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A NEW OUTLOOK OF TAYLORSVILLE	360 WOOD ROAD TAYLORSVILLE, NC 28681

(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 and the Alexander County Department of Social Services conducted a follow-up survey and complaint investigation on June 19 - 20, 2018. The complaint investigation was initiated by the Alexander County Department of Social Services on May 30, 2018.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility was not maintained in a hazard free environment related to the numerous flies in the facility. The findings are: Observation on 06/19/18 at 9:30am of the dining room revealed: -There were multiple flies on the dining room tables. -There were flies on the walls of the dining room. -There were flies on the dining room ceilings. -There were dead flies on the window ledge in the dining room.	D 079		

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D 079	Continued From page 1 -There was a non-working fly light on wall in the dining room. Confidential interviews with 5 residents revealed: -"There are flies on our food when we eat". -The flies "got bad" about 2 months ago. -"I had a fly in my orange juice at breakfast one morning". -The staff had used flyswatters to control the flies. -The flies had got into the building when the doors were held open from wheelchair residents going in and out to smoke. Interview with Staff F, Personal Care Aide (PCA), on 06/19/18 at 10:45am revealed: -The flies came in when residents hold the doors open. -The flies had been getting worse over the past several months. -The flies seemed to be worse in the dining room area. -They had seen residents "swatting" away flies when in the dining room. Interview with a, Dietary Aide on 06/19/18 at 1:25pm revealed: -He had not seen flies in the kitchen. -The flies were mostly in the dining room. -"There is a fly light in the dining room", but he could not remember when it last worked. Interview with Staff B, Dietary Aide, on 06/20/18 at 10:15am revealed: -There was a farm with cows close to the facility. -There had not been flies in the kitchen. -There was lots of flies in the dining room. Interview with the Resident Care Coordinator (RCC) on 06/19/18 at 2:45pm revealed: -The facility's fly lights were just serviced a few	D 079		

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D 079	Continued From page 2 weeks back by a pest control company. -She had notified the pest control company that the lights sill did not work. -The outside of the facility had been sprayed for flies. -The flies were so bad because they were close to a cow farm. -After the pest control service came she checked and found that 2 of the 3 fly lights did not work. Review of a service contract dated 6/4/18 from a pest control company revealed the description of services provided "commercial monthly pest control service" and "Monthly fly light service". Interview on 06/20/18 at 2:45pm with a representative from the pest control company revealed: -The individual who provided the service on 06/04/18 was "let go" because of not providing services to various facilities. -They are going to be replacing the fly lights with "new ones". -They are going to be re-spraying for flies on the outside of the facility.	D 079		
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: FOLLOW UP TO A TYPE B VIOLATION.	D 273		

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D 273	Continued From page 3 The Type B Violation was abated. Non-compliance continues. The findings are: Based on interviews and record reviews the facility failed to assure referral and follow-up to meet the routine and acute health care needs of 1 of 3 sampled residents (Resident #1) with a referrral for an opthalmology appointment. Review of Resident #1's current FL2 dated 05/17/18 revealed diagnoses included bipolar disorder and intellectual disability. Review of Resident #1's Resident Register revealed: -An admission date of 05/21/18. -Resident #1 had a Guardian. Review of Resident #1's hospital discharge summary dated 05/21/18 revealed: -The hospital physician recommended that Resident #1 see the opthalmologist due to complaints of dizziness. -The hospital's Discharge Follow-up instructions documented "Please schedule appointment [opthalmology] when settled in new home." Record review for Resident #1 revealed a physician's order dated 06/04/18 for a referral to see the opthalmologist. Interview with Resident Care Coordinator (RCC) on 06/19/18 at 1:00pm revealed: -She attempted to make an appointment for Resident #1 to see the eye doctor. -She did not schedule an appointment due to the eye doctor's office not being "able to get her in quicker."	D 273		

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D 273	Continued From page 4 Attempted telephone interview with Resident #1's Nurse Practitioner (NP) on 06/20/18 at 10:00am was unsuccessful.	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 and interviews the facility failed to assure the food preparation table and can opener, dry food storage area shelves and floor, reach-in refrigerator, reach-in freezer, stove and ventilation hood were free from contamination. The findings are: Observations of the reach-in refrigerator on 06/19/18 at 10:35am revealed: -There were (2) one gallon plastic bags on the bottom shelf which contained lettuce. -The lettuce inside the bags were submerged in a brownish gray liquid. -The bottom shelf of the refrigerator had a brown liquid which appeared to have leaked from the plastic bags. Observations of the reach-in freezer on 06/19/18 at 10:40am revealed: -There was a heavy buildup of a layer of ice around the inside of the freezer door.	D 282		

