Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054006	A. BUILDING: _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 24-26, 2018.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 1 resident sampled (#5), with generalized weakness, who had five unwitnessed falls and six assisted falls during staff transfers between November 2017 and July 2018, resulting in facial lacerations and orbital contusions on two occasions that required emergency treatment. The findings are: Review of Resident #5's current FL-2 dated 11/16/17 revealed: -Diagnoses included irritable bowel syndrome, vitamin B deficiency, unspecified glaucoma, cerebral infarction, and other partial intestinal obstruction. -Resident #5 was partial blind in her left eye, hard of hearing, and semi-ambulatory. Review of the Resident Register revealed	D 270		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Regional Director — 8/31/18

STATE FORM 6899 KXRH11 If continuation sheet 1 of 41

Received on 8/31/18
Amended per conversation with Regional Director of Facility on 11/8/18

Reviewed & Accepted

Facility Survey Consultant
09/28/18

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D 282	Continued From page 13	D 282		
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 observation, interviews and record reviews the facility failed to assure the refrigerators and floors in the dining rooms of the assisted living and the special care unit (SCU) were kept clean and in good repair; and the walls, oven, stove, can opener and ice maker in the kitchen were clean and in good repair. The findings are: Observation on 07/24/18 at 11:29am of the refrigerator, counter and microwave in the assisted living dining room on 07/24/18 at 11:29am revealed: -The refrigerator gasket on the lower part of the door was loose and dragged on floor when the door was opened. -There were black sticky stains on the floor in front of the refrigerator door. -The freezer door had ice build-up on the inside of the ice maker making the freezer door hard to open. -The bottom of the inside of the microwave had dark stains in the corners. -The top of the counter bedside the microwave had scattered crumbs. Observation on 07/24/18 at 11:35am of the kitchen counter-mounted can opener revealed	D 282	See ATTACHED	

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D 282	Continued From page 18 4:10pm revealed: -She was not aware of any problems with the cleanliness of the kitchen or dining room areas in the assisted living unit or Special Care Unit. -She relied on the dietary manager and the Special Care Coordinator to make sure the areas were all kept clean. -She would follow-up with maintenance to ensure the new gasket for the refrigerator was ordered. -She would follow-up with the dietary manager to make sure dietary staff was keeping the kitchen and dining areas clean according to the cleaning checklist for dietary.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to pass snacks to all residents in the Special Care unit (SCU) and Assisted Living (AL) side of the facility. The findings are: Observation on 07/24/18 at 10:07am in the Special Care Unit (SCU) revealed: -There were 2 staff in the living room. -There was a clear bowl of fresh cut up fruit covered with clear wrap dated 07/24/18 sitting on	D 298	See ATTACHED	

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D 298	Continued From page 23 complaints of residents not being offered snacks at least 3 times a day at the facility. -"The personal care aides may be late sometimes passing the snacks or the resident may be in another resident's room" when snacks are being passed out. -She had spoken with the Special Care Coordinator about snacks in the Special Care Unit and staff had passed out snacks late to the residents in the unit on 07/24/18 for 10:00am snack. -She would have the supervisor to be responsible to ensure the personal care aides passing out snacks at their designated times. -She would need to further investigate to insure all residents are getting 3 snacks offered to them every day.	D 298		
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 administer medications with meals as ordered by the prescribing physician for 2 of 2 sampled residents (Resident #6 and #7).	D 358	See attached	

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D 358	Continued From page 28 Interview with Administrator on 7/5/18 at 3:58pm revealed: -She believed the facility's policy on medications with food was 30 minutes prior to breakfast, lunch or dinner. -She would clarify the facility's policy on medications given with food with each resident's provider. -She was unaware that Staff D and G were giving medications ensuring the residents were offered food. -There was no written policy specific to medications with food that she could locate. -She would clarify with management to ensure that all residents with medications that required food would be offered food for compliance with the provider's orders. -She would educate all MAs to give food with a medication when specified in the provider's order.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the Electronic	D 366	See ATTACHED	

PLAN OF CORRECTION for Follow Up Survey completed July 26, 2018 (KXRH11)

Spring Arbor of Kinston

HAL-054-006

Lenoir County

It is Spring Arbor of Kinston's policy and standard practice to comply with all North Carolina Adult Care rules and state regulations.

10A NCAC 13F .0901(b) Personal Care and Other Staffing

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms

It is Spring Arbor of Kinston's policy to provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

Plan of Correction

At time of Survey, an immediate Plan of Protection was implemented for Resident #5. This included 1:1 supervision through the completion of this resident's antibiotic treatment on 7/29/18.

A Care Plan meeting was held with Resident #5's daughter on 7/26/18 to discuss increased care needs and the need to find alternate placement for her mother. Daughter agreed to the discharge, but was unsuccessful in finding immediate and affordable placement. Spring Arbor worked closely with its therapy provider following Survey to review and further develop appropriate fall management strategies for this resident and collaborated with her physician and daughter to meet care needs until placement could be found. Resident #5 was placed on Hospice Care on 7/31/18.

Resident #5 was transferred to an appropriate care facility on 8/29/18.

All residents identified at High Risk for Falls at time of Survey were reviewed and discussed by Resident Care Coordinator and Executive Director and evaluated for continued appropriateness. These evaluations were documented and were completed by the end of the day on 7/27/18.

Prevention of Re-Occurrence

The Rose Program, Spring Arbor's enhanced Falls Management & Interventions program, was rolled out in Spring Arbor Kinston during the first several weeks of August. This included reassessment of every resident for Falls Risk; identification and implementation of appropriate falls management interventions for each resident as indicated; education of care staff on these interventions; and communication of risk factors and interventions with each resident or responsible party.

The Rose Program also includes a weekly Falls Management meeting to discuss ongoing falls management needs, challenges and educational opportunities. Therapy providers have been invited (and have agreed) to participate in this weekly meeting, to provide the perspective and input from PT, OT and ST as needed to help develop the most effective interventions for each resident to increase safety and reduce incidence of falls. Spring Arbor's therapy provider has worked closely with the RCC, CCC and the ED in the development of all current falls management interventions in place for residents.

Spring Arbor will continue to hold its Quarterly Fall Awareness Training and Education program in collaboration with a Therapy Provider. A class was held on 8/14/18, with the next one scheduled for 11/13/18. These classes are conducted by a Licensed Physical Therapist.

Monitoring Responsibility and Frequency

The Resident Care Coordinator is responsible for coordinating and scheduling Fall Awareness trainings. These trainings are offered to all Direct Care Staff and will be held a minimum of 4 times per year (quarterly).

Management of the "The Rose Program" is the primary responsibility of both the Resident Care Coordinator and Cottage Care Coordinator, with weekly review and input from the Executive Director as well as direct care staff and physical therapy as appropriate.

The Regional Director and/or the Director of Quality & Education (RN) will review falls incidents data, in addition to interventions and compliance with The Rose Program Falls Management & Interventions program during monthly on-site visits.

Plan of Correction Completion Date: August 25, 2018

10A NCAC 13F .0904(a)(1) Nutrition and Food Service

(a) Food Procurement and Safety in adult Care Homes
(1) The kitchen, dining room and food storage areas shall be clean, orderly and protected from contamination.

It is Spring Arbor of Kinston's policy and practice to maintain kitchens, dining rooms and food storage areas that are clean, orderly and protected from contamination.

Plan of Correction

On 7/24/18, the following were immediately cleaned/corrected:

- Floor in front of AL dining room refrigerator cleaned.
- Microwave located in AL dining room cleaned.
- Counter top beside AL microwave cleaned.
- Kitchen can opener cleaned and sanitized.
- AL refrigerator was defrosted.
- Ovens in Al and Cottage kitchens cleaned.
- Refrigerator in Cottage kitchen cleaned.

