5:01 p.m. revealed Resident #1 was served a pureed diet. Observation of the breakfast meal on 02/22/17 at 8:00 a.m. revealed Resident #1 was served a pureed diet. Review of the therapeutic diet "card" revealed Resident #1 was on a pureed diet with a milkshake for lunch and dinner, and a 206 cookie (The manufacturer's Instructions revealed a 206 cookie contained 200 calories and 6 grams of protein used for involuntary weight loss interventions) at 10:00 am, 2:00pm and 8:00 pm. Confidential interview with a staff member revealed Resident #1 was started on a pureed diet in January 2017. Review of a "Transport/MD Visit Form" dated	D 310	D310 The Resident Care Coordinator will review orders for therapeutic diets. A summary of all therapeutic diets will be maintained by the RCC. The RCC will provide a copy of the therapeutic diets to the dietary manager. The dietary manager will be responsible for serving meals that comply with the therapeutic diet orders. This practice will be implemented on or before April 10, 2017.	

D310 Addendum Per telephone with Mr. Hugh Campbell on 05/04/17.
The Resident Care Coordinator and the nurse consultant have reviewed all therapeutic diet orders to assure the Facility's diet list used by dietary matches the ordered diet.
The Administrator provided training to the dietary staff Related to all dietary changes must be ordered by the primary Care Provider.
The Resident Care Coordinator is responsible for providing all updated/changed diet orders to the Dietary manager
The nurse consultant will perform Chart audits (between 3-5 charts per week) to assure diet orders match the diet list

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D 310	Continued From page 30 12/12/16 revealed: -There was a handwritten entry on the right side of the form that was highlighted in yellow, "Appointment for weight loss, no changes" with initials "SC". -There was a handwritten entry beside the Resident #1's name "Follow up 04/13/17 at 11:00 a.m.". -There was a section labeled "Orders from the physician's visit" that was blank. -There was a section labeled "New diagnoses" that was blank. -The physician signed the form on 12/12/16. Review of an unsigned/untitled facility document identified by a Medication Aide (MA) as the forms used by the facility to notify and communicate with the physician for Resident #1 located in the resident record, dated 01/24/17 revealed: -The resident had lost 4 pounds. -The facility would like to give double portions, a 206 cookie three times per day. -A swallow evaluation was requested due to the resident pocketing food in his mouth. -The resident would be placed on weekly weights. -The section for the physician's signature and date was blank. Review of a copy of the untitled facility document identified by a MA as the forms used by the facility to notify and communicate with the physician dated 01/24/17 that was provided by the Executive Director (ED) on 02/24/17 for Resident #1 revealed: -The form had 2 separate faxed dates and times with the name of the physician's practice and fax number dated 02/24/17 at 6:24 p.m., and a second on 01/24/17 at 5:04 p.m. located at the bottom of the form. -The form had a fax date and time with the	D 310	The Special Care Unit Coordinator and the Dietary manager will observe the meals being served daily and the Resident Care Coordinator and the Executive Director will observe meals served randomly to assure therapeutic diets are served as ordered. Deb H. Hill	

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D 310	Continued From page 31 facility's name and fax number dated 01/24/17 at 10:47 a.m. at the top of the form. -There was documentation that Resident #1 had started on a pureed diet on 01/19/17 with double portions however this had been marked through with one line with documentation on the side that this information was given on the wrong patient from the RCC. -There was a separate entry signed by the physician's nurse dated 01/24/17 that documented the resident had not started a pureed diet yet. -There was a separate handwritten entry by the physician's RN dated 01/24/17 that she had spoken with the RCC who was told to order a swallow evaluation. -The Physician had signed the faxed form with a date of 01/28/17. Interview with the Administrator on 02/22/17 at 4:35 p.m. revealed: -The facility had initiated a quality improvement program monitoring weight loss for identified residents. -Resident #1 was included in the weight loss quality improvement. -Resident #1 had started to pocket food in this mouth. -Resident #1 had recently showed improvement and weight gain since the quality improvement interventions had been put into place including the pureed diet. -The Administrator would provide the quality improvement documentation regarding Resident #1 from January and February 2017. Review of a undated quality improvement documentation related to Resident #1 revealed: -The resident had a recent weight loss of 4 lbs. -The resident had lost 18 pounds since his	D 310		

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D 310	Continued From page 32 admission despite eating 100 % of meals and snacks. -The physician had been notified and saw the resident in the office with no interventions ordered. -The resident was diagnosed with hypothyroidism. -The physician would be notified again to seek interventions to stabilize his weight. -Additional interventions included: to call the physician and ask for an appointment, provide double portions of food at mealtime, 206 cookie will be provided three times per day, milk shake would be provided for lunch and dinner along with a meal, obtain an order for pureed food since the resident was pocketing food in his mouth, notify the physician of weights and follow up with weekly weights as well as in- house interventions, notify the family of weight and interventions planned and request for a physician appointment. Review of a second undated quality improvement program documentation related to Resident #1 revealed: -The resident had a 12 pound weight gain in one month. -Resident #1 was noted to pocket his food and his diet was downgraded to mechanical soft, the resident no longer pocketed his food. -The resident had an appointment scheduled with his physician in April 2017, no earlier appointment had been provided despite multiple requests. -Interventions included to provide double portions of food at mealtime, 206 cookie would be provided three times a day, milk shake would be provided for lunch and dinner along with his meal, obtain the order for pureed food to continue his diet and weekly weights. Interview with Resident #1's primary physician's	D 310		

