Revision Received 11-19-18 HAP

Division of Health Service Regulation

PRINTED: 11/02/2018
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey on October 10-12, 2018.	D 000		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure information provided on the current FL2 including the residents' nutritional shake order and blood pressure (BP) order with no parameters to contact the physician had been clarified by a prescribing practitioner for 1 of 5 sampled (Resident #1). The findings are: 1. Review of Resident #1's current FL2 dated 08/27/18 revealed: -Diagnoses included hypertension, dementia, chronic renal insufficiency, anemia, blindness,	D 238	See Attached [signature] 11/19/18	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FORM 6899 6L7H11 If continuation sheet 1 of 60

Reviewed And Accepted As Amended on 11-28-2018 HAP

Revised 11-28-18 per Corporate Compliance Office HAP

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D 238	Continued From page 1 cataracts and peripheral vascular disease. -The resident was intermittently confused. -There was no order for nutritional shakes. Review of a previous physician's order dated 07/16/18 nutritional shakes three times daily. Review of a subsequent physician's order dated 08/27/18 weekly weight due to decreased appetite. Observation of the refrigerator in the Assisted Living (AL) on 10/10/18 at 10:27 am revealed: -There was a full box of nutritional shakes available for administration. -The nutritional shakes were not labeled with residents' names. Review of Resident #1's July 2018 Medication Administration Record (MAR) revealed: -There was a handwritten entry for nutritional shakes three times a day scheduled at 8:00 am, 2:00 pm and 8:00 pm. -Staff documented nutritional shakes were administered as ordered for July 2018. Review of Resident #1's August, September, and October 2018 MAR revealed there was no entry for nutritional shakes three times daily. Review of the weight log for Resident #1 revealed: -The weight for August 2018 ranged from 160-162. -The weight for September 2018 ranged from 158-161. -The weight for October 2018 ranged from 160-161. Interview with the Dietary Manager on 10/10/18 at	D 238	See Attached Walk ED. 11/19/18	

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D 238	Continued From page 2 10:30 am revealed: -The nutritional shakes were kept in the AL refrigerator. -The medication aides (MAs) were responsible for administering the nutritional shakes to residents. -MAs obtained nutritional shakes from the kitchen as needed. Interview with the contracted pharmacy on 10/11/18 at 10:10 am revealed: -The nutritional shakes should be placed on the MARs. -The pharmacy did not receive the order dated 07/16/18 for nutritional shakes three times a day. Interview with a first shift MA, in the AL, on 10/11/18 at 11:15 am revealed: -She thought Resident #1 was ordered nutritional shakes twice a day. -The MA was responsible for administering nutritional shakes. -The nutritional shakes were kept in the AL refrigerator. -The nutritional shakes should be included on the MAR. -She thought the nutritional shakes were on the MAR in September 2018. -The last time she remembered administering the nutritional shakes to Resident #1 was in September 2018. -The third shift Supervisor was responsible for completing MAR audits nightly for the AL Unit and the Special Care Unit (SCU). -The third shift Supervisor completed MAR audits when the new monthly MARs were sent to the facility. Telephone interview with Resident #1's family member on 10/11/18 at 1:37 pm revealed:	D 238	See Attached JC Lolla EP 11/19/18	

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D 238	Continued From page 3 -He knew Resident #1 was initially ordered nutritional shakes. -The facility provided and administered nutritional shakes to Resident #1. -He did not know how often the nutritional shake was ordered. -He did not know if Resident #1 was supposed to be receiving the nutritional shakes. -He had noticed slight weight loss but did not feel it was related to the nutritional shakes. Interview with Resident #1's Primary Care Provider (PCP) on 10/12/18 at 12:10 pm revealed: -She expected Resident #1 to receive nutritional shakes as ordered. -The staff did not notify her the nutritional shakes were not administered for Resident #1 three times a day as ordered from August 2018 through October 2018. -She expected Resident #1 to be administered the nutritional shakes three times a day as ordered. -She signed the FL2 dated 08/27/18 and the staff did not contact her to clarify the nutritional shake order. -Not receiving the nutritional shakes as ordered could cause weight loss. Interview with the Resident Care Coordinator (RCC) on 10/12/18 at 3:00 pm revealed: -Nutritional shakes should be included on the MAR. -Staff were expected to document each time Resident #1's nutritional shake was administered. -The nutritional shakes were kept in the AL refrigerator. -MAs were responsible for administering the nutritional shakes. -She knew Resident #1 was ordered nutritional	D 238	See Attached KC Walker CD 11/19/18	

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D 238	Continued From page 4 shakes. -Staff informed her on 10/11/18 Resident #1 was not receiving the nutritional shakes as ordered from August 2018 through October 2018. -The order was handwritten on the July 2018 MAR but staff may not have faxed the order to the pharmacy as expected. -When the new month MARs were delivered the order was missed on the third shift audit and therefore missed every consecutive month thereafter. -She did not verify month to month audits after the MAR audits were completed by the third shift supervisor. Interview with the Executive Director on 10/12/18 at 4:30 pm revealed: -Staff should document on the MAR each time a nutritional shake was administered to Resident #1. -She knew Resident #1 was ordered nutritional shakes three times daily. -She did not know the nutritional shakes were not on the MAR three times a day from August 2018 through October 2018. -She did not know staff were not administering the nutritional shakes three times a day from August 2018 through October 2018 for Resident #1. -The nutritional shakes were kept in the AL refrigerator. -The MAs were responsible for administering Resident #1 the nutritional shakes three times a day as ordered. -The third shift MA/Supervisor was responsible for completing MAR audits nightly on the AL Unit and the SCU. -The third shift MA/Supervisor was responsible for comparing the new month MARs to the previous months MARs.	D 238	See Attached KL Lollum EQ 11/19/18	

