STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/28/17 - 06/30/17.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure walls, ceilings, and floors were kept clean and in good repair for 4 of 4 common resident bathrooms, one resident bedroom, the living room, the hallways, and the dining room. The findings are: Review of the facility's sanitation report dated 07/26/16 revealed: -The facility received a score of 93.5 on 07/26/16. -The facility had some walls in "bad repair". Observation on the Back Hall on 06/28/17 at 10:12 a.m. revealed: -There was a piece of black baseboard (about 1 and ½ feet long) missing from the wall beside the exit door at the end of the hall. -There was dried brown plaster on the wall where the baseboard was missing.	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 1 Interview with the Resident Care Coordinator (RCC) on 06/28/17 at 1:00 p.m. revealed: -She was not aware a piece of baseboard was missing on the Back Hall. -The facility had to be renovated after it flooded in October 2016. -She thought all baseboards were repaired during the renovation. A second observation of the Back Hall on 06/28/17 at 4:48 p.m. revealed the piece of baseboard was still missing. A third observation of the Back Hall on 06/29/17 at 4:30 p.m. revealed the missing piece of baseboard had been replaced. Observation of the male/female common bathroom on the Back Hall on 06/28/17 at 10:25 a.m. revealed there was dirt and debris on the floor in front of both toilets and both sinks. Interview with the RCC on 06/28/17 at 1:00 p.m. revealed: -She was not aware the floors in the bathroom on the Back Hall needed cleaning. -The housekeeper should clean the bathroom floors daily. A second observation of the male/female common bathroom on the Back Hall on 06/28/17 at 4:49 p.m. revealed the dirt and debris was still on the floor in front of both toilets and both sinks. A third observation of the male/female common bathroom on the Back Hall on 06/29/17 at 4:35 p.m. revealed the dirt and debris on the floor in front of both toilets and both sinks had been cleaned up.	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 2 Observation of the female bathroom on the Side Hall on 06/28/17 at 10:56 a.m. revealed: -There was a crack about 1 and ½ feet long in the tile at the top of the shower wall near the back of the shower. -There were dark yellow stains on the floor near the tub and near the toilets. -There was an uneven area on the floor about 3 inches in diameter near the toilet with missing flooring, exposing the cement subflooring. Interview with the housekeeper on 06/28/17 at 11:25 a.m. revealed: -She worked as the housekeeper 5 days a week from 9:00 a.m. - 1:00 p.m. -She cleaned residents' rooms, bathrooms, and common areas each day. -She usually started on the Front Hall and worked her way to the Side Hall and the Back Hall was done last. -She cleaned bathrooms every day including mopping the floors. -She usually dusted, swept, and mopped in the residents' rooms and common areas. -She was currently cleaning the Front Hall then she would clean the Side Hall and Back Hall. Interview with the RCC on 06/28/17 at 1:14 p.m. revealed: -She was not aware of the stains on the floor in the female bathroom on the Side Hall. -Housekeeping staff were supposed to clean everything in the bathrooms daily. -Personal care aides were supposed to "freshen up" the bathrooms when there was no housekeeper on duty in the afternoons and at night. -The floors in the female bathroom on the Side Hall were old and had not been replaced during a renovation in October 2016.	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 3 A second observation of the female bathroom on the Side Hall on 06/28/17 at 4:55 p.m. revealed: -There were still dark yellow stains on the floor near the tub and near the toilets. -There was an uneven area on the floor about 3 inches in diameter near the toilet with missing flooring, exposing the cement subflooring. A third observation of the female bathroom on the Side Hall on 06/29/17 at 5:00 p.m. revealed: -There were still dark yellow stains on the floor near the tub and near the toilets. -There was an uneven area on the floor about 3 inches in diameter near the toilet with missing flooring, exposing the cement subflooring. Observation of the male bathroom on the Side Hall on 06/28/17 at 11:07 a.m. revealed: -There were yellowish brown stains on the floor around the second toilet. -There was a urine odor in the bathroom. -There were cracks in the flooring near the half shower wall that exposed the cement subflooring. -The ceiling exhaust fan was covered with dust. -There were grayish brown stains on the floor of the shower. Interview with the RCC on 06/28/17 at 1:20 p.m. revealed: -She was not aware of the stains on the floor in the male bathroom. -They have a male resident that urinated on the floor frequently. -The housekeeper should clean the bathroom floors daily. A second observation of the male bathroom on the Side Hall on 06/28/17 at 4:58 p.m. revealed: -There were yellowish brown stains on the floor	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 4	D 074		

around the second toilet.
-The bathroom smelled like cleaning chemicals.
-There were cracks in the flooring near the half shower wall that exposed the cement subflooring.
-The ceiling exhaust fan was covered with dust.
-There were grayish brown stains on the floor of the shower.

Observation of the living room on the Front Hall on 06/28/17 at 12:45 p.m. revealed:
-The baseboard was missing on the walls around the built in desk in the living room.
-There was an area of missing paint about 4 feet long on the wall underneath the television mounted on the wall.

Interview with the RCC on 06/28/17 at 1:25 p.m. revealed:
-The missing strip of paint on the wall in the living room was caused when a cover for wires popped off the wall about a month ago.
-They had planned to put the wire cover back on the wall but had not done it yet.
-There was baseboard around the walls of the desk at one time but the desk was too high.
-They had to adjust the height of the desk in February or March 2017 and the baseboard was removed.
-They planned to replace the baseboard around the desk but she was not sure when it would be done.

Observation of the Front Hall common resident bathroom on 06/28/17 at 10:14 a.m. revealed:
-A wall outlet cover had medium dark brown rust stains.
-One of the switches on the wall outlet did not work when flipped up and down.
-The wall area above the wall light switch cover had medium brown rust stains.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 5	D 074		

-The light cover mounted on the wall above the sink was dirty and covered in black grime.
-The wall areas above the baseboard and below the window had several large areas with medium brown rust stains.
-The towel bar above the baseboard and below the window had several chipped paint areas and was covered with several dark brown and black stained areas.
-Ten wall tiles around the tub had dark brown and black stains with cracked grout.

Observation of the dining room area on 06/28/17 at 10:30 a.m. revealed two medium sized floor vents were dirty and covered with dried food particles, dark brown rust, and black grime.

Observation of resident room #6 on 06/28/17 at 10:45 a.m. revealed:
-A long black cable was hanging from the ceiling loosely behind the head of a resident's bed.
-The wall light switch cover was dirty and had several chipped and faded painted areas.

Based on observations and record reviews, interviews with the two residents who resided in resident room #6 were unsuccessful due to their cognitive status.

Interview with the housekeeper on 06/28/17 at 10:55 a.m. revealed:
-The Front Hall common residents bathroom's wall areas had been in that condition for as long as she could remember.
-She was responsible for cleaning the bathroom walls but those stains needed to be painted.
-The wall light switch cover and wall tile around the tub areas could not be cleaned and may need to be replaced.
-She was not responsible for cleaning the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 074	Continued From page 6 room floors. Interview with the RCC on 06/29/17 at 1:00 p.m. revealed: -She was unaware of the condition of the walls in the Front Hall common resident bathroom. -The facility did not have a maintenance person but she and the Administrator would have all the repairs made as soon as possible. -The Front Hall common resident bathroom was not renovated after the flood in October 2016 and some of the wall areas may have been damaged then. -The kitchen staff were responsible for cleaning and mopping the floors in the dining room area. -The floor vents in the dining room floor may need to be replaced because of the rust on them. -She would have the maintenance worker fix the black cable hanging from the ceiling area behind a resident's bed in resident room #6 and address all of the other areas of concern observed within the facility as discussed. Interview with the Administrator on 06/29/17 at 5:15 p.m. revealed: -She was not aware of the condition of the Front Hall common bathroom walls, floor vents in the dining room area, or the light switch and black cable hanging on the wall in resident room #6. -Housekeeping staff cleaned the residents' rooms daily but were not responsible for making repairs. -The facility did not have an on-site maintenance person but she called someone to complete repairs as needed. -She would make sure all necessary repairs were made as soon as possible.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 7 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure 4 of 4 common resident bathrooms, two resident bedrooms, the dining room, and the hallways were maintained in a clean and orderly manner and free of hazards . The findings are: Review of the facility's sanitation report dated 07/26/16 revealed: -The facility received a score of 93.5 on 07/26/16. -The female bathroom needed caulk around the sinks and tub. Observation of the male/female common bathroom on the Back Hall on 06/28/17 at 10:25 a.m. revealed: -There were two broken slats on the blind in the window. -The bottom of the bathroom door had multiple strips of wood peeling up from the bottom of the door. -Two green privacy curtains had multiple browns stains in different areas of the curtains. Interview with the Resident Care Coordinator	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 8 (RCC) on 06/28/17 at 1:00 p.m. revealed: -She was not aware the bathroom door on the Back Hall had wood strips peeling up. -The facility had to be renovated after it flooded in October 2016. -She thought the door was repaired or replaced during the renovation. -The housekeeper should clean the bathrooms daily. A second observation of the male/female common bathroom on the Back Hall on 06/28/17 at 4:49 p.m. revealed: -The window blind was still broken. -The door still had multiple strips of wood peeling up from the bottom. -Two green privacy curtains still had multiple browns stains and had not been cleaned. A third observation of the male/female common bathroom on the Back Hall on 06/29/17 at 4:35 p.m. revealed: -The window blind was still broken. -The door had multiple strips of wood peeling up from the bottom. -The two green privacy curtains had been cleaned. Observation of resident room #1 on 06/28/17 at 10:41 a.m. revealed there was a broken slat on the blind on the window on the right. Interview with the RCC on 06/28/17 at 1:00 p.m. revealed: -She was not aware the blind was broken in resident room #1. -They had replaced broken blinds throughout the facility several times. -Staff were supposed to report any broken blinds to her.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 9 -She would get the broken blind replaced. Observation of resident room #1 on 06/28/17 at 4:50 p.m. revealed the broken blind was still hanging in the window on the right. Interview with a resident in resident room #1 on 06/28/17 at 4:50 p.m. revealed: -He thought they had recently replaced the window blind. -He had not noticed the blind was currently broken. Observation of the fire door in the hallway on the Back Hall on 06/28/17 at 10:42 a.m. revealed: -There were multiple areas of missing / peeling paint and scratches on the door. -Some areas without paint were rusted. Interview with the RCC on 06/28/17 at 1:00 p.m. revealed: -She was not aware the fire door on the Back Hall was missing paint. -The facility had to be renovated after it flooded in October 2016. -The doors were painted at that time. -The wheelchairs hitting against the door may have caused the paint to chip off. -They would have to get the doors repainted. Observation of the female bathroom on the Side Hall on 06/28/17 at 10:56 a.m. revealed: -The black frame on both mirrors above the two sinks had missing wood and paint on the bottom of the frames. -The seat was up on the first toilet and there was yellow urine in the bowl. -There were multiple brown stains on the toilet rim and toilet seat. -The second toilet had streaks of brown stains on	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 10	D 079		

the toilet seat.
-There were multiple yellowish brown stains in the bottom of the bathtub and dirt and debris.
-Both sinks had missing paint and caulking around the wall and the back of the sinks.
-There was a shower chair and a raised toilet seat stored in the bathtub.

