STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034103	A. BUILDING: _____ B. WING _____	12/08/2017

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SALEMTOWNE	2000 SALEMTOWNE DRIVE WINSTON-SALEM, NC 27106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on December 6-8, 2017.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 4 staff sampled (Staff C) was tested for Tuberculosis (TB) disease upon hire in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel record revealed: -There was no hire date documented in the record. -Staff C was hired as a housekeeper. -There was documentation Staff C had a TB skin test read as negative on 12/17/09. -There was no documentation Staff B had a TB skin test within the past 12 months. -There was no documentation Staff B had a TB skin test after 08/31/17, effective date of the facility's licence.	D 131		

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D 131	Continued From page 1 Interview on 12/08/17 at 10:05 am with Staff C revealed: -She had worked for the company since 2009. -She recalled she had a TB skin test completed upon hire in 2009, but was sure she had not completed a second TB skin test. -She was unaware she needed to complete a second TB skin test. Interview 12/08/17 at 12:45 pm with the Administrator revealed: -She was not aware Staff C did not have a second TB skin test. -The Human Resource office would have been responsible to ensure Staff C had a first and second TB skin test. -She would make sure Staff C had a first and second TB skin test. Interview on 12/08/17 at 9:00 am with Human Resource office staff revealed: -The Human Resource office was responsible to ensure TB skin test was completed for Staff C. -She was sure Staff C did not have a first and second TB skin test, since 8/31/17.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by:	D 137		

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D 137	Continued From page 2 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to access Health Care Personnel Registry (HCPR) before hiring to assure no substantiated findings for 2 of 4 sampled staff (Staff B and Staff C). The findings are: A. Review of Staff B's personnel record revealed: -Staff B was hired on 11/13/17 as a medication aide. -There was no documentation a Health Care Personnel Registry Check (HCPR) was completed before hiring on 11/13/17. Interview on 12/08/17 at 10:18 am with Staff B, Medication Aide revealed: -She started working at the facility the first week in November 2017, as a medication aide. -Her responsibilities were administering medications to residents. -She was unaware what a HCPR check was, the Administrator handled all her paperwork. Interview on 12/07/17 at 4:40 pm with the Administrator revealed: -She was aware the HCPR was to be completed for new staff upon hire. -She was not sure why the report was not completed for Staff B. -She was responsible to ensure all staff hired by her had required documents. -She would make sure a HCPR report was completed for Staff B. B. Review of Staff C's personnel record revealed: -There was no hire date documented in the record.	D 137		

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D 137	Continued From page 3 -Staff C was hired as a housekeeper. -There was no documentation a HCPR had been completed for Staff C. Interview on 12/08/17 at 10:05 am with Staff C revealed: -She worked at the facility since 2009. -She worked as a housekeeper. -She did not know what a HCPR was and no one had ever mentioned to her that one needed to be done. Interview 12/08/17 at 12:45 pm with the Administrator revealed: -Completing HCPR for her staff was her responsibility. -She was aware HCPR had to be completed on staff that worked directly with the residents, but she was unaware they needed to be completed on housekeeping staff. -She would make sure to complete HCPR on Staff C. The facility failed to access the HCPR upon hire for 2 of 4 sampled staff (Staff B and C). This failure was detrimental to the safety of residents in that the facility had no knowledge if staff had substantiated findings, which constitutes a Type B violation. The facility provided a Plan of Protection as follows: -Health Care Personnel Registry checks were completed for Staff B and C with no findings. -Human resource will complete HCPR checks on all staff who work in the Assisted Living community upon hire. -The human resource office will monitor staff records quarterly for 1 year and then bi-annually	D 137		

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D 137	Continued From page 4 thereafter to ensure HCPR checks were completed on staff. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 23, 2018.	D 137		
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 review and interviews, the facility failed to assure 1 of 4 sampled residents (Resident #3) were tested upon admission for tuberculosis (TB) disease. The findings are: Review of Resident #3's current FL2 dated 12/31/16 revealed diagnoses included hypertension, shortness of breath, diabetes mellitus II, chronic kidney disease and peripheral vascular disease. Review of Resident #3's Resident Register revealed she was admitted to the facility on	D 234		

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D 234	Continued From page 5 12/17/10. Review of Resident #3's record revealed: -There was documentation of a TB test dated 12/12/13. -There were no results documentated for the TB test dated 12/12/13. -There was documentation of a TB testing date of 04/16/17 with the test being placed by a Licensed Practical Nurse (LPN). -There were no results documented for either TB test. Interview on 12/08/17 at 3:20 pm with an LPN employed at the facility revealed: -She was unable to locate TB test results for Resident #3. -The facility's nurses were responsible for administering TB tests to new residents and documenting both the administration and the test results in the residents' electronic medical records (EMR). -She was unsure as to why there were no TB test results for Resident #3. Interview on 12/08/17 at 1:14 pm with the facility's Administrator revealed: -She was aware residents were required to have TB skin tests administered upon admission. -Resident #3's TB test had been administered prior to the facility changing to the new computer system. -She and a representative from the computer program company were responsible for entering resident information into the new computer system. -She was unsure as to why there were no TB test results entered for Resident #3.	D 234		

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D 235	Continued From page 6	D 235		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im	D 235		

10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations

(b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter.
(c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

This Rule is not met as evidenced by:
Based on record reviews, interviews, and observations, the facility failed to assure 4 of 4 sampled residents (#2, #3, and #4) had a current medical examination completed as evidenced by three residents (#2, #3 and #4) not having FL2's prior to admission, and one resident (#1) having an examination date recorded on the an FL2 of no more than 90 days prior to admission to the facility.

