| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and a complaint investigation on June 20-22, 2017. | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on record reviews and interviews the facility failed to follow up with a primary care provider after three emergency room visit post a fall for 1 of 5 sampled residents (Resident #2).<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 09/07/16 revealed diagnoses Dementia, history of hyperlipidemia, depression, and supra ventricular rhythm.<br><br>Review of Resident #2's Resident Register revealed he was admitted to the facility on 09/08/16.<br><br>Review of the facility incident report dated 05/06/17 revealed:<br>-Resident #2 was found lying on his back in the bathroom.<br>-The resident had a chin laceration.<br>-Resident #2 was sent to the emergency room for evaluation. | D 273 | | |

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| D 273 | Continued From page 1<br>-The resident's family was notified on 05/06/17 at 5:45 PM and a message was left.<br>-The resident's primary care provider was notified on 05/06/17 at 5:50 PM and a message was left.<br><br>Review of the hospital discharge paperwork dated 05/07/17 revealed:<br>-Resident #2 had been treated for a fall and a facial laceration.<br>-Discharge instructions included to follow up with primary care provider within 3 days on 05/10/17.<br><br>Review of Resident #2's progress/care notes revealed there was no documentation that he had followed up with his primary care provider.<br><br>Review of the facility incident report dated 05/22/17 revealed:<br>-Resident #2 was found lying on the floor beside a chair in his bedroom.<br>-The resident had a skin tear and some bruising on his left forearm.<br>-Resident #2 was sent to the emergency room for evaluation.<br>-The resident's family was notified on 05/22/17 at 10:55 AM and a message was left.<br>-The resident's primary care provider was notified on 05/22/17 at 4:41 PM and a message was left.<br><br>Review of the hospital discharge paperwork dated 05/22/17 revealed:<br>-Resident #2 had been treated for an accidental fall and an acute lower UTI, and advanced Dementia.<br>-Discharge instructions included to follow up with primary care provider within 2-3 days.<br><br>Review of Resident #2's progress/care notes revealed there was no documentation that he had followed up with his primary care provider. | D 273 | | |

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| D 273 | Continued From page 2<br><br>Review of the facility incident report dated 05/26/17 revealed:<br>-Resident #2 stood up from dining room table and lost his balance and fell hitting his head.<br>-The resident had a skin tear on his right forearm.<br>-Resident #2 was sent to the emergency room for evaluation.<br>-The resident's family was notified on 05/26/17 at 10:05 AM.<br>-The resident's primary care doctor was notified on 05/26/17 at 10:10 AM and a message was left.<br><br>Review of the hospital discharge paperwork dated 05/26/17 revealed:<br>-Resident #2 had been treated for an accidental fall and an unspecified head contusion.<br>-Discharge instructions that said to follow up with primary care provider within 3 days on 05/29/17.<br><br>Review of Resident #2's record revealed there was no documentation that he had followed up with his primary care provider.<br><br>Review of a faxed order request dated for 05/24/17 revealed:<br>-The facility had notified another primary care provider to come and evaluate Resident #2.<br>-The primary care provider signed this order on 06/09/17 and said she would follow up with resident at next facility visit.<br><br>Confidential interview with a staff member on 06/22/17 at 8:05 AM revealed:<br>-Resident #2 was very active when he first arrived at the facility and would walk around and try to fix things at the facility.<br>-Resident #2 walked independently and without the use of an assistive device.<br>-Resident #2 started having a lot of falls the last | D 273 | | |

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month or two he was at the facility.
-The facility had to get a new primary care provider due to his old primary care provider refusing to see him due to non-payment.
-When the facility notified the new primary care provider she was on vacation and sent orders back saying she would see Resident #2 at the next facility visit.
-The new primary care provider never actually did a visit with Resident #2 due to him being discharged before she did a facility visit.
-If Resident #2 needed to be seen by a doctor, and there was not one available they would have to send him out to the emergency room.
-She felt that Resident #2 had been declining since the first of May, and was not as active as he was when he first arrived to the facility.

Telephone interview with a family member of Resident #2 on 06/22/17 at 9:27 AM revealed:
-Resident #2 had been living at the facility since September 2016.
-When he first arrived he was very active and would walk around and participate.
-The last month or two that he was at the facility she felt he had declined.
-He was not as active and was having a lot of falls.
-She was not sure how many total falls he had, but she was told that he did have 3 in one week at the end of May 2017.
-She had been made aware by the facility about the falls.
-She had never spoken to the primary care provider and was unaware if he was coming to see Resident #2 or not.
-The facility had told her they were switching to another primary care provider and they would be seeing Resident #2 on 06/05/17.
-She was not aware that the new primary care

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provider ever came to see Resident #2.
-Resident #2 was shuffling his gait more towards the end of his time at the facility.
-She thought the last 6 weeks or so he was at the facility.
-She was not aware of a primary care provider seeing Resident #2 since he had been falling in May.

Attempted telephone interview with a second family member of Resident #2 on 06/22/17 at 9:46 AM revealed the family member was unavailable for interview at this time.

Confidential interview with a second staff member on 06/22/17 at 9:49 AM revealed:
-When Resident #2 arrived to the facility in September 2016 he was very active and walked around a lot.
-He started having a lot of falls and slowly declining towards the end of April or beginning of May 2017.
-The facility attempted to get him in with his primary care provider after the emergency room visit, but they would not see him due to a payment issue.
-The facility attempted to switch Resident #2 to another primary care provider after the other primary care provider refused to see himg.
-The new primary care provider was on vacation and did not see him before he was discharged.
-All the times that Resident #2 was sent to the hospital post a fall and the facility was to follow up with the primary care provider, the facility called the old primary care provider but there is no documentation of those calls.
-The staff started to assist Resident #2 with ambulating and personal care needs due to his decline.
-The primary care provider had been made aware

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but continued to tell the facility he would follow up at the next facility visit.
-The facility did not have any documentation of these calls.