Interview with the RCC on 06/28/17 at 1:14 p.m. revealed:
-Housekeeping staff were supposed to clean everything in the bathrooms daily.
-Personal care aides were supposed to "freshen up" the bathrooms when there was no housekeeper on duty in the afternoons and at night.
-The brown stains on the toilet may be caused by a resident who chews tobacco and sometimes spits in the toilet.
-They were not supposed to store the raised toilet seat in the tub so she would have it removed.

A second observation of the female bathroom on the Side Hall on 06/28/17 at 4:55 p.m. revealed:
-The mirrors had not been replaced.
-Both toilets had been cleaned.
-The stains in the bathtub had not been removed.
-Both sinks had missing paint and caulking around the wall and the back of the sinks.
-The raised toilet seat stored in the bathtub had been removed from the bathroom.

A third observation of the female bathroom on the Side Hall on 06/29/17 at 5:00 p.m. revealed:
-The mirrors had not been replaced.
-The stains in the bathtub had not been removed.
-Both sinks had missing paint and caulking around the wall and the back of the sinks.

Observation of the male bathroom on the Side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 11 Hall on 06/28/17 at 11:07 a.m. revealed: -There was white paint missing and paint peeling off the cabinet under the sink exposing wood with dark brown stains. -There was a dead brown bug on the floor between the sink cabinet and the first toilet. -The first toilet was elongated but it had a round toilet seat, leaving about ½ inch gap between the rim and the seat. Interview with the housekeeper on 06/28/17 at 11:25 a.m. revealed: -She worked as the housekeeper 5 days a week from 9:00 a.m. - 1:00 p.m. -She cleaned residents' rooms, bathrooms, and common areas each day. -She usually started on the Front Hall and worked her way to the Side Hall and the Back Hall was done last. -She cleaned bathrooms every day including, sinks, showers, and tubs. -She usually dusted, swept, and mopped in the residents' rooms and common areas. -She was currently still cleaning on the Front Hall and she would do the Side Hall next, then the Back Hall. Interview with the RCC on 06/28/17 at 1:20 p.m. revealed: -She had not noticed the toilet seat on the first toilet was too short. -She would have the toilet seat replaced. -The sink overflowed last week and was repaired by a plumber. -The overflow of water may have caused the paint to start peeling away from the sink cabinet. -The facility had roaches "bad at one time" but the exterminating company had been coming monthly and it was better.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 12 A second observation of the male bathroom on the Side Hall on 06/28/17 at 4:58 p.m. revealed: -The paint on the sink cabinet was still peeling off. -The dead brown bug was no longer on the floor. -The first toilet still had a toilet seat that was too short. A third observation of the male bathroom on the Side Hall on 06/29/17 at 4:55 p.m. revealed: -The short toilet seat on the first toilet had been replaced with an elongated seat. -The strips of peeling paint had been pulled off of the sink cabinet, exposing the wood underneath. Observation of the fire door connecting the Side Hall and the Front Hall on 06/28/17 at 11:17 a.m. revealed more than 3/4th of the paint on the fire door was missing exposing a dark brown color under the beige paint. Interview with the RCC on 06/28/17 at 1:20 p.m. revealed: -The facility had to be renovated after it flooded in October 2016. -The doors were painted at that time. -The wheelchairs had rubbed against it. -They would have to get the door repainted. Observation of the dining room door on 06/28/17 at 12:50 p.m. revealed: -The metal protective strip attached to the bottom of the door was about 1 foot high and covered the width of the door at the bottom. -The right side of the metal strip was pulled away from the door and curved around leaving sharp metal edge sticking out about 1/2 inch from the door. Interview with the RCC on 06/28/17 at 1:00 p.m. revealed:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 13 -She was working on trying to find a new metal strip for the bottom of the dining room door. -She had noticed it was peeling back about 2 weeks ago. -She planned to get it repaired once she found a new metal strip. Observation of the Front Hall common resident bathroom on 06/28/17 between 10:00 a.m.-12:00 p.m. revealed: -The faucets to the bathtub were spotted with white colored deposits. -The bathtub had discolored grout with brownish stains. -The interior of the bathtub had large black stained areas around the drain under the faucet. -The non-slip tread strips were peeling away from inside the bottom of the bathtub. -The faucet and handrails inside of the shower were covered with a hazy white residue. -The top and entire back of the white shower chair positioned inside of the tub was dirty with black marks. Observation of resident room #6 on 06/28/17 at 10:45 a.m. revealed: -Several piles of unfolded clothing stacked on top of two chairs. -Some of the piles of unfolded clothing had fallen to the floor and were hanging off of two chairs in the bedroom by the two closets. -A pile of unfolded clothing was on top of a wheeled walker and was falling over to the floor. -Several clothing items were hanging across the rocking chair seat and on the back of the rocking chair. -Several shirts and tops were hanging on the door knobs of both closets. -The closet doors could not close because of the clothing piled on the closet floor.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 14 -Two large boxes were on the floor and were overfilled with clothing. -Some of the clothes in the boxes were folded and some were unfolded. -Clothing items were hanging from the tops of the boxes. -Several clothing items were piled on the tops of two dressers. -There was a pillowcase filled with clothing on the floor by a resident's bed in front of the nightstand. -There was a wire hanger with a light brown stained washcloth on it hanging from the windowsill by a resident's bed. Based on observations and record reviews, interviews with the two residents who resided in resident room #6 were unsuccessful due to their cognitive status. Interview with the housekeeper on 06/28/17 at 10:55 a.m. revealed: -She was responsible for cleaning the bathrooms. -The tile around the tub areas could not be cleaned and may need to be replaced. Observation of the Front Hall common resident bathroom on 06/29/17 at 11:40 a.m. revealed: -The faucets to the bathtub were spotted with white colored deposits. -The bathtub had discolored grout with brownish stains. -The interior of the bathtub had large black stained areas around the drain. -The non-slip tread strips were peeling away from inside the bottom of the bathtub. -The faucet and handrails inside of the shower were covered with a hazy white residue. -The top and entire back of the white shower chair positioned inside of the tub was dirty with black marks.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 15 Observation of resident room #6 on 06/29/17 at 11:40 a.m. revealed: -Several piles of unfolded clothing stacked on top of two chairs. -Some of the piles of unfolded clothing had fallen to the floor and were hanging off of two chairs in the bedroom by the two closets. -A pile of unfolded clothing was on top of a wheeled walker and was falling over to the floor. -Several clothing items were hanging across the rocking chair seat and on the back of the rocking chair. -Several shirts and tops were hanging on the door knobs of both closets. -The closet doors could not close because of the clothing piled on the closet floor. -Two large boxes were on the floor and overfilled with clothing. -Some of the clothing in the boxes were folded and some unfolded. -The clothing was hanging from the tops of the boxes. -Several clothing items were piled on the tops of two dressers. -There was a pillowcase filled with clothing on the floor by a resident's bed in front of the nightstand. -The wire hanger with a light brown stained washcloth had been removed from the windowsill by a resident's bed. Interview with the RCC on 06/29/17 at 1:00 p.m. revealed: -She was unaware of the condition of the tub and shower areas in the Front Hall common resident bathroom. -The facility did not have a maintenance person but she and the Administrator would have all the repairs made as soon as possible. -She was aware that resident room #6 was very	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 079	Continued From page 16 cluttered. -The two residents who reside in resident room #6 kept their room that way. -She tried to keep their room as uncluttered as possible by placing seasonal clothing items in storage for the residents but that did not help. -She would talk with the families of the two residents regarding the excessive clutter of clothing in resident room #6. Interview with the Administrator on 06/29/17 at 5:15 p.m. revealed: -She was not aware of the condition of the tub/shower areas in the Front Hall common resident bathroom. -Housekeeping cleaned the residents' bathrooms daily but were not responsible for making repairs. -The facility did not have an onsite maintenance person, but she would call someone to complete all repairs. -She would make sure all necessary repairs were made as soon as possible to the bathroom areas. -She was aware of the condition of resident room #6 with excess clothing throughout the room. -She would work with the RCC to ensure resident room #6 was as clutter free as possible.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 17	D 113		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures at 6 of 9 fixtures sampled (sinks and bathtubs) in 3 of 4 common bathrooms used by residents were maintained at a minimum of 100 degrees Fahrenheit (F) and did not exceed 116 degrees F.

The findings are:

Observation of the Front Hall common resident bathroom on 06/28/17 at 10:19 a.m. revealed:
-The hot water temperature in the bathtub was 122 degrees F.
-Steam was observed within a few seconds of turning on the water.

Observation of the female common bathroom on the Side Hall on 06/28/17 at 10:58 a.m. revealed:
-The hot water temperature at the first sink was 118 degrees F.
-The hot water temperature at the second sink was 118 degrees F.
-The hot water temperature in the bathtub was 118 degrees F.
-No steam was observed.

Observation of the male common bathroom on the Side Hall on 06/28/17 at 11:07 a.m. revealed:
-The hot water temperature at the sink was 118 degrees F.
-The hot water temperature in the bathtub was 118 degrees F.
-No steam was observed.

Interview with the housekeeper on 06/28/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 18 11:25 a.m. revealed: -There had not been any issues with the hot water to her knowledge. -No residents had complained about the water temperature being too hot. -No residents had been burned to her knowledge. Interview with the Resident Care Coordinator (RCC) on 06/28/17 at 1:00 p.m. revealed: -She was not aware of any issues with the hot water temperatures. -She or the supervisor on duty usually checked the water temperatures weekly. -She usually checked the water temperatures at the sinks because she assumed it would be the same at the bathtubs. -She was unsure of the required hot water temperature range but she thought it could not go over 114 degrees F. -Residents used sinks and bathtubs/showers in all 4 common bathrooms. -She was not sure if the facility had 2 or 3 hot water heaters. -The facility flooded in October 2016 and the residents were evacuated from 10/10/16 - 11/16/16 so the facility could be renovated. -She thought the hot water heaters were replaced during the renovations. -The facility did not have maintenance staff so she would call a local plumber to come and check the hot water heaters. Review of the facility's 2017 water temperature log revealed: -Staff were checking water temperatures at one fixture (not specified) in each of the 4 common resident bathrooms once weekly. -The weekly hot water temperatures ranged from 100 degrees F - 108 degrees F from 01/04/17 - 06/23/17.	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 19 Interview with the Administrator on 06/28/17 at 4:15 p.m. revealed: -They had the hot water heaters replaced with two new ones when the facility flooded in October 2016. -She was not aware of any current problems with the hot water temperatures. Interview with the RCC on 06/28/17 at 4:18 p.m. revealed: -She called a local plumbing company and they would come in the morning (06/29/17) to check the hot water heaters. -She would notify staff about the hot water temperatures. -She would post warning signs in the common bathrooms for the hot water temperatures. Observation of the female common bathroom on the Side Hall on 06/28/17 at 4:57 p.m. revealed: -The hot water temperature at the first sink was 118 degrees F. -The hot water temperature at the second sink was 118 degrees F. -The hot water temperature in the bathtub was 118 degrees F. -No steam was observed. -A warning sign was posted in the bathroom. Interview with a plumbing technician on 06/29/17 at 10:15 a.m. revealed: -The facility had two hot water heaters. -He thought one hot water heater was for the kitchen and the other one was domestic for the rest of the facility. -The thermostat was turned on "high" on both hot water heaters so he turned the domestic hot water heater to the "low" setting. -The thermostats for these hot water heaters did	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 20	D 113		

not have number ranges, only high or low settings.
-The water piping system in the facility was very old and used gate valves instead of mixing valves.
-The facility should wait a few hours and then recheck the water temperatures to see if the adjustment helped.
-If not, they should call the plumbing company back and they may have to change out a gate valve or put on a mixing valve.