The findings are:

A. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 09/01/17.

Review of Resident #2's current FL2 dated 11/21/17 reveled there was no FL2 completed upon admission to the facility.

Review of Resident #2's current FL dated 11/21/17 revealed diagnoses included heart

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D 235	Continued From page 7 murmur, esophageal obstruction, hernia, osteoporosis, and hyperlipidemia. Review of Resident #2's assessment and care plan revealed the care plan was completed 11/11/17 (more than 30 days after admission), and signed by the physician on 11/21/7 (more than 45 days after admission). Interview on 12/07/17 at 10:00 am with the Administrator revealed: -She was unaware Resident #2 needed an FL2 prior to admission to the facility. -The resident came with medications and physician wrote orders for refills. Refer to interview on 12/08/17 at 1:14 pm with the facility's Administrator. C. Review of Resident #4's current FL2 dated 11/21/17 revealed: -There was no FL2 completed upon admission to the facility. -Diagnoses of multiple sclerosis, sick sinus syndrome, anemia, cystostomy with suprapubic catheter, and diabetes. Review of Resident #4's Resident Register revealed the resident was admitted to the Assisted Living facility on 07/11/17. Review of Resident #4's assessment and care plan revealed the care plan was completed 11/11/17 (more than 30 days after admission), and signed by the physician on 11/21/7 (more than 45 days after admission). Interview on 12/07/17 at 10:00 am with the Administrator revealed: -She was unaware Resident #4 needed an FL2	D 235		

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D 235	Continued From page 8 prior to admission to the facility. -The resident came to the assisted Living facility with prior orders from a Skilled Nursing facility and the provider continued those. -She did not have a copy of the resident's previous FL2 that she had had in the skilled nursing facility. Refer to interview on 12/08/17 at 1:14 pm with the facility's Administrator. Interview on 12/08/17 at 1:14 pm with the facility's Administrator revealed: -The facility had obtained their license to operate as an Assisted Living Facility (ALF) on 08/31/2017. -She was responsible for ensuring each resident had a current FL2. -She was unaware the examining date recorded on the FL2 should be no more than 90 days prior to the resident's admission to the facility.	D 235		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide supervision	D 269		

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D 269	Continued From page 9 of residents in accordance with each resident's assessed needs, care plan and current symptoms for 1 of 4 sampled residents (Resident #4) with physical decline and a history of falls. The findings are: Review of Resident #4's current FL2 dated 11/21/2017 revealed: -Diagnoses of multiple sclerosis, sick sinus syndrome, anemia, cystostomy with suprapubic catheter, and diabetes. -The resident was noted to be semi-ambulatory with a wheelchair. -The resident required assistance with bathing and dressing. Review of Resident #4's Resident Register revealed the resident was admitted to the Assisted Living facility on 07/11/2017. Review of Resident #4's current care plan dated 11/11/2017 revealed: -The resident required assistance with bathing, dressing, grooming and transferring to and from wheelchair. Review of Incident Reports for Resident #4 revealed: -On 09/11/17 at 09:30 am, a nurse responded to the resident's personal alarm and found the resident lying on the bathroom floor with her head propped up on the wall. Resident's wheelchair was "noted outside the bathroom with the brakes unlocked." Report notes that the resident stated "I was sitting back down and the wheelchair was not locked." Staff obtained vital signs, began neurological checks, and assisted the resident off of the floor. -On 10/05/17 at 04:45 am, Resident #4 was	D 269		

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D 269	Continued From page 10 found lying face down near her bathroom sink. Resident stated "I was trying to get up and slipped and fell." Report noted that the resident was using the bathroom when she fell. Staff obtained assistance from a nurse aide and the supervisor in charge to assess the resident and transfer her back to the toilet. Resident #4 was then assisted to re-dress and transferred back to her motorized wheelchair. The provider was notified by electronic note and family was called by telephone. -On 10/05/17 at 08:00 pm, Resident #4 activated her personal alarm (PAL) and was found by staff sitting on her bathroom floor in front of her motorized wheelchair. The resident said "I slid off the chair trying to get to the commode, I did not get hurt." Staff assisted the resident to the toilet and obtained vital signs. Assessment noted no apparent injuries. Family was notified but no documentation the provider was notified. -On 10/15/17 at 04:50 pm, staff responded to the resident's personal alarm and found the resident lying in the floor of the bathroom resting against the shower. Her wheelchair was noted to be in the doorway. Resident #4 said, "I think the toilet chair gave way and I just fell. I didn't hit my head or get hurt." Staff assessed the resident for injuries and found none. Vital signs were obtained. Staff left a voicemail for the resident's family member and sent an electronic note to the provider. -On 12/04/17 at 06:50 am, staff found Resident #4 lying in the bathroom floor in front of the toilet with her head resting on her motorized wheelchair. The resident said she lost her balance and fell. Staff assessed the resident for injuries and reported none. There was no documentation of vital signs, contact with the family member, or notification of the provider on the incident report.	D 269		