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D 310	Continued From page 33 nurse on 02/24/17 at 9:30 a.m. revealed: -There was no order signed for a pureed diet. -The RCC was told to order a swallow evaluation for Resident #1 on 01/24/17. -The physician would not want Resident #1's diet changed until the swallow evaluation was done and until the physician evaluated him. Interview with the Administrator on 02/24/17 at 12:00 p.m. revealed: -The Administrator understood from the Dietary Manager that it was ok to "downgrade" a therapeutic diet from a mechanical diet to a pureed diet. -The signed untitled document identified as the form used to notify and communicate with the physician for Resident #1 dated on 01/24/17 was not received until 02/23/17. -The Administrator was not aware that a physician's order was needed to decrease Resident #1 from a mechanical soft diet to a pureed diet. - While Resident #1 was on a pureed diet with double portions, milkshakes twice a day and the 206 cookie three times per day the resident had shown a weight gain and no longer pocketed food in his mouth. -The facility would follow Resident #1's current physician order for a mechanical soft diet until the physician ordered a different therapeutic diet. 2. Review of Resident #3's current, hospital generated FL-2 dated 01/26/17 revealed diagnoses included pneumonia and schizophrenia. Review of the "Hospitalist Discharge Summary" for Resident #3 dated 01/26/17 revealed: -Resident #3 was hospitalized from 01/16/17-01/26/17.	D 310		

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D 310	Continued From page 34 -Discharge diagnoses included acute hypoxic respiratory failure, paroxysmal atrial fibrillation (PAF), non-sustained ventricular tachycardia (NSVT), dysphagia, diabetes mellitus, hypertension, and schizophrenia. -The "Discharge Plan of Care" orders included an order for cardiac and diabetic mechanical soft diet with thin liquids. -Resident #3's hospital discharge summary was electronically signed by the physician. Observation of Resident #3 during the breakfast meal on 02/22/17 from 8:37am-8:48am revealed: -Resident #3 was served scrambled eggs, sliced bacon, grits, a biscuit, sliced orange, and cereal. -Resident #3 did not exhibit any signs and symptoms of swallowing difficulty or choking while eating the meal. Review of the dietary card (facility dietary reference list) for Resident #3 on 02/22/17 at 8:19am revealed: -There were check marks on the card documenting Resident #3's diet as "Regular" and "no concentrated sweets (NCS)." -Mechanical soft was not documented as the texture for Resident #3's diet. Interview with the Dietary Manager (DM) on 02/22/16 from 8:19am-8:26am revealed: -Resident #3 was on a NCS diet. -There was only one resident who resided on the Assisted Living side of the facility that was on a mechanical soft diet (the DM named the resident, it was not Resident #3). -For mechanical soft diets, meats were cut finely or ground in the food processor and soft vegetables and starches were served. -The Medication Aides (MAs) brought copies of residents' diet orders to the DM.	D 310		

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D 310	Continued From page 35 -Upon receipt of the orders from the MAs, the DM was responsible for updating the diet list cards with each residents' ordered diet and making sure the resident was served their ordered diet. Interview with Resident #3 on 02/22/17 at 7:50am revealed: -He did not know what kind of diet he was on. -He "sometimes" coughed when he ate but did not have any swallowing difficulty. Interview with the Executive Director (ED) on 02/21/17 at 5:50pm revealed: -The facility's process for hospital discharge orders was to have the facility's contracted Registered Nurse (RN) Consultant, Assisted Living Manager, or Executive Director review all hospital discharge orders to assure the orders were implemented. -Resident #3 was currently on a regular diet because he had not been compliant with a diabetic (NCS) diet. Interview with the ED and Administrator on 02/22/17 at 9:45am revealed: -The ED and Administrator were unaware of any diet changes for Resident #2 since his last hospitalization and discharge (on 01/26/17). -Resident #3 was non-compliant with his diabetic (NCS) diet and was on a regular diet. -The ED and Administrator did not know why Resident #3 was seen by their contracted home health provider for speech therapy but had requested copies of the home health notes from the contracted provider. -Resident #3 made most of his own physician appointments and drove himself to most of his appointments. Telephone interview with a Speech Pathologist	D 310		

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D 310	Continued From page 36 (SP) from the facility's contracted home health provider on 02/22/17 at 1:10pm revealed: -Resident #3 was ordered a mechanical soft diet when he was discharged from the hospital (on 01/26/17). -The SP did not change Resident #3's diet orders when she provided him with speech therapy; Resident #3 should still be on the diet ordered on the hospital discharge (mechanical soft). -When visiting Resident #3 in the facility, the SP recalled Resident #3 was non-compliant with his diet order; The SP recalled Resident #3 ate a regular textured diet and went out to eat on his own and his friend brought him food that was not of mechanical soft texture. -The SP never observed Resident #3 have any swallowing problems on the regular diet texture. -Resident #3 did not have any dysphagia and was ordered the mechanical soft diet due to "pulmonary issues" which made him at risk for aspiration due to his coughing. -Resident #3 was alert and oriented and able to verbalize and demonstrate understanding of the education provided related to aspiration prevention; he met his goals and was discharged from speech therapy on 02/14/17. -Resident #3 was "an aspiration risk at any (diet) texture" due to his severe chronic obstructive pulmonary disease (COPD). Interview with the Administrator on 02/22/17 at 3:45pm revealed: -Resident #3's mechanical soft diet ordered on the hospital discharge on 01/26/17 was "missed" and was never implemented by the facility. -Physician and hospital discharge orders were supposed to be reviewed and implemented by the facility's contracted RN Consultant, Assisted Living Manager, or Executive Director. -Whoever was reviewing the orders was	D 310		