Observation of the Front Hall common resident bathroom with the plumbing technician on 06/29/17 at 10:18 a.m. (after thermostat turned down) revealed:
-The water temperature at the bathtub was 122 degrees F with the plumbing technician's thermometer.
-The water temperature at the bathtub was 120 degrees F with the surveyor's thermometer.
-Steam was observed within a few seconds of turning on the water.
-A warning sign was posted in the bathroom.

Observation of the male common bathroom on the Side Hall with the plumbing technician on 06/29/17 at 10:25 a.m. (after thermostat turned down) revealed:
-The water temperature at the sink was 122 degrees F with the plumbing technician's thermometer.
-The water temperature at the sink was 120 degrees F with the surveyor's thermometer.
-Steam was observed within a few seconds of turning on the water.
-A warning sign was posted in the bathroom.

Observation of the Front Hall common resident bathroom with the RCC on 06/29/17 at 10:40 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 21 (after thermostat turned down) revealed: -The water temperature at the sink was 110 degrees F with the RCC's metal prong thermometer. -The water temperature at the sink was 114 degrees F with the surveyor's thermometer. -The water temperature at the bathtub was 120 degrees F with the RCC's metal prong thermometer. -The water temperature at the bathtub was 116 degrees F with the surveyor's thermometer. Interview with a resident on 06/29/17 at 4:28 p.m. revealed: -There had not been any problems with the water temperatures except it was cold that morning (06/29/17). -She used the bathroom independently and she had not been burned by the water. Interview with a second resident on 06/29/17 at 4:49 p.m. revealed: -The water temperatures were warm but not too hot. -She had not been burned by the water. Observation of the Front Hall common resident bathroom on 06/29/17 at 4:45 p.m. revealed: -The water temperature at the sink was 120 degrees F. -The water temperature at the bathtub was 120 degrees F. -No steam was observed. Observation of the male common bathroom on the Side Hall on 06/29/17 at 4:55 p.m. revealed the water temperature at the sink was 118 degrees F. Observation of the female common bathroom on	D 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 22	D 113		

the Side Hall on 06/29/17 at 5:00 p.m. revealed:
-The hot water temperature at the first sink was 118 degrees F.
-The hot water temperature at the second sink was 118 degrees F.
-The hot water temperature in the bathtub was 118 degrees F.
-No steam was observed.

Interview with the RCC on 06/29/17 at 5:35 p.m. revealed:
-She had rechecked the water temperatures a few minutes ago and the water temperatures were below 100 degrees F.
-She tried to call the plumbing company around 4:30 p.m. today but they were already closed.
-She would call them first thing in the morning to come back to the facility to work on the hot water heaters.

Interview with a second plumbing technician on 06/30/17 at 9:47 a.m. revealed:
-He had readjusted the thermostats on both hot water heaters to the lowest setting a few minutes ago.
-If that did not work, the facility should let the plumbing company know and they would have to add mixing valves.

Observation of the male common bathroom on the Side Hall on 06/30/17 at 9:54 a.m. (after both thermostats turned down) revealed the water temperature at the sink was 90 degrees F.

Observation of the Front Hall common resident bathroom on 06/30/17 at 9:58 a.m. (after both thermostats turned down) revealed:
-The water temperature at the sink was 92 degrees F.
-The water temperature at the bathtub was 92

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 113	Continued From page 23 degrees F. Interview with a medication aide on 06/30/17 at 11:30 a.m. revealed: -She was not aware of any issues with the hot water in the facility. -She had not noticed any problems with the hot water. -Some of the residents used the bathroom independently but no residents had complained about the water temperature. -No residents had been burned by the water. Observation of the Front Hall common resident bathroom on 06/30/17 at 4:54 p.m. revealed: -The water temperature at the sink was 90 degrees F. -The water temperature at the bathtub was 90 degrees F. Observation of the female common bathroom on the Side Hall on 06/30/17 at 4:57 p.m. revealed: -The water temperature at the first sink was 88 degrees F. -The water temperature at the second sink was 88 degrees F. -The water temperature at the bathtub was 88 degrees F. Interview with the Administrator on 06/30/17 at 5:00 p.m. revealed: -She had called the plumbing company again today and they were going to install a mixing valve next week. -She had ordered a new thermometer for the facility to use to check the water temperatures.	D 113		
D 169	10A NCAC 13F .0509 Food Service Orientation	D 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 169	Continued From page 24 10A NCAC 13F .0509 Food Service Orientation The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. Registered dietitians are exempt from this orientation. The orientation program is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a staff person in charge (kitchen service staff) of food preparation and serving of meals, had completed a food service orientation program, established by the department or an equivalent within 30 days of hire for 3 of 4 kitchen staff sampled (Staff D, E, and G). The findings are: Review of the Food Establishment Inspection reports for the facility kitchen dated 03/22/17 and 06/23/17 cited as a repeat risk factor "no certified food protection manager present. Must have serve safe or other approved course." 1. Review of Staff D's personnel record on 06/29/17 revealed: -Staff D was hired on 06/01/15. -She had not completed a food service orientation training since employment. Interview with Staff D on 06/29/17 at 9:23 a.m. revealed:	D 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 169	Continued From page 25 -She had worked at the facility as a Cook for over one year now. -She had tried to pass the food orientation test, but had not been able to pass it successfully. -She had not received food service orientation training within thirty days of hire at the facility. -She was responsible for preparing, cooking, and serving the meals for all residents at the facility. Refer to interview with the Resident Care Coordinator (RCC) on 06/28/17 at 10:05 a.m. Refer to interview with the Administrator on 06/30/17 at 9:38 a.m. 2. Review of Staff E's personnel record on 06/29/17 revealed: -Staff E was hired on 03/13/17. -He had not completed a food service orientation program since employment. Interview with Staff E on 06/30/17 at 12:45 p.m. revealed: -He had been working at the facility for a little over three months. -He had not taken the food service orientation test since employment. -He did not order the food at the facility. -He was responsible for preparing, cooking, and serving the meals to all residents. Refer to interview with the Resident Care Coordinator (RCC) on 06/28/17 at 10:05 a.m. Refer to interview with the Administrator on 06/30/17 at 9:38 a.m. 3. Review of Staff G's personnel record on 06/29/17 revealed: -Staff G was hired on 04/18/17.	D 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 169	Continued From page 26 -She had not completed a food service orientation training program since employment. Interview with Staff G on 06/29/17 at 9:10 a.m. revealed: -She had worked at the facility for over two months. -She had not had any food service orientation training since employment. -She was responsible for preparing, cooking, and serving the meals to all residents. -She had not been scheduled to take food service orientation since employment at the facility. Refer to interview with the Resident Care Coordinator (RCC) on 06/28/17 at 10:05 a.m. Refer to interview with the Administrator on 06/30/17 at 9:38 a.m. _____ Interview with the Resident Care Coordinator (RCC) on 06/28/17 at 10:05 a.m. revealed: -The facility did not have a Dietary Manager. -The facility had four kitchen staff who prepared and served all meals. -She was not aware of any of the four kitchen staff completing the food orientation program. -She knew three of the four kitchen staff had tried to complete the food orientation program but could not pass the test. -The Administrator had taken the food service orientation program test and had successfully passed it. -She and the Administrator were responsible for ordering the food for the facility and not the kitchen staff. Interview with the Administrator on 06/30/17 at 9:38 a.m. revealed:	D 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 169	Continued From page 27 -She took the food service orientation training and passed the test after three of the kitchen staff did not pass the food service orientation test. -None of the kitchen staff had the food service orientation since employment. -She did not prepare and serve the food to the residents. -She thought her successful completion of the food service orientation training would cover the kitchen staff who prepared and served the residents of the facility. -If the kitchen staff had completed the food service orientation, they would be more likely to follow the dietitian's menu and prepare all resident meals with the specified portion sizes and diet textures. -She would schedule another kitchen staff person as soon as she could to complete the food orientation training since she could not count herself as a trained kitchen staff person.	D 169		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 2 of 3 sampled residents (#1, #2) as related to failure to notify the primary care	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 28	D 273		

provider of coughing episodes for a resident (#1) with swallowing difficulties and a history of aspiration pneumonia and failure to obtain physical therapy / occupational therapy for a resident (#2) who required assistance with all activities of daily living due to weakness and decreased mobility.

The findings are:

1. Review of Resident #1's current FL-2 dated 02/21/17 revealed:
-Diagnoses included chronic obstructive pulmonary disease, dementia, hypertension, acute stroke, and depression.
-The resident was intermittently disoriented.
-There was an order for a dysphagia level 3 diet. (A dysphagia 3 diet consists of moist foods in bite sized pieces and thin liquids may need to be thickened depending on swallowing issues).
-The FL-2 did not indicate a physician's order for a thickener to be added to the resident's liquids.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/01/17.

Review of Resident #1's diet order dated and signed by the physician on 04/14/17 revealed:
-A diet order for a pureed, no added salt diet with thickener for liquids.
-There was no order to specify thickener consistency.

