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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 10/18/17 - 10/20/17 and 10/23/17-10/26/17. The complaint investigation was initiated on 09/20/17 by Harnett County Department of Social Services.	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 the dining room floor was kept clean and in good repair and failed to keep the mini blinds in the windows of the dining room clean. The findings are: Review of the facility's sanitation report dated 10/25/17 revealed the facility received a score of 93. Observation of the dining room floor on 10/19/17 at 9:33 a.m. revealed: -There was a black build-up of dirt and grime along the edges of the floor baseboards with a heavier concentration in the front section of the dining room. -There was collected dust and debris in the	D 074		

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corners of the floor throughout the dining room.
-The floor around the first 3 tables had scattered black scuff marks.
-There were long black scuff marks around a second table located close to an outer window.
-There were scattered areas of a black build-up on the dining room floor.
-The floor covering had 2 chipped areas that exposed the black under layer surface of the floor.

Interview with a Dietary Aide (DA) on 10/ 19/17 at 3:46 p.m. revealed the DAs did the sweeping and mopping three times daily in the dining room after the residents' meals were served.

Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed:
-The DM had worked at the facility since 2013 and in his current role as DM since last year.
-Dietary Aides were responsible for cleaning tables, sweeping and mopping the floors every day in the dining room.
-The DM and the cook were responsible to assure all cleaning was done in the kitchen and dining room at the end of their shift.
-The DM was not sure who was responsible to do the "deeper cleaning" of the dining room floor and baseboards but thought it may be housekeeping or maintenance.
-The DM had noticed the black build-up along the floor's baseboards a few weeks ago.
-The DM had a laminated cleaning schedule for dietary staff to follow that was posted in the kitchen.
-The DM or the Cook assigned the cleaning tasks.
-The laminated cleaning schedule had been missing for about 2-3 weeks but the DM had planned to have the cleaning schedule reposted

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as soon as possible.
-All dietary staff had been instructed by him about the cleaning tasks for the dining room.
-The DM or the Cook were required to physically walk around the dining room at the end of each shift to assure all cleaning needs had been done.
-The DM knew that some cleaning tasks were missed from time to time.

Interview with Maintenance person on 10/25/17 at 10:31 a.m. revealed:
-Maintenance was responsible for stripping and buffing the floor.
-The dining room floor was last stripped and buffed in the spring of this year and it was time to be done again.
-The Maintenance person usually stripped and buffed the dining room floor 2-3 times per year.

Confidential interview with a staff member revealed:
-The black build-up around the baseboards and floor "bothered the staff member" but the staff never heard any of the resident's complaining about it.
-The staff member had not reported the black build-up to management.

Confidential interview with a second staff member revealed dietary staff mopped after the residents meals but did not have time to do detailed mopping in the dining room.

Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed:
-The dining room floor had some damaged areas that could not be removed, other areas were scuffs and other areas were dents.
-The baseboard edges had been damaged and

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pushed in at the bottom that adjoined the floor which made it difficult to clean in the edges.
-Dietary staff were responsible for sweeping and mopping three times a day and to assure the dining room floor remained clean.
-The dining room was planned for renovation the end of November 2018.

Observation of the dining room floor on 10/24/17 at 4:20 p.m. revealed:
-The black build-up had been removed along the baseboards.
-The Black scuff marks had not been removed.

Observation of the blinds in the dining room on 10/24/17 at 4:23 p.m. revealed:
-There was a mini blind hanging in the window on the right side of the dining room that was heavily soiled in orange and red stains that covered the bottom fourteen slats of the mini blind.
-There was a second mini blind hanging in a window of the dining room with a brown spattered stains across the lower 12 slats.
-There was another mini blind hanging in a window of the dining room that had dust and grime that covered most of the slats.
-There were seven other mini blinds in the dining room that had a build-up of dust and with brown stained specks scattered across the mini blinds.

Confidential interview with a resident revealed the blinds in the dining room needed to be cleaned.

Confidential interview with a staff revealed the staff had never seen anyone clean the blinds in the dining room.

Interview with the Cook on 10/19/17 at 3:55 p.m. revealed the cook was not sure who cleaned the blinds in the dining room but thought it would be

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D 074	Continued From page 4 housekeeping staff. Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed the DM was not sure who was responsible to clean the blinds in the dining room but thought it may be housekeeping or maintenance. Interview with a second housekeeper on 10/23/17 at 12:18 p.m. revealed she had never cleaned the mini blinds in the dining room. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed kitchen staff were responsible to clean the blinds in the dining room. Interview with Maintenance person on 10/25/17 at 10:31 a.m. revealed: -He had cleaned the blinds in the dining room before. -He last cleaned the blinds just before the spring of 2017 and were due to be cleaned now. Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed: -The dining room was planned for renovation the end of November 2018 and all of the blinds in the dining room would be replaced. -Dietary staff were responsible to clean the blinds as needed.	D 074		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows	D 083		

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in resident use areas to provide for resident privacy;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observation and interviews, the facility failed to replace vertical window mini blinds in 2 occupied resident rooms, 1 occupied resident room with bent slats in the blind and a broken curtain rod, 1 mini blind with bent slats in the front Parlor (a common sitting area) and 2 mini blinds in the dining room.

The findings are:

Interview with a resident assigned to room #105 on 10/23/17 at 11:59 a.m. revealed:
-The mini blind in her room had been broken more than 6 months ago.
-The mini blind was damaged and the curtain rod had been torn down by a previous roommate one night after her roommate with dementia "flipped out".
-She had spoken with the current Assistant Executive Director about replacing the blind and the curtain rod but it had not been done yet.
-She could not remember when she had told the Assistant Executive Director about the mini blind and the curtain rod but it had been a few months ago.

Observation in resident room #105 on 10/23/17 at 12:14 p.m. revealed:
-The mini blind had several bent slats resulting in a gap which permitted unobstructed vision from outside to the inside.
-There was not a curtain over the window and a curtain rod was standing upright in the corner of the room.

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D 083	Continued From page 6 -The resident's room was located beside the courtyard and a common sitting area was in view from the resident's window. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed the Housekeeping Supervisor had not noticed the mini blind or curtain rod in resident room #105. Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed: -He was told about the need for a new mini blind and the curtain rod needed to be replaced in resident room #105 about 2 weeks ago. -He was currently trying to locate a part to attach the curtain rod to in order to rehang the curtain. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -The Assistant Director was aware that the mini blind and curtain rod needed to be replaced in resident room #105 and had a quote to re-due the curtain rod. -The mini blind would be replaced today (10/25/17). Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of resident room #206 on 10/18/17 at 11:28 a.m. revealed there were greater than ten broken and or bent slats in the mini blind hanging in the window resulting in a gap which permitted unobstructed vision from outside to inside.	D 083		

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D 083	Continued From page 7 Based on an attempted interview with the two residents that resided in room #206 on 10/18/17 at 11:39 a.m. revealed the residents were not interviewable. Interview with a Housekeeper on 10/23/17 at 12:18 p.m. revealed: -The resident's in resident room #206 pulled and tugged on the blinds a lot to look out. -The blinds in resident room #206 had been bent for several months. -She had not reported the bent blinds to anyone. Observation of the blind in room #206 on 10/23/17 at 12:20 pm revealed the blind with the bent slats had been removed leaving nothing to cover the window. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -The residents in room #206 would only allow a family member to do heavy cleaning in the room. -The family member comes twice yearly to do heavy cleaning. The family member just came a few days ago and took the mini blind down in the room. The facility had replaced the mini blind for the window in room #206. Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of an occupied resident room #109 on 10/25/17 at 6:38 p.m. revealed:	D 083		

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-The mini blind had greater than eight bent slats resulting in a gap which permitted unobstructed vision from outside to inside.
-The resident's room was located beside the courtyard and a cemented walkway was in view from the resident's window.

Interview with one of the residents assigned to room #109 on 10/25/17 at 6:38 p.m. revealed she had just been moved into the room today.

Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m.

Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m.

Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m.

Observation of the mini blinds in the dining room on 10/24/17 at 4:23 a.m. revealed:
-There was a mini blind hanging in the window on the right side of the dining room with six bent slats.
-There was a second mini blind hanging in a window of the dining room that had one broken slat.

Interview with the Administrator, Assistance Executive Director and the Marketing Director on 10/20/17 at 9:34 a.m. revealed the dining room was planned for renovation the end of November 2018 and all of the blinds in the dining room would be replaced.

Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed the mini blinds would be replaced in the dining room when the renovation was done.

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D 083	Continued From page 9 Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Observation of the mini blind hanging in the right window in the front Parlor of the facility on 10/23/17 at 12:18 p.m. revealed the mini blind had 5 bent slats on the right side of the blind. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed the mini blind with the bent slats had been removed from the front Parlor. Refer to the interview with the Maintenance person on 10/25/17 at 10:31 a.m. Refer to the interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. Refer to the interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed: -Staff were expected to fill out a maintenance work request when needed repairs were seen at the facility. -He inspected the facility daily and completed repairs when he seen them. Interview with the Housekeeping Supervisor on 10/25/17 at 9:40 a.m. revealed the Housekeeper Supervisor had noticed some bent and broken	D 083		

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D 083	Continued From page 10 mini blinds in the facility and when she saw a broken or bent mini blind she would verbally tell maintenance. Interview with the Assistant Executive Director on 10/25/17 at 10:39 a.m. revealed: -Residents "mess with the blinds" and eventually the mini blinds became damaged. -The facility had received an estimate for new mini blinds in the facility a few months ago. -Maintenance was expected to do a physical walk through of the facility for needed repairs.	D 083		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 7 resident's sampled (#1, #4) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:	D 234		

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1. Review of Resident #1's current FL-2 dated 06/13/17 revealed diagnoses included syncope collapse, congestive heart failure, acute kidney failure, and late effects of cerebrovascular disease.

Review of Resident #1's Resident Register revealed an admission date of 06/25/14.

Review of Resident #1's tuberculosis (TB) tests revealed:
-There was one TB skin test placed on 08/12/14 and read as negative on 08/14/14.
-There was an untitled document for an admission/yearly TB screening dated 05/17/17 for a Purified Protein Derivative (PPD) test site of the left forearm for the resident however, there was no documentation to indicate who placed or read the TB skin test or when it was read.
-There was no documentation of any other TB skin tests in the record.