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D 269	Continued From page 11 There was no incident report found for the date of 9/25/17. -There was no documentation of interventions put in place to safeguard the resident post-fall. Review of Resident #4's Nurse's Notes revealed: -An entry on 9/11/17 at 10:10 am documenting a fall and subsequent assessment with neurological checks (neuro check) "WNL (Within Normal Limits), MOE (Movement of Extremities) x 4 without issues." -An entry on 9/11/17 at 6:06 pm noting "some bleeding from suprapubic catheter," with "small amount of dried blood around cath site and tubing." No active bleeding was noted. Staff noted they applied the suprapubic dressing as ordered and would "notify the urologist if bleeding continued." -An entry on 9/12/17 at 2:57 am documenting "resident fall f/u (follow up) day 1. MOE x 4. No c/o (complaints of) pain this shift. Suprapubic cath showed no signs of bleeding." -An entry on 9/12/17 at 2:16 pm documenting "fall f/u day 2. MOE x 4 without any issues. Res(ident) denies any pain or discomfort ... Transfers independently. Neuro check WNL." -An entry on 9/12/17 at 11:58 pm documenting "Fall f/u day 2. Resident MOE x 4 ... No new c/o pain or discomfort from recent falls. Neuro's and VS (Vital Signs) WNL." -An entry on 9/13/17 at 1:59 pm documenting "Fall f/u day 3. Resident able to voice needs. Voices no c/o pain or discomfort ... no apparent injuries noted." -An entry on 9/14/17 at 1:11 am documenting "VSS (vital signs stable) and WNL. Fall f/u day 3 w/o (without) s/s (signs and symptoms) of apparent injury noted. No c/o voiced. No acute distress noted." -An entry on 9/25/17 at 11:57 pm documenting	D 269		

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D 269	Continued From page 12 that the resident "activated her PAL alarm but no one came, so she slid down out of her autochair and crawled to her bed to activate the pullcord beside her bed. She states she did not fall. She states she touched her head gently on the wall ... performed a neuro check on her but she (resident) refused VS. She states she does not consider what she did a fall and refuses any follow up with VS or neuro checks. They're (sic) no s/s of injury, no scrapes or bruises, no knots to skull area." -An entry on 10/05/17 at 5:42 pm documenting a fall in the bathroom. Writer noted, "asked resident if any pain in anyway [sic], resident denied any pain ... resident was checked for injury, no injury noted at this time. Resident was assisted back onto the commode." - An entry on 10/05/17 at 5:44 pm documenting the same information as the note at 5:42 pm. There was an addition of, "PRF (electronic note) sent to Dr." -An entry on 10/05/17 at 5:49 pm documenting, "Resident stated she did not hit her head when she fell. No noted marks or injury noted at this time." -An entry on 10/06/17 at 4:08 am documenting a fall that occurred at "approx. 8:15 pm on 10/05/17." The writer noted that the resident was "found sitting on the bathroom floor in front of her power chair. She stated, 'I just slid off the chair trying to get on the commode seat.' No injury noted. Alert and oriented to person, place and time. Assisted up by (staff names). Instructed resident to call for assistance when ready to leave bathroom." VS were recorded and it was noted that staff called family and left a voicemail to inform them of the fall. -An entry on 10/06/17 at 6:59 pm documenting "Fall f/u day 2. MOEx4 without issues. Denies pain or discomfort."	D 269		

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D 269	Continued From page 13 -An entry on 10/07/17 at 3:43 am documenting "VSS and WNL. Fall f/u day 2 w/o s/s of apparent injury noted. No c/o of pain or discomfort. No acute distress noted." -An entry on 10/07/17 at 6:08 pm documenting "Fall f/u day 2. Res(ident) denies any pain or discomfort ... Res(ident) reported some bleeding from cath site, cath was changed this past week." -An entry on 10/08/17 at 12:51 am documenting "VSS and WNL. Fall f/u day 3 w/o s/s of apparent injury noted. No c/o voiced. No acute distress noted. Reported scant amount of bleeding from SP (suprapubic) cath change last week." -An entry on 10/08/17 at 1:23 pm documenting "Fall f/u day 3. Denies any pain or discomfort. MOE x 4 without any issues ... Small amount of bleeding noted around suprapubic cath site. Cleaned and applied dressing as ordered." -An entry on 10/15/17 at 6:14 pm documenting "Resident pushed PAL @~1650 (4:50 pm). When staff arrived resident was noted to be on the floor in the bathroom resting against shower door ... Resident stated, 'I think the toilet chair gave way when I was getting on the toilet and I just hit the floor. I didn't hit my head or get hurt. I tned to relax when I fall.' Skin sweep performed and no injuries noted. PRF for Dr. placed to notify of fall. (Family member) notified of fall via telephone. VSS." -An entry on 10/16/17 at 4:31 am documenting "VSS and WNL. Fall f/u day 1 w/o s/s apparent injury noted. No c/o voiced. No acute distress noted." -An entry on 10/17/17 at 4:24 am documenting "Fall f/u day 2. MOE x 4. No c/o pain or discomfort due to recent fall. No injuries noted that are related to recent fall." -An entry on 10/17/17 at 1:53 pm documenting "Fall f/u day 3. MOE x 4 without any issues ... No complaints of pain or discomfort voiced."	D 269		

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	HAL034103	A. BUILDING: _____ B. WING _____	12/08/2017