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D 310	Continued From page 37 supposed to give copies of diet orders to the Dietary Manager. -If the RN Consultant, Assisted Living Manager, or Executive Director missed a diet order, the DM could not implement the order because she did not get a copy of the order. -The Administrator expected hospital discharge orders to be implemented or clarified as needed by the RN Consultant, Assisted Living Manager, or Executive Director. Interview with the Administrator on 02/23/17 at 8:50am revealed: -The ED had made multiple attempts to contact Resident #3's physician by telephone on 02/21/17, 02/22/17, and again earlier that morning (02/23/17); the physician had not returned any of the telephone calls. -Resident #3 had an appointment with his physician that day (02/23/17) at 12:30pm which he would transport himself to. -The ED would send notification with Resident #3 to his physician's appointment that day (02/23/17) requesting clarification of his diet order. Review of an undated document on facility letter head identified by the Administratpr as a note for Resident #3 to take to his physician during his appointment on 02/23/17 revealed: -Resident #3 "had a (sic) order for a modified diet (mechanical soft). He has been eating a regular diet at [facility name] and obtaining food from outside vendors (restaurants). Can [Resident #3's name] have an order to resume his normal diet?" -"Thank you! [Executive Director's name]." -The ED requested the physician call the facility. Review of the physician orders for Resident #3 dated 02/23/17 revealed there was an order which read "change diet to regular."	D 310		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify treatment orders for oxygen use for 1 of 5 residents sampled (#4). The findings are: Review of Resident #4's FL-2 dated 10/20/16 revealed: -Diagnoses included fetal alcohol syndrome with mild mental retardation, dilated cardiomyopathy, chronic systolic heart failure, and atrial fibrillation. -There was no order for oxygen use. Review of Resident #4's Resident Register revealed an admission date of 09/30/15. Observation of Resident #4 on 02/21/17 10:38am revealed: -He was sitting upright in his bed in his room.	D 344	D344 Oxygen related orders will be added to the MAR (medication administration record) and tracked daily by requiring the Med Techs to initial and document observation of compliance or variation from stated order(s) for oxygen usage. This practice will be implemented on or before April 10, 2017. D344 Addendum Per telephone with Mr. Hugh Campbell on 05/02/17. All Residents requiring Oxygen have been identified, orders reviewed and added to the Medication Administration record Any oxygen orders needing Clarification have been submitted to the primary care provider and received. This area is monitored through random chart audits by the Resident Care coordinator and the Nurse consultant weekly (3-5 charts per week) Oxygen orders are currently added to the MAR by The RCC and SCUC (Resident Care Coordinator and the Special Care Unit Coordinator) RN	

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D 344	Continued From page 39 -He was wearing oxygen by nasal cannula (NC); the oxygen concentrator was set to deliver oxygen at 3.5 LPM. -He removed the NC tubing/oxygen; the tubing fell to the floor. -His breathing was even and unlabored. Interview with Resident #4 on 02/21/17 at 10:30am revealed: -He wore oxygen whenever he needed it. -He was not supposed to wear the oxygen all of the time; he was supposed to wear it every night. -It should be "between 3 and 31/2" LPM. -He did not know how long he had worn oxygen. Interview with Resident #4 on 02/21/17 at 4:48pm revealed staff does not help him with his oxygen as resident was able to put it on himself. Review of the physician orders for Resident #4 revealed: -An order dated 10/12/12 for oxygen, 2 LPM (liters per minute), 8 hours per day. -A certificate of medical necessity, dated 01/24/14, for portable oxygen, 2 liters, 8 hours during sleep with an initial certificate date of 10/12/12. -There were no other oxygen orders found for Resident #4. Interview with Executive Director (ED) on 02/21/17 at 5:00 p.m. revealed: -Resident #4 has had oxygen since he was admitted to the facility in 2015. -Resident #4 wore oxygen when he took a nap and at night. Interview with ED on 02/21/17 at 5:50pm revealed: -The ED thought Resident #4's oxygen should be	D 344		

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D 344	Continued From page 40 at 2 LPM. -He had not had any changes to the oxygen since admission. Record review of the Licensed Health Professional Support (LHPS) evaluations for Resident #4 revealed oxygen administration and monitoring was not listed on the LHPS evaluations dated 10/21/15, 12/16/15, 03/10/16, 06/02/16, 09/08/16, and 12/08/16. Interview with Resident #4's Primary Care Provider (PCP) on 02/22/17 at 10:12am revealed: -The PCP took over Resident #4's care two months ago. -PCP was not aware that Resident #4 was on oxygen. -Resident #4 must not use it continuously. -The oxygen must have come with Resident #4 from his previous primary care provider. Interview with Assisted Living Manager on 02/23/17 at 3:25pm revealed: -Resident #4 wore oxygen at night. -Staff would check it nightly to assure it was on 2 liters because the resident will play with it sometimes. Observation and interview of Resident #4 on 02/23/17 at 3:48pm revealed: -He was laying on the bed with his oxygen on at 3.5 LPM. -Resident said he got winded, put on his oxygen, and turned the knob to adjust the level. Interview with a Nursing Assistant (NA) on 02/23/17 at 3:55pm revealed: -The NA worked 3:00p.m-11:00pm. -Resident #4 wore his oxygen at night. -The NA did not monitor Resident #4's oxygen	D 344		