Interview with the Health Service Director (HSD) on 10/25/17 at 8:42 a.m. revealed:
-She was not aware the TB skin test for Resident #1 was incomplete.
-She would find out if they had more information on file for the TB skin in Resident #1's thinned record.

Based on observations, interviews and record reviews, Resident #1 was not interviewable.

Interview with Resident #1's family member on 10/24/17 at 6:45 p.m. revealed the family member was "not sure" if the resident had received a one step or two step TB screening and could not provide any additional information regarding the resident's history of TB screening's at the time the resident was admitted.

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A second interview with the HSD on 10/25/17 at 7:25 a.m. revealed:
-There was no additional documentation for a second TB test for Resident #1.
-The HSD would contact the primary care provider for an order for a 2 step TB screening.

2. Review of Resident # 4's current FL-2 dated 6/1/2017 included diagnoses of diabetes II, hyponatremia, hyperkalemia, insomnia, heart murmur, and hypertension.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 5/4/2012.

Review of Resident #4's tuberculosis (TB) tests revealed:
-There was documentation of a TB test placed on 11/16/2011 and read as negative on 11/18/2011.
-There was no other TB testing found in Resident #4's record.

Interview with Resident #4 on 10/20/17 at 9:07 a.m. revealed the resident was unable to recall any information regarding his past TB screenings.

Interview with the Health Service Director on 10/20/2017 at 3:30 p.m. revealed, she would have to review the resident's old records to see if she could find Resident #4's second TB skin test.

Interview with HSD on 10/24/2017 at 3:30 p.m. revealed:
-She was not able to find Resident #4's second TB skin test in his old records.
-She faxed the primary care provider (PCP) and received an order faxed on 10/23/2017 at 4:16 p.m. that the facility can do TB skin testing for

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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, record reviews, and interviews, the facility failed to assure the health care needs of 5 of 7 residents sampled (#2 #3, #4, #5 and #6) were met by failing to notify the health care provider of Resident #2, who was experiencing continued itching and rashes, Resident #4, who continued to complain of ear pain after antibiotic ear drops ran out earlier than ordered, Resident #6, with finger stick blood sugar results outside of the established parameters; failing to follow up with a Neurologist for monitoring of a progressive disease and to schedule an Optometry appointment for Resident #5; and failing to follow-up with a urology appointment for Resident #3. The findings are: 1. Review of Resident #2's current FL-2 dated 2/13/17 revealed diagnoses of degenerative joint disease (DJD), hypertension (HTN) and hallucinations. Review of Resident #2's Resident Register	D 273		

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revealed the resident was admitted to the facility on 03/01/17.

Review of Resident #2's care plan dated 3/02/17 revealed the resident's skin was normal.

a. Interview with Resident #2 on 10/18/17 at 10:50am revealed:
-She begin "itching all over my body about 2 months ago and tried to wash it away but it did not help".
-The staff told the resident she used too much detergent when washing her clothes, but the itching continued after she decreased the amount of detergent.
- The staff instructed the resident to stop scrubbing her groin and vaginal area too much when bathing. The resident started rinsing twice during bathes.
-The resident's physician ordered "some powder" over a month ago and the staff "put the powder on the itching" but it did not help. The resident stopped the staff from using it.
-The resident's family member transported the resident to her primary physician a few days ago (the resident did not remember the date) and he administered a "shot" and started a new medication for the itching. The itching was better.

Interview with Resident #2's family member on 10/20/17 at 11:15am revealed:
-The resident had been complaining of itching and had rashes under her breasts and in her groin area for about 2 months.
-The resident perspired a lot and retained moisture in the folds of her skin.
-The Health Service Director (HSD) discussed the use of detergent when the resident washed her clothes with the family member and the resident should use less detergent to decrease

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itching (the resident washed her own clothes).
-About 2 months ago, the resident's primary physician ordered medication for itching, but the resident refused the medication.
-The family member did not know if the facility contacted the physician about the resident's complaint of continued itching.
-After 2 months of itching, the family member took the resident to her primary physician and the resident received a steroid injection and several prescriptions to treat the rashes and itching. The resident was getting better.

Interview with the HSD on 10/20/17 at 2:10pm revealed:
-She was aware Resident #2 had been complaining of itching for several weeks.
-The HSD talked with staff about the use of detergent since the resident washed her own clothes.
-Because the family member was at the facility frequently (several times a week), the facility relied on the family member to communicate with the resident's physician, because he was an "outside" physician and did not make visits to the facility to see his residents.
-The family member would follow-up with the physician and report any problems.
-The family member transported the resident back and forth to all of her physician when needed and called the physician to report any problems or changes.
-For residents who received medical care from an "in house" physician (the medical group who traveled to the facility and provided medical care to residents), any medical changes would be emailed to the physician by the HSD and the physician would respond immediately.
- For residents who received medical care from an outside physician, changes would be reported

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to the family by the HSD or medication aides (MA) and the family would follow-up with the physician.
-Resident #2's family member transported her to her primary physician on 10/16/17 due to the resident continued to complain of itching. The resident received a "shot" and prescriptions for medications.
-The family member had followed up with the physician 3-4 times about the resident's complaint of itching, but because of the resident's confusion, it has been difficult for the physician to come up with a treatment for the itching/rash.
-The resident's family has not placed any stipulations on when and who could contact the resident's physician.
-The facility would always contact the physician to report any medical emergencies.

Interview with a 2nd shift personal care aide (PCA) on 10/20/17 at 2:55pm revealed:
-Resident #2 had complained of itching for about 2 months.
-When assisting the resident with showers, she complained of itching, but no rashes observed.
-The resident always sweated when she was in her room because her roommate kept the heat on and the room was hot.
-The PCA did not report the resident's itching to the MA because the MA was aware of the resident's itching.

Interview with a 1st shift MA on 10/23/17 at 11:20am revealed:
-Resident #2's family always transported her to medical appointments.
-The resident complained of itching all over about 2 months ago.
-In September 2017, the resident was ordered Nystatin powder (used to treat fungal skin

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infections) but the resident refused the powder and it was stopped.
- The resident continued to complain of itching.
-The resident continued to complain of itching until her family transported her to her physician on 10/16/17 and the resident was started on new medications and a topical ointment.
-The HSD was responsible for reporting resident changes/problems to the health care providers, but the MAs also reported if the HSD was not available.
-The MA did not contact the resident's physician to report the itching because the resident's family member took the resident to all of her appointments

Interview with a 2nd shift MA on 10/23/17 at 4:10pm revealed:
-Resident #2 had been complaining about itching for about 2 months.
-Her primary physician ordered nystatin powder the first of last month to be applied to the resident's back, under her breasts, on her feet, on her groin area and between her toes (which were areas the resident complained of itching) but the resident refused the treatment after only a few applications. The resident stated the powder did not help with the itching.
-The MA did not report the resident's refusal to use Nystatin powder or continued itching to her physician.

Review of a Physician Encounter report dated 9/01/17 revealed:
-The Resident #2's chief complaint was itching under her breast and groin.
-The resident complained of itching under her breast and in her groin. Stated she has been itching for the past month and has been using baby powder.

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-The resident was diagnosed with candidiasis of skin and urinary tract infection.
-The resident was ordered Nystatin Powder 100,000 unit/gram topical powder, apply to affected areas 2 times a day and 1 cup of plain vanilla yogurt to her morning tray to help prevent yeast infections.

Review of a Physician Encounter report dated 9/14/17 revealed:
-The resident was in to be evaluated for itching and to get urine checked to make sure the urinary infection was cleared up.
-The resident was diagnosed with a rash and the Nystatin topical powder was continued 2 times a day to affected areas.

Review of a Physician Encounter report dated 10/16/17 revealed:
-The resident's chief complaint was itching.
-Upon skin inspection, rash was noted underneath the resident's breasts and rash of right groin was worse than rash of left groin.
-The resident was diagnosed with urticaria/hives (a kind of skin rash with red, raised, itchy bumps).
-The resident was administered 4mg of Dexamethasone injection (intramuscular injection used to treat severe allergic reactions) and ordered Diflucan 150mg, 1tablet every day for 5 days (used to treat fungal and yeast infections); Zantac 150mg, 1 tablet 2 times a day (used as an antihistamine to treat rashes and hives) and Prednisone 10mg, 1 tablet every day for 5 days (used to treat allergic disorders).

Interview with the Resident #2's primary physician's nurse on 10/23/17 at 7:05pm revealed:
-On 9/01/17, Resident #2's family member brought her to the physician's office to be

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assessed because of complaint of itching. The resident had been using baby powder to control the itching.
-Nystatin Powder was ordered to be used on affected areas 2 times a day. The facility to keep medication in the medication cart.
-On 9/14/17, the resident's family member brought her in for a urine screen to check for a urinary tract infection. The physician noted the resident was itching but did not change medication or assess for rash.
-On 10/9/17, the resident's family member contacted the physician and asked for an order for A and D ointment to apply to a rash (no documentation of were the rash was located).
-On 10/16/17, the resident's family member brought her into the physician's office to be treated for itching and multiple areas of rashes. The resident was administered a Dexamethasone injection in the physician's office, ordered Diflucan, Prednisone, Zantac and continue Benadryl cream (used as a topical treatment for itching).
-There was no documentation in the resident's record of the facility's request to discontinue Nystatin Powder.
-If the treatments for the resident's rash/itching were not effective, the physician expected the facility to report symptoms and keep him updated.
-The physician would have referred the resident to a dermatologist or allergist if he was aware of failed treatment because the resident was allergic to multiple medications and continued itching/rashes could be an allergic reaction.

Interview with another 1st shift MA on 10/25/17 at 11:15am revealed:
-Resident #2 had order for Nystatin Powder on 9/01/17. The resident complained the powder did not improve the itching and after a few days, the

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resident refused the powder.
-On 9/13/17, the MA faxed a request to the resident's physician to discontinue the Nystatin Powder due to the resident refused treatment.
-The physician never responded to the fax and the medication was not discontinued. The MA did not follow-up.
-The resident continued to inform staff she was itching without relief, but the MA did not know if her physician was informed.