In addition, materials to replace AL dining room refrigerator gasket were ordered on 7/24/18 and gasket replaced 7/25/18.

The difficulty in properly cleaning walls behind steam table in AL kitchen had been recognized prior to Survey and material to replace was on hand in the community and ready to be hung. The walls were covered with an easier-to-clean wall material on 7/24/18.

This plan of correction was completed in advance of the Survey team exiting the community.

Prevention of Re-Occurrence

The Cleaning Checklist for the AL Kitchen was modified to reflect all items that should be cleaned daily after dinner service. A Cleaning Checklist for Cottage refrigerator and stove was developed and implemented. Housekeeping is responsible for cleaning these items weekly on Fridays and as needed and will initial checklist after each cleaning is completed.

Monitoring Responsibility and Frequency

The Food Service Director is responsible for reviewing cleaning checklist daily (M-F) to ensure that cleaning tasks have been completed as assigned

The Cottage Care Coordinator is responsible for reviewing Cottage kitchen cleaning checklist weekly on Mondays to ensure that cleaning has been completed as assigned. She will direct any concerns to Housekeeping and/or the Maintenance Director.

The Executive Director/designee will also visually inspect AL and Cottage kitchens on a weekly basis to assure compliance.

Plan of Correction Completion Date : ~~July 25, 2018~~ July 27, 2018

Amended per phone conversation with Regional Director of Facility on 9/28/18

RN MSN 9/28/18

10A NCAC 13F .0904(d)(2) Nutrition and Food Service

(d) Food Requirements in Adult Care Homes

(2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks

It is Spring Arbor of Kinston's policy to offer or make available snacks to each resident between each meal for a total of three snacks per day, and to show this on the menu as snacks.

Plan of Correction

A Daily Snack Checklist was developed for staff to utilize each time snacks are passed. Staff indicate on this form if a resident received a snack and will note the reason if they do not receive a snack.

The daily staff assignment sheet was revised to reflect that the Med Tech is responsible to ensure that snacks are distributed in a timely manner three times each day between meals. The Med Tech is responsible to sign the assignment sheet attesting that snacks were distributed and offered to residents.

Prevention of Re-Occurrence and Monitoring Responsibility

Med Techs were inserviced on 8/14 about the new Snack Checklist and their responsibility to ensure that snacks are passed out and documented by staff in a timely manner three times a day between meals; and that they must immediately notify the Supervisor-in-Charge or the Resident Care Coordinator if there are any concerns or problems.

In AL, the Resident Care Coordinator is responsible to review the daily assignment sheets to ensure compliance. In the Cottage, the Cottage Care Coordinator is responsible to review the daily assignment sheets to ensure compliance. In the absence of the RCC or CCC, a designated manager or weekend Manager on Duty will assume the responsibility to review the daily assignment sheets.

The Food Service Director is responsible to review the completed Snack Checklist daily (M-F) to monitor compliance. She is to report any concerns to RCC/CCC as appropriate. In the absence of the FSD, a designated manager or weekend Manager on Duty will assume the responsibility to review the completed Snack Checklist.

Plan of Correction Completion Date : August 14, 2018

10A NCAC 13F .1004(a) 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.

It is Spring Arbor of Kinston's policy to assure that the preparation and administration of medications is in accordance with orders by a licensed prescribing practitioner which are maintained in the resident's chart.

Plan of Correction

Contact was made with Resident #6's physician and Resident #7's physician, and clarification was obtained for those medications ordered to be taken with meals. These medication orders were revised to read "to be taken with food."

A complete review was conducted of all current medications ordered to be taken with meals. Contact was made with each resident's physician, to discuss if medications could be ordered "with food" instead of "with meal."

Prevention of Re-Occurrence and Monitoring Responsibility

Education was held for all Med Techs, to reinforce the specific time requirement of medications ordered to be taken "with meals." This was conducted by the Resident Care Coordinator on 8/14/18.

It is the responsibility of the Resident Care Coordinator to review all new medication orders and to be aware of medications with specific administration time requirements. The RCC will provide ongoing education to Med Techs on the topic of compliance with timely medication administration. The RCC or a designated manager will randomly observe administration of a med ordered "with meals" on a weekly basis for a period of one month, then monthly thereafter.

Plan of Correction Completion Date: August 28, 2018

PLAN OF CORRECTION for Follow Up Survey completed July 26, 2018 (KXRH11)

10A NCAC 13F .1004 (i) Medication Administration

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

It is Spring Arbor of Kinston's policy for the recording of medication administration to be by the staff person who administers the medication immediately following administration and observation of the resident actually taking the medication.

Plan of Correction

Clarification Notes were made in the appropriate Accuflo record for each affected resident to clearly identify the specific Med Tech who administered medications on 7/24/18 on 3pm – 11pm shift. This included Residents #6, #8, #9, #11, #12, #13)

Following Survey, immediate re-education was held with all Med Techs, emphasizing the requirement to administer medications only under their own assigned Accuflo log-in credentials.

Prevention of Re-Occurrence and Monitoring Responsibility

Each new Med Tech will be provided Accuflo login credentials in advance of the first day that they are scheduled to administer medications. It is the responsibility of the Resident Care Coordinator to verify with each Med Tech that their assigned login is functional before the Med Tech is scheduled to administer medications.

The Resident Care Coordinator will continue to reinforce in monthly Med Tech meetings the importance of logging off immediately upon completing any task on med cart laptops.

The Resident Care Coordinator will monitor compliance in this area through random weekly med pass observations and eMAR audits.

Plan of Correction Completion Date: August 23, 2018

G.S. 131D-21(2) 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.**

It is Spring Arbor of Kinston's policy and practice to assure compliance with all Resident Rights, including the Right to receive care and services that are adequate and appropriate for each individual resident

Plan of Correction

10A NCAC 13F .0901(b) At time of Survey, an immediate Plan of Protection was implemented for Resident #5. This included 1:1 supervision through the completion of this resident's antibiotic treatment on 7/29/18. A Care Plan meeting was held with Resident #5's daughter on 7/26/18 to discuss increased care needs and the need to find alternate placement for her mother. Spring Arbor worked closely with its therapy provider following Survey to review and further develop appropriate fall management strategies for this resident and collaborated with her physician and daughter to meet care needs until placement could be found. Resident #5 was placed on Hospice Care on 7/31/18. Resident #5 was transferred to an appropriate care facility on 8/29/18.

All residents identified at High Risk for Falls at time of Survey were reviewed and discussed by Resident Care Coordinator and Executive Director and evaluated for continued appropriateness. These evaluations were documented and were completed by the end of the day on 7/27/18.

The Rose Program, Spring Arbor's enhanced Falls Management & Interventions program, was rolled out in Spring Arbor Kinston during the first several weeks of August. Reassessments of fall risk were conducted on all residents, with appropriate interventions determined and implemented. Weekly Falls Management meetings were implemented.

Resident Rights training and Rose Program Falls Management and Resident-Specific Interventions training was conducted throughout August at daily Stand-Up meetings for each shift, at Staff meetings and at the Med Tech meeting on 8/14/18. Each of these trainings reinforced the responsibility of each team member to assure that every resident receives personalized care, services and supervision to maintain his/her health, safety and welfare. Training was conducted by the Resident Care Coordinator, Cottage Care Coordinator and the Executive Director. Resident Rights training was conducted by the Regional Director on 8/30/18. The local Ombudsman is scheduled to conduct an additional all-staff Residents Right training on 9/12/18.

Prevention of Re-Occurrence

Resident Rights training will be conducted for all employees upon hire and annually thereafter. In addition, Resident Rights will be reviewed and reinforced regularly at staff by the Executive Director/designee.