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D 269	Continued From page 14 -An entry on 10/18/17 at 2:47 am documenting "Fall f/u day 3. MOE x 4 ... No c/o pain or distress due to recent fall. VS WNL." -An entry on 12/04/17 at 9:16 am documenting a fall in front of the resident's toilet. "Resident stated she lost her balance. I don't hurt any where. Staff assist (sic) resident for injury, no injury noted at that time. Resident was helped up back onto the commode and CAN (nurse aide) finnish (sic) helping resident get dress (sic) for the day. Suggested to resident to put shoes or socks with grip bottoms on before getting up." -An entry on 12/05/17 at 6:36 am documenting "Fall f/u day 2. VS WNL. No c/o pain or discomfort this shift." -An entry on 12/05/17 at 6:27 pm documenting "Fall f/u day 1. Voices no c/o pain or discomfort at this time ... PT (physical therapy) eval(uation) emailed to (physical therapist) per MD request. Neuro appointment to be made next business day. VSS." -An entry on 12/06/17 at 10:13 am documenting "Resident fall f/u day2 ... A&O (alert and oriented) x3. MOE x4. Voices no c/o pain or discomfort at this time. No visible signs of injury." -An entry on 12/07/17 at 4:38 am documenting "VSS and WNL. Fall f/u day 3 w/o s/s apparent injury noted. No c/o voiced. No acute distress noted. MOEx4. Alert and oriented x4. Pleasant and cooperative with staff." Interview on 12/07/17 at 8:30 am with Resident #4 revealed: -She fell "often." -She was not familiar with her motorized wheelchair as it "was a loaner," and she had run into the walls several times, causing holes in the drywall. -"My bathroom is too narrow and when I fall in there I can't get up."	D 269		

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D 269	Continued From page 15 -She had not injured herself in any of her falls. -She had multiple sclerosis and it caused her intermittent periods of weakness that increased her falls. -She mainly fell trying to transfer in her bathroom, or from her bed to her wheelchair. -She did not have room to maneuver her motorized wheelchair in her bathroom to allow her room to pivot when transferring from her wheelchair to the toilet or back. -When she moved to the Assisted Living facility, the building maintenance staff removed a portion of the bathroom wall to allow her wheelchair to roll into the bathroom, but there was not enough room to turn the chair. -The facility was building a new Assisted Living facility that would have larger suites and more accessible bathrooms, and she planned to move there when it opened. -She was not sure when the new section would be completed. Observation on 12/07/17 at 8:30 am in Resident #4's bedroom revealed several holes above the molding, approximately 6 inches from the floor, along the wall leading to the exit door, and to the bathroom. Interview on 12/07/17 at 1:45pm with Licensed Practical Nurse (LPN) revealed: -Resident #4 had transferred from the Skilled Nursing facility to the Assisted Living facility when it opened. -The provider had "upgraded" her level of care because she was "very lucid and independent." -Resident #4 had a long history of falls in skilled nursing care but had "gotten better lately." -The resident had multiple sclerosis (MS) that caused varying levels of weakness "depending on if she had a flare-up."	D 269		

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D 269	Continued From page 16 -The resident was considered independent with toileting and could transfer herself from her motorized wheelchair to the toilet and back. -When the resident fell, staff would assess her for injury, then assist her back to her wheelchair or bed. -Resident #4 had not sustained any injuries from her falls. -Staff performed assessments for injury and mental status changes, "neuro checks," for three days after a fall. -Staff were to notify the family and the provider each time a fall took place and document this in the electronic medical record (EMR). -Staff were to also complete an incident report each time they witnessed or discovered a fall. -She thought they had a fall policy in place for the facility but she wasn't sure. -After the resident's last fall on 12/04/17, the provider had ordered a Physical Therapy (PT) evaluation. -She was not aware of any other interventions in place to prevent Resident #4 from falling again. Interview on 12/07/17 at 12:25 pm with Resident #4's primary care provider (PCP) revealed: -She had ordered a PT evaluation for the resident after she was informed of her last fall to evaluate her mobility. -She received an electronic message from staff to notify her when a fall occurred. -She was aware the resident had experienced several falls in the past three months. -Resident #4 "had a history of falls for many years due to her MS." -It was the "resident's responsibility to call for help to the bathroom and she had been encouraged to do so." -The facility had a fall policy.	D 269		

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D 269	Continued From page 17 Interview on 12/08/17 at 1:08 pm with the Administrator revealed: -She was aware Resident #4 had a history of falls. -There was a fall policy in place for the Skilled Nursing facility, but she had not completed a fall policy for the new Assisted Living facility at this time. -She planned to complete a fall policy "immediately," based on the fall policy in place in skilled nursing. -Staff documented an incident report after each fall. -Staff also completed a "fall assessment" for 3 days after a fall. -Staff had "encouraged Resident #4 to put on shoes or no-slip socks before getting up so she wouldn't fall." -Staff had also encouraged Resident #4 to "call for help to the bathroom." -She did not know if these interventions were documented in the Nurse's Notes. -"I'd have to go back and look." -She was aware a PT evaluation had been ordered and it was completed earlier that day, but she had not "seen the notes" yet. Telephone interview on 12/08/17 at 4:45 pm with the Physical Therapist revealed: -She was employed through a contract company for the facility in both Skilled Nursing and Assisted Living. -She had worked there for 4 and 1/2 years. -She evaluated Resident #4 quarterly when the resident was living in the Skilled Nursing facility. -The resident moved to Assisted Living in July 2017. -The resident had not been evaluated in the past 9 months. -The resident had a history of falls in the Skilled	D 269		