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D 344	Continued From page 41 and does not know how many liters Resident #4 received because he put the oxygen on himself. A second review of the physician orders for Resident #4 revealed a clarification order dated 02/23/17 for oxygen, 2 LPM at bed time, and as needed for shortness of breath. Interview with the Administrator on 02/22/16 at 3:45pm revealed: -Physician and hospital discharge orders were supposed to be reviewed and implemented by the facility's contracted RN Consultant, Assisted Living Manager, or Executive Director. -The Administrator expected orders to be implemented or clarified as needed by the RN Consultant, Assisted Living Manager, or Executive Director. -The facility did not currently have a system in place to monitor residents' use of oxygen. -The facility would implement a system for monitoring residents' oxygen. .	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 42 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to administer medication as ordered to 1 of 5 residents sampled (#4) for a blood thinner medication which was not held according to the prescribing practitioner's orders prior to a cardiac catheterization. The findings are: Review of Resident #4's current FL-2 dated 10/20/16 revealed diagnoses included fetal alcohol syndrome with mild mental retardation, dilated cardiomyopathy, chronic systolic heart failure, and atrial fibrillation. Review of Resident #4's Resident Register revealed an admission date of 09/30/15. Record review of a physician order for Resident #4 dated 11/28/16 revealed: -The new diagnosis was documented as abnormal stress test. -There was an order for Eliquis 5 mg by mouth twice daily. (Eliquis is used to prevent blood clots due to irregular heartbeats. Eliquis affects your blood clotting proteins, therefore, it can cause serious bleeding). -"Hold Eliquis starting 12/06/16, patient scheduled for cardiac catheterization on 12/08/16 at 9:00am" at the local hospital. Interviews with a Medication Aide (MA) on 02/22/17 at 8:50am and 2/24/17 at 2:00pm revealed: -The MA could not recall any specific medication orders from December 2016 for Resident #4. -When a medication was held (not given), the MA	D 358	D358 The Resident Care Coordinator (or designee in RCC's absence) will be responsible for reviewing orders before placing in residents' chart. Additionally, the RCC will be responsible for transferring relevant information to other sections of the chart (i.e. Medication Administration Record). This practice will be implemented on or before April 10, 2017. D358 Addendum per telephone with Mr. Hugh Campbell on 05/02/17 The Nurse Consultant will Perform Chart audits (between 3-5 charts per week) to assure all medications are administered to residents as ordered.	

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D 358	Continued From page 43 would document the appropriate charting code for not giving the medication on the front of the MAR, and indicate the reason in the nurse's notes on the back of the MAR. Review of December 2016 Medication Record (MAR) for Resident #4 revealed: -An entry for Eliquis 5 mg, 1 tablet by mouth twice daily, to be administered at 8:00am and 8:00pm. -Documentation indicated Resident #4 was on leave of absence from the facility for doses scheduled on 12/06/16 at 8:00am and 8:00pm, 12/07/16 at 8:00am, and 12/8/16 at 8:00am. -Documentation of medication aide's initials indicating Eliquis was given to Resident #4 on 12/07/16 at 8:00pm. -No notes were documented on the back of the MAR about the Eliquis being held beginning 12/06/16. Interview with a second MA on 02/24/17 at 3:40pm revealed: -The MA's acknowledged documentation of her initials on Resident #4's December MAR on 12/07/16 at 8:00pm indicating that Resident #4 received his Eliquis medication. -The MA would have circled her initials if the medication had been held. Review of "Drugs Released to The Patient" form for Resident #4 dated 12/05/16 revealed: -Seventeen tablets of Eliquis 5 mg was released with Resident #4 on 12/05/16. -Eliquis medication was returned to the facility on 12/7/16 at 2:15pm, but number returned was not indicated. Interview with Resident #4's family member on 02/24/17 at 10:06 am revealed: -Resident #4 was out of the facility on 12/05/16 - 12/07/16 visiting with family.	D 358		

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D 358	Continued From page 44 -Resident #4's medication was released with him. -Resident #4's family member did not remember if the facility gave instructions to hold Resident #4's Eliquis beginning 12/06/16. -The family member was present for Resident #4's heart catheterization procedure (on 12/08/16) and was not aware of any problems during the procedure. Review of the hospital discharge summary for Resident #4 dated 12/08/16 revealed: -Resident #4 had a left heart catheterization on 12/08/16. -Resident #4 was to resume medications as prescribed by the doctor. Interview with a Registered Nurse (RN) at Resident #4's physician's office on 2/22/17 at 10:38 am revealed: -Resident #4 was seen on 12/08/16 for a cardiac catheterization procedure. -During a catheterization procedure, the artery was punctured, creating a tendency for bleeding; therefore, if a patient was taking an anticoagulant medication such as Eliquis, it would be stopped prior to the catheterization and restarted after the catheterization. -In preparation for Resident #4's catheterization, the physician ordered Resident #4's Eliquis medication held on 12/06/16, as it takes two days for the effects of the medication to get out of the system. -Resident #4 was to resume the Eliquis medication after the catheterization (the night of 12/08/17). -The physician was not informed by the facility that Resident #4's Eliquis was not held for two days prior to the procedure and went forward with the cardiac catheterization procedure on 12/08/16.	D 358		