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D 282	Continued From page 5 -The rubber seal on the freezer door was loose and did not provide a good seal when the door was shut. Observations of the food preparation table with can opener attached on 06/19/18 at 10:45am revealed: -The food service menu book was stuck to the table with a brown grease-like substance. -The entire surface of the table was tacky to the touch. -The can opener had a heavy buildup of a black substance around the base and the blade had a thick buildup of a black substance. Observations of the dry food storage area on 06/19/18 at 10:50am revealed: -The floor had loose debris in the corners of the storage room. -The shelves were covered with what appeared to be tinfoil with loose debris of a fine dry substance resembling sand or sugar crystals. -There were three boxes of canned vegetables which was sitting on the floor. -Observations of the stove top and ventilation hood over the stove on 06/19/18 at 10:55 revealed: -A heavy buildup of black burnt grease and food which flaked away upon touch. -The filters in the ventilation hood over the stove had been burned and the metal filaments were hanging out over the stove. Interview with the dietary staff on 06/19/18 at 11:00am revealed: -He had not had time to throw the bad lettuce out. -There was not a posted cleaning schedule for the kitchen. -It was the responsibility of whoever was working	D 282		

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in the kitchen to make sure it was clean before they left for the day.
-The can opener was rusted and would not come clean.
-He would get the lettuce thrown out when he cleaned "Today" [06/19/18].
-He always made sure the stove was wiped down before he left.

Interview with the Resident Care Coordinator on 06/19/18 at 11:15am revealed:
-The lettuce looked "rotten" in the refrigerator.
-The cooks should have thrown out the lettuce as soon as it went bad.
-She would make sure that the refrigerator was cleaned out before the cook left today [06/19/18].
-It was the responsibility of whoever was working in the kitchen to make sure the kitchen was clean.
-The can opener was rusty and hard to clean.
-She would order a new can opener immediately to replace the old one.
-There had been a grease fire several months back and they had not been able to get the ventilation filters in the hood replaced.

Observation of the reach-in refrigerator on 06/20/18 at 10:30am revealed:
-The (2) one gallon bags of rotten lettuce observed on 06/19/18 were still in the refrigerator.
-The brown puddles of liquid which had leaked from the lettuce bags were still on the bottom of the refrigerator.

Interview on 06/20/18 at 10:45am with a second dietary worker revealed:
-Everyone who works in the kitchen is responsible for keeping the kitchen clean.
-She had noticed that the bad lettuce was in the refrigerator and was going to throw it away after

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D 282	Continued From page 7 she completed breakfast for the residents.	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, 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 observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) was free of abuse and neglect, as evidenced by the facility leaving Resident #1 on the floor of her room from 05/28/18 to 05/30/18, without helping the resident get off of the floor and without providing meals or beverages during that time. The findings are: Review of Resident #1's current FL2 dated 05/17/18 revealed: -Diagnoses of bipolar disorder and intellectual disability. -She was independent with ambulation, transfers and eating. -She required minimum assistance with toileting and dressing. Review of Resident #1's Resident Register	D 338		

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revealed:
-An admission date of 05/21/18.
-Resident #1 had a Guardian.

Review of Resident's #1's Care Plan dated 06/04/18 revealed:
-The assessment date was documented as 5/23/18.
-It was signed by the Nurse Practitioner (NP) for the facility on 06/4/18.
-The Social/Mental Health section documented: "Bipolar Disorder, Intellectual Disability. Resident likes to sit and lay in the floor often. Will put her pillows and blankets in the floor as well."
-Resident #1 was sometimes disoriented and had adequate memory, hearing and vision.
-Resident #1 had limited ability with ambulation and locomotion, and limited range of motion with upper extremities.
-Her weight was 313 pounds.
-She was totally dependent for ambulation, bathing, dressing, grooming, hygiene, and transferring.
-She was totally dependent for food preparation.
-She was independent with eating and toileting.

Observation of Resident #1 on 05/30/18 at 11:25am revealed:
-Resident #1 was lying on her mattress, which was on the floor.
-She was covered in blankets with her head covered.