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D 269	Continued From page 18 Nursing facility, "mostly between the chair and bed." -Resident #4 was assessed for a new motorized wheelchair in September and was "driving a loaner until her new chair arrives." -She had assessed the resident that morning after receiving a referral from the primary care provider. -"The bathroom isn't ideal for her power chair." -She had ordered a grip bar that morning after the assessment to be placed next to the resident's shower to assist her with transferring to the toilet. -She had asked that morning for the bathroom trashcan to be moved to allow the resident to pivot for transfers. -She had taught the resident a new way to pivot during her evaluation to "help prevent falls." -She had instructed the resident to always wear non-slip footwear before attempting to transfer or get out of bed.	D 269		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the	D 280		

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D 280	Continued From page 19 tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure quarterly on site Licensed Health Professional Support (LHPS) evaluations by a Registered Nurse for 3 of 4 sampled residents (Residents #1, #3, and # 4) with LHPS tasks of medications administered through inhalation, urostomy care, medication administration through injections and FSBS. The findings are: A. Review of Resident #1's current FL2 dated 05/30/17 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety disorder, panic attacks, hypertension, reflux, and hyperlipidemia. -There was a physician's order for Ipraptropium/Sol Albutrol nebulizer three times a day (a medication used to treat COPD). Review of Resident #1's Resident Register revealed she was admitted to the facility on 08/04/17. Review of signed physician's orders in Resident	D 280		

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D 280	Continued From page 20 #1's electronic medical record (EMR) revealed: -There was an order dated 05/30/17 for Ipraptropium/Sol Albutrol nebulizer three times a day. -Resident #1 may self administer. Review of Resident #1's Licensed Health Professional Support (LHPS) revealed: -There was documentation it had been filled out but not completed by the facility's Registered Nurse (RN) on 11/10/17. -There was no task listed on the LHPS form. -There was no assessment documented on the form. Refer to interview on 12/08/17 at 10:53 am with the facility's Consultant Pharmacist. Refer to interview on 12/08/17 at 1:14 pm with the facility's Administrator. B. Review of Resident #4's current FL2 dated 11/21/2017 revealed: -Diagnoses of multiple sclerosis, sick sinus syndrome, anemia, cystostomy with suprapubic catheter, and diabetes. -An order for catheter care every shift. Review of Resident #4's Resident Register revealed she was admitted to the Assisted Living facility on 07/11/17. Review of Resident #4's Licensed Health Professional Support (LHPS) revealed: -There was documentation an LHPS form had been written by the facility's Registered Nurse (RN) on 11/10/17, but was incomplete. -There was documentation of personal care tasks on the LHPS form that included catheter care and FSBS.	D 280		

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D 280	Continued From page 21 -There was no documentation of a physical assessment, evaluation of the resident's progress to care being provided or recommended changes in the care of the resident. Refer to interview on 12/08/17 at 10:53 am with the facility's Consultant Pharmacist. Refer to interview on 12/08/17 at 1:14 pm with the facility's Administrator. C. Review of Resident #3's current FL2 dated 12/31/16 revealed: -Diagnoses included hypertension, shortness of breath, diabetes mellitus II, chronic kidney disease and peripheral vascular disease. -There was a physician's order for Lantus (a diabetes medication), inject 24 units every night. -There was a physician's order for Novolog (a diabetes medication), inject 6 units every day at dinner. -There was no documentation regarding Resident #3's urostomy or finger stick blood sugars (FSBS). Review of Resident #3's Resident Register revealed she was admitted to the facility on 12/17/10. Review of signed physician's orders in Resident #3's electronic medical record (EMR) revealed: -There was an order dated 3/11/11 to change Resident #3's urostomy bag as needed. -There was an order dated 8/06/17 to change I & O catheter every week. -There was an order dated 5/30/17 to obtain FSBS before dinner on Tuesdays and Fridays and before breakfast on Mondays and Thursdays. Review of Resident #3's Licensed Health	D 280		

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D 280	Continued From page 22 Professional Support (LHPS) dated 11/10/17 revealed: -The LHPS was incomplete. -There was documentation of personal care tasks currently present that included urostomy care, medication administration through injections and FSBS. -It was signed by the facility's Registered Nurse (RN). -There was no documentation of a physical assessment, evaluation of the resident's progress to care being provided or recommended changes in the care of the resident. Refer to interview on 12/08/17 at 10:53 am with the facility's Consultant Pharmacist. Refer to interview on 12/08/17 at 1:14 pm with the facitlity's Administrator. --- Interview on 12/08/17 at 10:53 am with the facility's Consultant Pharmacist revealed: -The pharmacy she was employed with provided medications for the facility's residents. -She conducted the pharmacy's quarterly pharmacy reviews. -The facility's RN had contacted their pharmacy requesting assistance with completing LHPS forms and they intended to begin providing this service in January 2018. Interview on 12/08/17 at 1:14 pm with the facility's Administrator revealed: -The facility had obtained their license to operate as an Assisted Living Facility (ALF) on 08/31/2017. -She was responsible for completing each resident's LHPS. -She was unaware that a physical assessment	D 280		