Interview with the HSD on 10/25/17 at 1:00pm revealed:
- Resident #2's primary physician referred the resident to a dermatologist on 10/24/17 and the physician's staff will make appointment.
-The resident continued to complain of itching and she told the resident family member to contact the physician and report the itching.
-The HSD nor the MAs had reported the resident's complaint of continued itching.

Refer to interview with the facility's Administrator on 10/24/17 at 4:30pm.

b. Review of a Physician Encounter report for Resident #2 dated 9/01/17 revealed:
-The Resident #2's chief complaint was itching under her breast and groin.
-The resident complained of itching under her breast and in her groin. Stated she has been itching for the past month and has been using baby powder.
-The resident was diagnosed with candidiasis of skin.
-The resident was ordered a treatment of 1 cup of "plain vanilla" yogurt to her morning tray to help prevent yeast infections.

Review of Resident #2's electronic medication

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administration record (EMAR) for September 2017 and October 2017 revealed the yogurt was not listed on the MARs.

Observation in the facility's dining room on 10/25/17 at 8:25am revealed Resident #2 was eating breakfast and yogurt was not on the table.

Interview with the Dietary Manager on 10/25/17 at 11:40am revealed:
-If the dietary was given an order to place a cup of yogurt on a resident's tray, the order would be treated like other diet orders and would be given to the resident with her meal as ordered.
-The Dietary Manager checked all orders and stated the yogurt order for Resident #2 was not given to the dietary staff and the resident has not received yogurt with her morning meal.

Interview with Resident #2 on 10/25/17 at 12:05pm revealed:
-The resident had never received yogurt with her meals at any time since the itching and yeast infection began 2 months ago.
-The resident would eat the yogurt if it was provided if it would help the yeast infection/itching.

Interview with Resident #2's primary physician's nurse on 10/25/17 at 10:35am revealed:
-The physician ordered 1 cup of "plain vanilla" yogurt on the resident's morning tray to prevent yeast infection.
-The order was ongoing and the resident should be receiving the yogurt every day. There was not a stop date for the yogurt.

Interview with the HSD on 10/25/17 at 1:00pm revealed:
-She did not know about the yogurt order.

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-Since this order was a treatment it should have been faxed to the pharmacy and put on the EMAR.
-The HSD would clarify the order today with the resident's physician and fax the order to the pharmacy.
-The Administrator informed the HSD on 10/24/17, she would have to review all orders from all medical providers.

2. Review of Resident #3's current FL-2 dated 8/1/17 revealed a diagnosis of MS (multiple sclerosis).

Review of Resident #3's Resident Register revealed he was admitted on 8/19/16.

Review of Resident #3's physician's orders revealed:
-There was an order written on 8/14/17 for Augmentin 500mg by mouth 2 times a day for 7 days (a medication used to treat infections).
-There was an order written on 8/30/17 for Macrobid 100mg by mouth 2 times a day for 7days (a medication used to treat infections) UTI (urinary tract infection).
-There was an order written on 9/19/17 for Cefdinir 300mg 1 by mouth 2 times a day for 7 days (a medication used to treat infections) UTI.
-Urology consult UTI's.

Interview with the Health Service Director (HSD) on 10/19/17 at 4:20 p.m. revealed, she would have to check on the appointment she was not sure if an appointment had been made.

Telephone interview with Resident #3's primary care provider (PCP) on 10/23/17 at 11:32 a.m. revealed:
-The PCP office writes the order for a referral.

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-The PCP office makes the referral to a specialists.
- The specialist office then calls the facility to set up the appointment with the facility transporter.
-There was a new staff doing the transportation at the facility now.
-The facility does not make the initial referral to a specialty.

Interview with HSD on 10/23/17 12:20 p.m. revealed:
-The facility had hired a new transportation person on 9/4/17 to take residents to their scheduled appointments.
-The transportation person was hired to work half the time as a PCA (personal care aide) and half the time as a transporter for resident appointments.
-The PCP had not always let the facility know about scheduled appointments for residents.
-The transporter was just told today about Resident #3 needing a urology appointment and will get the appointment today.
-The HSD and Administrator share a resident appointment computer calendar with the transporter.
-When a new order was received from a PCP the Medication Aide (MA) would review it and fax any new medication order to the pharmacy. If there is a doctor's appointment that needed to be made, the MA will let transporter know via text and e-mail.

Interview with the facility transportation person on 10/23/17 at 12:15 p.m. revealed:
-She started at the facility about one and a half months ago.
-She did not know about Resident #3 needing a urology appointment.
-She was just told today by the HSD that

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Resident #3 needing a urology appointment.
-She would make Resident #3 a urology appointment today.
-Transportation person reviews appointments with the HSD.

Telephone interview with office organizer for the provider at PCP's office on 10/25/2017 at 11:10 a.m. revealed:
-The facility should call to make the appointment once a referral was done by the PCP's office.
-The PCP office would fax the facility with the name of the doctor that they are referring the resident to.

Interview with a MA on 10/23/17 at 10:50 a.m. revealed:
-The Transportation person was responsible to bring back any documentation from the medical provider to the MAs.
-The MAs or the Transportation person would place referral appointments or follow up appointments on a board/calendar in the medication room so staff could keep track of appointments for the residents.
-All appointments were given to the HSD after the MAs received follow up needs documentation from the Transporter.
-Transportation would schedule "a lot of residents follow up appointments".

Telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. revealed:
-He was the only Transportation person for the facility for many years (greater than 5 years).
-He had transitioned into the MA role in June/July of 2017.
-The Transportation person was responsible to bring all documentation back from the residents'

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medical appointments and give it to the MA that was assigned to the hall the resident resided on.
-The MAs were responsible to assure the documentation from medical appointments were filed in the resident's record.
-The Transportation person was responsible for all follow-up appointments and to assure that the follow-up appointment was scheduled and done.
-Scheduled follow-up appointments were recorded and kept in his appointment book.
-The residents "appointment book was my bible".
-If a resident was scheduled for a return visit in 6 months, one year or whatever was planned, it was Transportation's responsibility to track and keep up with that appointment to assure the residents' follow up was done.
-MAs were not responsible to document follow-up appointments anywhere in the chart.
-The Transportation person was required to take a form to the medical provider to fill out during the appointments. The form had to be returned to the MA when there were labs, medications changes or when there were no medication changes, new or changed orders.
-If the resident only needed a follow up appointment then the form for the provider was not needed.
-As a MA, no documentation was required for follow up appointments.

Confidential interview with a staff revealed:
-Follow up needs were not always communicated or documented which had been an issue for the past year.
-The staff member felt there was a "disconnect" concerning follow up needs for the residents.
-The staff thought changes in staff working at the facility, changes in management, supervisors and the current system in place had caused appointments to be missed.

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-The staff felt that a 100 percent review of all residents' charts was needed.
-The previous HSD audited resident's charts.
-The current HSD had not been there long and had not had a chance yet to do a chart audit on all charts.
-Processes for follow up appointments had been improving some since the current HSD started.

Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed:
-The Transportation person was responsible for all follow-up appointments.
-Transportation was overseen by the Administrator or the HSD when there was a problem reported by the Transportation person related to the follow-up appointment.
-The Administrator did not have a system in place to assure all follow-up appointments were done.
-The Administrator expected the PCP to "keep track of that" since they were the ones that needed the information.

3. Review of Resident # 4's current FL-2 dated 6/1/2017 included diagnosis of diabetes II, hyponatremia, hyponatremia, hyperkalemia, insomnia, heart murmur, and hypertension.

Review of Resident #4's orders dated 9/18/17 included an order for Ciprodexotic drops 4 drops ot B/L ears bid x 7 days.

Interview with Resident #4's on 10/18/17 at 10:45 a.m. revealed:
-The resident was hard of hearing.
-The resident had received ear drops after an appointment with his primary care provider (PCP) 2 months ago.
-The resident had only received the ear drops twice and it was supposed to be for 7 days.

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-The resident still had ear pain but not every day.
-The resident does not remember if he told staff about the ear pain.
-The resident did not know if he needed another appointment with his PCP after the ear drops.
-The resident had not followed up with his PCP since receiving the ear drops.

Interview with a medication aide (MA) on 9/20/17 at 9:07 a.m. revealed:
-The MA had called the facility pharmacy to renew the ear drops when she could not find them on the medication cart on 9/23/17.
-The MA did not document the call to the pharmacy.
-The pharmacy would not refill them because his insurance would not pay for it.
-The MA called the residents PCP to notify them the resident did not have enough ear drops to complete the 7 days.
-The PCP office would not send another prescription to the pharmacy.
-The MA could not remember if she had notified the Health Service Director.
-Resident #4 had not mentioned to her that he has had ear pain since getting the ear drops.

Interview with the Health Service Director (HSD) on 10/23/17 at 8:10 a.m. revealed:
-The HSD would expect the MA to come to her if they were having trouble refilling a medication.
-The HSD did not remember hearing about Resident #4 running out of ear drops.

Telephone Interview with a nurse at Resident #4's PCP office on 10/25/17 4:55 p.m. revealed:
-The PCP office had no record of receiving a call from the facility requesting a refill of Ciprodex ear drops.
-The PCP office would expect to be notified of a

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medication not completed as ordered.
-It was possible that if the 7 days of Ciprodex ear drops were not completed and that the ear infection was not resolved that the resident could continue to have ear pain if the ear infection was not resolved.

4. Review of Resident #6's current FL-2 dated 03/02/17 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia.
-There was an order to call the primary care provider (PCP) for blood sugars greater than 400.
-There was an order for diabetic urine testing twice daily.

Review of a subsequent physician's order for Resident #6 dated 07/27/17 revealed there was an order to check blood sugars twice daily. Call MD if the blood sugar was greater than 400. If the blood sugar was less than 60 give 8 ounces of orange juice and repeat the blood sugar in 30 minutes. Call MD if blood sugar is still less than 60 scheduled for 7:30 a.m. and 4:30 p.m.

Review of Resident #6's electronic Medication Administration Records (eMARS) for August 2017 revealed:
-The Medication Aides (MAs) documented the resident's blood sugar was 409 on 08/04/17 at 7:30 a.m., 407 on 08/10/17 and 08/25/17 at 4:30 p.m.