PLAN OF CORRECTION for Follow Up Survey completed July 26, 2018 (KXRH11)

Monitor Responsibility & Frequency

The Resident Care Coordinator and/or Executive Director will monitor training records monthly to assure compliance with Resident Rights training requirements.

Documentation of attendance and completion of training will be maintained in employee records.

Plan of Correction Completion Date: ~~August 30, 2018~~ AUGUST 25, 2018

AMENDED per phone CONVERSATION with Regional DIRECTOR OF FACILITY ON 9/28/18

9/28/18

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D 270	Continued From page 1	D 270		

Review of the Resident Register revealed Resident #5 was admitted to the facility on 11/16/17.

Review of Resident #5's care plan dated 12/12/17 revealed:
-Resident #5 was oriented and hard of hearing.
-Resident #5 had very limited vision with partial left-eye blindness.
-Resident #5 required wheelchair transport by staff.
-Resident #5 was able to ambulate short distances with a walker with the assistance of physical therapy staff.
-Resident #5 had limited strength in her upper extremities.
-Resident #5 preferred to sleep in a recliner at bedtime.
-Resident #5 required limited assistance with eating, toileting, dressing, and grooming.
-Resident #5 required extensive assistance in ambulation, transferring, and bathing.
-Resident #5 required transfer assist, but it was not specified the number of staff needed to assist Resident #5 with transferring.
-There was no assessment of Resident #5's needs related to fall precautions.
-There had been no reassessments of Resident #5's care plan since 12/12/17 based on any change in Resident #5's care needs.

Review of Resident #5's licensed health professional support review dated 05/17/18 revealed:
-Resident #5 was alert but forgetful at times.
-Resident #5 used walker and wheelchair for mobility.
-Resident #5 was unable to self-propel a wheelchair or use a walker alone.
-Resident #5 needed transfer assistance and

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D 270	Continued From page 2	D 270		

assistance with the use of walker.
-Staff competency was validated for transfer assist for Resident #5.
-It was not specified the number of staff needed to assist Resident #5 with transferring.

Observation of Resident #5 on 07/25/18 at 8:25am revealed:
-Resident #5 was brought in to the dining room via wheelchair by staff for breakfast.
-Resident #5 was alert and required assistance with tray set up for her breakfast.
-Resident #5 had a large tan bandage over her right eye and a large purple bruise under her right eye.
-Resident #5 had scattered purple bruised spots to both forearms.
-Resident #5 was wearing heel protectors on both of her feet.
-Resident #5 required assistance with feeding from staff because she was not able to locate the food on her plate independently.

Interview with Resident #5 on 07/25/18 at 12:45pm revealed:
-She had fallen several times.
-She was not able to give the dates or times of when the falls had occurred.
-She could not recall the events leading up to the falls.
-"I just thought I could go to the bathroom by myself."
-She did need assistance from staff with transferring because "I'm too weak to do it by myself."
-Resident #5 was unable say how often staff checked on her or if any changes in her care after her falls.

Interview with the Resident Care Coordinator

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D 270	Continued From page 3	D 270		

(RCC) on 07/25/18 at 8:30am revealed:
-Resident #5's overall health condition had deteriorated over the last several months.
-Resident #5 had required more assistance with her care from staff with her feeding, dressing, bathing, and most of her activities of daily living.
-Resident #5 had some problems with some recent falls (unspecified dates) and increased generalized weakness.
-A care team meeting had been scheduled for 07/27/18 with Resident #5's family member to discuss a possible change in the level of care for Resident #5.
-Resident #5 needed more assistance and care than what staff could provide at the assisted living facility.

Review of the Resident Notes for Resident #5 dated 11/22/17 at 10:00pm revealed:
-Resident #5 was found on the floor of the bathroom in her room.
-Resident #5 denied any pain or discomfort.
-Resident #5 reported that she thought she could use the bathroom by herself but fell on her side.
-There was no documentation of any fall risk assessment or fall interventions for Resident #5 after Resident #5 was found on the floor of her bathroom on 11/22/17 at 10:00pm.

Review of Incident and Accident report for Resident #5 dated 01/05/18 at 3:20am revealed:
-The resident rang the call bell for help stating she was on the floor.
-The resident said she rolled off the bed trying to pick something up.

Review of the Resident Notes for Resident #5 dated 01/05/18 at 3:20am revealed:
-Resident #5 called for help to get off the floor.
-Resident #5 was assisted back to bed by the

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(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
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supervisor and the personal care aide (PCA).
-There were no injuries noted.
-There was no documentation of any fall risk assessment or fall interventions for Resident #5 after Resident #5 was found on the floor on 01/05/18 at 3:20am.

Review of Incident and Accident report for Resident #5 dated 01/28/18 at 4:45am revealed:
-The resident was found on the floor during rounds.
-The resident did not know how she ended up on the floor.
-The resident was assisted back to bed.

Review of the Resident Notes for Resident #5 dated 01/28/18 at 4:45am revealed:
-Resident #5 had been ringing her call bell all night and appeared confused about the time of the night.
-Staff found Resident #5 on the floor.
-Resident #5 stated "she didn't know how she got on the floor but she thought she could do it."
-There were no injuries noted.
-There was no documentation of any fall risk assessment or fall interventions for Resident #5 after Resident #5 was found on the floor on 01/28/18 at 4:45am.

Review of Incident and Accident report for Resident #5 on 01/29/18 at 5:00am revealed:
-The resident was assisted by staff into her recliner after using the bathroom, when she leaned forward and lost her footing.
-The resident was on the floor with blood coming from the right side of her head.
-Emergency Medical Services (EMS) was called to transport her to the hospital.
-Sutures were placed to her right forehead.

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D 270	Continued From page 5 Review of the Resident Notes for Resident #5 dated 01/29/18 at 5:00am revealed: -Resident #5 was assisted to her recliner by a PCA. -Resident #5 shifted her weight backward toward her recliner then leaned forward falling on the floor. -Resident #5 was bleeding from the right side of her head. -Resident #5 was transported to the emergency room for further treatment. -There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 01/29/18 at 5:00am. Attempted telephone interview on 07/26/18 at 10:30am with the third-shift supervisor who wrote the resident note for Resident #5 on 01/29/18 at 5:00am was unsuccessful. Review of Incident and Accident report for Resident #5 dated 03/12/18 at 1:00pm revealed: -The resident was lowered by staff to the floor due to weakness. -There was no sign of injury. Review of the Resident Notes for Resident #5 dated 03/12/18 at 1:30pm revealed: -Resident #5 found sitting on floor in her room. -A PCA asked a medication aide (MA) for assistance with Resident #5. -The PCA reported that she had lowered Resident #5 to the floor because of Resident #5's weakness. -No injuries noted. -There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 03/12/18 at 1:30pm. Review of the Resident Notes for Resident #5	D 270		

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dated 03/20/18 at 6:43pm revealed:
-Resident #5 was assisted to the floor by a PCA.
-Resident #5 had a 6-inch scratch across her mid-lower back.
-There were no other complaints of pain or discomfort.
-There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 03/20/18 at 6:43pm.

Review of the facility's fall notification and physician acknowledgment form for Resident #5 dated 04/03/18 revealed:
-Resident #5 was assessed at a high risk for falls with 4 falls within the last 3 months.
-The physician dated the form on 04/12/18 with an order for physical therapy evaluation for fall risk reduction.

Interview with the Administrator on 07/26/18 at 12:15pm revealed Resident #5 received physical therapy services following the physician's order for physical therapy evaluation on 04/12/18.