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D 280	Continued From page 23 and evaluation of the resident's progress was required. -She had contacted the facility's contracted pharmacy in October 2017 and again in November 2017 requesting their assistance in completing the LHPS. -The contracted pharmacy was scheduled to begin assisting her with completing LHPS assessments in January 2018.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for 2 of 4 sampled residents (Residents #3 and #4) with orders for no concentrated sweets (NCS) diet. The findings are: A. Review of Resident #3's current FL2 dated 12/31/16 revealed: -Diagnoses included hypertension, shortness of breath, diabetes mellitus II, chronic kidney disease and peripheral vascular disease. -An order for a NCS diet. Observation on 12/06/17 at 9:45 am of the kitchen area revealed: -There was a week-at-a-glance menu labeled	D 296		

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D 296	Continued From page 24 Week 1 Fall/Winter 2017 available on a clipboard. -There was no menu for the NCS diet. Review of a diet guideline book in the dining room revealed: -Resident #3 was to be served a NCS diet. Observation on 12/06/17 of the lunch meal service revealed: -Resident #3 was served the lunch meal in her room. -Resident #3 was served fried chicken, macaroni and cheese, collard greens, red velvet cake, 1 carton (8 oz) of 2% milk, 1 cup of coffee, and 1 glass of water. -Resident #3 ate 100% of her meal. Based on observations, interviews, and record reviews, it could not be determined if Resident #3 was served the appropriate diet due to no therapeutic menu for NCS diet available to staff guidance. Observation on 12/07/17 of the breakfast meal service revealed: -Resident #3 was served the breakfast meal in her room. -Resident #3 was served 1 sausage patty, scrambled eggs, 1 biscuit with gravy, 1 fresh fruit cup, 1 cup of decaffeinated coffee, creamer, margarine, and 2 packets of sucralose (artificial) sweetener -Resident #3 ate 100% of her meal. Based on observations, interviews, and record reviews, it could not be determined if Resident #3 was served the appropriate diet due to no therapeutic menu for NCS diet available to staff guidance.	D 296		

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D 296	Continued From page 25 Interview on 12/06/17 at 12:25 pm with Resident #3 revealed: -She had a diagnosis of diabetes. -Facility staff checked her blood sugar "almost daily" and administered insulin twice daily. -She was not aware she was on a NCS diet. -She was given a written menu at each meal to circle her choices for the next meal. -She had always selected what she wanted and no staff had ever encouraged her to make a different choice. -She was always served the food choices she selected. Refer to interview on 12/07/17 at 7:45 am with the Dining Server. Refer to interview on 12/06/17 at 9:45 am with the Dietary Manager (DM). Refer to interview 12/08/17 at 3:30 pm with the Registered Dietitian (RD). Refer to interview on 12/07/17 at 12:25 pm with Resident #3 and Resident #4's Primary Care Provider (PCP). Refer to interview on 12/08/17 at 12:25 pm with the Administrator. B. Review of Resident #4's current FL2 dated 11/21/2017 revealed: -Diagnoses of multiple sclerosis, sick sinus syndrome, anemia, cystostomy with suprapubic catheter, and diabetes. -An order for a no concentrated sweets (NCS) diet. Review of Resident #4's Resident Register revealed:	D 296		

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D 296	Continued From page 26 -The resident was admitted to the facility on 07/11/2017. Observation on 12/06/17 at 9:45 am of the kitchen area revealed: -There was a week-at-a-glance menu labeled Week 1 Fall/Winter 2017 available on a clipboard. -There was no menu for the NCS diet. Review of a diet guideline book in the dining room revealed Resident #4 was to be served a NCS diet. Interview on 12/06/17 at 11:45 with Licensed Practical Nurse revealed that Resident #4 ate lunch outside of the facility at least 3 to 4 days a week with her private caregiver, and would be out for lunch both days observed. Observation on 12/07/17 of the breakfast meal service revealed: -Resident #4 was served 1 boiled egg, 1 individually packaged cup of unsweetened applesauce, 2 pieces of bacon, 1 bowl of oatmeal, 1 mug of hot tea with 2 packets sucralose(artificial) sweetener, and 1 carton (8 oz) of skim milk. -Resident #4 consumed 100% of the meal including the hot tea and 75% of the skim milk. Based on observations, interviews, and record reviews, it could not be determined if Resident #3 was served the appropriate diet due to no therapeutic menu for NCS diet available to staff guidance. Interview on 12/07/17 at 7:45 am with Resident #4 revealed: -She ate the same thing for breakfast every day. -She did not eat lunch in the facility at least 4	D 296		

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D 296	Continued From page 27 days a week as she left the facility with a private sitter on those days. -She was aware she was supposed to have a NCS diet. -She felt like the facility did not offer enough choices for diabetics. -She ordered off the regular menu for dessert most days because she did not like the no sugar added options for dessert. Refer to interview on 12/07/17 at 7:45 am with the Dining Server. Refer to interview on 12/06/17 at 9:45 am with the DM. Refer to interview 12/08/17 at 3:30 pm with the Registered Dietitian (RD). Refer to interview on 12/07/17 at 12:25 pm with the facility's primary care provider Refer to interview on 12/08/17 at 12:25 pm with the Administrator Interview on 12/07/17 at 7:45 am with the Dining Server revealed: -She had been employed with the facility for 5 years. -Residents were given an order sheet at each meal to make selections for the following meal. -Pans of food were brought up from the main kitchen and she plated the food according to each resident's order sheet. -Residents on both a regular diet and therapeutic diets were given the option of choosing whatever they wanted to eat and drink and she would plate their food based on the selections they made on the order sheet.	D 296		