Telephone interview with a MA on 10/26/17 at 1:33 p.m. revealed:
-The MA remembered occasional incidents that Resident #6's blood sugars were greater than 400.
-The MA had checked Resident #6's blood sugar

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on 08/04/17 at 7:30 a.m.
-The MA did not call the PCP each time Resident #6's blood sugars were high because it was unusual for the resident's blood sugars to be over 400 and thought it could have been related to something the resident had eaten that day.
-The MA remembered that she did speak with the PCP after she had noticed that her blood sugars had been high a few times a "while back".
-The MA did not document when she had spoken with the PCP regarding the resident's elevated blood sugars.

Attempted interview with the Health Service Director on 10/26/17 at 2:15 p.m. was unsuccessful.

Telephone interview with the Administrator on 10/26/17 at 3:10 p.m. revealed:
-The Administrator expected blood sugar parameters to be followed as ordered.
-When Resident #6's blood sugars were out of the ordered parameter range the MA should have called the PCP and should have called the Administrator or the HSD for further directions.
-The Administrator expected for the MA to document in the communication book when the PCP was notified regarding Resident #6's blood sugars greater than 400.

Telephone interview with Resident #6's physician on 10/26/17 at 12:37 p.m. revealed:
-The physician expected to be notified when the resident's blood sugars were greater than 400 as ordered.
-The physician could not recall that she had been notified of the resident's blood sugars being greater than 400 however the blood sugars could have been reported to the Nurse Practitioner.
-She expected the facility to follow the order and

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call at the time the blood sugar levels were outside of the ordered parameters so direction and possible medication adjustments could be given.

5. Review of Resident #5's current FL-2 dated 12/06/16 revealed:
-Diagnoses included multiple sclerosis (MS), depressive disorder, hyperlipidemia, constipation and urinary incontinence.
-The resident was intermittently disoriented and semi-ambulatory using a wheelchair.

a. Review of a Neurology office visit report for Resident #5 dated 05/26/15 revealed assessment and plan included: no medication changes, refer to physical therapy, lab work for routine monitoring and return in 6 months and to call with questions in the interval.

Review of Resident #5's medical care visit notes, primary care orders, and Resident Notes did not reflect a follow-up appointment with a Neurologist after 05/26/15.

Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed:
-She had seen a Neurologist in the past but could not remember when she was last seen.
-The resident had daily pain and weakness in her legs and was taking medication for the pain which helped some.

Telephone interview with Resident #5's family member on 10/24/17 at 7:45 p.m. revealed the family member was not aware of any Neurologist appointments for the resident.

Interview with a Medication Aide (MA) on 10/23/17 at 10:03 a.m. revealed:

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-She was not sure if Resident #5 had any additional follow-up from her 05/26/15 appointment with the Neurologist.
-Visit notes from medical appointments should be filed in the resident's record after each visit.

A second interview with the MA on 10/23/17 at 10:50 a.m. revealed:
-The MA called the Neurologist's office and was told that a follow-up appointment was scheduled for 11/23/15 but the Neurologist's office canceled that appointment scheduled for 11/23/15 and no appointment was rescheduled from that point.
-She would follow-up with the PCP to see if Resident #5 still needed to go to a Neurologist if the resident had not been seen since 2015.
-The previous Transportation person was now in a MA role and possibly could give additional information related to the residents Neurologist appointments.

Telephone interview with a nurse from Resident #5's Neurologist on 10/23/17 at 9:40 am. revealed:
-The resident was an active patient.
-The resident had a scheduled follow up appointment on 11/23/15, however, this appointment was canceled.
-There was no documentation who canceled the follow-up appointment on 11/23/15.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37p.m. revealed:
-The PCP was aware that the resident went back in 2015 to the Neurologist and had a MRI and all medications for the resident was kept the same.
-The resident was referred to a Neurologist to manage her MS in 2014.
-She was not aware that the resident had not

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continued to follow up with the Neurologist and would have expected the facility to assure all follow-up appointments were done.

Telephone Interview with a nurse at Resident #5's Neurologist's office on 10/25/17 at 12:30p.m. revealed:
-Multiple Sclerosis was a progressive disease that required close monitoring of lab work, and medication adjustments.
-It was important for the resident to follow up with her Neurology appointments in order to monitor the resident's symptoms and to improve the resident's quantity and quality of life as much as possible.
-With proper oversight Multiple Sclerosis symptoms could be controlled and "kept at bay".

Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed the he was aware that Resident #5 had missed some Neurology appointments because the resident had refused to go to the appointments.

Refer to a second interview with the MA on 10/23/17 at 10:50 a.m.

Refer to a telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m.

Refer to a confidential interview with a staff.

Refer to an interview with the Administrator on 10/26/17 at 3:08 p.m.

Refer to a telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37 p.m.

b. Review of an Optometry office visit for

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Resident #5 dated 08/14/15 revealed an eye exam was done and the resident should return in one year for a re-evaluation.

Review of Resident #5's medical care visit notes, primary care orders, and Resident Notes did not reflect a follow-up appointment with an Optometrist office after 08/14/15.

Review of an Optometry visit for Resident #5 on 08/29/16 revealed:
-An examination was performed. The resident complained about cataracts in both eyes since 2011, severity was described as previously mild. The resident wore +2.50 readers continuously, the resident described the following signs and symptoms: blurred vision and headaches.
-Diagnoses and plan included that the resident had mild cortical cataracts, no surgery was advised at that time and the resident should return in one year for re-evaluation.

Interview with a Medication Aide (MA) on 10/23/17 at 10:03 a.m. revealed:
-She was not sure if Resident #5 had any additional follow-up from her 08/14/15 appointment with the Optometry provider.
-Visit notes from medical appointments should be filed in the resident's record after each visit.

A second interview with the MA on 10/23/17 at 10:50 a.m. revealed the previous Transportation person was now in a MA role and possibly could give additional information related to the residents Neurology and optometry appointments.

Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed:
-The resident was having headaches off and on and felt like she needed new glasses.

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D 273	Continued From page 34 -The resident seen an "eye doctor" but did not know how long it had been since she last went. -She told someone (staff member) that she needed to be seen by her eye doctor for new glasses but did not know who or when she told them but thought it had not been that long ago. -The resident did not know if an appointment had been made. Telephone interview with Resident #5's family member on 10/24/17 at 7:45 p.m. revealed; -The family member was concerned that the resident was having headaches and needed new glasses. -The family member had spoken with someone in administration at the facility about a year ago concerning the resident's need to be evaluated for new glasses but was not aware of any follow-up. Telephone interview with a Clinical Organizer with Resident #5's Optometrist provider on 10/23/17 at 12:39 p.m. revealed: -The resident was last seen in August of 2016. -Someone from the facility called this morning (10/23/17) and scheduled and appointment for the resident. The appointment was made for 10/30/17 at 2:00p.m. Telephone interview with a Technician at the Optometry office for Resident #5 on 10/25/17 at 11:30 a.m. revealed: -It was important for the health of the resident's eyes and vision to follow-up with eye care when there was a history of cataracts and MS. -Headaches could be related to declined eye sight and possible need for a change in glasses. Refer to a second interview with the MA on 10/23/17 at 10:50 a.m.	D 273		

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D 273	Continued From page 35 Refer to a telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. Refer to a confidential interview with a staff. Refer to an attempted to interview with the HSD on 10/26/17 at Refer to an interview with the Administrator on 10/26/17 at 3:08 p.m. Refer to a telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37 p.m. A second interview with the MA on 10/23/17 at 10:50 a.m. revealed: -The Transportation person was responsible to bring back any documentation from the medical provider to the MAs. -The MAs or theTransportation person would place referral appointments or follow up appointments on a board/calendar in the medication room so staff could keep track of appointments for the residents. -All appointments were given to the Health Service Director (HSD) after the MAs received follow up needs documentation from the Transporter. -Transportation would schedule "a lot of residents follow up appointments". Telephone interview with the previous Transportation staff on 10/24/17 at 8:13 p.m. revealed: -He was the only Transportation person for the facility for many years (greater than 5 years). -He had transitioned into the Medication Aide (MA) role in June/July of 2017.	D 273		

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D 273	Continued From page 36 -The Transportation person was responsible to bring all documentation back from the residents' medical appointments and give it to the MA that was assigned to the hall the resident resided on. -The MAs were responsible to assure the documentation from medical appointments were filed in the residents chart. -The Transportation person was responsible for all follow-up appointments and to assure that the follow-up appointment was scheduled and done. -Scheduled follow-up appointments were recorded and kept in his appointment book. -The residents "appointment book was my bible". -If a resident was scheduled for a return visit in 6 months, one year or whatever was planned, it was the Transportation's responsibility to track and keep up with that appointment to assure the residents' follow up was done. -MAs were not responsible to document follow-up appointments anywhere in the chart. -The Transportation person was required to take a form to the medical provider to fill out during the appointments. The form had to be returned to the MA when there were labs, medications changes or when there were no medication changes, new or changed orders. -If the resident only needed a follow up appointment then the form for the provider was not needed. -As a MA, no documentation was required for follow up appointments. -He could not recall any specific information regarding Resident #5's Neurology or Optometry appointments. Confidential interview with a staff revealed: -Follow up needs were not always communicated or documented which had been an issue for the past year. -The staff member felt there was a "disconnect"	D 273		

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concerning follow up needs for the residents.
-The staff thought changes in staff working at the facility, changes in management, supervisors and the current system in place had caused appointments to be missed.
-The staff felt that a 100 percent review of all residents' charts was needed.
-The previous HSD audited resident's charts.
-The current HSD had not been there long and had not had a chance yet to do a chart audit on all charts.
-Processes for follow up appointments had been improving some since the current HSD started.

Interview with the Administrator on 10/26/17 at 3:08 p.m. revealed:
-If a resident refused appointments, the MAs were responsible to document this on a physician communication report and have the resident sign the document. The information of the refusal should have been given to the provider to alert the provider of those refusals.
-The Transportation person was responsible for all follow-up appointments.
-Transportation was overseen by the Administrator or the Health Service Director (HSD) when there was a problem reported by the Transportation person related to the follow-up appointment.
-The Administrator did not have a system in place to assure all follow-up appointments were done.
-The Administrator expected the primary care provider to "keep track of that" since they were the ones that needed the information.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 10/26/17 at 12:37p.m. revealed:
-There had been a problem with missed follow-up appointments with the facility in the past.