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D 358	Continued From page 45 -Although the physician had to press and hold the area for a longer period of time, the procedure went well for Resident #4. Interview with the Administrator on 02/22/17 at 3:45pm revealed: -Physician and hospital discharge orders were supposed to be reviewed and implemented by the facility's contracted RN Consultant, Assisted Living Manager, or Executive Director (ED). -The Administrator expected orders to be implemented or clarified as needed by the RN Consultant, Assisted Living Manager, or ED. The facility's failure to hold Resident #4's Eliquis in compliance with the physician's order prior to his scheduled cardiac catheterization resulted in pressure having to be applied to the catheterization site for a time frame that was longer than usual and put Resident #4 at an increased risk for bleeding during and after the catheterization. This non-compliance was detrimental to the safety and welfare of the resident which constitutes a TYPE B violation. A Plan of Protection was requested from the Administrator on 03/14/17. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2017.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those	D 378		

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D 378	Continued From page 46 requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. Observation of the Medication Aide (MA) on duty in the Assisted Living (AL) section of the facility on 2/24/17 at 9:59am revealed the MA was outside at the smoking area. Observation of the Assisted Living medication storage room on 02/24/17 at 10:10am revealed: -The door was cracked open. -The MA or other staff were not present to monitor/supervise the unlocked medication room. -On top of the medication cart within the unlocked medication room were 22 blister packs of medications, several tubes of creams, and a bottle of liquid medication. -A resident was sitting in a wheelchair across the hall of unlocked medication room. Interview with the MA on duty in the AL section on 02/24/17 at 10:22am revealed: -The MA was just coming back from morning break. -Facility breaks were usually 10-15 minutes. -The MA was not aware the medication room was unlocked. -The MA thought the medication room was locked prior to going on break.	D 378	D378 The Medication Storage room traditional door knob has been replaced with a key pad door knob. Med Techs have been instructed to leave door closed unless the medication storage room is in use. This practice will be implemented on or before April 10, 2017. D378 Addendum Per telephone With Mr. Hugh Campbell On 05/02/17 The Administrator and the Executive Director will physically monitor the medication storage rooms to assure medications are stored under locked Security while not under direct supervision of Staff daily. Hugh B. Campbell	

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D 378	Continued From page 47 -The medication room should always be locked if the MA was not close by and able to see the medication room. Interview with Administrator on 2/24/17 at 10:30am revealed the medication room should always be locked or under supervision.	D 378		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to update a resident's profile to reflect the resident's current activities of daily living needs related to transferring.	D 464	D464 The Resident Care Coordinator will review all Plans of Care for Special Care Unit residents to ensure all POC are reviewed and updated as necessary at least quarterly. This practice will be implemented on or before April 10, 2017. D464 Addendum Per telephone with mr. Hugh Campbell on 05/02/17. The Special Care Unit Coordinator will be responsible to review/update the residents Profile/Care plan as needed and quarterly to assure the residents needs are reflected related to the residents current activities of daily living needs. The Resident Care Coordinator will be responsible to monitor this area at least quarterly.	

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D 464	Continued From page 48 ambulation, and ability to feed self and failed to update the profile quarterly for 1 of 2 residents (#1) sampled in the Special Care Unit (SCU). The findings are: Review of Resident #1's current FL-2 dated 06/28/16 revealed: -Diagnoses included dementia, Alzheimer's type, hypothyroidism, and hyperlipidemia. -The resident was constantly disoriented. -The resident was a wanderer and ambulatory. Review of Resident #1's Resident Register revealed an admission date of 07/01/16. Review of Resident #1's Resident Care Plan / Profile dated 07/01/16 revealed: -The resident required total assistance with bathing, dressing and toileting. -The resident's ambulation needs listed the resident as "self" for performance. Review of Resident #1's "Resident Profile / Care Plan 90- Day Review" revealed: -The SCUC had reviewed the profile and plan on 10/01/16. -The profile and care plan was current and accurate and reflected the status on the care plan dated 07/01/16. -The profile had not been updated or signed off by the SCUC since 10/01/16. Review of Resident #1's Pre-Admission Screening Assessment dated 06/29/16 revealed: -Dining Assistance required did not have a checked box for independent, needs physical assistance with eating, supervision, need for prompting for eating or reminders for meals. -The resident required total assistance in routine	D 464		

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D 464	Continued From page 49 medical needs, nursing tasks and physician appointments. Review of Resident #1's "ADL Service Plan" with an assessment date of 07/01/16 revealed: -The physician had signed and dated the plan on 09/07/16. -The resident required "set up and supervision" assistance to transfer to and from the bed and to and from the chair. -The resident required limited assistance to ambulate from room to room. -The resident required limited assistance with feeding. -The resident required limited assistance with utensil usage. Observation and interview with Resident #1 during the initial tour in the Special Care Unit (SCU) on 02/21/17 at 11:00 a.m. revealed the resident was not interviewable. Interview with the Special Care Unit Coordinator (SCUC) on 02/21/17 at 11:00 a.m. revealed: -There were no total care residents in the Special Care Unit (SCU). -Resident #1 required assistance with eating. -Resident #1 required assistance from 2 staff members to transfer. Interview with a Personal Care Aide (PCA) on 02/21/17 at 5:24 p.m. revealed: -Resident #1 required two people to transfer. -Resident #1 could not walk. Observation of Resident #1 in the SCU during the supper meal on 02/21/17 at 5:01 p.m. revealed: -2 staff members transferred Resident #1 from the recliner to a wheelchair by providing a 2 person total lift.	D 464		