Review of Incident and Accident report for Resident #5 dated 04/28/18 at 6:30am revealed:
-The resident slid out of the chair onto the floor while staff assisted her to her wheelchair.
-The resident had no injury.
-Resident #5's family was notified along with the RCC and the physician.
-Resident #5's vital signs were taken.

Review of the Resident Notes for Resident #5 dated 04/28/18 at 6:30am revealed:
-Resident #5 slid to the floor while being transferred from the couch to a wheelchair.
-Resident #5 was not in any discomfort.

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-Resident #5's vital signs were taken.
-There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 04/28/18 at 6:30am.

Review of Incident and Accident report for Resident #5 dated 05/01/18 at 10:31pm revealed:
-The PCA witnessed the resident sliding out of her chair on to the floor.
-It was not specified if the PCA was in the room or if the PCA was assisting Resident #5 with transferring when Resident #5 slid of out of the chair on 05/01/18.
-Resident refused to go to hospital.
-There were no injuries.

Review of Resident Notes for Resident #5 dated 05/01/18 at 10:45pm revealed:
-Resident #5 was witnessed by the PCA sliding out of her chair to the floor at 10:31pm.
-The PCA rang the call bell for assistance.
-Resident #5 was assisted by PCA and supervisor to her wheelchair.
-No injuries noted and vital signs taken.
-There was no documentation of any fall risk assessment or fall interventions for Resident #5 after Resident #5 was found on the floor on 05/01/18 at 10:31pm.

Review of physician's orders for Resident #5 dated 05/10/18 revealed a new order for a physical therapy evaluation.

Interview with the Administrator on 07/26/18 at 12:15pm revealed Resident #5 received physical therapy services following the physician's order for physical therapy evaluation on 05/10/18.

Review of the facility's fall notification and physician acknowledgment form for Resident #5

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D 270	Continued From page 8 dated 07/03/18 revealed: -Resident #5 had been assessed at a high risk for falls with 2 falls within the last 3 months. -The primary care provider dated the form on 07/10/18 with an order for a physical therapy evaluation for fall risk reduction. Review of Incident and Accident report for Resident #5 on 07/11/18 at 12:29am revealed the PCA assisted the resident with transfer from her wheelchair to her chair when the resident pivoted and fell backward towards the wheelchair and ended up on the floor. Review of the Resident Notes for Resident #5 dated 07/11/18 at 12:36am revealed: -Resident #5 was being transferred from her wheel chair. -Resident #5 was pivoting to her chair when she started to fall and was eased to the floor in a sitting position. -There was no injury. -There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 07/11/18 at 12:36pm. Review of Incident and Accident report dated 07/11/18 at 10:00pm revealed -The resident was being assisted into bed when she began to lean forward and was lowered onto the floor by the PCA. -Resident #5's family member, the RCC and physician were notified. -The resident did not have any injury. Review of Resident Notes for Resident #5 dated 07/11/18 at 10:38pm revealed: -Resident #5 was being assisted to bed when she sat down she leaned forward. -Resident #5 was lowered to the floor by the PCA.	D 270		

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D 270	Continued From page 9 -Resident #5 had no injury. -There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 07/11/18 at 10:38pm. Review of Incident and Accident report for Resident #5 dated 07/19/18 at 12:10pm revealed: -The resident rang her bathroom call light. -The resident was observed by the MA on the floor. -The MA called the RCC and resident was assisted to her wheel chair. -EMS was called and the resident was transferred to the emergency room. Review of the Resident Notes for Resident #5 dated 07/19/18 at 1:33pm revealed: -Resident #5 had fallen in her bathroom. -Resident #5's blood pressure was 200/137. -EMS was called and the resident was transferred to the emergency room where she received stitches over her right eye. Review of Resident #5's nurses' note dated 07/19/18 at 11:58pm: -The resident returned from the hospital with a new order for Keflex 500mg every 6 hours for 7 days (Keflex is an antibiotic used to treat or prevent infection). -She was to return to the hospital in 7 days to have sutures removed from over her right eye. -The resident did not have any complaints of pain. -There was no documentation of any fall risk assessment or fall interventions for Resident #5 after Resident #5 was found on the floor on 07/19/18 at 11:58pm. Emergency room records for Resident #5 for 07/19/18 were not available.	D 270		

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D 270	Continued From page 10 Review of Resident #5's Resident Notes dated 07/25/18 at 9:47pm revealed: -Resident #5 slipped while transferring from her wheel chair to her bed with assistance by a PCA. -Resident #5's legs "gave out and she was eased to the ground." -There was no injury. -There was no documentation of any staff training for transferring assistance with Resident #5 after the incident on 07/25/18 at 9:47pm. Interview with a first shift MA on 07/25/18 at 11:00am revealed: -Resident #5 had at least 3 falls in the last 2 months. -Resident #5 had increased weakness to her arms and legs and needed more help sometimes with transferring to get in and out of her wheelchair or recliner. -Resident #5 "sometimes required a one, two, or three person assist with transfers depending on how weak she was." -She judged how many staff were needed to assist with transferring Resident #5 by how Resident #5 was feeling at the time. -Resident #5 was forgetful at times and mainly stayed in her room. -Resident #5 tried to go to the bathroom sometimes without staff assistance which caused her falls. -Staff reminded Resident #5 to use the call bell but she forgot to use it sometimes. -Staff normally checked Resident #5 every 2 hours. -She was not aware of any type of fall precautions in place for Resident #5. -She was not given any instructions for increased supervision of Resident #5 after any of Resident #5's previous falls.	D 270		

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D 270	Continued From page 11 Interview with a resident on 07/26/18 at 11:00am revealed: -She was the suite mate for Resident #5. -Resident #5 required assistance from the staff to get out of her recliner chair to the wheelchair. -Resident #5 mainly stayed in her recliner most of the day except when she went down to the dining room for her meals. -The resident was not sure how often or if Resident #5 had fallen. -Staff helped Resident #5 do everything because Resident #5 was too weak to do things by herself. Interview with a first shift PCA 07/26/18 at 11:10am revealed: -Resident #5's health had declined since she moved to the facility. -The PCA increased her monitoring of Resident #5 since her admission. -Two staff were needed to assist Resident #5 with transferring from her recliner or wheelchair most of the time. -The PCA could assist in transferring Resident #5 without additional staff assistance if Resident #5 was in a cooperative mood. -Management did not give instructions on the frequency of checks for Resident #5. Telephone interview with Resident #5's physician on 07/26/18 at 11:54am revealed: -The PCP was aware Resident #5 had at least 3 or 4 falls in the last 3 months. -The staff at the facility made her aware each time Resident #5 had a fall whether there was an injury or not. -Resident #5 liked to sleep in her recliner and sometimes forgot to ask for assistance when trying to get up from the recliner. -Resident #5 could be very forgetful and tried to	D 270		

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get up by herself frequently.
-Resident #5's health had been declining over the last several months and Resident #5 had increased generalized weakness for at least 2 months.
-She had ordered physical therapy for Resident #5 several times but it only worked short-term.
-Resident #5 was at a high risk for falls.
-Increased supervision of Resident #5 would have been beneficial.
-Her expectation would have been for the facility to implement supervision checks of Resident #5 at least once every hour to help prevent falls.
-This expectation was not shared with staff at the facility.
-A care plan team meeting with her family member had been scheduled for 07/27/18 to discuss the possibility of upgrading Resident #5's level of care.