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D 273	Continued From page 38 -Missed appointments were high and "made us feel like we were beating our head against the wall". -The facility currently had a new Transportation person and follow up appointments seemed to be improving, "you've got to be committed". _____ The facility failed to assure contact with the Primary Care Provider (PCP) for acute care needs which resulted in untreated fungal infection/yeast infections and severe itching over multiple areas of Resident #2's body who endured the infections and itching for over 2 months and follow-up with an order for probiotic supplement; a urology appointment which was not scheduled for Resident #3, Resident #4 who continued to complain of ear pain after antibiotic ear drops ran out earlier than ordered, failed to assure follow up since 2015 with a Neurologist for monitoring of a progressive disease and an Optometry follow up appointment for Resident #5 who was having headaches and had complaints of needing new glasses, and failed to notify the resident's primary provider regarding finger stick blood sugar results obtained outside of the established parameters for Resident #6. The facility's failure was detrimental to the health and well-being of the residents, and constitutes a Type B Violation. _____ Review of an unaccepted Plan of Protection revealed: -"Hot Box" charting would be implemented 10/24/17. Med Tech Training for that wing would be required to chart concerns and or changes in condition. "Hot Box" charts are typically stored in the medication rooms when a chart is "Hot Boxed". It is moved to a special location that alerts/triggers staff to an outstanding charting need. Charting can occur anywhere; however the	D 273		

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D 273	Continued From page 39 Health service Director (HSD) would ensure that any charted documentation was read, acted upon if necessary and ultimately filed in the resident record with the facility. -The HSD and Administrator would ensure that a full audit of all resident charts would be completed by 11/03/17. The audit would serve as a discovery for any referrals and or changes in conditions that require additional follow up or execution. -The HSD and Administrator would ensure appropriate follow up or execution was completed. -HSD would provide oversight of transportation coordinator to ensure she obtained and or delivered appropriate documentation from the physician offices. -Staff would receive "small group" training, starting today 10/24/17, until all nursing staff had been reached. All staff would be trained by 10/27/17. Training would include information on how to detect a "change in condition." Training would be led by the Administrator and the HSD. -Charting would continue until resolutions had been noted by a physician; charts would remain "Hot Boxed" during that time. -The facility began using the attached "Physician Communication Form" on Tuesday 10/24/17. -Transportation Coordinator Responsible for outside appointments, HSD for internal appointments. -Progress note sheets would be made available to staff 10/24/17 by Administrator. -Notes from the facility staff and from physicians would be kept in a designated location in the chart. -HSD would ensure charts were "Hot Boxed" when residents were scheduled for MD appointments. -Follow up appointments would be managed by	D 273		

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D 273	Continued From page 40 Transportation Coordinator and HSD. Refusals would be documented in the resident's chart, family and the primary MD would be notified. -HSD would ensure orders on Physician Communication form had been carried out and results documented accordingly. -RN Consultant would review sample of charts quarterly to ensure compliance. First review would be in January 2018. -Administrator and QA Team would review charts to ensure compliance. First review would be December 2017. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 10, 2017.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the kitchen areas were kept clean and free from contamination related to a build-up substance/matter in the ice machine and stains and build-up on 2 metal shelves. The findings are: Observation of the ice maker in the kitchen on 10/18/17 at 4:47 p.m. revealed:	D 282		

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D 282	Continued From page 41 -There was a build-up of a wet, brownish black substance on the right inner wall and around the edges of an interior, upper white tilting shield that separated the ice bin from the upper vaulted section of the ice machine. -There were several pink and brown colored streaked areas on the right inner wall leading from the areas of the brownish black substance that was in a downward pattern, and approximately 1 inch from the ice in the machine. Observation of the ice maker in the kitchen on 10/19/17 at 8:40 a.m. revealed: -There was a build-up of a wet, brownish black substance on the right inner wall and around the edges of an upper, interior white tilting shield that separated the ice bin from the upper vaulted section of the ice machine. -There were several pink and brown colored streaked areas on the right inner wall leading from the areas of the brownish black substance that was in a downward pattern, approximately 4 inches from the ice in the machine. Interview with a Dietary Aide (DA) on 10/19/17 at 3:25 p.m. revealed: -The DAs wiped down the walls in the ice maker every other day, "possibly more than that". -Cleaning the mechanical parts of the ice maker was done by the Maintenance person. -She was not sure when maintenance last cleaned the ice maker. -The DA last wiped the inner walls of the ice maker with a damp cloth using dish detergent and water on Monday, 10/16/17. -The DA had not noticed any black build-up on the walls or the inner guard of the ice maker Monday (10/16/17). -When the walls of the ice maker were wiped down, she would use parchment type paper to	D 282		

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D 282	Continued From page 42 protect and cover the ice. Observation of the DA on 10/19/17 at 3:25 p.m. revealed the DA took a cloth dampened with water and removed the black brown substance on the inner wall, however, the pink colored area did not wipe off. Interview with a second DA on 10/ 19/17 at 3:46 p.m. revealed: -The DA had not noticed any build-up in the ice maker and was not told to inspect the inside of ice maker for build-up. -The Maintenance staff cleaned the ice maker and the DAs were responsible to wipe the inside of outside walls of the ice maker. Interview with the Cook on 10/19/17 at 3:55 p.m. revealed: -He could not remember the last time maintenance cleaned the ice maker. -There was not an assigned cleaning schedule for dietary staff. -The Marketing Director for the facility had told the Cook after the last inspection in September 2017 to "stay on top" of cleaning the ice maker more. Observation of the ice maker in the kitchen on 10/25/17 at 10:25 a.m. revealed: -A DA had removed the white interior guard and was cleaning the inside of the ice maker. -There was a thick tan colored matter adhered to the left inner wall that was approximately the size of a pencil's eraser. -The DA had collected the same thick brown colored matter that she had removed from the underside of the inner guard on her finger. The size of the brown colored matter covered the end of the DA's index finger.	D 282		

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-The inner tilting shield had been cleaned and was out of the ice machine on a cart.
-There was no brownish black build-up or thick tan matter in the inner vaulted area of the ice maker.

Interview with a DA on 10/25/17 at 10:25 a.m. revealed:
-The DA had already cleaned the vaulted area of the ice maker and the inner guard.
-The ice maker was new and the facility had only had it for a short time.
-The thick tan colored matter adhered to the left inner wall was the same matter that covered the underneath side of the white interior tilting shield before she cleaned it.
-The ice machine would be emptied and cleaned thoroughly. The ice would be discarded.
-The facility had ice to serve to the residents in a portable cooler.
-The DA never removed the white tilting shield to clean the ice maker before.
-The DA's usually wiped down the inner walls of the ice maker daily.

Interview with the Maintenance person on 10/25/17 at 10:31 a.m. revealed:
-He cleaned the ice machine in the kitchen one time per week by cleaning the bin edges but did not remove any of the parts to do the cleaning.
-He last cleaned the ice machine one day last week.
-He did not notice any black build up on the inner walls and bin edges of the ice maker.

Interview with the Dietary Manager (DM) in 10/20/17 at 9:07 a.m. revealed:
-Dietary staff were not responsible for wiping down the ice maker's inner walls every day. "However, we need to be more vigilant about that

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and probably should be wiped down every day".
-It was expected for the ice machine to have the white guard removed and empty the ice maker, take drip tray and filter out and clean it with soap, water and sanitizer weekly by dietary staff.
-It was possible that the weekly cleaning for the ice maker had been skipped some weeks.
-The DM or the Cook were required to physically walk around the kitchen at the end of each shift to assure all cleaning needs had been done.

Interview with the Administrator on 10/20/17 at 9:34 a.m. revealed:
-The ice machine was recently replaced, "it's not even a year old".
-The Administrator expected for the ice machine to be free of any build-up and should be clean at all times.
-He expected the DM to assure the proper cleaning was done to the ice maker.

Observation of a two- tiered metal table in the kitchen on 10/18/17 on 5:20 p.m. revealed there was 7 plastic cups stacked together, stored with the opening of the cups in a downward position, one box of individually wrapped straws and 2 coffee pot dispensers, stored on the lower shelf of the table.
-The lower shelf had brown stains scattered across the surface of the lower shelf.

Observation of two-tiered metal table in the kitchen on 10/19/17 at 8:41 a.m. revealed:
-The metal table located beside the stove had ½ of a loaf of white bread wrapped in a plastic covering, closed with a twist tie, 2-3 pieces of white bread wrapped in a second plastic covering with the end of the bag opened, and 2 hamburger buns in a third plastic covering with the opening of the bag folded.

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D 282	Continued From page 45 -The lower shelf of the table had several brown stains and a yellowish build-up scattered across the surface of the shelf. Interview with a Dietary Aide (DA) on 10/19/17 at 3:25 p.m. revealed: -The DA's and the Cook were responsible to keep the tables in the kitchen clean. -All of the tables were wiped down every other day and cleaned one time per week. -She had not noticed the yellow build-up and the scattered stains on the metal shelves. -Some of the areas were stains that could not be removed. Interview with a second DA on 10/19/17 at 3:46 p.m. revealed: -All areas in the kitchen were wiped down daily. -The cooks cleaned in the cooking areas of the kitchen and the DA's cleaned in the areas closer to the dishwasher. Interview with the Cook on 10/19/17 at 3:55 p.m. revealed: -There was not an assigned cleaning schedule for dietary staff. -Tables in the kitchen were wiped down with a soapy cloth daily and cleaned with a degreaser cleaner one time a week. Interview the Administrator on 10/20/17 at 9:34 a.m. revealed the Administrator depended on the dietary staff to keep all areas of the kitchen clean including the metal tables in the kitchen. Interview with the Dietary Manager (DM) on 10/20/17 at 9:07 a.m. revealed: -The DM had worked at the facility since 2013 and had been in his current role as DM since last year.	D 282		

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D 282	Continued From page 46 -The DM and the cook were responsible to assure all cleaning was done in the kitchen at the end of their shift. -The DM had a laminated cleaning schedule for dietary staff to follow that was posted in the kitchen. -The DM or the Cook assigned the cleaning tasks. -The laminated cleaning schedule had been missing for about 2-3 weeks but the DM had planned to have the cleaning schedule re-posted as soon as possible. -All dietary staff had been instructed by him about the cleaning tasks for kitchen. -The DM or the Cook were required to physically walk around the kitchen at the end of each shift to assure all cleaning needs had been done. -The DM knew that some cleaning tasks were missed from time to time. Review of the DM's cleaning schedule notes revealed there was no documentation included for the cleaning of the metal shelves or the ice machine. Review of the facility's DA's and the Cook's job responsibilities revealed: -Clean kitchen, dishes, dining area and food storage areas daily assuring sanitation standards and protection from possible food contamination. -Ensure work area was cleaned before departing shift. -Perform other duties as assigned.	D 282		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	D 338		

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Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews, observations and record reviews, the facility failed to assure 2 of 8 sampled residents were free from neglect and treated with dignity and respect related to Resident #3 who was scolded by staff and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while staff was using a cell phone.