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D 238	Continued From page 5 -If the nutritional shakes were not included on the MAR the third shift supervisor should have handwritten the order on the MAR. -She expected the staff to follow the physician's orders and make her aware of any errors or concerns. -The nutritional shake order was missed on the new monthly MAR audit completed by the third shift supervisor. Attempted Interview with Resident #1 on 10/12/18 at 1:30 pm was unsuccessful. 2. Review of Resident #1's FL2 dated 08/27/18 revealed: -Diagnoses included hypertension, dementia, chronic renal insufficiency, anemia, blindness, cataracts, and peripheral vascular disease. -The resident was intermittently confused. -There was a physician's order for Lisinopril 20 mg daily (Lisinopril is a beta blocker and used to treat high blood pressure). -There was a physician's order for Lopressor 50 mg twice daily (Lopressor is an ace inhibitor used to treat high blood pressure.) -There was an order to check Blood Pressure (BP) twice daily (no parameters were included). Review of a physician's order dated 08/13/18 revealed to check BP twice daily and call provider with BP greater than 140/90 and BP less than 100/50. Review of the Care Notes for Resident #1 revealed no documentation the physician was notified for clarification of orders for parameters as to when to call the physician for BP readings outside of parameters not included on the current FL2 dated 08/27/18.	D 238	See Attached FL Walk ED 11/19/18	

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D 238	Continued From page 6 Review of Resident #1's August 2018 Medication Administration Record (MAR) revealed: -There was an entry to check BP weekly on Monday and report to physician if BP was greater than 140/90 or BP was less than 100/50. -The scheduled times on the MAR to obtain the BP readings were 8:00 am and 8:00 pm. -The BP was not obtained or documented from 08/18/18 through 08/31/18. Review of the BP log for August 2018 revealed: -BP readings for 08/06/18 and 08/13/18. -The BPs ranged from 112/72 to 136/81. Review of Resident #1's September 2018 MAR revealed: -There was an entry to check BP twice daily and report to physician if BP was greater than 140/90 or BP was less than 100/50. -The scheduled times on the MAR to obtain the BP readings were 8:00 am and 8:00 pm. -The BP ordered twice daily was obtained as ordered from 09/01/18 through 09/30/18. Review of the BP log for September 2018 revealed: -There were 5 BP readings that were outside of the ordered parameters from 09/01/18 to 09/10/18. -The documented readings ranged from 108/53 to 154/96. -On 09/01/18 at 8:00 pm the BP was 154/96. -On 09/02/18 at 8:00 am the BP was 144/76 and at 8:00 pm the BP was 142/89. -On 09/21/18 at 8:00 pm the BP was 142/76. -There was no documentation that the physician was notified of the BP readings. Interview with a first shift Medication Aide (MA) on 10/11/18 at 11:15 am revealed:	D 238	See Attached 11/13/18	

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D 238	Continued From page 7 -The BP readings should be recorded on the BP log. -She did not know Resident #1 had BP results outside the ordered parameters. -The BP order without parameters on the FL2 dated 08/27/18 should have been clarified. -The MAs were responsible for obtaining BP as ordered and calling the physician for BP's outside of parameters. -The MA or the RCC was responsible for contacting the physician for clarification of orders. Telephone interview with the Nurse Practitioner (NP) on 10/12/18 at 12:10 pm revealed: -She ordered staff to check BP twice daily with parameters due to history of hypertension. -She expected the staff to continue with the ordered parameters. -The parameters should have been on the FL2 dated 08/27/18. -She was not notified for FL2 clarification regarding the BP ordered twice daily with no ordered parameters. Interview with the Resident Care Coordinator (RCC) on 10/12/18 at 3:00 pm revealed: -MAs were responsible for obtaining Resident #1's BP and documenting readings. -The MA or supervisor was responsible for contacting the physician if the BP was outside of the ordered parameters. -She knew Resident #1 was ordered BP twice daily with parameters. -Blood pressure readings should be documented on the BP log sheet with the MARs. -The MA or the RCC was responsible for contacting the physician for order clarification. -Physician notification should be documented in the resident's care notes.	D 238	See Attached 11/19/18	

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D 238	Continued From page 8 Interview with the Executive Director (ED) on 10/12/18 at 4:30 pm revealed: -MAs were responsible for obtaining and documenting Resident #1's BP. -She did not know Resident #1 was ordered BP twice daily. -She did not know there was an order to call the provider with BP greater than 140/90 or less than 100/50. -Blood pressure readings should be documented on the BP log in the MAR book. -If there were BP orders with no parameters ordered, the MAs were expected to contact the physician to clarify the orders. -The MA or the RCC was responsible for contacting the physician for order clarification. -The MAs should be documenting when they contact the physician in the resident care notes. Attempted interview with Resident #1 on 10/12/18 at 1:30 pm was unsuccessful.	D 238	See Attached Let Walk ISR 11/19/18	
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	D 270		

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D 270	Continued From page 9 reviews, the facility failed to provide supervision to 1 of 5 residents (#1) who had a history of falls. The findings are: Review of Resident #1's current FL-2 dated 08/27/18 revealed: -Diagnoses included hypertension, dementia, chronic renal insufficiency, anemia, blindness, cataracts, and peripheral vascular disease. -She was intermittently confused. -She was non-ambulatory. -She was incontinent of bowel and bladder. -She required assistance with bathing, dressing, and feeding. -Functional limitations included sight. Review of Resident #1's Care Plan dated 01/22/18 revealed: -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -The resident had very limited vision. -The resident was noted to have blindness and limited eye-hand coordination. Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 07/26/18 revealed: -The resident was evaluated for ambulation using assistive devices and transferring semi-ambulatory or non-ambulatory residents. -"Resident had several falls this quarter with no noted injury". -Staff assist with transfers to and from the wheelchair and with propelling wheelchair due to resident being blind. Observation of Resident #1 on 10/11/18 at 6:55 am revealed Resident #1 was resting in the	D 270	See Attached 11/9/18	