Interview with Resident #1 on 05/30/18 at 11:27am revealed:
-She stated that she had been lying on the floor for two days and that staff would not help her get up off of the floor.
-She asked repeatedly for staff to help or call Emergency Medical Services (EMS), but staff told

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her EMS would not come out anymore.
-Staff told her if she wanted off of the floor, she had to get up herself.
-Resident #1 stated that she wanted to get off of the floor.
-The medication aide (MA) was asked to assist Resident #1 off of the floor.
-Staff D went to Resident #1's room, and shut the door.
-Staff D opened the door and stated that she was unable to get Resident #1 out of the floor and then asked the housekeeper to assist.
-Staff D and the housekeeper tried again and were unable to get Resident #1 off of the floor.
-The AHS asked the Resident Care Coordinator (RCC) to call EMS for assistance.

Interview with Resident #1 on 05/30/18 at 11:47am revealed:
-She asked staff to call EMS "yesterday" and they did not.
-Staff told her EMS told the facility that they were not coming back out.
-She asked the night shift to call EMS and they said "the boss lady said EMS wasn't coming out".
-She had not eaten since being on the floor.
-She was mad because she was on the floor for 2 days, and when she told staff that something was wrong, they acted like they could not hear her.
-She fell out of bed and staff put her mattress on the floor and told her to get back in her bed.
-She felt sad because she had spent two days on the floor.

Observation of Resident #1's roommate on 05/30/18 at 11:47am revealed:
-The roommate was visibly upset as evidenced by fast paced walking and elevated tone and volume of voice.
-She was upset because her roommate had been

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on the floor for 2 days and staff would not help her.
-Resident #1 had been lying on her mattress on the floor for 2 days.
-None of the staff brought Resident #1 any food for 2 days.
-Staff did not offer Resident #1 any water while she was on the floor for 2 days.
-She had asked staff to bring Resident #1's food to her room, but they would not.
-She gave Resident #1 half of her own cheese sandwich and gave Resident #1 nutrition drinks that Resident #1 had in her closet.
-She offered to call EMS and was told by staff that she would personally be charged $500.
-She tried to help Resident #1 get off of the floor, but was unable to get her up.
-She stated staff changed Resident #1's incontinence brief when it was soiled.

Interview with Resident Care Coordinator (RCC) on 05/30/18 at 11:55am revealed:
-She was aware that Resident #1 had been on the floor for the past 2 days.
-She did not know why staff had not offered food to Resident #1.
-She called EMS for assistance, when requested of her to call on 05/30/18.
-Staff had attempted to get Resident #1 off of the floor, but they were unable to lift her.
-EMS workers were complaining about having to come and provide lift assistance.
-The facility was charged when EMS came out to the facility for lift assist.
-She had spoken with EMS and was instructed to call a backup phone number to request lift assistance (in order to not tie up 911 emergency calls).
-Resident #1's care plan documented that she "likes to sit and lay in the floor often".

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D 338	Continued From page 11 Review of EMS call reports for Resident #1 revealed: -On 05/21/18 at 4:10pm, facility staff called EMS for assistance lifting a 300 pound female who is in the floor. Caller stated there is only three female staff there and they cannot get the resident up from the floor. -On 05/21/18 at 9:12pm, facility staff called EMS for lifting assistance for resident in room #15, who is 38 years old. -On 05/22/18 at 8:54am, facility staff called for lifting assistance. -On 05/23/18 at 5:31am, facility staff called for lifting assistance for a 39 year old who fell out of bed. -On 05/24/18 at 3:53am, facility called in reference to a 38 year old female who has fallen in the floor and needing assistance, will be in room #15. -On 05/25/18 at 3:28am, facility called EMS due to a resident fall in room #15. -On 05/26/18 at 3:56am, facility called for lift assistance for a 38 year old female. Resident is located in hallway at nurses' desk. -On 05/30/18 at 11:32am, facility staff called EMS for lift assistance for 39 year old female. -On 06/16/18 at 6:34am, facility staff called for assistance for a resident who fell in room #15. -The facility called EMS every day, from 05/21/18 to 05/26/18. -The facility did not call EMS from 05/28/18 to 05/30/18, when Resident #1 was on the floor and needed lift assistance. Interview with Resident #1 on 06/01/18 at 11:00am revealed: -She had been on the floor for four days. -She did not get any food during those four days that she was on the floor, and that she asked for	D 338		

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meals but did not get any.
-There is a worker that refused to help her get up off of the floor and that numerous staff members told her that she could just stay on the floor.
-No staff member would help her get dressed.
-She liked residing at the facility and did not want to go anywhere else.
-She had been eating now that she was off the floor.
-The second shift staff was mean to her.
-She was rolling out of the bed and needed bed rails.