The findings are:

1. Review of Resident #3's current FL-2 dated 8/01/17 revealed a diagnosis of of the central nervous system.

Revire of Resident #3's Resident Register revealed an admission date of 8/19/16.

Review of Resident #3's Care Plan dated 8/01/17 revealed:
-The resident ambulated with the use of a wheelchair.
-The resident required limited assistance with toileting and transferring.

Interview with Resident #3 on 10/18/17 at 11:45am revealed:
-The resident had lived at the facility about 1 year.
-The resident was non-ambulatory and used a wheelchair for ambulation.

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-The resident required assistance with personal care which included assistance with bathing/showers, transfers and occasional incontinent care.
-The resident used the urinal when he was in bed; because his hands were weak, sometimes he would spill the urine on his bed and on himself.
-He had occasional incontinent episodes and required assistance with incontinent care.
-Sometimes the personal care aides (PCA) complained when the resident asked them to change urine soaked clothes and change bed linen.
-Earlier this week, the resident called a PCA (Staff B) to his room for assistance because he had urinated on himself. When the PCA (Staff B) walked in his room, the PCA (Staff B) told the resident "I'm not going to clean you up, I'm not here for that".
-The PCA (Staff B) left the resident's room and came back after an extended time (greater than 30 minutes) to clean the resident and change his clothes. The resident did not call for assistance after the PCA (Staff B) left his room.
-Yesterday (10/17/17) another PCA made him wait to change his linen after he had accidently spilled his urinal while using it. That PCA was just mean. "She sucks".
-A few months ago, the resident reported the staff behaviors to the Administrator and was told they would do something, but nothing was ever done.
-The resident had not reported any of the incidents to the Administrator or supervisors since.

Interview with a 2nd shift medication aide (MA) on 10/19/17 at 3:20pm revealed:
-Resident #3 had been living at the facility for about a year and required assistance with

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transfers.
-The resident had incontinent episodes and at times spilled his urinal and had required assistance with incontinent care and changing bed linen.
-The resident had complained about the PCAs talking to him disrespectful when he ask them to change clothes/linen after incontinent episodes or spilling urine from the urinal on his bed.
-The MA did not know if the resident reported his concerns to the administrator.
-The MA did not report the resident's complaints to the Administrator.

Interview with a 2nd shift PCA (Staff B) on 10/19/17 at 4:10pm revealed:
-At times Resident #3 had incontinent episodes and spilled urinal in his bed.
-Two days ago, the resident had an incontinent episode (urine and bowel movement) and the PCA (Staff B) provided incontinent care.
-The resident also spilled urine in his bed and the PCA (Staff B) had to change his linen and change his clothes.
-The resident joked around at times but the PCA (Staff B) did not argue with the resident or refuse to provide care when the resident called for assistance. He had never become upset when the PCA (Staff B) was providing care.
-If the PCA (Staff B) got frustrated for any reason while providing resident care, the PCA (Staff B) would take a time out and go outside and smoke.
-The PCA (Staff B) denied deliberately making the resident wait for incontinent care.

Interview with a resident on 10/20/17 at 1:50pm revealed:
-There were 2 PCA's who worked on 2nd shift who were not nice to Resident #3.
-They argued with him when he called them to

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help clean him up if he urinated on himself or spilled the urinal in his bed.
-They were disrespectful and made Resident #3 feel bad about being incontinent.
-Because of his diagnosis, Resident #3 was weak and at times needed more assistance.

Interview with the Health Service Director (HSD) on 10/23/17 at 4:00pm revealed:
-Resident #3 had reported an issue with a PCA (Staff B).
-The resident reported that when he told the PCA (Staff B) he needed to go to the bathroom the PCA (Staff B) would respond "I have already taken you" and the resident was never taken to the bathroom.
-The HSD was not aware the PCA (Staff B) was disrepectful, refused to provide immediate incontinent care and was argumentative when Resident #3 called for assistance.
-The resident was placed on a schedule for toileting for several months but that did not work and the toileting schedule was placed on the electronic Medication Administration Record (eMAR).

2. Review of Resident #10's FL-2 dated 10/15/17 revealed:
-Diagnoses included post-traumatic stress disorder, bipolar disorder, recurrent urinary tract infections, and allergies.
-The resident was non-ambulatory and used an electric wheelchair to ambulate.

Review of the Resident Register revealed Resident #10 was admitted to the facility on 11/18/16.

Review of Resident #10's Care Plan dated 11/21/16 revealed:

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D 338	Continued From page 51 -The resident required the use of a wheelchair to ambulate. -The resident required limited assistance for transferring, toileting, bathing and dressing. Interview with Resident #10 on 10/20/17 at 1:50pm revealed: -The resident had been living in the facility 11 months. -Most of the staff treated the resident well and took good care of him but there was always "bad apples in every bunch". -When the resident asked for assistance to transfer from the wheelchair to the commode, some of the staff acted as if "I'm bothersome". -The resident required minimal assistance to the bathroom. -The staff unstrap my feet and seatbelt and the resident could transfer himself. -The resident required assistance with cleaning up after having a bowel movement. -At least 2 times in the last month when the PCA (Staff B) was assisting the resident with transferring from his wheelchair to the commode, his hands slipped from the safety bar and he almost fell in the bathroom. The PCA (Staff B) was looking at her phone each time. -The bathroom issue was the only issue with a PCA (Staff B), who worked 2nd shift, who was not engaged (did not care and was attentive) when caring for the residents. -The Administrator and the Health Service Director (HSD) were aware of the problem and they may have addressed the problem but a few of the PCAs continue to neglect their duties when assisting the resident with transfers and it could be unsafe. Interview with a 2nd shift PCA on 10/19/17 at 4:10pm revealed:	D 338		

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D 338	Continued From page 52 -Resident #10 had certain staff he did not like. He stated there was 2 staff which talked mean to him. -He had complained some staff was neglectful when assisting him with transfers and he had almost fell more than one time recently. Interview with a another 2nd shift PCA (Staff B) on 10/20/17 at 2:55pm revealed: -Resident #10 required 1 person assistance when transferring to the commode. -The resident would hold onto the safety rails when transferring and staff stood near the resident to provide assistance if needed. -The resident had never fallen but his feet have slid while transferring and the staff had to assist him with transferring. -The PCA (Staff B) was not aware of staff using their cell phones while providing resident care. Interview with the Administrator on 10/23/17 at 4:00pm revealed: -Resident #10 had voiced concerns at one point (a few weeks ago) about a (named) PCA (Staff B) but now they are "BFF's". -The HSD did not feel the concern Resident #10 had was a "full blown grievance, just poor customer service". -Resident #10 had never mentioned any concerns about the staff using cell phones during care. -"That's not ok" for a resident to sit in wet clothes and not receive help from staff. -The HSD was concerned if that staff member would do that to an alert and oriented resident, then what would that staff member do to someone else. _____ The facility failed to assure residents were free from neglect and treated with dignity and respect	D 338		

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D 338	Continued From page 53 as evidenced by Resident #3 who was scolded and shamed by Staff B and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while Staff B was using a cell phone. The facility's failure to assure the rights of residents resulted in determient to the residents' safety and well-being, which constitutes a Type B Violation. Review of an unaccepted Plan of Protection received on 10/24/17 revealed: -The Administrator and of the Health Service Director (HSD) would immediately investigate grievances and if applicable, suspend any involved staff while investigation is taking place. -Any alleged resident rights violations would be reported to the county within 24 hours; HSD and or the Administrator would make these reports; resident rights issues involving staff would be reported to HCPR within 24 hours. -Staff would receive extensive resident rights training on 10/30/17 by the Administrator. -Staff would receive immediate resident rights training beginning 10/24/17 by the Administrator/HSD. Training would continue until all staff had been reached. -Ongoing compliance would be monitored quarterly by the Administrator and QA team using the following channels: Resident interviews, family conversations, review of incident reports. First QA will be December 2017. -Staff would continue to receive resident rights training quarterly, using an online education tool (named). -Staff with violent crimes on criminal background would not be hired. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 338		

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D 338	Continued From page 54 10, 2017.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based of observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 1 of 7 residents sampled, to include an as needed pain medication and a long acting insulin (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 03/02/17 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia. -There was an order for Levemir 12 units (a long acting injectable insulin used to treat high blood sugar) every morning. Hold for blood sugar less than 70. a. Review of a copied prescription from a dental clinic signed for Resident #6 dated on 05/09/17 revealed Ibuprofen 800mg (a nonsteroidal	D 358		

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anti-inflammatory medication used to treat pain) take one daily every eight hours as needed for pain.

Review of a physician's order for Resident #6 dated 07/27/17 revealed Ibuprofen 800 mg one every eight hours as needed for pain.

Review of a Consultant Pharmacist Communication to Physician form for Resident #6 dated 08/09/17 revealed:
-There was documentation from the pharmacist to the primary care provider (PCP) to please sign below to discontinue the short term order: ibuprofen as needed.
-There was a section for the physician's response to the recommendation/finding with instructions to check one of the following: "I agree" or "other (Please write a brief statement below concerning the rationale for your response to this recommendation)".
-On 09/11/17, the PCP signed the form. There was a check beside "I agree".
-There was handwritten entry on the upper right corner of the document faxed (named) pharmacy with no initials or signature for the entry.

Review of Consultant Pharmacist Progress note for Resident #6 dated 08/09/17 revealed there was documentation by a pharmacist that there were no medication related issues at the time of the review.