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D 270	Continued From page 10 hospital bed with both half bed rails in the up position. Observation of Resident #1's room on 10/12/18 at 3:00 pm revealed: -The bed rails had been removed. -There was a bed alarm on the mattress. Observation of Resident #1 on 10/12/18 at 4:05 pm revealed: -The resident was in her wheelchair in the dayroom. -The resident was leaned forward and leaning to the right. -There was no staff in the dayroom providing supervision for the residents in the dayroom. Review of the facility's "Falls Protocol" revealed: -After 3 falls in one month a falls risk assessment should be completed. -All residents identified to be at risk for falls should be placed on a falls management program. -The provider should be notified the resident was on a falls management program requesting further guidance or preventative measures via fall management fax. -The residents care plan should be updated to include the preventative measures. -After a fall the Supervisor was responsible for completing a falls investigation summary/incident report. -The supervisor should notify the provider. -The supervisor should ask the provider if a post fall 72 hour monitoring report should be completed. -The supervisor should document the notification of the provider on the incident report and implement any orders given. - The supervisor should notify the Director of all	D 270	See Attached 11/14/18	

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D 270	Continued From page 11 falls involving an injury or head trauma. -The incident report should be reviewed by the RCC within 24-72 hours. -The RCC shall assure all follow up was completed from the incident report and complete the falls risk assessment. -The RCC should add the resident to the falls management program if the falls risk assessment indicates such. -The RCC should assure the provider was notified of the resident being on a falls management program. -The RCC should assure the provider provided intervention measures for the facility to follow. -The RCC should assure the interventions measures were followed and documented. -The RCC should assure the residents plan of care was revised. -The RCC shall assure the facility staff were alert to changes made to the residents plan of care. -The RCC should assure the environment was assessed for needed changes (nightlight, rearrange room, assure DME equipment was operable and appropriate for the resident). -The falls safety committee should meet weekly to review all falls. -The committee should review intervention measures of all residents on the falls management program to assure the interventions were successful. -The committee should review all incident reports and follow up. -The committee should review the falls policy for needed revisions. -The committee should document meeting and minutes from the meetings. -The Director was responsible for overseeing and assuring the committee was active. Review of Resident #1's Progress Notes revealed	D 270	See Attached 11/14/18	

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D 270	Continued From page 12 the resident had 6 falls from 07/15/18 to 10/05/18. Review of Resident #1's Progress Notes dated 07/15/18 at 4:45 am revealed: -The resident was found on the floor. -No injuries were noted. -Staff obtained vital signs. -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports for Resident #1 dated 07/15/18 at 4:45 am revealed: -The resident had a fall/slip in the resident's room. -No injuries were noted. -The resident's family and provider were notified. Interview with Resident #1's family member on 10/11/18 at 1:37 pm revealed the staff notified him of the resident's accident on 07/15/18. Review of Resident #1's Progress Notes dated 07/30/18 at 5:15 am revealed: -The resident was found on the floor in her bedroom. -No injuries were noted. -Staff obtained vital signs. -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports for Resident #1 dated 07/30/18 at 5:15 am revealed: -The resident was found on the floor in the resident's room. -Staff obtained vital signs and staff assisted the resident back to bed. -No injuries were noted. -The resident's family and provider were notified.	D 270	See Attached 11/19/18	

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D 270	Continued From page 13 Review of Resident #1's record revealed: -There was an order dated 07/31/18 for a hospital bed with half bed rails. -There was a delivery receipt dated 09/12/18 from a contracted durable medical equipment (DME) supply company for an electric hospital bed with bed rails. Interview with a first shift Medication Aide (MA) on 10/11/18 at 11:15 am revealed: -On 07/30/18, Resident #1 was found on floor in her room. -No injuries were identified. -She notified the physician and the resident's family. -She had not been told to increase supervision for Resident #1 or to implement any interventions to reduce falls. -She knew the facility had a falls policy. Interview with Resident #1's family member on 10/11/18 at 1:37 pm revealed the staff notified him of the resident's accident on 07/30/18. Review of Resident #1's Progress Notes dated 08/11/18 at 1:15 am revealed: -The resident was found on the floor in her bedroom. -The resident had rolled out of bed wrapped in her bed covers. -No injuries were noted. -Staff obtained vital signs. -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports for Resident #1 dated 08/11/18 at 1:15 am revealed: -The resident was found on the floor in the	D 270	See Attached 11/9/18	

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D 270	Continued From page 14 resident's room. -Staff obtained vital signs and staff assisted resident back to bed. -No injuries were noted. -The resident's family and physician were notified. Interview with Resident #1's family member on 10/11/18 at 1:40 pm revealed the staff notified him of the resident's accident on 08/11/18. Telephone Interview with a third shift MA on 10/12/18 at 5:00 pm revealed: -On 08/11/18, the resident was found on the floor in her bedroom. -No injuries were noted. -The physician and family were notified of the fall. -She had not been told to increase supervision for Resident #1 or to implement any interventions to reduce falls. -The facility had a falls policy. Review of Resident #1's Progress Notes dated 08/24/18 at 5:10 am revealed: -The resident was found on the floor in her bedroom. -The resident had rolled out of bed wrapped in her bed covers. -No injuries were noted. -Staff obtained vital signs, -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports for Resident #1 dated 08/24/18 at 5:10 am revealed: -The resident was found on the floor in the resident's room. -Staff obtained vital signs and staff assisted resident back to her wheelchair. -No injuries were noted.	D 270	See Attached 11/5/18	

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D 270	Continued From page 15 -The resident's family and physician were notified. Interview with a first shift MA on 10/11/18 at 11:30 am revealed: -On 08/24/18, Resident #1 rolled out of her bed and was found on floor in her room. -No injuries were identified. -She notified the physician and the resident's family. -She had not been told to increase supervision for Resident #1 or to implement any interventions to reduce falls. -She knew the facility had a falls policy. Interview with Resident #1's family member on 10/11/18 at 1:45 pm revealed the staff notified him of the resident's accident on 08/24/18. Review of Resident #1's Progress Notes dated 09/01/18 at 8:30 am revealed: -The resident was found on the floor in her bedroom. -Resident #1 hit her head on the nightstand. -Staff obtained vital signs and the resident was sent to the hospital for evaluation. -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports revealed there was no form completed for 09/01/18. Interview with Resident #1's family member on 10/11/18 at 1:47 pm revealed the staff notified him of the resident's accident on 09/01/18. Review of Resident #1's Progress Notes dated 10/05/18 at 10:30 pm revealed: -The resident was found on the floor beside her bed.	D 270	See Attached. 11/19/18	