Interview with Resident #1 on 06/08/18 at 3:00pm revealed:
-Staff had left her on the floor 2-3 times this week.
-The MA and a personal care aide (PCA) helped her up this week.
-Another resident had to help her off of the floor and that staff would not help her get her up.

Confidential interview with a staff member revealed:
-Resident #1 was on the floor for at least two days and that she and her PCA had tried to get Resident #1 off of the floor but could not.
-She left the resident on the floor because she could not get her up.
-Resident #1 could get off of the floor when she wanted too, but would not.
-She and other staff left Resident #1 in the floor for several days.
-She called the Administrator and was informed not to call EMS, and that Resident #1 could stay on the floor.

Confidential interview with a second staff member revealed:
-Resident #1 was on the floor on 05/28/18 and

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D 338	Continued From page 13 that she changed the resident's incontinent brief and asked if she wanted breakfast. -Resident #1 refused her breakfast. -When Resident #1 was on the floor, she wanted to be up off the floor. -She continued to do 2 hour checks on Resident #1. -Resident #1's mattress was on the floor when checked on Resident #1 again. -Resident #1 stated that she wanted to be off the floor. -The MA and the RCC called EMS and they refused to come out because of the previous times they had to come. -When a resident was on the floor, they tried to encourage the resident to get up and they would help them up. -When they helped get Resident #1 off of the floor, it took 2 or more people. -If Resident #1 helped staff get her off of the floor, it only took 2 of them. -When there was enough staff members, Resident #1 would be able to get off the floor with assistance. -When a resident had a fall, the MA would check them for bumps or bruising. -Resident #1 would slide onto the floor. -When they assisted Resident #1 off of the floor, they had to bend her legs to her chest, and Resident #1 used her feet against another staff members for traction, to help get her off the floor. -When staff was able to get Resident #1 off of the floor, it took all 4 staff members. -Resident #1 "normally" refused breakfast, but staff took lunch to her, and Resident #1 refused to eat dinner. -There was another incident where Resident #1 was on the floor for several days (about a week after the first incident happened).	D 338		

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	HAL002007	A. BUILDING: _____ B. WING _____	R-C 06/20/2018

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D 338	Continued From page 14 Review of timesheets provided by the Administrator on 06/20/18 at 3:15pm revealed: -On day shift on 05/28/18 there were 2 PCAs, 1 MA, the cook, 1 housekeeping staff, and the Administrator on duty. -On night shift on 05/28/18 there was 1 PCA and 1 MA on duty. -On day shift on 05/29/18 there was 1 PCA, 1 MA, the cook, and 1 housekeeping staff on duty. -On night shift on 05/29/18 there was 1 PCA and 1 MA on duty. -On day shift on 05/30/18 there were 2 PCAs, 1 MA, the cook, 1 housekeeping staff, and the Administrator on duty. -On night shift on 05/30/18 there was 1 PCA and 1 MA on duty. Interview with Staff D, MA on 06/20/18 at 9:41am revealed: -Resident #1 was on the floor at the beginning of her shift on 5/30/18. -Resident #1 did not ask to get off of the floor. -Staff D offered to assist Resident #1 off of the floor at breakfast time, but Resident #1 refused. -She did not recall receiving report from 3rd shift on that day regarding Resident #1 being on the floor for an extended amount of time. -The RCC instructed her to leave Resident #1 on the floor if she wanted to be on the floor. -Resident #1 was on the floor in another resident's room one day when she was working. -The housekeeper assisted with getting Resident #1 off of the floor that day. Interview with Staff C, Housekeeper, on 06/20/18 at 10:20am revealed: -His typical schedule was Monday through Friday from 8:00am until 5:00pm. -On 5/30/18, Resident #1 was on the floor when he arrived at 8:00am.	D 338		

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D 338	Continued From page 15	D 338		

-Resident #1 was not on the floor when he left at 5:00pm.
-He denied hearing Resident #1 call out for help that day.
-Resident #1 had been on the floor at least three different times.
-He had only helped Resident #1 off of the floor once.
-Staff had called EMS for assistance twice to assist Resident #1 off of the floor.
-He had not received formal training regarding how to correctly lift and/or transfer a resident.

Review of Resident #1's record revealed:
-On 05/27/18 at 9:49am, resident was on the floor and would not help staff get her up. Staff member reported that she checked on her several times.
-On 05/28/18 at 1:56am, the resident was still on the floor. "She did not get herself up tonight". The resident requested the mattress to be put on the floor to sleep.
-On 05/29/18 at 6:25am, resident had been on the floor refusing to get up. Resident refused night time medication.
-On 5/29/18 at 5:10pm, resident refused to get off of the floor. Staff tried three times to get her off of the floor.
-On 5/29/18 at 10:10pm, resident was still on the floor asking for EMS to be called. The MA and PCA offered to help resident up, but EMS was not called.
-There were no incident reports from 05/28/18 to 05/30/18.