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CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 464	Continued From page 50 -A staff member wheeled Resident #1 into the dining room for supper. -Resident #1 required total assistance from staff to eat supper. Observation in the SCU on 02/22/17 at 8:06 a.m. revealed: -Resident #1 was sitting in a leather recliner in a reclined position in the corner of the living room with other residents and staff present. -Resident #1 required total assistance from staff to eat his breakfast and drink his beverages. -Resident #1 ate 100% of his meal. Interview with the SCUC on 02/22/17 at 9:15 a.m. revealed: -Resident #1 was able to walk when he initially came to the facility in July 2016. -She was not sure if Resident #1's plan of care included interventions related to his fall risk, potential for slipping out of a chair and scooting when seated. Interview with the Executive Director (ED) on 02/22/17 at 12:55 p.m. revealed Resident #1 was admitted to the facility around August 2016 and did not walk much but had received physical therapy and could walk about 20 feet at that time. Telephone interview with Resident #1's family member on 02/22/17 at 7:35 p.m. revealed: -The resident had a history of falling prior to coming to this facility. -The resident had some "pretty serious" falls shortly after he was admitted. -The resident had declined in his ability to ambulate rapidly but understood it may be related to his diagnoses of late stages of Alzheimer's dementia. -When he was initially admitted the resident was	D 464		

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D 464	Continued From page 51 "very motivated to walk around". -When the family member visited he was usually in his bed. -The resident was interested in people and liked to look around. Interview with a Nursing Assistant (NA) on 02/23/17 at 8:30 a.m. revealed: -Resident #1 could stand and walk with someone beside him in August of 2016. -Resident #1 had not stood up and walked in months. -Resident #1 had a good appetite but had to be fed. Interview with the Executive Director on 02/23/17 at 12:50 p.m. revealed: -The residents' plan of care was generated from the residents' assessment findings. -The assessment generates the activities of daily living ADL service plan. -Direct care staff document residents care provided on a task documentation work sheet that is generated from the ADL service plan. -The Resident Care Coordinator and the ED were responsible to provide the task documentation work sheet to direct care staff members. Review of Resident #1's Task Documentation Work Sheet for the beginning week of 02/10/17 revealed: -The resident required assistance from staff with transferring to and from the bed or chair by set up and supervision only. -The resident required limited assistance from staff to ambulate from room to room. -The resident required limited assistance from staff with feeding needs. -The resident required limited assistance from staff with utensil usage during a meal.	D 464		

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D 464	Continued From page 52 -There were staff initials entered each day for 1st, 2nd and 3rd shifts except 3rd shift for transferring to and from the bed and chair on 02/13/17 through 02/16/17. Interview with a NA on 02/24/17 at 8:45 a.m. revealed: -When a resident experienced any changes from their normal baseline staff were to immediately report that change to the SCUC, RCC or the Medication Aide (MA). -The NA was unsure when Resident #1's ADL needs changed in mobility and eating. -All residents task sheets should match the needs of the residents but if the needs of the resident did not match, it should be documented in the note section of the Task documentation work sheets or care notes then reported to the SCUC or the MA so the plan can be changed. -The NA had not noticed that Resident #1's task documentation work sheet did not match his current mobility and eating needs. Interview with the SCUC on 02/24/17 at 11:28 a.m. revealed: -Resident #1 had declined slowly over the months and began to require more hands on care in eating and mobility. -Direct care staff were required to notify the MA or the SCUC when changes were noted in the residents' ADL's. -The SCUC was responsible to review the Resident Profiles/ Care Plan every quarter for the residents in the SCU. -The ED was responsible to get any changes or updates done for the residents, then the ED faxes those changes to the physician for signature. -The SCUC kept a list with dates and names when the Resident Profiles / Care Plans were due.	D 464		

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D 464	Continued From page 53 -The SCUC must have missed Resident #1's review in January 2017. Telephone interview with the Resident Care Coordinator on 02/24/17 at 2:45 p.m. revealed: -Resident #1 came from another facility. -Resident #1 was debilitated with advanced dementia on admission. Interview with the ED on 02/23/17 at 4:45 p.m. revealed: -All ADL Service Plans should match the residents ADL needs. -They had updated Resident #1's service plan and faxed the plan to the physician for approval and signature. Interview with a nurse at Resident #1's physician office on 02/24/17 at 9:30 a.m. revealed the physician would have expected to be notified when a change occurred in the residents ability to perform an ADL, the physician expected to be notified about everything.	D 464		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;	D 482	D482 Executive Director will schedule training for all staff to review the rules and requirements for restraint use. This training will occur on or before April 10, 2017. D482 Addendum Per Telephone with Mr. Hugh Campbell on 05/02/17	

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D 482	Continued From page 54 (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interviews and record	D 482	Staff education was provided by the facility's Nurse Consultant. Staff will receive education related to rules and requirements for restraint use during orientation for all newly hired staff and ~~annually~~ PRN during annual staff trainings. The Executive Director and the Resident Care Coordinator will be responsible to monitor this area by Physical Observations during walk throughs daily.	

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D 482	Continued From page 55 review, the facility failed to assure 1 of 5 residents sampled (#1) was free from physical restraints as evidence by placing a resident in a reclining chair with a stool placed under the foot rest of the recliner that restricted the resident's movement. The findings are: Review of Resident #1's current FL-2 dated 06/28/16 revealed: -Diagnoses included dementia, Alzheimer's type, hypothyroidism, and hyperlipidemia. -The resident was constantly disoriented. -The resident was a wanderer and ambulatory. Review of Resident #1's Resident Register revealed an admission date of 07/01/16. Review of Resident #1's assessment and care plan dated 07/06/16 revealed: -The resident required total assistance with bathing, dressing and toileting needs. -The resident's ambulation needs listed as "self" under the performance level. -There were no interventions listed to address the resident's safety needs when seated in a chair. Review of Resident #1's "Resident Profile / Care Plan 90- Day Review" revealed: -The SCUC had reviewed the profile and plan on 10/01/16. -The profile and care plan was current and accurate and reflected the status on the care plan dated 07/01/16. -The profile had not been updated or signed off by the SCUC since 10/01/16. Observation and interview with Resident #1 during the initial tour in the Special Care Unit (SCU) on 02/21/17 at 11:00 a.m. revealed:	D 482		