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D 270	Continued From page 16 -The resident had her arm caught between the side rail and the mattress. -Resident #1 was complaining of pain and was transported to the hospital for evaluation. -Staff obtained vital signs. -There was no documentation of any increased supervision or implementation of interventions to reduce falls. Review of Accident/Incident Reports for Resident #1 dated 10/05/18 at 10:30 pm revealed: -The resident was found on the floor in the resident's room. -Staff obtained vital signs. -Resident complained of pain and the resident was transported to the hospital for evaluation. -The resident's family and physician were notified. -The resident returned from the hospital on 10/06/18 with no new orders. Review of the Emergency Department (ED) after visit summary dated 10/05/18 for Resident #1 revealed: -The documented reason for the ED visit was fall, hip pain, and arm pain. -The resident's diagnosis was right hip pain. -The resident was given instructions to follow up with the resident's Primary Care Provider (PCP) as needed. Interview with Resident #1's roommate on 10/10/18 at 5:19 pm revealed on 10/05/18, when the resident fell out of bed, Resident #1 was unable to remove her arm from the bed rail. Interview with a first shift MA on 10/11/18 at 11:35 am revealed: -She knew Resident #1 fell out of the bed and her arm was caught in the bed rail on 10/05/18. -She had not been told to increase supervision for	D 270	See Attached 11/8/18	

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D 270	Continued From page 17 Resident #1 or to implement any interventions to reduce falls. -She knew the facility had a falls policy. Interview with Resident #1's family member on 10/11/18 at 1:50 pm revealed the staff notified him of the resident's accident on 10/05/18. Interview with the Resident Care Coordinator (RCC) on 10/12/18 at 3:00 pm revealed: -She knew Resident #1 had fallen out of bed on 10/05/18 and her arm was caught in the bed rail. -She knew Resident #1 was sent to the hospital for evaluation after the incident on 10/05/18. -She had not told staff to increase supervision for Resident #1 or to implement any interventions to reduce falls. -The facility had a falls policy and staff were expected to follow the policy. Interview with the Executive Director (ED) on 10/12/18 at 4:30 pm revealed: -She was notified on 10/05/18 of Resident #1's incident and informed the resident was sent to the hospital. -She had not told staff to increase supervision for Resident #1 or to implement any interventions to reduce falls. -She expected staff to follow the falls policy. Telephone interview with a third shift MA on 10/12/18 at 5:15 pm revealed: -She was working on 10/05/18 when Resident #1 got her arm caught between the bed rail and the mattress. -She left the resident the way she found her until EMS arrived. -The resident was complaining of arm pain and she was transferred to the hospital via EMS to be evaluated.	D 270	See Attached. 11/19/18	

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D 270	Continued From page 18 -The resident returned on 10/06/18 on her shift with no new orders. -The resident had no fractures or injuries from the incident. -Every resident in the facility was checked on at least every two hours. -She did not remember if the resident had been placed on increased supervision. -When a resident was on increased supervision the staff were expected to document in the designated safety book. -She had not been told to increase supervision for Resident #1 or to implement any interventions to reduce falls. -The facility had a falls policy. Review of the facility safety book on 10/12/18 revealed no documentation of increased supervision after each fall. Based on observation, interviews, and record review Resident #1 was not interviewable. Refer to interview with Resident #1's roommate on 10/10/18 at 5:21 pm. Refer to interview with a first shift MA on 10/11/18 at 11:17 am. Refer to interview with Resident #1's family member on 10/11/18 at 1:39 pm. Refer to interview with a second first shift MA on 10/11/18 at 1:57 pm. Refer to interview with a first shift PCA on 10/11/18 at 2:02 pm. Refer to interview with the RCC on 10/12/18 at 3:02 pm.	D 270	See Attached Kt LcHnED 11/5/18	

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D 270	Continued From page 19 Refer to interview with the Executive Director (ED) on 10/12/18 at 4:32 pm. Interview with Resident #1's roommate on 10/10/18 at 5:21 pm revealed: -Resident #1's bed rails stayed up at all times when the resident was in the bed. -The staff kept Resident #1 in the dayroom after breakfast. -Resident #1 was blind and had fallen out of bed several times. -The bed rails seemed to be used for safety, to keep the resident from rolling/falling out of the bed. Interview with a first shift MA on 10/11/18 at 11:17 am revealed: -All of Resident #1's falls occurred in her room. -The resident had many incidents when she rolled/fell out of her bed. -The bed rails were used to "keep her in the bed" and decrease the risk for falls. -She remembered the side rails had been on the bed since last month. -The staff kept the bed rails up at all times when the resident was in the bed. -She knew Resident #1 fell out of the bed and her arm was caught in the bed rail on 10/05/18. -The hospital bed always stayed in the low position. -A fall mat was never used for the resident. -All residents in the facility were checked on at least every two hours. -She knew there was a fall policy and Resident #1 had been on increased supervision in the past (15 minute checks), but the MA was unable to provide dates or documentation. -When a resident was on increased supervision the staff were expected to document in the	D 270	See attached Kelly Walker ED 11/9/18	

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D 270	Continued From page 20 designated safety book. -If a resident fell and hit their head the staff would automatically send the resident to the hospital for evaluation. -For any fall the staff obtained vital signs, notified the family and provider, and completed an incident report. -She had not been told to implement any interventions for Resident #1 to reduce falls. Interview with Resident #1's family member on 10/11/18 at 1:39 pm revealed: -The staff called him after each incident and if the resident was sent to the hospital. -The bed rails were used for safety and to keep the resident from falling out of the bed. -She was blind and he did not feel the resident could adjust bed rails if needed. -He assumed the facility increased supervision after falls but was not sure if supervision was increased. Interview with a second first shift MA on 10/11/18 at 1:57 pm revealed: -She had increased falls recently. -Most of the resident's falls were from rolling/falling out of the bed. -The bed rails were used to keep the resident from falling out of the bed. -The bed rails had been on the bed a few weeks. -She had not been told to implement any interventions for Resident #1 to reduce falls. Interview with a first shift PCA on 10/11/18 at 2:02 pm revealed: -Most falls were caused from the resident falling out of the bed. -The bed rails were used to keep the resident in the bed and decrease falls. -The bed rails had been on the residents hospital	D 270	See Attached 11/9/18	