Review of the facility's handwritten diet list revealed:
-Resident #1 received a diet of "NAS thickener for liquids and pureed foods."
-The facility diet list did not specify the consistency of the thickener.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 29 Confidential interviews with three staff members revealed: -Resident #1 received his beverages during mealtimes first and without thickener added the majority of the time. -Resident #1 coughed a lot especially during mealtimes after drinking his beverages. -There was less coughing when thickener was added to Resident #1's beverages. -Sometimes the thickener was added halfway through the meal to Resident #1's beverages after he had drank most of them. -They had not notified the physician because everyone could hear Resident #1 cough excessively. Observation of Resident #1's breakfast meal on 06/29/17 at 8:43 a.m. revealed: -Resident #1 was served large portions of 1 cup or more of soft scrambled eggs, sausage, grits, and peaches. -The soft scrambled eggs were not pureed. -The sausage, grits, and peaches were pureed. -Resident #1 did not receive pureed toasted bread. -Resident #1 was served 8 ounces of milk, 8 ounces of water, 8 ounces of orange juice, and 10 ounces of coffee in a large mug without thickener added. -He coughed when he drank his beverages prior to receiving his food. -The surveyor intervened and notified a a facility staff person assisting other residents in the dining room that Resident #1 was drinking his beverages without thickener and coughing. -The Administrator took the resident's cups with orange juice and coffee into the kitchen and brought them back to the residents table after a few minutes.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 30 -The orange juice and coffee appeared to be nectar thick. -At 9:01 a.m., the Administrator placed a cup of water on the table and it appeared to be nectar thick. -From 9:01 a.m. - 9:23 a.m., the resident drank all of the orange juice and coffee and he drank 2 swallows of the water. -The resident did not cough while drinking the liquids with thickener. Interview with Resident #1 on 06/29/17 at 9:18 a.m. revealed: -He received his beverages before his meals without thickener added. -He was supposed to receive a pureed diet with "Thick-it powder" added to his beverages. -He coughed a lot during mealtimes especially after he drank his beverages. -Staff would ask him if he was okay when he "coughed hard" in the dining room. -He coughed less when the Thick-it powder was added to his beverages. Interview with a medication aide (MA) on 06/28/17 at 5:00 p.m. revealed: -Resident #1 "coughed hard" and a lot especially during mealtimes. -She had not reported Resident #1's excessive coughing to anyone and was unable to explain why. -She was unaware of a facility policy or procedure on how to add thickener. Observation of Resident #1's lunch meal on 06/29/17 at 12:20 p.m. revealed: -Resident #1 was served large portions of 1 cup or more of ham, turnip greens, yams, applesauce, and a roll. -The ham, turnip greens, and yams had several	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 31	D 273		

small chunks.
-The surveyor asked a kitchen staff person about the small chunks observed in Resident #1's food and was told "it was pureed."
-Resident #1 was served 8 ounces of tea and 8 ounces of water without thickener added.
-Resident #1 coughed excessively while at the table after drinking some of his beverages.

Review of a physician's visit form dated 06/13/17 revealed the primary care provider (PCP) wrote an order to be notified of any coughing episodes for Resident #1.

Telephone interview with Resident #1's PCP on 06/30/17 at 3:15 p.m. revealed:
-There was a signed and dated physician's order on 04/14/17 for no added salt, pureed diet with thickened liquids.
-A clarification of thickener consistency request was received from the facility on 06/29/17.
-The PCP's office faxed the order to the facility on 06/29/17 at 4:57 p.m.
-Resident #1 should receive a pureed diet due to past aspiration and swallowing issues prior to admission.
-The PCP wanted the resident to receive "honey" thickened liquids.
-There was no notification received from the facility regarding Resident #1 coughing during mealtimes or otherwise.
-The PCP wanted to be made aware of any coughing episodes for Resident #1 following the routine visit on 06/13/17 because of the resident's medical history and current diagnoses.

Interview with a second MA on 06/30/17 at 11:25 a.m. revealed:
-Resident #1 got thickener in his water when she administered his medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 32 -She was unsure what consistency the thickened liquids were supposed to be so she just used 1 scoop (labeled tablespoon). -She added 1 scoop of thickener to water in the 8 ounce cups kept on the medication cart. -Resident #1 sometimes coughed when she administered his medications. -She had not received training on how to prepare Resident #1's thickened liquids. Interview with Resident #1's guardian on 06/29/17 at 4:50 p.m. revealed: -The resident had a history of aspiration pneumonia and swallowing difficulties. -He coughed a lot because of having had pneumonia. -She thought the consistency of his thickener had been clarified after talking with the Resident Care Coordinator (RCC) when Resident #1 was admitted to the facility. -She had no other concerns regarding Resident #1's care. Interview with the RCC on 06/29/17 at 1:00 p.m. revealed: -She knew Resident #1 coughed often but did not know the wrong consistency of thickener or no thickener being added to his beverages may have caused him to cough during mealtimes. -Resident #1 was seen by the PCP for a routine visit on 06/13/17 and not for coughing episodes. -She had not notified the PCP that Resident #1 was coughing following his routine PCP visit on 06/13/17 because she was not aware of the PCP's order. Interview with the Administrator on 06/29/17 at 5:15 p.m. revealed: -She was aware Resident #1 coughed a lot during mealtimes.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 33	D 273		

-She had not notified Resident #1's PCP regarding the unspecified thickener consistency or excessive coughing.
-She was not aware the PCP wanted to be notified of any coughing episodes following Resident #1's physician's visit on 06/13/17.

2. Review of Resident #2's current FL-2 dated 05/02/17 revealed:
-The resident's diagnoses included diabetes mellitus, Alzheimer's dementia, atrial fibrillation, peripheral vascular disease, hypokalemia, transient ischemic attack, and alcoholism.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory with a wheelchair.
-The resident required assistance with bathing, dressing, and feeding (at times).

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/05/15.

Review of Resident #2's current assessment and care plan dated 05/02/17 revealed:
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident had limited range of motion and strength in his upper extremities.
-The resident was incontinent of bowel and bladder.
-The resident required supervision with eating.
-The resident was totally dependent with toileting, ambulation, bathing, dressing, grooming, and transferring.

Interview with a medication aide (MA) on 06/28/17 at 11:40 a.m. revealed:
-Resident #2 was a "heavy care" resident and required assistance with all activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 34	D 273		

living.
-The resident ate in his room and required feeding assistance.

Observation of Resident #2 in bed eating breakfast on 06/29/17 at 9:06 a.m. revealed:
-Resident #2 reached out slowly for the cup of water that was on his bedside tray table.
-Staff assisted Resident #2 with drinking some water from a straw by moving his cup closer to him and leaning the cup closer to his mouth.
-Staff fed Resident #2 the entire meal.

Observation of Resident #2 in bed eating lunch on 06/29/17 at 12:20 p.m. revealed:
-Resident #2 reached out very slowly for his cup of water but could not reach it.
-A staff person came into Resident #2's bedroom and sat down and began to assist the resident with his meal.
-The staff person fed Resident #2 the entire meal and assisted him with drinking his beverages.

Interview with a personal care aide (PCA) on 06/29/17 at 12:25 p.m. revealed Resident #2 needed staff assistance with eating his food and drinking beverages because he was weak on one side and ate slowly.

Interview with the Cook on 06/29/17 at 12:38 p.m. revealed:
-Resident #2 could feed himself but it took him a very long time because of the weakness in his arms.
-Staff helped Resident #2 with his meals during mealtimes.

Review of a physician's order for Resident #2 dated 03/22/17 revealed there was an order to provide physical therapy / occupational therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 35 (PT/OT) for mobility of the resident. Review of Resident #2's record revealed no documentation the resident had received any PT/OT as ordered on 03/22/17. Interview with the Resident Care Coordinator (RCC) on 06/30/17 at 6:40 p.m. revealed: -The medications aides were supposed to notify the RCC of any orders for PT/OT referrals. -The RCC usually made the PT/OT appointments. -She was not sure if Resident #2 had PT/OT. -If the resident had PT/OT, there should be documentation of the visits in the resident's record. -She could not find any documentation that the PT/OT order for Resident #2 was implemented. -She would contact the PT/OT agency. Interview with Resident #2 on 06/30/17 at 5:04 p.m. revealed: -He was unable to bear weight and he could not walk. -He had not walked in years. -His upper body and arms were weak. -He had not received PT/OT. -He would like to receive PT/OT to try to strengthen his upper body. -He did not know why he had not received any PT/OT. Attempt to contact the agency that provided PT/OT services to the facility on 06/30/17 was unsuccessful. Attempt to contact Resident #2's primary care provider on 06/30/17 about the PT/OT order was unsuccessful.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 36 The failure of the facility to notify the PCP of Resident #1's excessive coughing episodes as ordered by the PCP on 06/13/17 and who had a history of swallowing difficulties and aspiration pneumonia resulted in excessive coughing episodes which placed the resident at risk of choking or aspirating. This failure was detrimental to the resident's health and well-being and constitutes a Type B Violation. Review of the facility's plan of protection dated 06/30/17 revealed: -Resident #1's physician would be contacted immediately regarding his coughing episodes. -Staff would be in-serviced immediately to contact the supervisor and Resident Care Coordinator (RCC) regarding any change in Resident #1's eating and drinking pattern by observing him and reporting any changes observed during and after meals. -Physical therapy order would be followed up for Resident #2 and documentation would be maintained on file. -The medication aide (MA) and/or RCC would follow up with PT appointments. -All staff would be in-serviced regarding residents' changes in condition, especial eating and drinking habits. -Staff would observe and report immediately any changes, including coughing, to the supervisor. -The supervisor would document any changes every day in the resident progress notes, including coughing. -Any changes in any resident's condition would be documented and followed up with the physician. -The RCC would monitor and record weekly an ongoing progress note of the resident and report to the physician if any changes were observed.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 273	Continued From page 37 -The Administrator would monitor resident records monthly for any changes and make sure any changes were followed up with the physician. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2017.	D 273		
D 307	10A NCAC 13F .0904(e)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (e) Therapeutic Diets in Adult Care Homes: (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to clarify the consistency of thickened liquids for 1 of 1 residents sampled (#1) who required thickened liquids and had swallowing difficulties and a history of aspiration pneumonia. The findings are: Review of Resident #1's current FL-2 dated 02/21/17 revealed: -Diagnoses included chronic obstructive	D 307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 307	Continued From page 38	D 307		

pulmonary disease, dementia, hypertension, acute stroke, and depression.
-The resident was intermittently disoriented.
-There was an order for a dysphagia level 3 diet. (A dysphagia 3 diet consists of moist foods in bite sized pieces and thin liquids may need to be thickened depending on swallowing issues).
-The FL-2 did not indicate a physician's order for a thickener to be added to the resident's liquids.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/01/17.

Review of Resident #1's diet order dated and signed by the physician on 04/14/17 revealed:
-There was a diet order for a pureed, no added salt diet with thickener for liquids.
-There was no order to specify thickener consistency.

Review of the facility's handwritten diet lists revealed:
-Resident #1 received a diet of "NAS thickener for liquids and pureed foods."
-The facility diet list did not specify the consistency of the thickener.