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D 482	Continued From page 56 -The resident was sitting in a leather recliner in a reclined position in the corner of the living room with other residents and staff present. -The foot rest of the recliner had a round foot stool underneath. -Attempted interview with the resident revealed the resident was not interviewable. Observation in the SCU on 02/21/17 at 5:01 p.m. revealed: -Resident #1 was sitting in the same leather recliner in a reclined position in the corner of the living room with other residents and staff present. -2 staff members transferred Resident #2 from the recliner to a wheelchair by providing a 2 person total lift. -A staff member wheeled Resident #1 into the dining room for supper. Interview with a Personal Care Aide (PCA) on 02/21/17 at 5:24 p.m. revealed: -Resident #1 required a two person transfer. -Resident #1 could not walk. Observation in the SCU on 02/22/17 at 8:06 a.m. revealed: -Resident #1 was sitting in the same leather recliner in a reclined position in the corner of the living room with other residents and staff present. -The foot rest of the recliner had a round foot stool underneath. -Resident #1 ate his breakfast with the back of the recliner in an upright seated position. -Resident #1 required total assistance by a staff member to eat breakfast. Interview with the Nursing Assistant (NA) that fed Resident #1 breakfast on 02/22/17 at 8:15 a.m. revealed: -The recliner was Resident #1's personal chair.	D 482		

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D 482	Continued From page 57 -Resident #1 enjoyed sitting in the chair. -The foot stool underneath the foot portion of the chair, holds the chair in a reclined position. -The reclined position of the chair prevented Resident #1 from scooting, "When he scoots he will move the whole chair and he would be out of the chair". -Staff kept the stool underneath the foot rest to protect Resident #1's safety so he would not get up, try to walk and fall. Observation of Resident #1 in the living room of the SCU on 02/22/17 at 8:20 a.m. revealed: -Resident #1 was rocking back and forth, reaching for a side table while sitting in a reclined position in the chair. -Resident #1 would occasionally use his hand to pound and rock a nearby side table. -Resident #1 would occasionally hit himself on the head with his hand. -A staff person gave Resident #1 a sock to hold and the resident stopped pounding on the table and hitting himself with his hand. Review of Resident #1's Pre-Admission Screening Assessment dated 06/29/16 revealed the resident had compulsive behaviors that included hitting his head. Interview with a Personal Care Aide (PCA) /Medication Aide (MA) on 02/22/17 at 9:06 a.m. revealed: -Resident #1 would lean to the front of the chair when the foot rest was down and the chair would go with him. -Resident #1 would "scoot" in the chair when the recliner's foot rest was down. -Resident #1 had a wheelchair but he would slide out of it. -Resident #1 liked to sit in a "fetal position".	D 482		

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D 482	Continued From page 58 -Staff had to keep the foot stool underneath the recliner's foot rest all the time when Resident #1 sat in the chair so he would not fall, "That's his favorite chair". Interview with the SCUC on 02/22/17 at 9:15 a.m. revealed: -When Resident #1 sat in the recliner he would "scoot" the recliner all over the building. -The foot stool was placed underneath the recliner's foot rest to keep him safe. -Resident #1 could sit in a wheelchair but had a tendency to slip out. -She was unsure if the physician was aware of Resident #1's "scooting" and the need to keep a foot stool underneath the recliner's foot rest. -She was not sure if Resident #1's plan of care included interventions related to his fall risk, potential for slipping out of a chair and scooting when he was seated. Interview with the Executive Director (ED) and the Administrator on 02/22/17 at 10:25 a.m. revealed: -Staff were told by Resident #1's family member that he was a "recliner man". -The recliner was never intended to be a restraint for Resident #1. -The foot stool under the foot rest would be removed immediately. -The Administrator and the Executive Director would work on a plan for Resident #1. Interview with the ED and the Administrator on 02/22/17 at 12:55 p.m. revealed: -The leather recliner did not belong to Resident #1. -A family member had informed the ED that Resident #1 liked to sit in a recliner. -The foot stool underneath the recliner's foot rest was placed to prevent Resident #1 from scooting.	D 482		

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D 482	Continued From page 59 -Resident #1 had scooted so much he had broken the right side of the chair. -If Resident #1 sat on the loveseat in the SCU, he scoots, if he sat in the chair without the foot stool he scoots. -The ED was not sure if Resident #1's physician was aware of him scooting when he was in a seated position. -Resident #1 was removed from the propped recliner that morning and was now in a wheelchair. -The Administrator understood that the chair propped with a foot stool was considered a restraint however the staff did not see it as one. Telephone interview with Resident #1's family member on 02/22/17 at 7:35 p.m. revealed: -The resident had a history of falling prior to coming to this facility. -The resident had some "pretty serious" falls shortly after he was admitted. -The family member was contacted by the facility this week and was told that the facility chair the resident sat in was broken and the facility had contacted the physician to replace the chair for the resident. -When the family member visited he was usually in his bed. -The resident was interested in people and liked to look around. Observation of the leather recliner in the living room of the SCU on 02/24/17 at 8:45 a.m. revealed another resident was sitting in the leather recliner without the foot rest extended. A second interview with the NA that assisted Resident #1 to eat breakfast on 02/22/17 on 02/24/17 at 8:45 a.m. revealed: -Resident #1 started sitting in the leather recliner	D 482		