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D 270	Continued From page 21 bed for about a year. -The bed rails were kept up at all times when the resident was in the bed. -All hospital beds were kept in the lowest position. -The resident had been placed on increased supervision (15 minute checks) since September 2018. -There was no documentation provided for increased supervision since September. -Staff should document increased supervision in the designated safety book. -She had not been told to implement any interventions for Resident #1 to reduce falls. Interview with the RCC on 10/12/18 at 3:02 pm revealed: -All residents were checked on at least every two hours. -A resident would be placed on increased supervision due to confusion, falls, behaviors, or any change in status. -She did not know if Resident #1 was placed on increased supervision after falls. -When a resident was on increased supervision the staff were expected to document in the designated safety book. -She knew Resident #1 had several falls/incidents. -The facility policy was to keep hospital beds in the lowest position. -No fall mat was ordered for Resident #1. -A fall mat was discussed with the PCP and ordered for Resident #1 on 10/12/18. -She had not told staff to implement any interventions for Resident #1 to reduce falls. Interview with the Executive Director (ED) on 10/12/18 at 4:32 pm revealed: -The side rails were used for safety and positioning as needed.	D 270	See Attached 11/19/18	

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D 270	Continued From page 22 -All residents were checked on at least every two hours or as needed. -A resident would be placed on increased supervision due to falls, behaviors, frequent toileting, or change in condition. -She did not know if Resident #1 was placed on increased supervision after falls. -When a resident was on increased supervision the staff were expected to document in the designated safety book. -All hospital beds were kept in the lowest position. -A fall risk assessment was not completed on Resident #1. -A bed alarm and chair alarm was ordered on 10/11/18 for Resident #1. -The bed rails were removed on 10/11/18. -A fall mat had been ordered on 10/11/18 for Rsident #1. -She had not told staff to implement any interventions for Resident #1 to reduce falls. The facility failed to assure that residents were supervised which resulted in one resident (#1) falling out of bed and her arm was caught between the half bed rail and the mattress and no interventions were implemented to prevent falls. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/11/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 11, 2018.	D 270	See Attached 11/19/18	

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D 273	Continued From page 23	D 273		
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: Based on interviews and record reviews, the facility failed to assure physician notification for 1 of 5 sampled residents (#3) by not reporting elevated blood pressures (BP) outside of the physician's ordered parameters. The findings are: Review of Resident #3's FL2 dated 06/11/18 revealed: -Diagnoses included Alzheimer's dementia, hypertension, restless leg syndrome, hypocalcemia, myasthenia gravis, vitamin D deficiency, and osteoarthritis. -The resident was constantly confused. Review of a physician's order dated 07/16/18 revealed to check blood pressure (BP) daily and call provider with BP greater than 140/85 and BP less than 100/50. Review of Resident #3's August 2018 Medication Administration Record (MAR) from 08/01/18 to 08/31/18 revealed: -There was an entry to check BP daily and report to physician if BP was greater than 140/85 or BP was less than 100/50. -The scheduled times on the MAR to obtain the BP readings were 10:00 am.	D 273	See Attached Kat Ludlow RN 11/5/18	

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D 273	Continued From page 24 -There was no documentation on the MAR the physician was notified of the BP readings. Review of the BP log for August 2018 from 08/01/18 to 08/31/18 revealed: -There were 5 readings that were outside of the ordered parameters from 08/01/18 to 08/31/18. -The documented BP readings ranged from 111/72 to 141/84 . -Examples of BP exceeding ordered parameters included. -BP reading for 08/07/18 was 138/92. -BP reading for 08/20/18 was 141/84. -BP reading for 08/21/18 was 136/90. -BP reading for 08/27/18 was 138/90. -BP reading for 08/29/18 was 132/97. -There was no documentation the physician was notified of the BP readings. Review of the Care Notes for Resident #3 revealed no documentation the physician was notified of the BP readings obtained for August 2018. Review of Resident #3's September 2018 MAR from 09/01/18 to 09/30/18 revealed: -There was an entry to check BP daily and report to physician if BP was greater than 140/85 or BP was less than 100/50. -The scheduled times on the MAR to obtain the BP readings were 10:00 am. -There was no documentation on the MAR the physician was notified of the BP readings. Review of the BP log for September 2018 from 09/01/18 to 09/30/18 revealed: -There were 3 readings that were outside of the ordered parameters from 09/01/18 to 09/30/18. -The documented BP readings ranged from 107/59 to 141/81.	D 273	See Attached 11/19/18	

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D 273	Continued From page 25 -BP readings that exceeded ordered parameters were as follows: -BP reading for 09/09/18 was 141/81. -BP reading for 09/13/18 was 132/88. -BP reading for 09/18/18 was 138/90. -There was no documentation the physician was notified of the BP readings. Review of Resident #3's record revealed no documentation the physician was notified of the BP readings obtained for September 2018. Review of Resident #3's October 2018 MAR from 10/01/18 to 10/11/18 revealed: -There was an entry to check BP daily and report to physician if BP was greater than 140/85 or BP was less than 100/50. -The scheduled times on the MAR to obtain the BP readings were 10:00 am. -There was no documentation on the MAR the physician was notified of the BP readings. Review of the BP log for October 2018 from 10/01/18 to 10/11/18 revealed: -There were 1 readings that were outside of the ordered parameters from 10/01/18 to 10/11/18. -The documented BP readings ranged from 107/59 to 141/81. -BP readings that exceeded ordered parameters were as follows: BP reading on 10/01/18 was 135/90. -There was no documentation the physician was notified of the BP readings. Review of Resident #3's record revealed no documentation the physician was notified of the BP readings obtained for October 2018. Interview with a first shift Medication Aide (MA) on 10/11/18 at 11:15 am revealed:	D 273	See Attached 11/15/18	