Review of the manufacturer's directions for Thick-it Instant Food and Beverage Thickener revealed:
-The amount of thickener added was based on the consistency and the type of beverage.
-The directions included using a measuring scoop.
-The measuring scoop should be leveled off and slowly added while stirring briskly until the thickener was dissolved.
-Allow the thickened liquid to stand at least 30 seconds to 1 minute. When mixed with milk, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 307	Continued From page 39 thickened milk should be allowed to stand for 5 to 10 minutes. Observation of Resident #1's dinner meal on 06/28/17 at 5:15 p.m. revealed: -Resident #1 was served large portions of 1 cup or more of chicken, rice pilaf, vegetables, and cake that all had several small lumps. -Resident #1 did not receive a pureed roll. -Resident #1 was served 8 ounces of tea and 8 ounces of water served without thickener added. -Resident #1 began to cough after drinking some of his beverages. Interview with a medication aide (MA) on 06/28/17 at 5:00 p.m. revealed: -The MAs added the thickener to Resident #1's food and beverages. -She added the thickener to Resident #1's food because he would not drink the beverages if it was added to them. -She was not sure what consistency of thickener Resident #1 received. -She added two scoops of Thick-it to Resident #1's food. -Resident #1 coughed hard and a lot especially during mealtimes. -She had not reported Resident #1's excessive coughing to anyone. -She was unaware of a facility policy or procedure on how to add thickener. Telephone interview with Resident #1's primary care provider (PCP) on 06/30/17 at 3:15 p.m. revealed: -There was a signed and dated order on 04/14/17 for no added salt, pureed diet with thickened liquids. -A clarification of thickener consistency request was received from the facility on 06/29/17.	D 307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 307	Continued From page 40	D 307		

-The PCP's office faxed the order to the facility on 06/29/17 at 4:57 p.m.
-Resident #1 should receive a pureed diet due to past aspiration and swallowing issues prior to admission.
-Resident #1 should receive a no added salt diet due to his diagnosis of hypertension.
-The PCP wanted the resident to receive "honey" thickened liquids.

Interview with a second MA on 06/29/17 at 10:45 a.m. revealed:
-Resident #1 coughed a lot but not any different than when he first came to the facility.
-She did not know what consistency of thickener Resident #1 received.

Interview with a third MA on 06/30/17 at 11:25 a.m. revealed:
-Resident #1 got thickener in his water when she administered his medications.
-She was unsure what the consistency the thickened liquids were supposed to be so she just used 1 scoop (labeled tablespoon).
-Resident #1 sometimes coughed when she administered his medications.

Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:00 p.m. revealed:
-Resident #1 received a no added salt, pureed diet with thickened liquids.
-She was unaware the MAs were adding different amounts of Thick-it to Resident #1's beverages.
-She thought Resident #1 received a "nectar thickened" consistency.
-She had notified Resident #1's PCP to clarify the consistency of the thickener for liquids on 06/29/17.

Interview with the Administrator on 06/29/17 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 307	Continued From page 41 5:15 p.m. revealed: -Resident #1's beverages were supposed to be prepared using the thickener. -She was not sure of the consistency of Resident #1's thickener but knew it was added to his liquids. -The thickener should be added to Resident #1's liquids before being placed in front of him. -She was not aware the MAs were preparing the thickener differently, putting some in his food and different amounts in his beverages. -She was aware Resident #1 coughed a lot during mealtimes. -She had not notified Resident #1's PCP regarding the unspecified thickener consistency or excessive coughing. -The facility would follow Resident #1's current physician order for a no added salt, pureed diet with honey thickened liquids and would clarify as needed. _____ The failure of the facility to clarify the physician's order for the consistency of the thickener for Resident #1 with known swallowing difficulties and a history of aspiration pneumonia resulted in coughing episodes which placed the resident at risk for choking and aspirating. This failure was detrimental to the health and well-being of the resident and constitutes a Type B Violation. _____ Review of the facility's plan of protection dated 06/29/17 revealed: -Resident #1's physician's office was called immediately to clarify the order regarding the consistency of thickened liquid to be specific and to ensure ongoing consistency with thickened liquids and diet order. -Once clarified, the correct diet order would be	D 307		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 307	Continued From page 42 placed in the kitchen for the dietary staff to be informed of the resident's diet. -All physicians' orders would be clarified for specific consistency to prevent any risks to residents. -All staff would be in-serviced and instructed on how to ensure the right diet and right consistency of liquid for the resident was mixed. -All new orders pertaining to residents' diets would be clarified with the physician before implementing. -Staff would be in-serviced to monitor the resident at all meals to ensure the right diet and liquid consistency was given. -The RCC would observe weekly for correct diet/consistency of fluid. -The Administrator would monitor every 2 weeks for consistency and correct diet as ongoing quality assurance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2017.	D 307		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure therapeutic diets were served as ordered and according to	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 43	D 310		

specified portion sizes for 3 of 3 residents sampled (#1, #2, #3) with physician's orders for a pureed diet with thickened liquids (#1) and no concentrated sweets diets (#2, #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 02/21/17 revealed:
-Diagnoses included chronic obstructive pulmonary disease, dementia, hypertension, acute stroke, and depression.
-The resident was intermittently disoriented.

Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility on 03/01/17.

Review of Resident #1's diet order dated and signed by the physician on 04/14/17 revealed a diet order for a pureed, no added salt diet with thickener for liquids.

Observation of the kitchen area on 06/28/17 at 10:50 a.m. revealed:
-Two handwritten lists of residents with diets were posted on the wall of the bulletin board.
-Resident #1 had a diet of "no added salt (NAS), thickener for liquids and pureed foods" listed.

Interview with a Cook on 06/28/17 at 10:52 a.m. revealed:
-She followed the handwritten diet lists with the residents' diets noted that were posted in the kitchen on the bulletin board.
-She prepared all of the residents' meals by following the handwritten facility listing.
-The Resident Care Coordinator (RCC) had written the facility diet lists but the Cook was unable to specify when the lists were written.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 44 -She kept the handwritten facility diet lists updated quarterly or more frequently as needed. -She knew the residents very well and what diets they received because she had worked there for nearly thirteen years. -She did not use the dietitian's menu with specified portion sizes, but followed the facility handwritten diet lists of residents posted in the kitchen area when needed. -The dietitian's menus were in a notebook kept in the kitchen pantry area. -She used a large metal spoon to measure when preparing the residents' plates of food. -She wanted to make sure the residents had plenty of food on their plates and enjoyed their food, so she served large portions. -She prepared the modified diets using a blender and by making sure their food was moistened. -Resident #1 would not drink the liquids with thickener in it so he was given all liquids without thickener. -She did not put the thickener in Resident #1's liquids. -The medication aides (MAs) put the thickener powder in Resident #1's food because he would not drink the beverages with the thickener in them. -Resident #1 received a pureed diet with regular liquids. Observation of the dinner meal preparation on 06/28/17 at 4:52 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Review of the Dietitian's Menu for the dinner meal for 06/28/17 revealed pureed diets were to receive 1/3 cup chicken (pureed), ½ cup rice pilaf (pureed), 3/8 cup vegetables (pureed), 3/8 cup sour cream cake (pureed), and 1/3 cup roll	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 45 (pureed). Observation of Resident #1's dinner meal on 06/28/17 at 5:15 p.m. revealed: -Resident #1 was served large portions of 1 cup or more of chicken, rice pilaf, vegetables, and cake that all had several small lumps. -Resident #1 did not receive a pureed roll. -Resident #1 was served 8 ounces of tea and 8 ounces of water without thickener added. Confidential interviews with three staff members revealed: -All resident diets were served as regular diets except for the one resident who received a pureed diet. -Every resident's food looked the same to them. -All of the residents were served "very good, large" portions of food on their plates. -They thought all of the residents' plates were supposed to "look alike so no one resident would have something different on their plate than another resident." -The staff were aware Resident #1 received a pureed diet. -Sometimes Resident #1's food had lumps in it, and was not pureed properly all of the time. -Resident #1 received regular liquids like all of the other residents the majority of the time. -Thickener was added to Resident #1's food sometimes and to his beverages other times, but not all of the time. -Resident #1 was supposed to have thickener in his beverages before he drank them, but did not the majority of the time. Observation of the breakfast meal preparation on 06/29/17 at 8:10 a.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 46 Review of the Dietitian's Menu for the breakfast meal for 06/29/17 revealed pureed diets were to receive 1 serving eggs (pureed), 1 serving meat (pureed), and ¼ cup toasted bread (pureed). Observation of Resident #1's breakfast meal on 06/29/17 at 8:43 a.m. revealed: -Resident #1 was served large portions of 1 cup or more of soft scrambled eggs, sausage, grits, and peaches. -The soft scrambled eggs were not pureed. -The sausage, grits, and peaches were pureed. -Resident #1 did not receive pureed toasted bread. -The resident received 8 ounces of milk, 8 ounces of water, 8 ounces of orange juice, and 10 ounces of coffee in a large mug without thickener added. Interview with a second Cook on 06/29/17 at 9:10 a.m. revealed: -She followed the handwritten diet lists when she prepared the residents' meals. -She liked to make sure all residents received a "good sized" portion of food on their plates. -She used measuring cups the majority of the time when preparing the residents' plates, but had not done so that morning because food preparation was running behind that day. -She prepared the residents' plates using the large metal spoons. -She "normally" pureed Resident #1's food, but the blender had broken that morning (06/29/17) prior to breakfast being prepared. -She made sure Resident #1's eggs and other breakfast food items were cooked as soft as possible before serving it. -She had done the best she could to make sure the modified diets were as soft as possible	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 47	D 310		

because she had no other way to blend their food.
-She had informed the Administrator regarding the need for a new blender that morning after the blender had broken.
-Resident #1 received a pureed diet with thickener added to his food and liquids.

Interview with a third Cook on 06/29/17 at 9:23 a.m. revealed:
-She referred to the handwritten diet lists when needed when preparing the residents' meals.
-She knew the residents and what diets they received.
-She prepared the residents' plates using the large metal spoons.
-She made sure the pureed diets were as soft as possible by mashing it with a fork and making sure their food was cut up as needed.
-Resident #1 received a pureed diet with thickener added to his liquids.

Interview with Resident #1 on 06/29/17 at 9:18 a.m. revealed:
-Some of his food was served with lumps and was thick.
-He received large portions of food at every meal.
-He ate his food because it tasted good and he did not want to complain to anybody.
-Some staff added the "Thick-it powder" to his food instead of to his beverages.
-He received his beverages before his meals without thickener added.
-He was supposed to receive a pureed diet with "Thick-it powder" added to his beverages.