Interview with the Administrator on 07/26/18 at 12:15pm revealed:
-Resident #5 had approximately 2 or 3 falls in last 3 months.
-Resident #5 had been assessed in April and July 2018 and was considered at high risk for falls.
-The facility had contacted Resident #5's physician for physical therapy evaluations in April and July 2018, but no other interventions had been regarding Resident 5's falls.
-The physical therapy worked for Resident #5, but Resident #5 reverted back to being a fall risk after finishing physical therapy because of her generalized weakness.
-The facility did not have any other interventions for Resident #5 even though she kept falling.
-She didn't like chair alarms or bed alarms because the resident was usually already on the floor when the alarms went off.
-Resident #5's room was not large enough to

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accommodate a fall mat.
-She had not thought about moving Resident #5 closer to the nurse's station for monitoring.
-Resident #5's health status had declined in recent months and it sometimes took more staff to assist her with transfers.
-"It was hard to say how many staff it took to assist with the resident with transfers because it depended in how weak she (Resident #5) was".
-Resident #5 may need one, two, or three person assist to transfer based on how Resident #5 may be feeling for the day.
-The Administrator was unable to specify how it was determined on a daily basis the number of staff needed to assist with transfers for Ressident #5.
-She was not aware that Resident #5 had fallen on the evening of 07/25/18.
-She would investigate to see what needed to be done with Resident #5's supervision.
-The supervisors usually reported to her whenever a resident had a fall.

Interview with the Administrator on 07/26/18 at 3:15pm revealed the facility's fall risk reduction protocol was outdated and they did not use this for their fall assessments.

Telephone interview with a family member of Resident #5 on 07/26/18 at 2:35pm revealed:
-Resident #5 had fallen several times in the last couple of months.
-She was not sure the number of falls Resident #5 had since she was admitted to the facility.
-Resident #5 seemed to be getting weaker and was sometimes forgetful.
-Resident #5 would forget to call for help to the bathroom sometimes and have a fall.
-She was not aware of any fall precautions put in place by the facility to prevent Resident #5 from

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D 270	Continued From page 14 falling. _____ The facility's failure to provide supervision of a resident (#5) who continued to have multiple falls, including falls during staff transfers, resulted in the resident suffering multiple bruises, two lacerations to her face and head that required sutures, and head trauma that required two emergency room visits which placed the resident at substantial risk of serious injury and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/26/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 25, 2018.	D 270		
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 observation, interviews and record reviews the facility failed to assure the refrigerators and floors in the dining rooms of the assisted living and the special care unit (SCU) were kept clean and in good repair; and the walls, oven, stove, can opener and ice maker in the kitchen were clean and in good repair.	D 282		

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D 282	Continued From page 15 The findings are: Observation of the refrigerator, counter and microwave in the assisted living dining room on 07/24/18 at 11:29am revealed: -The refrigerator gasket on the lower part of the door was loose and dragged on floor when the door was opened. -There were black sticky stains on the floor in front of the refrigerator door. -The freezer door had ice build-up on the inside of the ice maker making the freezer door hard to open. -The bottom of the inside of the microwave had a dark sticky substance in the corners. -The top of the counter bedside the microwave had scattered crumbs. Observation on 07/24/18 at 11:35am of the kitchen counter-mounted can opener revealed there was black sticky material on the top, bottom, and all sides. Observation on 07/24/18 at 11:36am of the walls behind and on the side of the steam table revealed dark food drips extending 4-feet in height from the floor. Observation on 07/24/18 at 11:39am of the oven and stove in the kitchen revealed: -There were black and brown colored stains on the doors and sides of both ovens. -There were brown colored stains near the knobs and the back of the stove. -There was a brown stain running down the front of the oven door. -There were dark stains inside the oven on the bottom. Observation of the food pantry revealed the floor	D 282		

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D 282	Continued From page 16 near a rack had a 4-inch square dark rust colored stain. Observation on 07/24/18 at 4:47pm in the SCU dining room revealed: -The base vent of the refrigerator at the floor was coated with thick brown dust and dirt. -The bottom shelf of the freezer section of the refrigerator was covered with light-colored sticky material and several ice cubes. Interview with a dietary aide on 07/25/18 at 3:36pm revealed: -The dietary staff was responsible for all cleaning in the dining room and kitchen except shampooing the carpet. -The linoleum in front of the kitchen door was supposed to be swept and mopped by the dietary staff after every shift. -The cook was responsible for cleaning the microwave in the dining room. -The microwave was supposed to be cleaned daily, but she was unsure of the last time the microwave had been cleaned. -The refrigerator in the dining room was supposed to be cleaned daily. -She had checked the refrigerator on 07/25/18 and noted it needed cleaning. -She was not sure when the refrigerator was last cleaned by the dietary staff. -She was also aware the gasket at the bottom of the refrigerator door was broken and had been broken for at least 2 weeks. -She forgot to report the broken gasket to the dietary manager. -She had not noticed the freezer of the refrigerator was iced over because she had not looked at it. -She had noticed there were several food stains on the 2 walls surrounding the steam table in the	D 282		

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kitchen.
-The walls surrounding the steam table were supposed to be wiped down at least once daily as part of the daily cleaning.
-She was not sure when the walls had been cleaned last.
-The oven and stove were deep cleaned once a year and staff spot cleaned spills and stains as needed.
-The can opener needed to be scrubbed down every time staff used it, but she was not sure when the can opener was cleaned.
-Dietary staff is not responsible for cleaning the dining room in the Special Care Unit.
-The dietary staff had a cleaning checklist with cleaning tasks.
-The dietary staff were supposed to clean according to their cleaning checklist, but the dietary staff did not have to sign off on the cleaning checklist.
-The dietary manager did not check to make sure cleaning tasks were completed by the dietary staff.

Interview with the dietary manager on 07/25/18 at 3:52pm revealed:
-The dietary staff was only responsible for the cleaning the dining room and the kitchen on the assisted living side.
-The linoleum in front of the kitchen door was swept and mopped at least 2 times a day, but staff tried to clean the area three times a day.
-She had not noticed the black stains on the linoleum.
-The linoleum was last cleaned on the evening of 07/24/18.
-The dietary aide was responsible to clean the microwave and the refrigerator in the dining room at least once a week.
-She had not checked the cleanliness of either

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the microwave or the refrigerator.
-She was not sure the last time the microwave or the refrigerator had been cleaned.
-She was aware the gasket at the bottom of the refrigerator door had been broken for at least 3 or 4 weeks.
-She reported the need for a new gasket to the maintenance person.
-The maintenance person had not ordered a new gasket yet to replace the worn refrigerator gasket.
-The oven and stove in the kitchen had not been cleaned for about a month.
-The oven and stove were to be deep cleaned this month.
-The walls around the steam tables were supposed to be wiped down daily by the dietary staff.
-She was not sure the last time that the dietary staff had cleaned the 2 walls surrounding the steam table in the kitchen.
-The facility was in the process of replacing the tile board surrounding the steam table so that the walls would be easier clean for the dietary staff.
-The dietary staff had not been cleaning the can opener in the kitchen.
-The can opener was supposed to be taken down daily and put in the dishwasher to be cleaned.
-She was not sure when the last time the can opener had been cleaned.
-She had a cleaning checklist for the dietary staff to use to maintain the cleanliness of the kitchen.
-The dietary staff knew the cleaning checklist by memory and she did not require the dietary staff to sign off if they had completed their cleaning tasks.
-She did not monitor the dietary staff to ensure cleaning tasks were being done.
-She would be checking the dietary staff to ensure cleaning tasks were being done.
-She and the other dietary staff did not have