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D 273	Continued From page 26 -She did not know Resident #3 had BP results outside the ordered parameters. -The MAs were responsible for obtaining BP as ordered and calling the physician for BP's outside of parameters. -The MA was responsible for notifying the provider. -Provider notification regarding Resident #3's BP readings should have been documented in the resident care notes. -The BP's outside of parameters for August-October 2018 should have been called to the provider. -The BP readings should be recorded on the BP log. -The MA was responsible for obtaining and recording the BP. -BP results were documented on the BP log. -If the BP was outside the ordered parameters the MA was responsible for calling the provider. -If the provider was notified, the contact would be documented in the resident's care notes. Telephone interview with the Nurse Practitioner (NP) on 10/12/18 at 12:10 pm revealed: -She ordered staff to check BP daily with parameters due to a history of hypertension. -She expected staff to check Resident #3's BP as ordered and notify the physician of BP outside of parameters as ordered. Interview with the Resident Care Coordinator (RCC) 10/12/18 at 3:00 pm revealed: -MAs were responsible for obtaining Resident #3's BP and documenting readings. -She knew Resident #3 was ordered BP daily with parameters. -She did not know Resident #3 had BP reading requiring provider notification.	D 273	See Attached Let Walked 11/5/18	

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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D 273	Continued From page 27 -Blood pressure readings should be documented on the log sheet with the MARs. -If BP parameters were ordered, the MA's were expected to call the physician if they obtain BP readings outside the parameters. -Physician notification should be documented in the resident's care notes. -She did not know the physician was not notified of the BP readings outside the parameters for September 2018. Interview with the ED on 10/12/18 at 4:30 pm revealed: -MAs were responsible for obtaining Resident #3's BP and documenting BP readings. -She did not know Resident #3 was ordered BP daily. -She did not know there was an order to call the physician with BP greater than 140/85 or less than 100/50. -She did not know the staff did not call the provider for the BP readings outside the parameters for August-October 2018. -Blood pressure readings should be documented on the BP log in the MAR book. -If there were parameters to call the provider, the MAs should be calling the provider if they obtain BP readings outside the parameters. -The MAs should be documenting when they call the physician in the care notes.	D 273	See Attached Kat Lilly ED 11/14/18	
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	D 298		

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D 298	Continued From page 28 a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure snacks were offered or made available to all residents 3 times a day. The findings are: Review of the Week 2 menu for October 7-13, 2018 revealed there was a morning snack, evening snack and bedtime snack listed on the menu. Inter with the Dietary Manager (DM) on 10/10/18 at 10:30 am revealed snacks were to be served at 9:30 am, 3:30 pm, and 7:30 pm. Observation on 10/10/18 at 9:30 am, 3:30 pm, and 7:30 pm in the Assisted Living (AL) and Special Care Unit (SCU) revealed: -No announcement was heard for snacks being available for residents at designated snack times. -No snacks were offered in the Assisted Living or Special Care Unit. Observation on 10/11/18 at 9:30 am, 3:30 pm, and 7:30 pm in the Assisted Living and Special Care Unit revealed: -No announcement was heard for snacks being available for residents at designated snack times. -No snacks were offered in the AL or SCU. Observation on 10/12/18 at 9:30 am in the AL and SCU revealed: -No announcement was heard for snacks being available for residents at designated snack times.	D 298	See Attached 11/12/18	

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D 298	Continued From page 29 -No snacks were offered in the AL or SCU. Observation on 10/12/18 at 4:05 pm revealed a member of the dietary staff were delivering snacks room to room in the AL. Interview with the first shift Medication Aide (MA) in the AL on 10/12/18 at 11:35 am revealed: -Resident's in the AL and SCU should receive snacks two times a day. -The dietary staff prepared the snacks and delivered to the residents. -Dietary staff went room to room and delivered snacks to the AL residents. -On 10/11/18, the morning snack was delivered room to room by the wait staff. Interview with a resident in the AL on 10/12/18 at 11:40 am revealed: -Staff provide snacks "sometimes". -She did not recall snacks being served on 10/10/18, 10/11/18, or the morning snack on 10/12/18. -When snacks were provided they consisted of juice, water, cookies, or crackers. Interview with the MA in the SCU on 10/12/18 at 11:42 am revealed: -Snacks were provided two times a day. -The dietary staff prepared and bring the snack over to the SCU. -SCU staff were responsible for distributing snacks to the residents in the SCU. -SCU residents were gathered in the common area and snacks were given to the residents. -The residents who were not in the common area had a snack delivered to their room. -She thought a snack was provided on 10/12/18 in the morning but she was not sure who assisted with the snack.	D 298	See Attached KL Walker RD 11/1/18	

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D 298	Continued From page 30 Interview with a Personal Care Aide (PCA) in the SCU on 10/12/18 at 11:45 am revealed: -Snacks were served three times a day. -She thought the morning snack was served but could not provide a time or which staff assisted with the snack. -The kitchen dietary staff prepared the snack and the SCU staff gathered the SCU residents in the common area for snack. Interview with the Resident Care Coordinator on 10/12/18 at 3:00 pm revealed: -Snacks were provided three times a day. -The dietary staff prepared and delivered snacks to the AL unit room to room. -The dietary staff prepared the snack and took them to the SCU. -The SCU staff were responsible for providing the snacks to the SCU residents. -The SCU residents were gathered in the common area for snacks. -She did not know if snacks had been served 10/10/18 through 10/12/18. -She did not know snacks were not served according to the menu from 10/10/18-10/12/18. Interview with the dietary staff on 10/12/18 at 3:55 pm revealed: -Snacks were provided for all residents at 9:30 am and 3:30 pm. -The facility did not provide a bedtime snack. -The dietary staff were responsible for preparing and delivering snacks to the AL and SCU. -The SCU staff served snacks to residents. -The dietary staff served snacks to the AL residents. -Snacks were not served on 10/11/18. -The morning snack was not provided on 10/12/18.	D 298	SEE Attached 11/19/18	

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D 298	Continued From page 31 -She was not sure why the snacks were not provided as scheduled on the menu. Interview with the Executive Director on 10/12/18 at 4:30 pm revealed: -Snacks were served to all residents three times a day. -The dietary staff prepared and delivered snacks to the SCU. -SCU staff then served snacks to the SCU residents. -The dietary staff prepared and served snacks room to room in the AL unit. -The DM and the Supervisor were responsible for assuring snacks were served according to the diet menu. -She did not know snacks were not served according to the menu from 10/10/18-10/12/18.	D 298	See Attached 11/19/18	
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements In Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily in the	D 299		