Observation of lunch meal preparation on 06/29/17 at 12:07 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 48 Review of the Dietitian's Menu for the lunch meal for 06/29/17 revealed pureed diets were to receive 1/3 cup meat of choice (pureed), 1 serving starchy vegetables (pureed), 3/8 cup vegetables (pureed), 3/8 cup fruit (pureed), and 1/3 cup roll (pureed). Observation of Resident #1's lunch meal on 06/29/17 at 12:20 p.m. revealed: -Resident #1 was served large portions of 1 cup or more of ham, turnip greens, yams, applesauce, and roll. -The ham, turnip greens, and yams had several small chunks. -The resident received 8 ounces of tea and 8 ounces of water without thickener added. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:00 p.m. revealed: -Resident #1 received a no added salt, pureed diet with thickened liquids. -She had notified Resident #1's primary care provider (PCP) to clarify the consistency of the thickener for liquids. Telephone interview with Resident #1's PCP on 06/30/17 at 03:15 p.m. revealed: -There was a signed and dated order on 04/14/17 for no added salt, pureed diet with thickened liquids. -A clarification of thickener consistency request was received from the facility on 06/29/17. -Resident #1 should receive a pureed diet due to past aspiration and swallowing issues prior to admission. -Resident #1 should receive a no added salt diet due to his diagnosis of hypertension. Refer to interview with the Resident Care	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 49 Coordinator (RCC) on 06/29/17 at 1:00 p.m. Refer to interview with the Administrator on 06/29/17 at 5:15 p.m. 2. Review of Resident #2's current FL-2 dated 05/02/17 revealed: -The resident's diagnoses included diabetes mellitus, Alzheimer's dementia, atrial fibrillation, peripheral vascular disease, hypokalemia, transient ischemic attack, and alcoholism. -There was a diet order for no concentrated sweets (NCS). Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 06/05/15. Review of the facility's diet list revealed Resident #2 was on a NCS diet. Review of Resident #2's June 2017 medication administration record (MAR) revealed the resident's blood sugar ranged from 67 - 286 from 06/01/17 - 06/30/17. Observation of the kitchen and pantry areas on 06/28/17 at 10:50 a.m. revealed: -Two handwritten lists of residents with diets were posted on the wall of the bulletin board. -Resident #2 had a diet of "no concentrated sweets (NCS)" listed. -There were three large boxes of pink sweetener packets. -There was a variety of sugar free snacks on the kitchen pantry shelves. Interview with a Cook on 06/28/17 at 10:52 a.m. revealed: -She followed the handwritten diet lists with the	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 50	D 310		

residents' diets noted that were posted in the kitchen on the bulletin board.
-She prepared all of the residents' meals by following the handwritten facility listing.
-The Resident Care Coordinator (RCC) had written the facility diet listing and kept it updated.
-She knew the residents very well and what diets they received because she had worked there for nearly thirteen years.
-She did not use the dietitian's menu with specified portion sizes but followed the facility handwritten diet lists of residents posted in the kitchen area when needed.
-The dietician's menus were in a notebook kept in the kitchen pantry area.
-She used a large metal spoon to measure when preparing the residents' plates of food.
-She wanted to make sure the residents had plenty of food on their plates and enjoyed their food so she served large portions.
-All of the residents received the same foods when she cooked.
-The diabetic residents received unsweetened tea and the facility staff in the dining room were supposed to make sure the residents received sweetener packets.
-She did not hand out the sweetener packets to residents because she was in the kitchen.
-Resident #2's meals were taken to his room by staff to assist him.
-Resident #2 received a no concentrated sweets diet according to the facility handwritten lists.

Confidential interviews with three staff members revealed:
-All resident diets were served as regular diets except for the one resident who received a pureed diet.
-Every resident's food on their plates looked the same to them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 51 -All of the residents were served "very good, large" portions of food on their plates. -They thought all of the residents' plates were supposed to "look alike so no one resident would have something different on their plate than another resident." -The residents who received a no concentrated sweets diets were given sweetener packets the majority of time especially when they ate in the dining room. -When staff fed Resident #2 in his room, the resident was not always given sweetener packets to use in his beverages, sugar free jelly or desserts. -Resident #2 was not given condiments to use with his food the majority of the time. Observation of the dinner meal preparation on 06/28/17 at 4:52 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Observation of the breakfast meal preparation on 06/29/17 at 8:10 a.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Review of the Dietician's Menu for the breakfast meal on 06/29/17 at 8:40 a.m. revealed no concentrated sweets diets were to receive 1 serving eggs, 1 serving meat, and ¼ cup toasted bread with 1 each reduced calorie jelly and sweetener packets. Observation of Resident #2's breakfast meal plate on 06/29/17 at 9:06 a.m. revealed: -Resident #2 was served large portions of 1 cup or more of soft scrambled eggs, sausage, grits, and peaches in light syrup with regular jelly. -Resident #2 did not receive reduced calorie jelly.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 52 -Resident #2 did not receive sweetener packets. Interview with the Cook on 06/29/17 at 9:10 a.m. revealed: -She followed the handwritten diet lists when she prepared the residents' meals. -She liked to make sure all residents received a "good sized" portion of food on their plates. -She used measuring cups the majority of the time when preparing the residents' plates but had not done so that morning because food preparation was running behind that day. -She prepared the residents' plates using the large metal spoons. -The diabetic residents received the same jelly as the other residents. -She was unsure if Resident #2 received sweetener packets or not because his plate was taken to his room by facility staff. -Resident #2 received a NCS diet. Interview with a second Cook on 06/29/17 at 9:23 a.m. revealed: -She referred to the facility handwritten diet lists when needed when preparing the residents meals. -She knew the residents and what diets they received. -She prepared the residents' plates using the large metal spoons. -She tried to make sure the diabetic residents received unsweetened tea and sugar free desserts. -She could not recall whether or not she had given sweetener packets to Resident #2 because he ate in his room. -Resident #2 received a NCS diet. Interview with Resident #2 on 06/29/17 at 12:30 p.m. revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 53 -He received large portions of food on his plate. -Sometimes his beverages tasted sweet when he received them especially his tea. -He did not get a dessert the majority of the time. Observation of lunch meal preparation on 06/29/17 at 12:07 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Review of the Dietitian's Menu for the lunch meal on 06/29/17 at 12:15 p.m. revealed NCS were to receive 1/3 cup meat of choice, 1 serving starchy vegetables, 3/8 cup vegetables, 3/8 cup fruit, and 1/3 cup roll. Observation of Resident #2's lunch meal plate on 06/29/17 at 12:20 p.m. revealed: -Resident #2 was served large portions of 1 cup or more of ham, turnip greens, yams, applesauce, and roll. -The resident received 8 ounces of unsweetened tea and 8 ounces of water. -Resident #2 did not receive sweetener packets and a dessert of orange sugar free Jell-O. Refer to interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:00 p.m. Refer to interview with the Administrator on 06/29/17 at 5:15 p.m. 3. Review of Resident #3's current FL-2 dated 01/26/17 revealed the resident's diagnoses included diabetic retinopathy, Alzheimer's dementia, major neurocognitive disorder, schizoaffective disorder - bipolar type, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, deep vein thrombosis, reduced abdominal hernia, history of seizures,	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 54 and history of heart attack. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 12/28/15. Review of physician's orders dated 03/30/17 and 04/29/17 for Resident #3 revealed orders for a no concentrated sweets (NCS) diet. Review of the facility's diet list revealed Resident #3 was on a NCS diet. Review of Resident #3's June 2017 medication administration record (MAR) revealed the resident's blood sugar ranged from 94 - 185 from 06/01/17 - 06/29/17. Observation of the kitchen and pantry areas on 06/28/17 at 10:50 a.m. revealed: -Two handwritten lists of residents with diets were posted on the wall of the bulletin board. -Resident #3 had a diet menu of "no concentrated sweets (NCS)" listed. -There were three large boxes of pink sweetener packets. -There was a variety of sugar free snacks on the kitchen pantry shelves. Interview with a Cook on 06/28/17 at 10:52 a.m. revealed: -All of the residents received the same foods when she cooked. -The diabetic residents received unsweetened tea and the facility staff in the dining room were supposed to make sure the residents received sweetener packets. -She did not hand out the sweetener packets to residents because she was in the kitchen.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 55 Observation of the dinner meal preparation on 06/28/17 at 4:52 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Confidential interviews with three staff members revealed: -Every resident's food on their plates looked the same to them. -All of the residents were served "very large" portions of food on their plates. -They thought all of the resident's plates were supposed to "look alike so no one resident would have something different on their plate than another resident. -The residents who received NCS diets were given sweetener packets the majority of time. -Resident #3 did not always get sweetener packets with his meals. He usually had to ask for them at mealtimes. -Resident #3 received regular tea, jelly, and desserts the majority of the time. Observation of the breakfast meal preparation on 06/29/17 at 8:10 a.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Review of the Dietitian's Menu for the breakfast meal on 06/29/17 at 8:40 a.m. revealed no concentrated sweets diets were to receive 1 serving eggs, 1 serving meat, and ¼ cup toasted bread with 1 each reduced calorie jelly and sweetener packets. Observation of Resident #3's breakfast meal plate on 06/29/17 at 8:45 a.m. revealed: -Resident #3 was served large portions of 1 cup or more of soft scrambled eggs, sausage, grits, and peaches with regular jelly.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 56 -Resident #3 did not receive reduced calorie jelly. -Resident #3 did not receive sweetener packets. -He asked for coffee and sweetener packets from two staff before receiving them. Interview with a Cook on 06/29/17 at 9:10 a.m. revealed: -She followed the handwritten diet lists when she prepared the residents' meals. -She liked to make sure all residents received a "good sized" portion of food on their plates. -She used measuring cups the majority of the time when preparing the residents' plates but had not done so that morning because food preparation was running behind that day. -She prepared the residents' plates using the large metal spoons. -The diabetic residents received the same jelly as the other residents. -She was not sure if Resident #3 received sweetener packets during mealtimes because she worked mainly in the kitchen. -Resident #3 received a NCS diet. Interview with a second Cook on 06/29/17 at 9:23 a.m. revealed: -She referred to the handwritten diet lists when needed when preparing the residents meals. -She knew the residents and what diets they received. -She prepared the residents' plates using the large metal spoons. -She tried to make sure the diabetic residents received unsweetened tea and sugar free desserts. -She had given sweetener packets to Resident #3 because he ate in the dining room. -Resident #3 received a NCS diet. Interview with Resident #3 on 06/29/17 at 12:15	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 57 p.m. revealed: -He received large portions of food on his plate. -His beverages were sweet the majority of the time when he received them. -He had to ask for sweetener during mealtimes. -He got a regular dessert like everyone else the majority of the time. -Sometimes he received sugar free Jell-O. Observation of the lunch meal preparation on 06/29/17 at 12:07 p.m. revealed no measuring cups or spoons were used when serving the food to the residents' plates. Review of the Dietitian's Menu for the lunch meal on 06/29/17 at 12:15 p.m. revealed no concentrated sweets diets were to receive 1/3 cup meat of choice, 1 serving starchy vegetables, 3/8 cup vegetables, 3/8 cup fruit, and 1/3 cup roll. Observation of Resident #3's lunch meal plate on 06/29/17 at 12:20 p.m. revealed: -Resident #3 was served large portions of 1 cup or more of ham, turnip greens, yams, applesauce, and roll. -The resident was served 8 ounces of unsweetened tea and 8 ounces of water. -Resident #3 did not receive sweetener packets but did receive a dessert of orange sugar free Jell-O. Refer to interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:00 p.m. Refer to interview with the Administrator on 06/29/17 at 5:15 p.m. _____ Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:00 p.m. revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 310	Continued From page 58 -She had written the facility diet lists of residents and posted on the bulletin board in the kitchen for dietary staff. -She updated the handwritten facility diet list when needed. -She was not aware the kitchen staff were not following the Dietitian's menu with specified portion sizes. -She would make sure the kitchen staff followed the Dietitian's current menu with specified portion sizes and used measuring cups and spoons when serving therapeutic diets. Interview with the Administrator on 06/29/17 at 5:15 p.m. revealed: -She was unaware the kitchen staff were not following the therapeutic diet menus for the residents. -She was not aware the diet lists were followed for all residents instead of the Dietitian's menu with specified portion sizes. -The residents' meals were supposed to be prepared according to each residents' physician ordered diet. -The cooks were supposed to follow the Dietitian's menus with specified portion sizes and diet textures. -She was not aware the kitchen staff were not using measuring cups and spoons when serving the residents' plates. -She believed the kitchen had measuring cups, but she would make sure. -She would make sure the kitchen staff followed the Dietician's menu with specified portion sizes and diets for all residents. -The facility would follow Resident #1's current order for a no added salt, pureed diet with thickened liquids and clarify as needed to better meet what the facility offered.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 344	Continued From page 59	D 344		
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 interviews and record reviews, the facility failed to clarify medication orders for 1 of 3 residents sampled (#2) who was receiving sliding scale insulin 4 times a day and a scheduled insulin 3 times a day that were not included on the current FL-2 and had not been clarified. The findings are: Review of Resident #2's current FL-2 dated 05/02/17 revealed the resident's diagnoses included diabetes mellitus, Alzheimer's dementia, atrial fibrillation, peripheral vascular disease, hypokalemia, transient ischemic attack, and alcoholism. Review of a physician's order dated 03/29/16 (prior to the current FL-2) for Resident #2 revealed:	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 344	Continued From page 60 -There was an order to give Novolog insulin 4 units with each meal along with sliding scale insulin. -There was no parameters for the sliding scale listed in the order or how often it was to be administered. Review of a signed physician's order sheet dated 04/29/16 (prior to the current FL-2) revealed: -There was an order for Novolog insulin, check blood sugar 3 times daily followed by sliding scale insulin: < 199 = 0 units; 200 - 250 = 3 units; 251 - 300 = 5 units, 301 - 350 = 7 units; 351 - 400 = 10 units; 401 - 450 = 12 units, and > 450 = 14 units and call physician. -There was a second order for blood sugars to be checked 4 times daily. -There was an order for Levemir 17 units at bedtime. -There was not an order for Novolog insulin to be given with each meal. Review of Resident #2's current FL-2 dated 05/02/17 revealed: -The only order for insulin was for Levemir insulin 17 units at bedtime. (Levemir is long-acting insulin used to lower blood sugar.) -There was an order for fingerstick blood sugars (FSBS) to be checked 4 times a day. -There was a second order for FSBS to be checked once a day. Review of a subsequent physician's order dated 05/23/17 for Resident #2 revealed an order to increase Levemir to 18 units at bedtime. Review of Resident #2's April 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Novolog insulin, check blood sugar 3 times a day and at	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 344	Continued From page 61	D 344		