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D 296	Continued From page 28 Interview on 12/06/17 at 9:45 am with the General Manager of Culinary Services revealed: -He had been employed by the facility for 2 years. -He did not use a menu for the NCS diet. -He used the regular menu and followed the guidelines given to him by the dietitian on staff. -He was not aware that a separate therapeutic diet menu for all physician ordered therapeutic diets offered was needed. Interview on 12/08/17 at 3:30 pm with the RD for the facility revealed: -She created a therapeutic diet guideline sheet as a reference for nutrition services staff, but did not create separate menus for each therapeutic diet. -She was unaware a separate therapeutic diet menu for all physician ordered therapeutic diets offered was needed. Interview on 12/07/17 at 12:25 pm with the facility's primary care provider revealed: -"I am very liberal in enforcing diets. I feel it's more about encouraging residents to make good choices." -She had ordered the NCS diets for both residents while they were residents in Skilled Nursing (SN) and had carried the orders over when the residents moved to Assisted Living facility. -She felt that residents in AL should have less restrictions than residents in SN. -Both residents had diabetes and were also ordered FSBS. -She would only be concerned about what the residents were choosing to eat if she noticed a trend of high blood sugars. Interview on 12/08/17 at 12:25 pm with the Administrator revealed:	D 296		

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D 296	Continued From page 29 -She was not aware a separate therapeutic diet menu for all physician ordered therapeutic diets offered was needed. -"We don't have many residents that need therapeutic diets." -She thought the guidelines developed by the RD met the state requirements. -She planned to ensure the facility would maintain a matching therapeutic diet menu for all physician-ordered therapeutic diets in the future.	D 296		
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 on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner for 1 of 4 sampled residents (Resident #4) with a physician's order for premarin cream. The findings are: Review of Resident #4's current FL2 dated 11/21/17 revealed: -Diagnoses of multiple sclerosis, sick sinus	D 358		

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D 358	Continued From page 30 syndrome, anemia, cystostomy with suprapubic catheter, and diabetes. -An order for premarin cream 0.625 mg (used to treat vaginal atrophy due to menopause), apply 0.5 grams (g) into vagina 3 times a week on Monday, Wednesday and Friday. Review of Resident #4's Resident Register revealed an admission date of 7/11/17. Review of Resident #4's electronic medical record (EMR) revealed: -A signed physician's order sheet dated 05/02/2017 with an order for premarin cream 0.625 mg, apply 0.5 g into vagina 3 times a week on Monday, Wednesday and Friday. Review of Resident #4's October 2017 electronic Medication Administration Record (eMAR) revealed: -An entry for premarin cream 0.625 mg, apply 0.5 g into vagina 3 times a week on Monday, Wednesday and Friday at bedtime. -The medication was not documented as administered on 10/04/17, 10/06/17, 10/09/17, 10/11/17, 10/13/17, 10/18/17, 10/20/17, 10/25/17, and 10/27/17. -There was no documentation why the medication had not been administered. Review of Resident #4's November 2017 eMAR revealed: -An entry for premarin cream 0.625 mg, apply 0.5 g into vagina 3 times a week on Monday, Wednesday and Friday at bedtime. -The medication was not documented as administered on 11/01/17, 11/03/17, 11/08/17, 11/10/17, 11/15/17, and 11/17/17. -There were no notes added detailing why the medication had not been administered.	D 358		

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D 358	Continued From page 31 Telephone interview on 12/08/17 at 09:47 am with a second shift LPN revealed: -She worked 12 hour shifts from 7:00 pm to 7:00 am. -She rotated shifts with another LPN who worked the nights she did not. -Resident #4 had "several different creams," including the premarin cream. -All creams and ointments for residents were supposed to be stored on the treatment cart unless the resident self-administered the medication. -She had not administered the premarin cream in "several months" because it had been unavailable on the treatment cart. -She marked "not administered" on the eMAR on the dates 10/04/17, 10/06/17, 10/11/17, 10/13/17, 10/18/17, 10/20/17, 10/25/17, 10/27/17, 11/01/17, 11/03/17, 11/08/17, 11/10/17, 11/15/17, and 11/17/17. -She did not record a reason for not administering the medication because "it had to be documented in a different place and it was too hard to go back and forth during the med pass." -She had not told the administrator that she could not find the cream. -She had mentioned to other staff "in passing" that she could not find the cream, but had not formally reported it missing. -She thought she had reordered the cream from the pharmacy but it was never received. -She did not contact the pharmacy to follow up on the refill request. -She had documented the cream as administered on 12/06/17 in error and had not actually administered the cream. -She had not searched for the cream in the resident's room. -She had not administered the cream in October,	D 358		

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D 358	Continued From page 32 November or December. Review of Resident #4's December 2017 eMAR revealed: -An entry for premarin cream 0.625 mg, apply 0.5 g into vagina 3 times a week on Monday, Wednesday and Friday at bedtime. -The medication was documented as administered on 12/01/17, 12/04/17, and 12/06/17. Review of medications on hand for administration for Resident #4 on 12/08/17 at 10:25 am revealed premarin cream and the applicator tube were not available on the treatment cart. Surveyor entered the resident's room with the Licensed Practical Nurse (LPN) supervisor on 12/08/17 at 10:30 am. A search by the LPN supervisor of Resident #4's nightstand in resident's room revealed one tube of premarin cream, not in the box and without a pharmacy label, underneath the resident's personal items. No applicator tube was observed in the nightstand or resident's room. The premarin cream tube had been opened but looked full. Interview on 12/08/17 at 11:20 am with a representative for the contracted pharmacy provider revealed: -Premarin cream was packaged from the manufacturer with metered applicator tubes marked in 0.5 g increments up to 2 g. -Each premarin cream tube contained 1.06 ounces (30.05 grams) of medicated cream, equal to about 60 doses of medication based on the 0.5 g dosage. -The last dispensed date for the premarin cream from the pharmacy was in May 2017. -If administered correctly, the medication would	D 358		