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D 282	Continued From page 19 responsibility for the cleanliness of the dining room in the Special Care Unit. -The personal care aides in the Special Care Unit took care of that area. Interview with the Special Care Coordinator on 07/25/18 at 4:05 revealed: -She saw the food stains in the oven and in the refrigerator on 07/24/18. -She cleaned the oven and the refrigerator on 07/24/18. -It was the responsibility of the third shift aide to clean the dining room area in the Special Care Unit. -She was not sure when the last time the oven or the refrigerator were cleaned. -She did not have a cleaning checklist for the third shift aide to review. -She did not check to ensure the third shift aide performed the cleaning in the dining room. Interview with the Administrator on 07/25/18 at 4:10pm revealed: -She was not aware of any problems with the cleanliness of the kitchen or dining room areas in the assisted living unit or Special Care Unit. -She relied on the dietary manager and the Special Care Coordinator to make sure the areas were all kept clean. -She would follow-up with maintenance to ensure the new gasket for the refrigerator was ordered. -She would follow-up with the dietary manager to make sure dietary staff was keeping the kitchen and dining areas clean according to the cleaning checklist for dietary.	D 282		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service	D 298		

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D 298	Continued From page 20 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to offer snacks to all residents in the Special Care unit (SCU) and Assisted Living (AL) side of the facility. The findings are: Observation on 07/24/18 at 10:07am in the Special Care Unit (SCU) revealed: -There were 2 staff in the living room. -There was a clear bowl of fresh cut up fruit covered with clear wrap dated 07/24/18 sitting on the table in the living room. -There were no spoons or cups next to the bowl of fruit. -There were 7 residents sitting at another table playing bingo with a volunteer. -There were 3 residents sitting on the left side of the living room sleeping in chairs. -At 10:45am the full bowl of fruit was still sitting on the table with the plastic cover on it. -No residents were observed being served the fruit or a beverage. Interview with the Special Care Coordinator (SCC) at 10:11am revealed: -Snacks were served on the SCU three times a day at 10:00am-2:00pm-7:00pm. -The kitchen would deliver the snacks to the SCU.	D 298		

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D 298	Continued From page 21 -It was the responsibility of the personal care assistants (PCA)'s to offer the snacks out to the residents in the SCU. Observation on 07/24/18 between 1:00pm and 3:00pm in the assisted living side of the facility there were no snacks being served. Interview with a resident on 07/24/18 at 2:08pm revealed: -Staff only served snacks to the residents on the assisted living side once or twice a day. -Snacks were sometimes served at 10:00am and then sometimes a second snack was served around 3:00pm. -Snacks were not served in the evening after dinner. -Snacks were kept on the snack cart from the kitchen but the staff did not offer out the snacks to the residents in their rooms. Observation in the Living room of the SCU on 07/24/18 at 2:03pm revealed: -There were 9 residents sitting in the Living room. -There were 2 PCA's talking with the residents. -At 2:34pm the PCA offered crackers and water to the 9 residents in the living room. -The 6 residents that were in there rooms were not offered a snack. Observation on 07/24/18 at 4:45pm in the SCU dining room revealed: -There was a refrigerator that had 2 pitchers of beverages. -On the bottom shelf of the refrigerator was a clear bowl full of various fruit labeled "a.m. snack" with clear wrap dated 07/24/18. Interview with a personal care assistant (PCA) on 07/24/18 at 5:07pm revealed:	D 298		

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D 298	Continued From page 22 -She did not know if that was the same bowl of fruit that was on the table in the living room in the morning but she thought it could be. -She thought the kitchen would usually send various fruits for snacks in the mornings. Interview with a second resident on 07/25/18 at 8:20am revealed: -Residents were only served snacks 2 times a day on the assisted living side of the facility. -Staff did not serve snacks to the residents after dinner. -Snacks were only served at 10:00am and 3:00pm. -Staff served popcorn, crackers, cookies, fresh fruit, fruit snacks, and juice from the snack cart when snacks were served to the residents. Interview with a third resident on 07/25/18 at 10:20am revealed: -"Staff usually did not offer her any snacks." -The resident did not know what the scheduled snack times were. -"I was surprised to get this half of an orange today but they (staff) didn't give me nothing to drink." -She usually had her family to bring snacks for her to eat at the facility. Interview with a fourth resident on 07/25/18 at 10:29am revealed: -He usually kept to himself, but staff did not offer snacks to him three times a day. -Staff usually came to his room and offered the resident snack about 2 or 3 times a week. -The resident often refused the snacks when the staff offered them to him because he did not like the snack selection. Interview with a fifth resident on 07/25/18 at	D 298		

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D 298	Continued From page 23 10:40am revealed: -Staff only offered snacks to the residents on the assisted living side of the facility about 2 times a day. -Staff gave the residents a snack in the morning about 10:00am and the resident sometimes got a snack in the evening after dinner. -Staff did not offer snack to the resident 3 times a day. -Staff served the resident cookies, fruits, cheese snacks, crackers, and juices during snack times. -The resident was not sure if the facility had a schedule for snack times to be served to the residents. Observation 07/25/18 at 10:25am in the SCU living room revealed: -There were 7 residents sitting in the living room on the SCU. -There were 2 PCA's in the living room. -A PCA was offering a snack of 3 orange slices and a cup of milk to the 7 residents sitting in the living room. -There was no observation of the 8 residents in their rooms being offered a snack. Interview with a PCA that was in the living room of the SCU on 07/24/18 at 10:40am revealed she thought she had offered the fruit out for snack yesterday but she could not be sure. Interview with the special care coordinator (SCC) on 07/25/18 at 10:45am revealed: -She expected the PCA's to offer the snacks at 10:00am-2:00pm-7:00pm to all the residents even if they were in there rooms. -She does not usually check to see if they have passed out the snacks to the residents. -From now on she would be checking on PCA's to be sure snacks were passed out to all the	D 298		

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D 298	Continued From page 24 residents. Interview with the dietary manager on 07/25/18 at 3:52pm revealed: -The dietary staff were only responsible to provide the snacks for the snack carts for the staff to offer the snacks to the residents. -The dietary staff put the snack carts by the door of the dining room when they were ready for the care staff to pick up. -The staff from the assisted living unit and the Special Care Unit picked up the snack carts and passed out the snacks. -Snacks were supposed to be offered at 10:00am, 2:00pm, and 8:00pm. Interview with the Administrator on 07/25/18 at 4:10pm revealed: -She was not aware of any problems or complaints of residents not being offered snacks at least 3 times a day at the facility. -"The personal care aides may be late sometimes passing the snacks or the resident may be in another resident's room" when snacks were being passed out. -She had spoken with the Special Care Coordinator about snacks in the Special Care Unit and staff had passed out snacks late to the residents in the unit on 07/24/18 for 10:00am snack. -She would have the supervisor to be responsible to ensure the personal care aides were passing out snacks at their designated times. -She would need to further investigate to insure all residents are getting 3 snacks offered to them every day.	D 298		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 25 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 administer medications with meals as ordered by the prescribing physician for 2 of 2 sampled residents (Resident #6 and #7). The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 4:00pm medication pass on 07/24/18. 1. Review of Resident #6's current FL-2 dated 04/27/17 revealed: -Diagnoses included diabetes, dementia, hypertension, osteoporosis and glaucoma. -A physician's order for Citrical plus vitamin D 250/200 milligrams (mg) (used to treat calcium deficiency) take 1 tablet twice a day with food. -A physician's order for Donezepil 5mg (used to treat dementia) take 1 tablet twice a day with meals. Observation of Resident #6's medication administration on 07/24/18 at 4:25pm revealed: -The second shift medication aide (MA)administered Citrical plus vitamin D 250/200	D 358		

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D 358	Continued From page 26	D 358		

mg and Donezepil 5mg.
-The MA asked Resident #6 if she had eaten any food recently.
-Resident #6 stated that she had "plenty of food available" but did not eat any food along with her medication.
-Resident #6 was not offered food along with her medications.

Interview with the second shift MA on 07/24/18 at 4:30pm revealed:
-He always asked residents if they had just eaten or had food available when medications indicated "to take with food."
-If the residents were going to eat breakfast, lunch or dinner within the next hour that it was an acceptable time frame when giving medications that specifically stated to be given with food.
-Resident #6 had never complained of any discomfort related to her medications listed to be given with food.
-Resident #6 always had snacks available in her room.
-He took Resident #6's "word" that she had already eaten on several occasions.