bedtime followed by sliding scale insulin: < 199 = 0 units; 200 - 250 = 3 units; 251 - 300 = 5 units, 301 - 350 = 7 units; 351 - 400 = 10 units; 401 - 450 = 12 units, and > 450 = 14 units and call physician. (Novolog is rapid-acting insulin used to lower blood sugar.)
-The blood sugars and Novolog sliding scale insulin were documented as administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 7:30 p.m. from 04/01/17 - 04/30/17.
-There was a handwritten entry for Novolog insulin, give 4 units before every meal and it was documented as administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m. from 04/01/17 - 04/30/17.
-There was an entry for Levemir insulin 17 units at bedtime and it was documented as administered at 8:00 p.m. from 04/01/17 - 04/30/17.
-The resident's blood sugar ranged from 64 - 278 from 04/01/17 - 04/30/17.

Review of Resident #2's May 2017 MAR revealed:
-There was a handwritten entry for Novolog insulin, check blood sugar 3 times a day and at bedtime followed by sliding scale insulin: < 199 = 0 units; 200 - 250 = 3 units; 251 - 300 = 5 units, 301 - 350 = 7 units; 351 - 400 = 10 units; 401 - 450 = 12 units, and > 450 = 14 units and call physician.
-The blood sugars and Novolog sliding scale insulin were documented as administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 7:30 p.m. from 05/01/17 - 05/31/17.
-There was a handwritten entry for Novolog insulin, give 4 units before every meal and it was documented as administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m. from 05/01/17 - 05/31/17.
-There was an entry for Levemir insulin 17 units at bedtime and it was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 344	Continued From page 62	D 344		

administered at 8:00 p.m. from 05/01/17 - 05/22/17.
-There was a handwritten entry for Levemir 18 units at bedtime and it was administered at 8:00 p.m. from 05/23/17 - 05/31/17.
-The resident's blood sugar ranged from 60 - 379 from 05/01/17 - 05/31/17.

Review of Resident #2's June 2017 MAR revealed:
-There was a handwritten entry for Novolog insulin, check blood sugar 3 times a day and at bedtime followed by sliding scale insulin: < 199 = 0 units; 200 - 250 = 3 units; 251 - 300 = 5 units, 301 - 350 = 7 units; 351 - 400 = 10 units; 401 - 450 = 12 units, and > 450 = 14 units and call physician.
-The blood sugars and Novolog sliding scale insulin were documented as administered at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 7:30 p.m. from 06/01/17 - 06/30/17.
-There was a handwritten entry for Novolog insulin, give 4 units before every meal and it was documented as administered at 7:30 a.m., 11:30 a.m., and 4:30 p.m. from 06/01/17 - 06/30/17.
-There was an entry for Levemir insulin 18 units at bedtime and it was documented as administered at 8:00 p.m. from 06/01/17 - 06/29/17.
-The resident's blood sugar ranged from 67 - 286 from 06/01/17 - 06/30/17.

Review of all subsequent physician's orders for Resident #2 since the current FL-2 dated 05/02/17 revealed:
-There was no subsequent orders for Novolog sliding scale insulin or Novolog scheduled insulin.
-There was no documentation the physician was contacted to clarify the orders for Novolog sliding scale insulin or Novolog scheduled insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 344	Continued From page 63 Interview with a medication aide (MA) on 06/30/17 at 4:45 p.m. revealed: -She gave the Novolog insulin as documented on the MARs. -She was not aware Novolog sliding scale insulin and the scheduled Novolog insulin with meals was not included on the current FL-2. -She had not contacted anyone to clarify the orders. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 4:10 p.m. revealed: -The MA on duty was responsible for clarifying medication orders when the order was received if needed. -The MA was supposed to let the RCC know if any orders had to be clarified. -The MA would implement the order and put in the RCC's box. -The RCC tried to check the orders in the box daily to make sure orders were complete and being followed. -She would contact the resident's primary care provider for clarification. Interview with Resident #2 on 06/30/17 at 5:04 p.m. revealed: -He usually got insulin before meals. -The MAs usually checked his blood sugar 3 or 4 times a day. -His blood sugar usually ran high. Attempted telephone interview with Resident #2's PCP on 06/30/17 regarding the insulin orders was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 64 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 6 residents (#4, #5, #6, #7) observed during the medication pass including errors with insulin (#6), a medication used to treat high blood pressure (#4), a medication for pain and inflammation (#7), a medication for acid reflux (#5) and for 2 of 4 residents sampled (#3, #4) for errors with a transdermal patch for dementia (#4) and a potassium supplement (#3). The findings are: 1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 28 opportunities during the 7:30 a.m. / 8:00 a.m. medication pass on 06/29/17. A. Review of Resident #6's current FL-2 dated 05/05/17 revealed the resident's diagnoses included type II diabetes, Alzheimer's dementia, hypertension, acute stroke, hyperlipidemia, and mild urinary tract infection. Review of a physician's order dated 06/20/17 for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 65 Resident #6 revealed there was an order for Lantus insulin, 5 units in the mornings before breakfast. (Lantus is long-acting insulin used to lower blood sugar.) [According to the Lantus manufacturer, a safety test should be performed before each injection. A dose of 2 units should be dialed up and the injection button pressed until the dose window shows a "0" and insulin is seen coming from the needle. This removes air bubbles to ensure the most accurate dose and it ensures the pen and needle are working properly. When administering the insulin, the injection button should be pressed all the way down and held in for 10 seconds to make sure the full dose is administered.] Review of Resident #4's June 2017 medication administration record (MAR) revealed: -There was a handwritten entry for Lantus inject 5 units every morning 15 minutes before breakfast. -Lantus was scheduled to be administered at 8:00 a.m. -The resident's blood sugar ranged from 77 - 400 from 06/01/17 - 06/29/17. Observation during the 8:00 a.m. medication pass on 06/29/17 revealed: -The medication aide (MA) dialed the Lantus insulin pen to 5 units and injected the insulin into Resident #6 at 8:30 a.m. -The MA did not perform a safety test with a 2 unit air shot prior to dialing the 5 units ordered and administering the insulin. -The MA held the injection for 3 seconds instead of 10 seconds as required. Interview with the MA on 06/29/17 at 12:50 p.m. revealed: -Resident #4 just started using the insulin pen	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 66	D 358		

about a week ago.
-No other residents used an insulin pen.
-She had not been trained on how to use the insulin pen at the facility but she had used an insulin pen before.
-She was not aware a 2 unit test dose should be performed before each use.
-She was not aware the injection should be held for 10 seconds.

Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:30 p.m. revealed:
-Resident #4 was the only resident who used an insulin pen and that just started recently.
-There had been no training on the use of the insulin pen.
-Staff who administered the insulin were diabetics themselves so she thought they knew how to use the insulin pen.

Interview with the Administrator on 06/29/17 at 1:33 p.m. revealed:
-She is a nurse so she is aware a 2 unit test dose was required with the Lantus insulin pen prior to each use.
-She was also aware the injection should be held in.
-She would make sure the MAs received training on the use of the insulin pen.

Interview with Resident #6 on 06/29/17 at 4:52 p.m. revealed:
-Her blood sugar "usually ran okay".
-She was not sure how often she received insulin or how often her blood sugar was checked.

B. Review of Resident #5's current FL-2 dated 05/02/17 revealed:
-The resident's diagnoses included Alzheimer's dementia, paranoid schizophrenia, and drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 67	D 358		

dependence.
-There was an order for Prilosec 40mg take 1 capsule before a meal. (Prilosec is used to treat acid reflux.)

Review of Resident #5's June 2017 medication administration record (MAR) revealed:
-There was an entry for Prilosec 40mg 1 capsule before a meal.
-Prilosec was scheduled to be administered at 7:30 a.m.

Observation of the medication pass on 06/29/17 revealed:
-The medication aide (MA) administered morning medications to Resident #5 at 8:12 a.m.
-Prilosec 40mg was not administered when the other morning medications were administered.
-The MA documented all morning medications, including the Prilosec, as administered on the MAR.