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D 299	Continued From page 32 Assisted Living (AL) and the Special Care Unit (SCU). The findings are: Observation of the reach-in-cooler in the AL kitchen on 10/10/18 at 10:27 am revealed: -One gallon of 2% milk (opened) and five gallons of 2% milk (unopened) were available to be served. -The census was 45, 25 resident's in the AL and 20 resident's in the SCU. -There was enough milk to serve all the resident's in the facility. Observation of the refrigerator in the SCU on 10/10/18 at 10:30 am revealed there was no milk. Review of the menu for 10/10/18-10/12/18 revealed two percent milk was to be served for the breakfast meal service only. Observation of the lunch meal service on 10/10/18 from 11:00 am to 12:40 pm revealed: -Milk was not offered to AL resident's. -Milk was served to one resident in the AL. -No milk was offered or served to the SCU residents. Observation of the dinner meal service on 10/10/18 from 5:00 pm to 6:45 pm revealed: -Milk was not offered to AL resident's. -Milk was served to one resident in the AL. -No milk was offered or served to the SCU residents. Observation of the breakfast meal service on 10/11/18 at 7:00 am to 8:35 am revealed milk was served to all the residents in the AL and the SCU.	D 299	See Attached 11/19/18	

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D 299	Continued From page 33 Interview with a resident in the AL on 10/10/18 at 10:00 am revealed: -Milk was served during the breakfast meal service. -Milk was provided upon request for lunch and dinner meals. Interview with a second resident in the AL Unit on 10/10/18 at 10:05 am revealed: -Milk was served during the breakfast meal service. -She did not mind that milk was only served at the breakfast meal service. Interview with the Dietary Manager on 10/10/18 at 10:27 am revealed: -Milk was served twice a day to residents in the AL and the SCU. -The dietary staff were responsible for making sure the AL residents were served milk twice a day. -The SCU staff were responsible for making sure the residents in the SCU were served milk twice a day. Interview with the dietary staff on 10/12/18 at 11:43 am revealed: -Milk was served in the AL and the SCU at breakfast. -Milk was available at lunch and dinner upon request in the AL and SCU but staff do not offer. -There is one resident in the AL that was served milk with each meal because she has requested milk with each meal. Interview with a PCA, who worked in the SCU, on 10/12/18 at 11:45 am revealed: -Milk was served twice a day at breakfast and dinner. -SCU staff were responsible for making sure SCU	D 299	See Attached Kct LxlRN ED 11/19/18	

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D 299	Continued From page 34 residents were served milk twice a day. Interview with a Medication Aide (MA), who worked in the SCU, on 10/12/18 at 11:47 am revealed: -Milk was served twice a day at breakfast and dinner. -The SCU staff were responsible for making sure milk was served to residents twice a day. Interview with the Resident Care Coordinator on 10/12/18 at 3:00 pm revealed: -The staff were expected to serve milk to all residents twice a day. -The dietary staff were responsible for making sure the AL residents were served milk twice a day. -The SCU staff were responsible for making sure the SCU residents were served milk twice a day. -She did not know the residents were not served milk twice a day. Interview with the Executive Director on 10/12/18 at 4:00 pm revealed: -Milk should be served to all residents twice a day. -She did not know the residents were not served milk twice a day. -The RCC was responsible for observing meals.	D 299	See Attached 11/19/18	
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 35 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 1 of 5 residents (#4) with orders for nutritional supplements were served ordered. The findings are: Review of Resident #4's current FL-2 dated 04/23/18 revealed: -Diagnoses included dementia, atrial fibrillation, heart failure, hypertension, muscle weakness, and other encephalitis. -An order was written for a nutritional supplement one can three times a day. Review of Resident #4's physician orders revealed: -An order dated 05/14/18 to discontinue the nutritional supplement. -An order dated 05/14/18 to start nutritional shakes two times a day. Review of Resident #4's May 2018 medication administration record (MAR) revealed: -A handwritten entry for nutritional shake twice daily scheduled for 8:00 am and 8:00 pm. -There was documentation of administration twice daily from 05/14/18 at 8:00 am and 8:00 pm to 05/31/18 at 8:00 am and 8:00 pm. Review of Resident #4's June 2018 MAR revealed: -A handwritten entry for nutritional shake twice daily scheduled for 8:00 am and 8:00 pm.	D 310	see Attached 11/19/18	

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D 310	Continued From page 36 -There was documentation of administration twice daily from 06/01/18 at 8:00 am and 8:00 pm to 06/30/18 at 8:00 am and 8:00 pm. Review of Resident #4's July 2018, August 2018, September 2018, and October 2018 medication administration record (MAR) revealed no entry for nutritional shakes was on the MARs. Observation of Resident #4 in the Special Care Unit (SCU) on 10/11/18 at 8:20 am to 9:15 am post breakfast revealed a nutritional shake was not given to Resident #4. Based on observations, interviews and record reviews it was determined Resident #4 was not interviewable. Interview with Resident #4's family member on 10/11/18 at 9:20 am revealed she did not know of any changes regarding the nutritional shakes. Interview with the contracted pharmacy on 10/11/18 at 10:00 am revealed: -The nutritional shakes were placed on the MARs. -The pharmacy did not know why the nutritional shakes for Resident #4 were never placed on the MAR by the pharmacy. -The items placed on the MAR by the pharmacy such as treatments and oxygen varied from facility to facility. Interview with the Nurse Practitioner (NP) on 10/12/18 at 12:07 pm revealed: -Resident #4 had an order for nutritional shakes because in May 2018 her intake was low and she exhibited behaviors that inhibited her intake. -Resident #4 was refusing to eat in May 2018. -The facility did not notify her about Resident #4	D 310	See Attached Kt Walker 11/14/18	