Confidential interview with a third staff member on 06/22/17 at 10:15 AM revealed:
-Resident #2 had started declining in status over the last 6 weeks.
-It was harder for him to walk and he would shuffle with his feet when he did walk.
-Resident #2 did have a lot of falls the month of May 2017, but she was not sure how many.
-If they could not get up with the primary care provider then they were to send the patient out to the emergency room.

Attempted telephone interview with a primary care provider of Resident #2 on 06/22/17 at 10:35 AM revealed the practitioner was unavailable for interview at this time.

Attempted telephone interview with a second primary care provider of Resident #2 on 06/22/17 at 10:40 AM revealed the practitioner was unavailable for interview at this time.

Interview with the Executive Director on 06/22/17 at 10:45 AM revealed:
-Resident #2 started declining in the Spring, she thinks around April 2017.
-Resident #2 started having a lot of falls in May 2017.
-Resident #2 had been sent to the hospital when he had a falls.
-The facility attempted to have Resident #2 follow up with his primary provider, but the provider refused to see him due to non-payment on the account.
-The last scheduled visit with Resident #2's

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| D 273 | Continued From page 6<br>primary care provider was scheduled for 05/22/17, the resident was unable to go due to the office calling and stating that they would not see him due to his balance on his account.<br>-The facility attempted to get him in with another practitioner, but she was on vacation and could not see him until she came back.<br>-They did notify the primary care practitioner about the falls and change in status, but the practitioner would always respond back see resident at next facility visit.<br>-If the resident needed to be seen immediately and no practitioner was available then they would send him to the emergency room.<br>_____<br>The facility failed to assure that a resident was seen by a primary care provider post an emergency room visit related to falls. The resident had emergency room visits related to falls and no follow up with a primary care provider had been done. The facility's noncompliance was detrimental to resident's safety and constituted a Type B Violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 18, 2017. | D 273 | | |
| D 282 | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. | D 282 | | |

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| D 282 | Continued From page 7<br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure the kitchen's oven, deep fryer, ice-maker, and microwave were cleaned and protected from contamination.<br><br>The findings are:<br><br>Observation of the oven on 6/20/17 at 11:25am revealed:<br>-The stove flame control knobs and oven temperature knobs were covered in a thick tarry grime.<br>-The temperature indicator numbers on the oven control knob could not be read through the thick tarry substance.<br>-The two handles on the two oven doors were covered in grime and had a sticky substance.<br>-The exterior of the oven doors and side panels were stained and had a sticky substance.<br><br>Observation of the deep fryer conveyor on 6/20/17 at 11:35am revealed:<br>-There was a heavy coating of grease with multiple black and brown crumbs on the stainless steel back splash.<br>-The sides and front of the deep fryer had multiple drip marks of grease running down the sides.<br><br>Observation of the microwave on 6/20/17 at 11:40am revealed:<br>-The exterior right side of the door was dirty and sticky.<br>-There were tan stains on all interior surfaces.<br>-All interior surfaces had several areas with sticky substances.<br><br>Observation of the icemaker unit on 6/20/17 at 11:52am revealed: | D 282 | | |

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| D 282 | Continued From page 8<br>-The intake vent filter was dirty and the grate was sticky.<br>-The sides of the unit were dirty with drip-marks.<br>-There was a puddle of water extending 2 feet from the front of the ice machine.<br>-There were 5 ice cubes in the puddle of water at the base of the ice machine.<br><br>Interview with a kitchen staff aide on 6/20/17 at 11:54am revealed:<br>-The kitchen staff clean the kitchen, but do not sign any cleaning schedule sheet.<br>-All surfaces are wiped down between meals.<br>-She could not recall the last time the kitchen had a deep cleaning.<br><br>Interview with the Kitchen Manager on 6/20/17 at 11:56am revealed:<br>-The kitchen staff performed general cleaning, but do not sign any cleaning schedule sheet.<br>-All surfaces are wiped down between meals.<br>-The deep fryer was emptied weekly and cleaned.<br>-The Maintenance Director removed the plastic overflow guard several months ago on the inside of the ice machine to clean.<br>-The ice piled up without the overflow guard and caused ice to spill out when the door is opened which created a puddle at the base of the unit.<br>-She was unaware if the overflow guard would be replaced.<br>-The oven was old and needed to be replaced.<br>-The microwave was needed to be replaced.<br>-There were work request orders for the replacement of the oven and microwave, but she was not sure when they were put in.<br>-She could not remember the last time the kitchen had a deep cleaning.<br><br>Interview with the Maintenance Director on 6/20/17 at 1:30pm revealed he was not notified | D 282 | | |

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| D 282 | Continued From page 9<br>that the ice machine required any repairs or maintenance.<br><br>Interview with the Administrator on 6/20/17 at 1:30pm revealed:<br>-She supervised the Kitchen Manager.<br>-She was unaware that the cleaning schedule was not being followed.<br>-The expectation was for dietary staff to clean all areas daily and as needed.<br>-The Kitchen Manager should ensure that the oven, microwave and deep fryer were cleaned.<br>-She was unaware that the ice machine overflowed due to a missing part.<br>-She would determine the level of cleaning needed for each kitchen appliance.<br>-She would replace any kitchen appliance if unable to be cleaned or repaired.<br>-She would contact the Maintenance Director to repair the ice machine. | D 282 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to healthcare. | D912 | | |

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| D912 | Continued From page 10<br><br>The findings are:<br><br>Based on record reviews and interviews the facility failed to follow up with a primary care provider after three emergency room visit post a fall for 1 of 5 sampled residents (Resident #2). [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] | D912 | | |