Confidential interview with a third staff member revealed:
-Resident #1 had been left in the floor at least one time.
-She tried to get Resident #1 off of the floor.
-Resident #1 could get herself off of the floor

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D 338	Continued From page 16	D 338		

"when she wanted too".
-She did not know anything about Resident #1 not getting any food or the fact that Resident #1 was on the floor for two days.
-Resident #1 needed at least 2 or more people to get her up off of the floor.

Confidential interview with a fourth staff member revealed:
-He knew about Resident #1 being on the floor on 05/30/18.
-Resident #1 was offered food but she refused it each time.
-He did not hear Resident #1 yelling out for help, and she did not ask for help to get off the floor.
-Resident #1 had only been on the floor at least 3 times in the past.
-He only had to help lift her once, but he suggested to the RCC and MA that they should call EMS.
-He had not been trained on how to lift residents off the floor.
-When Resident #1 asked to get off the floor in the past, he suggested to other staff that they call EMS for his safety and the resident's safety.

Interview with Staff B, cook, on 06/20/18 at 8:57am revealed:
-She did not recall Resident #1 being on the floor for 2 days.
-She was allowed to take food to the residents' rooms if they are sick or unable to come to the dining room.
-She had taken food to Resident #1's room in the past.
-She could not recall her work schedule for the last week of May.

Confidential interview with a resident on 06/20/18 at 9:02am revealed:

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D 338	Continued From page 17 -She witnessed Resident #1 being on the floor for two days. -Staff refused to help Resident #1 off of the floor. -She heard staff say they were teaching Resident #1 "a lesson". -Resident #1 tried crawling down the hall and staff "drug" her back to her room. -She recalled that the RCC was in the facility during those two days. -Staff told Resident #1 that she would have to get herself up. -No staff called EMS for assistance for those two days. -Staff did try to get her up but were unsuccessful. -No staff brought food to Resident #1 for those two days. -Resident #1's roommate tried to bring her food, but the cook, Staff A, would not let roommate take food to Resident #1, stating that no food was allowed outside the kitchen. Confidential interview with a second resident on 06/20/18 at 2:55pm revealed: -He did not recall Resident #1 being on the floor for two days. -He did assist Resident #1 off of the floor with the help of staff and two other male residents. -He did not hurt himself while assisting Resident #1 off of the floor. -He stated Resident #1 was difficult to get up off of the floor. -She would not pull her legs underneath her, she stiffened her legs and "rises like a pole". Interview with Resident #1's Guardian on 06/20/18 at 1:30pm revealed: -The facility failed to contact her about Resident #1 being on the floor for two days. -The facility failed to notify her that Resident #1 had been sleeping with her mattress on the floor.	D 338		

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D 338	Continued From page 18 -She was familiar with Resident #1's behaviors. Interview with the Administrator on 06/20/18 at 1:39pm revealed: -The only staff member who contacted her about Resident #1 being on the floor was Staff E, PCA. -She told Staff E, PCA to let Resident #1 be in the floor if she wanted to be there. -She told Staff E, PCA to offer her food and drinks and to help her off of the floor if she requested to get up. -EMS charged the facility when they provided lift assistance. -"The Facility does not have a choice, EMS bills the facility." -She denied passing the cost to the resident. Attempted telephone interview with the Nurse Practitioner on 06/20/18 at 10:00am and at 2:31pm was unsuccessful. _____ The failure of the facility to to assure Resident #1 was free of abuse and neglect, as evidenced by the resident being left on the floor of her room from 05/28/18 to 05/30/18, without providing assistance to the resident to get up off of the floor and without providing meals or beverages during that time, was detrimental to the health, safety and welfare of Resident #1, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/20/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION IS AUGUST 4, 2018.	D 338		

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D911	Continued From page 19	D911		
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: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) was treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy regarding resident rights. The findings are: Based on observations, interviews and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) was free of abuse and neglect, as evidenced by the facility leaving Resident #1 on the floor of her room from 05/28/18 to 05/30/18, without helping the resident get off of the floor and without providing meals or beverages during that time. [Refer to Tag 338, Resident Rights 10A NCAC 13F .0909 (Type B Violation)].	D911		