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D 358	Continued From page 33 have been due for refill at the beginning of October 2017. Interview on 12/07/17 at 12:25 pm with Resident #4's primary care provider revealed: -She prescribed the premarin cream for vaginal atrophy secondary to menopause. -Her expectation was that the cream would be administered as ordered three days a week on Monday, Wednesday and Friday. -If the medication was not available, she expected that staff would inform her. -If the medication was not administered, she expected that staff would inform her. -She had not been notified that Resident #4 was not receiving the premarin cream. -Not receiving the prescribed cream as ordered could lead to vaginal discomfort and pain for the resident. -She had not written an order for the premarin cream to be self-administered. Interview on 12/07/17 at 04:45 pm with Resident #4 revealed: -Staff provided her with catheter care and catheter dressing changes every 12 hours. -She remembered receiving a vaginal cream (premarin) in the past but could not remember the name. -Staff applied two different creams to her suprapubic catheter area when the dressing was changed, but these were different from the vaginal cream. -Staff administered the vaginal cream when she received it and she did not apply it herself. -She thought staff used an applicator when administering the premarin cream but "it's been so long I can't remember." -She remembered receiving her suprapubic catheter cream at night in the past few months,	D 358		

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D 358	Continued From page 34 but not the vaginal cream. -She could "not remember the last time I received the vaginal cream but it has been a long time, at least several months." Telephone interview on 12/08/17 at 10:04 am with another second shift LPN revealed: -She worked opposite nights from the first night shift LPN. -She had not been told that the premarin cream was unavailable. -She administered the cream on the ordered nights and documented this on the eMAR. She had a routine where she "provided the catheter care and put her suprapubic cream on while changing the dressing, and then placed some of the premarin cream on Resident #4's finger for her to rub on her vagina." -The premarin cream was "sometimes on the treatment cart and sometimes in the resident's nightstand." -She would remove all needed creams or ointments for all residents from the treatment cart and place them on the medication cart before beginning her medication pass. -She had documented that she administered the cream on 12/04/17, which was the last time she had administered it. -She "would just look for it (premarin cream) in the resident's room if I couldn't find it on the treatment cart." -The premarin cream was kept "in a plastic bag with her (the resident's) name on it." Interview on 12/08/17 at 11:15 am with the Administrator revealed: -She was aware the premarin cream should be administered with an applicator. -No staff had told her they could not find the premarin cream.	D 358		

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D 358	Continued From page 35 -No staff had informed her that the premarin cream was not being given consistently or correctly. -She had not audited the resident's eMAR and had not noticed the premarin cream was not administered. -The facility did not have an eMAR audit system in place. -She did not know why the premarin cream was in the resident's nightstand and not on the treatment cart. -She did not know where the applicators for the premarin cream were.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriated, and in compliance with relevant federal and state laws and rules and regulations related to Health Care Personnel Registry (HCPR). The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 sampled staff (Staff B and Staff C) had no	D912		

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D912	Continued From page 36 substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag 0137 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (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.	D935		

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D935	Continued From page 37 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 2 staff sampled (Staff B) who administered medications had employment verification or completed the 5-10-15 hour state approved medication administration training courses as required, or had a Medication Clinical Skills Competency checklist completed prior to administering medications. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 11/13/17 as a medication aide. -Staff B passed the written medication aide exam on 11/04/09. -There was no documentation of employment verification showing Staff B worked as a medication aide within the past 24 months. -There was no documentation Staff B had the 5-10-15 hour medication aide training. -There was no documentation Staff B had the Medication Clinical Skills Competency checklist. Review of the residents' November 2017 and December 2017 medication administration	D935		

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D935	Continued From page 38 records revealed: -Staff B documented administration of medications on 11/29/17, 11/30/17, 12/04/17, 11/05/17, 12/06/17, 12/07/17 and 12/08/17. Interview on 12/08/17 at 10:18 am with Staff B, Medication Aide revealed: -She started working at the facility the first week in November 2017, as a medication aide. -Her responsibilities were administering medications to the residents. -She administered oral medications, eye drops and nebulizer treatments. -She took the written medication aide exam in 2009, but had not worked as a medication aide for many years. -When she was hired by the facility, she went through training modules related to the facility's procedures and protocol. -She did not have training related to the state approved 5-10-15 medication aide training or Medication Aide Clinical Skills Competency checklist. Interview on 12/07/17 at 4:40 pm with the Administrator revealed: -Staff B was the only medication aide in the facility. -She was unaware Staff B needed the 5-10-15 hour medication aide training, and the Medication Aide Clinical Skills Competency training. -She was responsible to ensure all staff hired by her received the required training. -She would make sure Staff B received the 5-10-15 hour medication aide training, and the Medication Aide Clinical Skills Competency checklist.	D935		