Interview with the MA on 06/29/17 at 10:00 a.m. revealed:
-The residents usually went to the dining room to eat breakfast by 8:20 a.m.
-She overlooked the Prilosec and forgot to punch it out from the bubble card.
-She usually administered the Prilosec at the same time as the medications scheduled for 8:00 a.m.
-She would contact the primary care provider (PCP) to see if it was okay to administer the Prilosec now.

Interview with the MA on 06/29/17 at 10:05 a.m. revealed she spoke with the PCP via telephone and got a verbal order to give the Prilosec now.

Observation on 06/29/17 at 10:07 a.m. revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 68 the MA administered Prilosec 40mg to Resident #5. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:30 p.m. revealed: -The MAs had been trained to read the MARs and give all medications at the scheduled time. -Prilosec should have been administered at the scheduled time. Review of a physician's order dated 06/29/17 at 10:13 a.m. for Resident #5 revealed an order to give Prilosec dose now due to missed dose before breakfast today only. Interview with Resident #5 on 06/29/17 at 4:20 p.m. revealed: -She usually got her morning medications before she ate breakfast. -She was unsure of the names of the medications she took. -The medications sometimes irritated her stomach. -She denied having heartburn or indigestion. C. Review of Resident #7's current FL-2 dated 05/02/17 revealed: -The resident's diagnoses included dementia, mental retardation, renal mass, and acute encephalopathy. -There was an order for Mobic 15mg 1 tablet daily with a meal for pain and inflammation. (Mobic is used to treat pain and inflammation.) Review of Resident #7's June 2017 medication administration record (MAR) revealed: -There was an entry for Mobic 15mg every day for pain/inflammation with a meal. -Mobic was scheduled to be administered at 8:00 a.m.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 69 Observation of the medication pass on 06/29/17 revealed: -Mobic 15mg was administered to Resident #7 at 8:26 a.m. -The resident was in bed in her room. -The medication aide (MA) stated the resident would go to the dining room to eat breakfast. Observation of Resident #7 on 06/29/17 at 9:22 a.m. revealed: -The resident did not come out of her room to go to the dining room until 9:22 a.m. -The resident was served breakfast at 9:24 a.m. -Mobic was administered at 8:26 a.m., 58 minutes before the meal instead of with the meal as ordered. Interview with the MA on 06/29/17 at 12:30 p.m. revealed: -The residents usually start eating breakfast by 8:20 a.m. -She usually gave medications ordered with meals 15 to 30 minutes before the meals. -Resident #7 would not eat breakfast some days. -She would usually give the resident a snack if she did not eat breakfast. -She would wait to give the snack until 9:00 a.m. to see if the resident would get up and eat breakfast. -She did not give Resident #7 a snack that morning on 06/29/17. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:25 p.m. revealed: -The facility's policy was to administer medications ordered with meals while the resident was eating the meal. -The MAs have been trained and they know medications ordered with meals should be given	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 70 with the meal. Interview with Resident #7 on 06/29/17 at 4:49 p.m. revealed: -She usually got her morning medications before she ate breakfast. -She did not eat breakfast some days and staff was aware she did not always eat breakfast. -The medications did not irritate her stomach. Telephone interview with Resident #7's primary care provider (PCP) on 06/30/17 at 3:15 p.m. revealed when a medication was ordered with a meal, she expected it to be administered with the meal while the resident was eating. D. Review of Resident #4's current FL-2 dated 03/20/17 revealed: -The resident's diagnoses included dementia, hypertension, acute kidney injury, and sepsis and influenza A - resolved. -There was an order for Metoprolol 50mg twice a day with meals. (Metoprolol lowers blood pressure and is best absorbed when taken with a meal.) Review of Resident #4's June 2017 medication administration record (MAR) revealed: -There was an entry for Metoprolol 50mg twice a day with meals. -Metoprolol was scheduled to be administered at 8:00 a.m. and 5:00 p.m. Observation of the medication pass on 06/29/17 revealed: -Metoprolol 50mg was administered to Resident #4 at 8:20 a.m. -The resident was in bed in her room. -The medication aide (MA) stated the resident would go to the dining room to eat breakfast.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 71 Observation of Resident #4 on 06/29/17 revealed: -The resident was served breakfast in the dining room at 8:39 a.m. -Metoprolol was administered before the meal instead of with the meal as ordered. Interview with the MA on 06/29/17 at 12:30 p.m. revealed: -The residents usually start eating breakfast by 8:20 a.m. -She usually gave medications ordered with meals 15 to 30 minutes before the meals. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:25 p.m. revealed: -The facility's policy was to administer medications ordered with meals while the resident was eating the meal. -The MAs have been trained and they know medications ordered with meals should be given with the meal. Interview with Resident #4 on 06/29/17 at 4:25 p.m. revealed: -She was unsure when she usually received her medications. -The medications did not irritate her stomach. Telephone interview with Resident #4's primary care provider (PCP) on 06/30/17 at 3:15 p.m. revealed when a medication was ordered with a meal, she expected it to be administered with the meal while the resident was eating. 2. Review of Resident #3's current FL-2 dated 01/26/17 revealed: -The resident's diagnoses included diabetic retinopathy, Alzheimer's dementia, major neurocognitive disorder, schizoaffective disorder -	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 72	D 358		

bipolar type, hypertension, hyperlipidemia, chronic obstructive pulmonary disease, deep vein thrombosis, reduced abdominal hernia, history of seizures, and history of heart attack.
-There was an order for Potassium Chloride ER 10mEq 2 tablets once daily. (Potassium Chloride ER is a potassium supplement used to treat low potassium levels. Potassium Chloride ER is extended-released and can irritate the mouth and throat and should not be crushed.)

Review of a physician's orders dated 11/29/16 and 04/29/17 for Resident #3 revealed orders to crush all medications that can be crushed.

Review of Resident #3's June 2017 medication administration record (MAR) revealed:
-There was an entry for Potassium Chloride ER 10mEq take 2 tablets every day.
-Potassium Chloride ER was scheduled to be administered at 8:00 a.m.

Interview with the medication aide (MA) on 06/30/17 at 11:20 a.m. revealed:
-She usually crushed all of Resident #3's tablets, including the Potassium Chloride ER tablets and put them in applesauce to administer to the resident.
-She opened any capsules and put them in applesauce as well.

Observation of Resident #3's medications on hand on 06/30/17 revealed:
-There was a supply of Potassium Chloride ER 10mEq tablets dispensed on 06/01/17.
-There was a red sticker on the bubble card that read "Do not chew or crush".

Interview with the MA on 06/30/17 at 11:55 a.m. revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 73 -She had not noticed the Do Not Crush sticker on the Potassium Chloride bubble card. -She crushed the Potassium Chloride tablets every day. Interview with the Resident Care Coordinator (RCC) on 06/30/17 at 12:07 p.m. revealed: -They had a Do Not Crush list for the MAs to use. -She was not aware Resident #3's Potassium Chloride ER tablets were being crushed. Interview with the Administrator on 06/30/17 at 12:08 p.m. revealed: -There was a Do Not Crush list for the MAs to use. -She would contact the primary care provider (PCP) to change the Potassium Chloride to a liquid. Review of the Do Not Crush list provided by the Administrator on 06/30/17 revealed Potassium Chloride tablets were included on the list and should not be crushed. Telephone interview with Resident #3's PCP on 06/30/17 at 3:00 p.m. revealed: -The resident's Potassium Chloride tablets should not be crushed. -The resident had not complained about any gastrointestinal symptoms. -She could change the tablets to a liquid formulation. Interview with Resident #3 on 06/30/17 at 5:30 p.m. revealed the resident's medication did not irritate his throat or stomach. 3. Review of Resident #4's current FL-2 dated 03/20/17 revealed: -The resident's diagnoses included dementia,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 74	D 358		

hypertension, acute kidney injury, and sepsis and influenza A - resolved.
-There was an order for Exelon 9.5mg/24 hour patch, apply transdermal patch once daily. (Exelon patch is used to treat all stages of dementia. Exelon patch should be changed every 24 hours at the same time every day.)

Review of Resident #4's June 2017 medication administration record (MAR) revealed:
-There was an entry for Exelon 9.5mg/24 hour patch, apply 1 patch every day, do not apply to the same area more than once every 14 days.
-The Exelon patch was documented as administered at 8:00 a.m.
-There was no documentation of the sites the patch was being applied.
-There was no documentation of the patch being removed.

Observation during the medication pass on 06/29/17 revealed:
-The medication aide (MA) applied an Exelon 9.5mg/24 hour patch on Resident #4's right waist at 8:21 a.m.
-The MA dated and initialed the patch prior to applying it.
-No patch was observed to be removed.

Interview with the MA on 06/29/17 at 12:30 p.m. revealed:
-She usually rotated the site of the patch but she did not document because she usually worked most days and was the one applying the patch.
-She thought the Exelon patch was supposed to be removed at bedtime like Nitroglycerin patches (for heart/chest pain) have to be removed.
-Second shift staff usually removed the Exelon patch at bedtime but they did not document the removal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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 358	Continued From page 75 -She was not aware the Exelon patch should remain on the resident for 24 hours. Interview with the Resident Care Coordinator (RCC) on 06/29/17 at 1:25 p.m. revealed: -She was not aware staff was removing the Exelon patch at night. -Staff should follow the order and if they had any question, staff should come to her or contact the physician. Interview with a personal care aide (PCA) on 06/30/17 at 9:15 a.m. revealed: -She usually worked on second shift as a PCA. -Resident #4's Exelon patch was usually removed at night because a new one was put on every morning. -She did not think anyone documented when the patch was removed. -The patch would sometimes come off while the resident was being bathed 3 times a week. Interview with Resident #4 on 06/29/17 at 4:25 p.m. revealed she did not know when the patch was applied or removed. Telephone interview with Resident #4's primary care provider (PCP) on 06/30/17 at 3:15 p.m. revealed: -The Exelon patch should be worn 24 hours a day and changed about the same time every day. -She was not aware staff was taking off Resident #4's Exelon patch at night. -Resident #4 could benefit from wearing the patch 24 hours a days as ordered.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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
D912	Continued From page 76 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. 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 to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care and nutrition and food service. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 2 of 3 sampled residents (#1, #2) as related to failure to notify the primary care provider of coughing episodes for a resident (#1) with swallowing difficulties and a history of aspiration pneumonia and failure to obtain physical therapy / occupational therapy for a resident (#2) who required assistance with all activities of daily living due to weakness and decreased mobility. [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to clarify the consistency of thickened liquids for 1 of 1 residents sampled (#1) who required thickened liquids and had swallowing difficulties and a history of aspiration pneumonia. [Refer to Tag D307 10A NCAC 13F .0904(e)(1) Nutrition and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054064	A. BUILDING: _____ B. WING _____	06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE MEMORY UNIT OF KINSTON	1406 EAST SHINE STREET KINSTON, NC 28501

(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
D912	Continued From page 77 Food Service (Type B Violation).]	D912		