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D 482	Continued From page 60 with the foot propped with a foot stool about a month ago. -The chair broke and would wobble when Resident #1 sat forward. -Other residents in the SCU used the chair now. Interview with the SCUC on 02/23/17 at 9:20 a.m. revealed: -The foot rests on Resident #1's wheelchair had been removed to prevent him from scooting out of the wheelchair and hurting himself on the foot rests. -A device to monitor his attempts to rise from a chair or bed was never implemented for Resident #1. -Since Resident #1 had a history of falls a matt had been ordered and placed by the resident's bed. A telephone interview with a nurse from Resident #1's physician office on 02/24/17 at 9:30 a.m. revealed: -There were no notes in the chart related to the resident needing interventions for scooting while in a seated position. -The physician would not agree to a propped up chair for Resident #1. The facility's failure not to implement a least restrictive alternative in the care process of the resident to allow free movement and not consulting with the physician resulted in limiting the free movement of a resident who was placed in a reclining chair propped with a foot stool. The failure of the facility impacted the well-being of the resident, which constitutes a Type B Violation. Review of a Plan of Protection dated 02/22/17 revealed: -The foot stool placement under the foot rest	D 482		

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D 482	Continued From page 61 would be immediately eliminated. -The resident may continue to use the reclining chair, but only if the stool was not placed under the foot rest. -Resident #1's physician was contacted and an order for a remote controlled chair was requested to assist the resident with transferring, sitting and standing. -The facility would request clarification / restriction on the utilization of a remote controlled chair. -To ensure that unauthorized restraints were not used in the future, the facility sought to educate staff about the rules regarding restraints. -Today at approximately 2:00 p.m. the Administrator reviewed with the Executive Director (ED), the Resident Care Coordinator (RCC), and the Special Care Unit Coordinator (SCUC), the definition of a physical restraint and also gave several examples of what constitutes a restraint and reviewed rules and regulations for HAL (Housing for Assisted Living) facilities use of restraints. -The facility would schedule a continuing education unit on restraints for all staff- currently no commitment for a date however the facility hoped to schedule within the next 90 days. THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2017.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 62 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident received care and services which are adequate, appropriate, and in compliance with rules and regulations related to health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to notify the physician of the acute and chronic health care needs of 2 of 5 residents sampled (#1, #3) as evidenced failing to notify the physician of elevated finger stick blood sugar results outside of the ordered parameters (results ranging from 364-532) for a diabetic resident (#3) for 9 of 13 opportunities in February 2017; failing to monitor and notify the physician of non-compliance with continuous oxygen therapy (#3); failing to notify the physician for acute changes in a resident's condition and complaints of weakness, shortness of breath, coughing, and not feeling well for several days (#3); and failing to schedule a speech consult for a resident known to pocket food in his mouth while eating (#1). [Refer to Tag D0273 10A NCAC 13F .0902(b) (Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to administer medication as ordered to 1 of 5 residents sampled (#4) for a blood thinner medication which was not held according to the prescribing practitioner's orders prior to a cardiac catheterization. [Refer to Tag D0358 10A NCAC 13F .1004(a) (Type B Violation)].	D912	D912 Executive Director will schedule training for all staff to review and explain the Declaration of Resident's Rights. Specific responses to the issues raised included above. This practice will be implemented on or before April 10, 2017.	

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D915	Continued From page 63	D915		
D915	G.S. 131D-21(5) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 5. Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right except in emergencies, to be free from a chemical and physical restraints unless authorized for a specified period of time by a physician according to clear and indicated medical need as related to the use of physical restraints and alternatives. The findings are: Based on observation, interviews and record review, the facility failed to assure 1 of 5 residents sampled (#1) was free from physical restraints as evidence by placing a resident in a reclining chair with a stool placed under the foot rest of the recliner that restricted the resident's movement. [Refer to Tag D0482 10A NCAC 13F .1501 (Type B Violation)].	D915	D915 Executive Director will schedule training for all staff to review and explain the Declaration of Resident's Rights. Specific responses to the issues raised included above. This practice will be implemented on or before April 10, 2017.	
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065035	A. BUILDING: _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	4200 JASMINE COVE WAY WILMINGTON, NC 28412

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D934	Continued From page 64 home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 6 staff sampled (Staff B) completed the state mandated infection control training annually. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired 05/07/15 as a Medication Aide (MA)/Nurse Assistant (NA). -There was documentation that Staff B completed the state mandated infection control training on 05/12/15. -There was no other documentation of Staff B completing any additional infection control training in 2016. Interview with Staff B on 02/24/17 at 11:10am revealed: -She was hired about two years ago as a Medication Aide. -She had completed the infection control training course; she thought she last completed infection control training "a few months" after she began working at the facility. -Staff B had not had any other infection control training since she was hired.	D934	D934 Executive Director will schedule infection control training for existing employees at least every six months. The ED will be responsible for ensuring that existing employees receive/attend the training at least annually. This practice will be implemented on or before April 10, 2017.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D934	Continued From page 65 Interview with the Executive Director (ED) and Administrator on 02/24/17 at 3:48pm revealed: -Documentation of staff training and credentials was maintained in each staff's personnel record. -The ED was responsible for staff training and credentials. -The ED maintained a spreadsheet to track infection control training. -Infection control training was offered multiple times each year at the facility; staff were expected to complete infection control training annually.	D934		