Interview with Resident #6 on 07/25/18 at 10:05am revealed:
-She always at breakfast before any medication because of a previous history of stomach upset from morning medications.
-She never had any stomach problems with her afternoon medications as she ate throughout the day.
-The medication aides always would tell her to make sure she had eaten but had never offered her food.
-She had plenty of food in her room at all times and would often eat something after the medication aides left the room after her afternoon

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D 358	Continued From page 27 medication administration. Interview with Resident #6's primary care provider (PCP) on 07/26/18 at 3:13pm revealed: -The PCP's expectation was that the resident's Citrical plus vitamin D 250/200 mg and Donezepil 5mg should be taken with food to prevent gas and stomach upset. -The medications could be taken with a meal or with a snack. -Her expectation was that "at least some crackers should be given at the same time as the medications." -Medications listed to be given with food or meals were written as such to prevent side effects. Refer to interview with the Resident Care Coordinator (RCC) on 7/25/18 at 3:45pm. Refer to interview with Administrator on 7/5/18 at 3:58pm. 2. Review of Resident #7's current FL-2 dated 07/03/18 revealed: -Diagnoses included hypertension, anxiety, asthma and diabetes. -A physician's order Metformin ER 1000mg (used to treat diabetes) 1 tablet with evening meal. Observation of Resident #7's medication administration on 07/24/18 at 4:45pm revealed: -The second shift MA administered Metformin ER 1000mg. -The second shift MA did not ask Resident #7 if she had eaten any food. -The second shift MA did not offer any food to Resident #7. -The resident was not eating any food at the time of administration.	D 358		

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D 358	Continued From page 28 Interview with the second shift MA on 07/24/18 at 4:55pm revealed: -Medications that were listed to give with food or meals could be given 30 minutes before a meal. -Resident #7 had never complained of any stomach upset. -She did not keep food on the cart to offer residents. -The facility's policy allowed her to administer medications "30 minutes before or after the listed medication time on the computer if it said with food or meals." Interview with Resident #7 on 07/25/18 at 10:24am revealed: -She never had stomach upset due to medications. -When the MAs were administering her medications, it was usually just before she was going to eat breakfast, lunch or dinner. -She did not know that her medication was ordered to take with food. -Some medication aides always would tell her to make sure she had eaten but had never offered her food. -She had plenty of food in her room at all times but was never told to eat. Interview with Resident #7's PCP on 07/26/18 at 2:58pm revealed: -The PCP's expectation was that the resident's Metformin ER 1000 mg should be taken with food to prevent nausea. -The medications could be taken with a meal or with a snack. -Her expectation was that Resident #7 take the medication with at least one bite of food. -Medications listed to be given with food or meals were written as such to prevent side effects.	D 358		

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D 358	Continued From page 29 Refer to interview with the Resident Care Coordinator (RCC) on 7/25/18 at 3:45pm. Refer to interview with Administrator on 7/25/18 at 3:58pm. _____ Interview with the RCC on 7/25/18 at 3:45pm revealed: -She thought the facility's policy for medication administration was 30 minutes before a meal for those medications that required "with food" or "with meals." -She was unaware that medications listed as "with meals" were being given greater than 30 minutes prior to a meal. -No residents had complained of stomach issues related to medications being given without food. -The doctor's orders sometimes said with food so the administration times were usually set around meal times. -She did not know if MAs kept food on the cart. Interview with Administrator on 7/5/18 at 3:58pm revealed: -She believed the facility's policy on medications with food was 30 minutes prior to breakfast, lunch or dinner. -She would clarify the facility's policy on medications given with food with each resident's PCP. -She was unaware that the MAs were giving medications without ensuring the residents were offered food. -There was no written policy specific to medications with food that she could locate. -She would clarify with management to ensure that all residents with medications that required food would be offered food for compliance with the PCP's orders. -She would educate all MAs to give food with a	D 358		

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	HAL054006	A. BUILDING: _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING ARBOR OF KINSTON	3207 CAREY ROAD KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 medication when specified in the PCP's order.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure the Electronic Medication Administration Records (eMARs) were accurate to include the initials of the medication aide (MA) which administered the medications for 6 of 6 sampled residents (Resident #6, #8, #9, #11, #12 and #13) with orders for medications to be administered at 4:00pm and 5:00pm. The findings are: 1. Review of Resident #6's current FL-2 dated 04/27/18 revealed: -Diagnoses included diabetes, dementia, hypertension, osteoporosis and glaucoma. -A physician's order for Citrical plus vitamin D 250/200 milligrams (mg) (used to treat calcium deficiency) take 1 tablet twice a day with food. -A physician's order for Donezepil 5mg (used to treat dementia) take 1 tablet twice a day with food.	D 366		

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D 366	Continued From page 31 -A physician's order for finger stick blood sugar (FSBS) checks 4 times daily. Observation of Resident #6's medication administration on 7/24/18 at 4:15pm revealed the second shift MA was administering the 5:00pm medications and performing the FSBS. Review of July 2018 eMAR's for Resident #6 revealed: -Citrical plus vitamin D 250/200 mg was scheduled to be given twice a day at 8:00am and 5:00pm. -Donezepil 5mg was scheduled to be given twice a day at 8:00am and 5:00pm. -The RCC's initials were documented as the MA who administered the 5:00pm medications and not MA who actually administered the medications. Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm. Refer to interview with a MA on 07/26/18 at 4:34pm. Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm. Refer to interview with Administrator on 7/26/18 at 3:12pm. 2. Review of Resident #8's current FL-2 dated 12/14/17 revealed: -Diagnoses included recurrent pulmonary embolism, mild heart failure, renal hepatic cyst, mental retardation, diabetes, hypertension, hypoxia, schizophrenia, chest pain, osteoporosis, right leg edema, unstable angina and degenerative disc disease.	D 366		

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D 366	Continued From page 32 -A physician's order for Metformin HCL 500mg (used to treat diabetes) take 1 tablet twice daily. Observation of Resident #8's medication administration on 7/24/18 at 4:35pm revealed the second shift MA was the MA administering the 5:00pm medications. Review of July 2018 eMAR's for Resident #8 revealed: -Metformin HCL 500mg was scheduled to be given twice a day at 8:00am and 5:00pm. -The RCC's initials were documented as the MA who administered the 5:00pm medications and not the second shift MA who actually administered the medications. Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm. Refer to interview with a MA on 07/26/18 at 4:34pm. Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm. Refer to interview with Administrator on 7/26/18 at 3:12pm. 3. Review of Resident #9's current FL-2 dated 12/18/17 revealed: -Diagnoses included vascular dementia, gastro esophageal reflux disease, anemia, osteoporosis, hyperlipidemia, hypertension osteoarthritis, hyperkalemia, carotid arterial disease and atrial fibrillation. -A physician's order for Brimonidine 0.2% eye drops (used to treat glaucoma) into each eye twice a day. -A physician's order for Dorzolamide-Timolol	D 366		

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D 366	Continued From page 33	D 366		

drops (used to treat glaucoma) into each eye twice a day.
-A physicians order for finger stick blood sugar check (FSBS) three times daily.

Observation of Resident #9's medication administration on 7/24/18 at 3:51pm revealed the second shift MA was the MA administering the 4:00pm medications.

Review of the July 2018 eMAR's for Resident #6 revealed:
-Brimonidine 0.2% eye drops was scheduled to be given twice a day at 8:00am and 4:00pm.
-Dorzolamide-Timolol drops was scheduled to be given twice a day at 8:00am and 4:00pm..
-The RCC's initials were documented as the MA who administered the 4:00pm medications and not the second shift MA who actually administered the medications.

Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm.

Refer to interview with a MA on 07/26/18 at 4:34pm.

Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm.

Refer to interview with Administrator on 7/26/18 at 3:12pm.

4. Review of Resident #11's current FL-2 dated 01/13/18 revealed:
-Diagnoses included altered mental status and urinary tract infection.
-A physician's order for Metoclopramide 5mg (used to treat gastro esophageal reflux disease) take 1 tablet twice a day.

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D 366	Continued From page 34 -A physician's order for Omeprazole DR 40 mg (used to treat gastro esophageal reflux disease) take 1 tablet twice a day. Observation of Resident #11's medication administration on 7/24/18 at 4:25pm revealed the second shift MA was the MA administering the 5:00pm medications. Review of July 2018 eMAR's for Resident #6 revealed: -Metoclopramide 5mg was scheduled to be given twice a day at 8:00am and 5:00pm. -Omeprazole DR 40 mg was scheduled to be given twice a day at 8:00am and 5:00pm. -The RCC's initials were documented as the MA who administered the 5:00pm medications and not the MA who actually administered the medications. Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm. Refer to interview with a MA on 07/26/18 at 4:34pm. Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm. Refer to interview with Administrator on 7/26/18 at 3:12pm. 5. Review of Resident #12's current FL-2 dated for 03/29/18 revealed: Diagnoses included heart failure, anemia, cardiac pacemaker, prosthetic heart valve, atrial fibrillation and muscle weakness. -A physician's order for Omeprazole DR 40 mg (used to treat gastro esophageal reflux disease) take 1 tablet twice a day before a meal.	D 366		

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D 366	Continued From page 35 Observation of Resident #6's medication administration on 7/24/18 at 4:05pm revealed the second shift MA was the MA administering the 5:00pm medications. Review of July 2018 eMAR's for Resident #6 revealed: -Omeprazole DR 40 mg was scheduled to be given twice a day at 8:00am and 5:00pm. -The RCC's initials were documented as the MA who administered the 5:00pm medications and not the second shift MA who actually administered the medications. Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm. Refer to interview with a MA on 07/26/18 at 4:34pm. Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm. Refer to interview with Administrator on 7/26/18 at 3:12pm. 6. Review of Resident #13's current FL-2 dated for 02/05/18 revealed: -Diagnoses included sepsis, pneumonia, atrial fibrillation, acute encephalopathy, congestive heart failure, coagulopathy and elevated troponin. -A physician's order for Warfarin Sodium 3mg (used to prevent blood clots) take 1 tablet daily Observation of Resident #13's medication administration on 7/24/18 at 4:10pm revealed the second shift MA was the MA administering the 5:00pm medications.	D 366		

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D 366	Continued From page 36	D 366		

Review of July 2018 eMAR's for Resident #6 revealed:
- Warfarin Sodium 3mg was scheduled to be given once a day at 5:00pm.
-The RCC's initials were documented as the MA who administered the 5:00pm medications and not the second shift MA who actually administered the medications.

Refer to observation of medication administration on 07/24/18 between 3:50pm and 4:40pm.

Refer to interview with a MA on 07/26/18 at 4:34pm.

Refer to interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm.

Refer to interview with Administrator on 7/26/18 at 3:12pm.

Interview with another second shift MA on 07/26/18 at 4:27pm revealed:
-She had passed medications on 07/24/18 on second shift for her first time independently on the medication cart under the Special Care Unit Coordinator (SCC) credentials.
-She had worked at the facility in the past and had recently restarted her employment a week ago.
-The facility's computer system would not let her log in under her own credentials for one day due to a glitch with her logon credentials.
-The Administrator and the SCC permitted her to use the SCC's credentials for one shift for the greater good of the residents until the "computer people could fix the logon problem."
-The SCC logged in for her and would not give up her password.
-The SCC said she would change the medication

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D 366	Continued From page 37 administration initials for the shift she worked to reflect her initials when the computer problem was cleared up. -No one in the facility was supposed to share passwords or pass medications under another person's credentials. Interview with the SCC on 07/26/18 at 3:10am revealed: -She permitted a MA to pass medications under her credentials for one shift on the special care unit. -The MA had worked at the facility before with logon credentials that were inactive. -The MA was hired about two weeks ago and just began passing medications since returning to the facility. -The person responsible for the facility's eMAR system was supposed to fix her logon which eventually was fixed on 07/26/18. -The SCC's initials were edited to reflect the MA's initials after the computer credential problem was fixed. -It was not facility policy to permit other staff members to use other staff credentials when passing medications. -The Administrator and the SCC approved the second shift special care unit MA to pass medications under the SCC initials until it was fixed, then the other MA's initials would be edited to reflect the person who actually passed the medications on the special care unit. _____ Observation of medication administration on 07/24/18 between 3:50pm and 4:40pm revealed: -The second shift MA administered medications to 6 residents. -The second shift MA minimized the screen on his computer each time he stepped away.	D 366		

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D 366	Continued From page 38 -The second shift MA did not log onto the computer between medication administration using logon credentials. Interview with the MA on 07/26/18 at 4:34pm revealed: -He always logged on under his own name when passing medications. -The RCC must have used the computer after he logged on around 3:00pm as he did not notice her credentials were onscreen as the active user during his medication administration. -Staff were not supposed to share logons or passwords with other staff. -All MAs are expected to login when the shift begins and to logout when leaving the facility. -He should have checked the screen to see that the RCC was currently logged into his computer between medication administrations. -The medication cart computers were supposed to always be logged out when unattended. Interview with the Resident Care Coordinator (RCC) on 7/26/18 at 2:45pm revealed: -She did not administer any medications on 07/24/18. -She logged into the second shift MA's computer on the medication cart during the afternoon of 07/24/18 to print some eMARs and forgot to log out when the second shift MA had already begun his medication administration. -The second shift MA must have continued to use her logon credentials without signing in under his name. -The second shift MA was not around when she logged onto the computer on his medication cart. -It was her fault for not logging out of the system. -The second shift MA probably thought he was still logged in under his name when he unlocked the computer screen to continue administering	D 366		

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D 366	Continued From page 39 medications. -Medication administrations on 07/24/18 which reflected the RCC's initials during the second shift MA's shift were corrected to reflect his initials. Interview with Administrator on 7/26/18 at 3:12pm revealed: -She was unaware that the RCC had logged into the second shift MA's medication administration computer during his shift on 07/24/18. -She expected all staff to log out of all computers after using them. -Staff were not permitted to share logons or passwords with fellow staff. -All staff should be aware of the person's name at the top of the computer screen to ensure they are passing medications under their own credentials. -The RCC used the second shift MA's computer to print eMARS and forgot to log out. -All new hires and rehires such as the second shift special care unit MA will not be allowed to pass medications until they have the ability to put their own credentials into the system. -She was aware that the second shift special care unit MA was passing medications in the memory care unit on one shift due to a login issue and was permitted for the one shift to use the RCC's credentials. -The RCC's initials were replaced with second shift special care unit MA's initials on 07/26/18 to reflect the person who actually performed the medication administration. -Medication administrations on 07/24/18 which reflected the RCC's initials during the second shift MA's shift were corrected to reflect his initials.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D912		

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D912	Continued From page 40 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 observartions, interviews, and record reviews, the facility failed to assure residents received care and services to maintain the residents health, safety, and welfare related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 1 resident sampled (#5), with generalized weakness, who had five unwitnessed falls and six assisted falls during staff transfers between November 2017 and July 2018, resulting in facial lacerations and orbital contusions on two occasions that required emergency treatment. [Refer to Tag D 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D912		