Review of Resident #6's electronic Medication Administration Records (eMAR) for September 2017 revealed:
-There was an entry for Ibuprofen 800 mg one tablet every 8 hours as needed for pain.
-Ibuprofen 800mg was documented as administered on 09/19/17 for complaints of a

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toothache, 09/23/17 for complaints of body pain, and 08/26/17 for complaints of a back ache, 08/28/17 and on 09/30/17 at 7:15 a.m. and 5:05 p.m. for complaints of a toothache.

Review of Resident #6's eMAR for October 2017 revealed:
-There was an entry for Ibuprofen 800 mg one tablet every 8 hours as needed for pain.
-Ibuprofen 800mg was documented as administered on 10/03/17 for complaints of pain, 10/05/17 at 7:37 a.m. and 3:29 p.m. for complaints of a toothache/headache and for pain.

Interview with a Supervisor/Medication Aide (MA) on 10/25/17 at 10:55 a.m. revealed:
-The MAs were responsible to send all medication orders to the pharmacy by fax at the time the PCP wrote the order.
-MA's could not add or change any medications on the residents' eMAR.
-The pharmacy added medications to the eMAR.
- After an order was written for a new or changed medication, the order was placed in a stackable tray in the medication room until the new or changed order "pops up in the system". MAs were responsible to check the orders in the stackable tray each shift.
-The Supervisor/MA had given Resident #6 an Ibuprofen 800 mg yesterday (10/24/17) for a toothache. She would remove the Ibuprofen 800 mg from the medication cart for Resident #6 immediately and fax the order to the pharmacy so the medication could be discontinued.

Attempted interview with the Health Service Director on 10/26/17 at 2:15 p.m. was unsuccessful.

Interview with the facility's pharmacy provider on

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D 358	Continued From page 57 10/26/17 at 9:51 a.m. revealed: -Ibuprofen 800mg one tablet every 8 hours as needed for pain that was ordered for Resident #6 was discontinued yesterday (10/26/17). -When residents' pharmacy reviews were done, the pharmacist would leave the Consultant Pharmacist Communication to Physician form with a designated person at the facility that same day and the facility would be responsible to have the form sent to the PCP for review. Telephone interview with the Administrator on 10/26/17 at 3:10 p.m. revealed the Administrator expected all medication orders to be followed as written. Telephone interview with Resident #6's PCP on 10/26/17 at 12:37 p.m. revealed she expected medication orders to be implemented and discontinued as written. b. Review of a physician's order for Resident #6 dated 07/27/17 revealed Levemir flex touch (a prefilled insulin device) inject 12 units subcutaneous every morning, hold for blood sugar less than 70 to be administered at 7:30 a.m. Review of a subsequent physician's order for Resident #6 dated 09/05/17 revealed to start Levemir 10 units subcutaneous at hour of sleep. Review of Resident #6's electronic Medication Administration Records (eMARS) for August 2017 revealed: -There was an entry for Levemir Flex pen inject 12 units subcutaneous every morning. Hold for blood sugar less than 70 to be administered at 7:30 a.m. -The Medication Aide (MA) documented on	D 358		

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08/17/17 at 7:30 a.m. Levemir was not administered because the medication was not on the cart.

Review of Resident #6's eMAR for September 2017 revealed:
-There was an entry for Levemir inject 12 units subcutaneous every morning, hold for blood sugar less than 70 to be administered at 7:30 a.m. to be administered at 7:30 a.m. The medication was discontinued on 09/06/17.
-There was an entry for Levemir inject 12 units subcutaneous every morning and 10 units every evening, hold for blood sugar less than 70 to be administered at 7:30 a.m. and 8:00 p.m.
-The MA documented on 09/01/17 at 7:30 a.m. Levemir "Site: missed med".

Review of Resident #6's eMAR for October 2017 revealed:
-There was an entry for Levemir inject 12 units subcutaneous every morning and 10 units every evening, hold for blood sugar less than 70 to be administered at 7:30 a.m. and 8:00 p.m.
-The MA documented on 10/05/17 at 8:00 p.m. Levemir was not administered "out of stock".
-The MA documented on 10/06/17 at 7:30 p.m. Levemir was not administered "med on order".

Interview with a Supervisor/Medication Aide (MA) on 10/25/17 at 10:55 a.m. revealed:
-The MAs were responsible to reorder insulin flex pens when the resident had one flex pen left on the medication cart.
-Refills were done electronically through the eMAR system by selecting "reorder".
-She was not aware that Resident #6 had ever ran out of her Levemir.

Confidential interview with a staff member

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D 358	Continued From page 59 revealed reordering medication was a simple process of clicking a button in the eMAR system. No residents should ever run out of a medication. Attempted telephone interview on 10/26/17 at 1:33 p.m. with the MA who documented Levemir was not administered on 10/05/17 and 10/06/17 was unsuccessful. Telephone Interview with the Administrator on 10/26/17 at 3:10 p.m. revealed: -MA's were responsible to reorder the resident's medications through the eMAR system. The timing of the reorder depended on the medication but should have been done 2-3 days in advance. -The Administrator expected the residents' medications to be on hand at all times and for medications to reordered timely to prevent missed doses. Telephone interview with Resident #6's PCP on 10/26/17 at 12:37 p.m. revealed: -The PCP expected for Levemir to be on hand at the facility and to be administered as ordered. -The PCP would also be expected to be called if a medication was not available to assess for an alternative on how to treat until the medication was available.	D 358		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by:	D911		

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D911	Continued From page 60 Based on observations, record reviews and interviews, the facility failed to treat at least two residents (#3, #10) with respect and dignity and his or her individuality. The findings are: 1. Based on interviews, observations and record reviews, the facility failed to assure 2 of 8 sampled residents were free from neglect and treated with dignity and respect related to Resident #3 who was scolded by staff and left in urine soaked clothes and bed linens for extended periods, and Resident #10 who almost fell during transfer to commode while staff was using a cell phone. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type B Violation)].	D911		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free of neglect related to health care. The findings are: 1.Based on observations, record reviews, and interviews, the facility failed to assure the health care needs of 5 of 7 residents sampled (#2 #3, #4, #5 and #6) were met by failing to notify the health care provider of Resident #2, who was experiencing continued itching and rashes, Resident #4, who continued to complain of ear	D914		

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D914	Continued From page 61 pain after antibiotic ear drops ran out earlier than ordered, Resident #6, with finger stick blood sugar results outside of the established parameters; failing to follow up with a Neurologist for monitoring of a progressive disease and to schedule an Optometry appointment for Resident #5; and failing to follow-up with a urology appointment for Resident #3. [Refer to Tag D237, 10A NCAC 13F .0902 Health Care (b) (Type B Violation)].	D914		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to respond to 1 of 2 sampled residents requests (Resident #5) to be moved to another room due to physical altercations and verbal arguments with her roommate. The findings are: Review of the facility's resident room assignment dated 10/04/17 revealed Resident #5 and Resident #6 were assigned to resident room 207. Review of Resident #5's current FL-2 dated 12/06/16 revealed: -Diagnoses included multiple sclerosis (MS), depressive disorder, hyperlipidemia, constipation and urinary incontinence.	D917		

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D917	Continued From page 62 -The resident was intermittently disoriented and semi-ambulatory using a wheelchair. Review of Resident #5's Resident Register revealed an admission date of 02/18/09. Interview with Resident #5 on 09/20/17 at 1:05 p.m. revealed: -Resident #6 hit her. The resident reported that Resident #6 slapped her every day, but had not hit her today (09/20/17). -Resident #5 told the "girls here" but was told to leave her (Resident #6 alone). -They had been roommates too long. Interview with Resident #5 on 10/18/17 at 11:20 a.m. revealed: -The resident had lived at the facility for 7 years and did not like living there. -Resident #6 (her roommate) does not pray, "I pray, I believe in God, she don't". -"I don't like it here because of her" (Resident #5 pointed to Resident #6). -She (Resident #6) called me a dummy, "I can read, she can't". Interview with Resident #5 on 10/19/17 at 4:25 p.m. revealed: -Resident #6 called her a [expletive] all the time. -Resident #6 called everybody "mama", "I'm not her mama, she is dark and I am white". -Resident #6 was mad because "I can read and she can't". Interview with Resident #5's family member on 10/24/17 at 7:15 p.m. revealed: -Resident #5 had reported to the family member that her roommate would slap her and called her a [expletive]. -The family member had seen one interaction	D917		

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recently when the family member was visiting. Resident #6 came into the room and said abruptly "what yall want". The family member stated "you could feel her attitude".
-The family member remembered talking to the Administrator a year or so ago about getting Resident #5 moved to another room. The family member was not sure if it was the current Administrator or a prior Administrator.
-Recently, the family member spoke with someone in Administration and asked where they were as far as adequate spacing to move the resident but still nothing had been done to move the resident to another room.
-The family member was told by the resident that she had told the Administrator a few months ago that she could not get along with her roommate and wanted to be moved to another room.

Interview with a Personal Care Aide (PCA) on 09/25/17 at 2:47 p.m. revealed:
-Any little thing agitated Resident #5.
-Resident #5 did not go out of her room a lot unless it was to smoke or eat.

Interview with a second PCA on 10/19/17 at 4:04 p.m. revealed Resident #5 "starts stuff".

Interview with the Health Service Director (HSD) on 09/25/17 at 3:12 p.m. revealed Resident #5 was overly dramatic.

Review of Resident #6's current FL-2 dated 03/02/17 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, schizophrenia, depression, urge incontinence, and hyperlipidemia.
-The resident was intermittently disoriented and semi-ambulatory with the use of a walker.

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D917	Continued From page 64 Review of Resident #6's Resident Register revealed an admission date of 02/18/03. Interview with Resident #6 on 09/20/17 at 1:53 p.m. revealed: -The resident did not like her roommate (Resident #5). -Resident #5 talked "junk" to her and pushed the door on her, and Resident #6 slapped her (Resident #5) in the face but Resident #5 slapped her first. -Resident #5 called her stupid and the resident told her "I'm not stupid like you". -The resident told Resident #5 "you [expletive] and pee in the bed". -Resident #5 had hit her twice. -Resident #5 hit her yesterday. -The resident hit Resident #5 when she messed with the fan. Resident #5 kept doing it; the resident hit Resident #5 on the back of the arm and she hit her back. -The resident did not tell staff. -The resident and Resident #5 fight a lot and the resident wanted a different roommate. Interview with a Medication Aide (MA) on 09/20/17 at 2:18 p.m. revealed: -Resident #6 "runs hot and cold with everybody". -Resident #6 could walk down the hall, pass 8 people and would have a problem with 3 of them. -Resident #6 would push and call people names. -Resident #6 initiated a lot with others but the MA could not think of a specific incident. Interview with the Administrator on 09/20/17 at 3:00 p.m. revealed: -Everyone loved Resident #6. -The Administrator would place Resident #6 on a waiting list for a new roommate. He did not have anywhere to move her.	D917		

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D917	Continued From page 65 Second interview with the Administrator on 09/25/17 at 2:19 p.m. revealed: -He had talked to Resident #6. -Resident #6 had never reported that anyone had hit her. Interview with Resident #6 on 09/25/17 at 2:29 p.m. revealed: -The resident did not like anybody, just the Assistant Executive Director (named). -She did not like her roommate (Resident #5). Interview with a third PCA on 09/25/17 at 2:47 p.m. revealed: -Resident #6 exaggerated a lot. She would say someone was going to do something to her but that was just her and it would not be true. -Resident #6 was playful and would say someone hit her at the same time she would be standing beside the PCA and nobody had hit her; she was childlike. Interview with a second MA on 09/25/17 at 3:00p.m. revealed: -Resident #6 would say random people would hit her a lot and somebody had cursed her out. -Resident #6 would pretend like somebody had done something to her but they had not done anything. Interview with a third MA on 09/20/17 at 2:18 p.m. revealed since the MA had worked at the facility Resident #5 and Resident #6 had been roommates. Interview with a fourth MA on 09/20/17 at 2:31 p.m. revealed: -Resident #5 and Resident #6 got along terribly. -Resident #5 and Resident #6 had their	D917		

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arguments but she had never seen a physical fight between the two.
-They both yell from time to time but Resident #6 would yell at anyone.
-Resident #5 did not talk much.
-Resident #5 and Resident #6 had been roommates for 2 years.
-The MA had not reported any issues between Resident #5 and Resident #6 to the Administrator or to the Assistant Executive Director.
-Resident #6 was usually walking out of the room when she would hear Resident #5 and Resident #6 arguing, then Resident #6 would go to the front Parlor (common area) and would start yelling.

Interview with a fifth MA on 09/20/17 at 2:43 p.m. revealed:
-Resident #5 and Resident #6 did not get along.
-Resident #5 and Resident #6 would argue about the room, it was both of them, not just one.

Interview with a fourth PCA on 09/25/17 at 2:47 p.m. revealed:
-There was a lot of 'bickering" that goes on between Resident #5 and Resident #6, they holler at each other, they did not get along.
-Resident #5 and Resident #6 would yell at each other about the lights, about the door, it didn't matter.
-The PCA had never seen Resident #5 and Resident #6 hit each other.
-The PCA had heard Resident #5 say that Resident #6 was going to hit her but Resident #6 would be in bed.

Interview with a sixth MA on 09/25/17 at 3:00p.m. revealed:
-Resident #5 and Resident #6 fussed all the time. They were both like children.

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-The MA did not think that they hit each other.
-Resident #5 would tell the MA that Resident #6 had cursed her out.
-Resident #5 never told her that Resident #6 had hit her.

Interview with a fifth PCA on 10/19/17 at 4:04 p.m. revealed:
-Resident #5 "bosses" Resident #6 around.
-Resident #5 and Resident #6 had never gotten along since they had been roommates.
-Resident #5 talked about Resident #6 a lot.
-Resident #6 did not bother Resident #5, it was Resident #5 that would agitate Resident #6.
-The PCA remembered a few months ago, Resident #5 told the PCA that Resident #6 had hit her (Resident #5).
-Resident #5 told the PCA that Resident #6 could hit her but she could not hit Resident #6 back or she would get in trouble. The PCA told Resident #5 that did not make any sense.
-The PCA reported Resident #5's concern that Resident #6 had hit her to the Medication Aide (MA).
-Resident #6 was "spoiled" (by staff) and had a mind like a child and Resident #5 knew that.

Interview with a Housekeeping staff on 10/23/17 at 12:18 p.m. revealed
-Resident #5 and Resident #6 fuss a lot.
-She often would hear Resident #5 and Resident #6 yelling at each other in the hallway.
-She had not reported the yelling to anyone because everyone knew they argue a lot.

Confidential interview with a resident revealed Resident #5 and Resident #6 argued and had never gotten along since they started being roommates.

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D917	Continued From page 68 Interview with Resident #6 on 10/20/17 at 3:05 p.m. revealed the resident liked "living here" and liked her roommate (Resident #5). Interview with the Administrator on 09/20/17 at 3:00 p.m. revealed: -The Administrator was not aware of Resident #5 and Resident #6 fighting. -Resident #5 had complained about Resident #6 but not about anyone hitting. -Resident #5 had complained that Resident #6 was in the room and was naked when she had a visitor. -Staff had not reported anything about them fighting. Interview with the Assistant Executive Director on 09/25/17 at 2:15 p.m. revealed: -They had talked to Resident #5 and Resident #6. -Resident #6 reported that another resident had hit her and not Resident #5. -They were still planning to move either Resident #5 or Resident #6 when a bed became available. Interview with the HSD on 09/25/17 at 3:12 p.m. revealed: -Resident #5 and Resident #6 had issues. -Recently, Resident #5 complained that Resident #6 placed too much toilet paper in toilet and the HSD had to oversee that. -Both Resident #5 and Resident #6 have alleged that the other had hit the other one but the HSD had never witnessed it. -The HSD would take the residents seriously but she had observed them and there was no indication of anything physical. It was hard to find 100% proof. Telephone interview with the Marketing Director on 10/26/17 at 12:08 p.m. revealed:	D917		

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-He was responsible for room assignments for the residents.
-He was not aware of any issues with Resident #5 and Resident #6 until the AHS had reported some issues the end of September 2017.

Interview with the Administrator, the Assistant Executive Director and the HSD on 10/23/17 at 4:00p.m. revealed Resident #5 and Resident #6 had arguments but the arguments were more like sibling rivalry.

Telephone interview with the PCP for Resident #5 and Resident #6 on 10/26/17 at 12:37 p.m. revealed:
-Resident #5 had talked to the PCP about "tiffs" she and Resident #6 had.
-Resident #5 and Resident #6 both had intellectual disabilities.
-Arguments between Resident #5 and Resident #6 were "more like grade school children". "It was not an issue that either one would had have been in agony" because of their relationship.
-She would expect the facility to take action if a resident was being mistreated or had reported that they could not take it anymore staying in a room with their roommate; however, between Resident #5 and Resident #6, it was more of a need to redirect and tell them to ignore the other.
-The PCP had never been told that Resident #6 had hit Resident #5.
-The PCP did not think there had been anything dangerous between Resident #5 and Resident #6.
-The PCP would expect for the facility to investigate all resident concerns.

Telephone interview with the Administrator on 10/26/17 at 3:08 p.m. revealed:
-Resident #5 reported to the Administrator once

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several months ago that Resident #6 was naked and she did not like that. Resident #5 then laughed about it and asked for money for cigarettes.
-Neither Resident #5 nor Resident #6 had asked to be moved into another room.
-No staff had reported Resident #5 and Resident #6 were hitting each other.
-No one had reported that Resident #5 wanted to be moved into another room.
-When issues occur between residents, the Administrator would separate them and initiate an investigation, interview other staff, and other alert and oriented residents.

Observation of Resident #5 on 10/25/17 at 6:38 p.m. revealed she had been moved to resident room #109B.

Interview with Resident #5 on 10/25/17 at 6:38 p.m. revealed:
-She liked her new room.
-She was happy because she liked her roommate.

Telephone interview with the Marketing Director on 10/26/17 at 12:08 p.m. revealed Resident #5 was moved to another room yesterday since a bed became available after two other residents were discharged.

_____

The facility failed to provide a reasonable response to Resident #5's requests to be moved to another room due to the resident's concerns related to physical altercations and verbal arguments with Resident #6, who had been her roommate for years. The facility's failure to respond to the request was detrimental to the safety and well-being of Resident #5 and Resident #6 which constitutes a Type B Violation.

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D917	Continued From page 71 Review of an unaccepted Plan of Protection received on 11/22/17 revealed: -The facility would follow up on any existing requests immediately. -Everyday ADL requests would be carried out by care staff without question. -Any requests outside the care staff's everyday scope of work would be referred the the supervisor in charge and/or administrative team. Non-routine requests (ie room changes) would be recorded in the chart. Follow up would be recorded in the chart by supervisor and/or administrative team. -The Administrator would educate staff on resident rights. Education would take place by 12/16/17. Education would include follow up actions staff should take when resident(s) make requests. -Facility would discuss resident requests in stand up meetings, quarterly QA meetings and resident council meetings. -Any requests would be promptly recorded and timely followed up on. Administrative team would ensure this occurred. -Ongoing resident rights and customer service training would occur throughout the year using an online education program (named). The Administrator would assign this training. -Grievance forms would be made available to residents at the next council meeting. The Activity Director would instruct residents how to use the form. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 10, 2017.	D917		

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D935	Continued From page 72	D935		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding	D935		

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exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews, the facility failed to assure 1 of 2 medication aides (Staff C) who administered medications in the facility had completed the 5 hour, 10 hour or the 15 hour state approved medication administration courses as required.

The findings are:

Review of Staff C's personnel file revealed:
-Staff C was hired on 7/28/14 as a Medication Aide/Supervisor.
-Staff C passed the written medication aide exam on 1/20/2011.
-Staff C complete the Medication Clinical skills check list on 8/18/14.
-There was no documentation of Staff C completing the 5 hour, 10 hour or 15 hour state approved medication aide training.

Review of sampled Resident #3's Electronic Medication Administration Record (eMAR) for October 2017 revealed Staff C documented the administration of medications 1 time.

Review of sampled Resident #4's eMAR revealed Staff C documented the administration of medications 2 times in September and October 2017.

Interview with facility's Administrator on 10/25/17 at 11:00 am revealed the Administrator was not

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D935	Continued From page 74 able to supply any further medication administration training documents for 5 hour, 10 hour or 15 hour state approved medication aide trainings.	D935		