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D 310	Continued From page 37 not receiving nutritional shakes from July 2018 to October 2018. -She did not have any concerns about Resident #4 not receiving the nutritional shakes from July 2018 to October 2018 because Resident #4 was eating without difficulty. -Resident #4 had gained weight since May 2018. Interview with a SCU day shift medication aide (MA) on 10/11/18 at 1:48 pm revealed: -The nutritional shakes for residents were placed on the MAR. -The MAs documented on the MAR when nutritional shakes were administered to the residents. -She did not know Resident #4 had an order for nutritional shakes. -She had not given a nutritional shake to Resident #4. Interview with a SCU second shift MA on 10/11/18 at 3:38 pm revealed: -Resident #4 did not receive nutritional shakes. -She did not recall Resident #4 having an order for nutritional shakes and if she did it would be on the MAR. Interview with another SCU day shift MA on 10/12/18 at 10:15 am revealed: -The nutritional shakes were placed on the MAR by the third shift Supervisor. -Resident #4 did not receive nutritional shakes but an order for nutritional shakes was placed on the MAR on 10/12/18. -Prior to 10/12/18, she did not give Resident #4 nutritional shakes. Interview with the Resident Care Coordinator (RCC) on 10/12/18 at 12:45 pm revealed: -The MARs were updated monthly by the third	D 310	See Attached 11/19/18	150

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D 310	Continued From page 38 shift Supervisor. -The third shift Supervisor was responsible for transcribing handwritten entries from one MAR to another MAR. -The pharmacy placed nutritional shakes on the MARs unless the order was written at the mid-month point or right after MARs were processed. -She and the Executive Director (ED) were responsible for ensuring the third shift MA completed monthly updates of the MARs. -The nutritional shakes were placed on the MAR by the third shift MA if the order was written mid-month or right after MARs were processed. -She did not know Resident #4 did not receive nutritional shakes from July 2018 through October 2018. -She was told by the first shift MA that the order was missing on the October 2018 MAR and was transcribed on the October 2018 MAR. -She maintained a log book for weights but did not know Resident #4's weight at this time. -The NP was not contacted about the missed nutritional shakes. Interview with the ED on 10/12/18 at 4:00 pm revealed: -The third shift Supervisor was responsible for transcribing orders to the MAR and for MARS month to month. -The MAs were responsible for giving the nutritional shakes and documenting on the MAR. -She did not know Resident #4 had not received nutritional shakes from July 2018 through October 2018. -She expected the third shift Supervisor and RCC to be responsible for orders placed on the MAR from month to month. Review of the weight log for Resident #4	D 310	SEE attached 11/19/18	

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D 310	Continued From page 39 revealed: -There was a weight documented for May 2018 of 156 lbs. -There was a weight documented for June 2018 of 158 lbs. -There was a weight documented for July 2018 of 158 lbs. -There was a weight documented for August 2018 of 160 lbs. -There was a weight documented for September 2018 of 160 lbs.	D 310	See Attached 11/19/18	
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 residents sampled (#2) had physicians' orders to self-administer an anti-fungal shampoo, a hormone replacement vaginal cream, and 2 eye drops.	D 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 375	Continued From page 40 The findings are: Review of the facility's self-administration policy and procedure revealed: -Obtain a signed Self Administration of Medication Order for all medications the resident self administers. The corporate Self Administration Order should be used. -The Supervisor/designee will audit the resident compliance with Self-Administration of Medications using the corporate Compliance Audit form. "The checklist is placed in the front of their MAR [medication administration record] and is completed prior to the end of each month. Each section should be initialed by the staff member and any needed comments made. The staff should sigh the form once complete and place in the self-administer compliance binder. Any non-compliance issues will be reported to the Resident Care Coordinator (RCC) immediately. -"At anytime a resident is found to not be compliant with self-administration of medications the family, physician and the resident will be consulted by the RCC/Designee. RCC will document the results of the consultation in the resident's record." Review of Resident #2's current FL-2 dated 04/27/18 revealed: -Diagnoses included dizziness and giddiness, history of falling, orthostatic hypotension, pain in right lower leg, restless-leg syndrome, and hyponatremia. -The resident was oriented and required limited assistance with activities of daily living. Review of Resident #2's assessment and care plan dated 12/06/17 revealed: -The resident was ambulatory with rollator walker.	D 375	See Attached 11/14/18	

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D 375	Continued From page 41 -The resident was independent with average daily living tasks of eating, toileting, dressing, grooming, and transferring. -The resident required limited assistance with bathing. 1. Review of Resident #2's current FL2 dated 04/27/18 revealed an order for Premarin Vaginal cream (used for hormone replacement) apply to vagina Monday, Wednesday, and Friday. Review of Resident #2's physician's orders dated 07/23/18 revealed Premarin Vaginal cream apply to vagina 3 times a week on Monday, Wednesday, and Friday was ordered but there was no order to self-administer. Review of Resident #2's record revealed no subsequent physician's order for self-administration of Premarin Vaginal Cream. Observation on 10/11/18 at 11:20 am of medications on hand for administration kept in Resident #2's room revealed: -Resident #2 did not have a roommate. -The resident had a zipper pouch with medications stored inside. -The resident stored the medications in the zipper pouch in a dresser drawer in her bedroom. -A partial tube of Premarin Vaginal cream was included in the medications. The Premarin Vaginal cream tube was not in a box or bag and was not labeled with directions for use. Review of Resident #2's September 2018 and October 2018 medication administration records (MARs) revealed: -There was an entry on each MAR for Premarin Vaginal cream apply to vagina 3 times a week on Monday, Wednesday, and Friday.	D 375	See Attached 11/19/18	

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D 375	Continued From page 42 -Premarin Vaginal cream apply to vagina 3 times a week on Monday, Wednesday, and Friday was documented as administered 3 times weekly from 09/03/18 to 10/09/18. -There was no documentation on either MAR indicating the Premarin Vaginal cream was self-administered. Interview with Resident #2 on 10/11/18 at 11:23 am revealed: -She applied the Premarin cream herself. -She had been using the cream for several years and was familiar with when and how to apply the cream. -She applied the cream vaginally on Monday, Wednesday, and Friday. -She did not know where the container for the vaginal cream was located. Interview on 10/12/18 at 8:45 am with the RCC revealed: -Resident #2's did not have an order to self-administer Premarin Vaginal cream documented in her record. -The RCC did not know Resident #2 was self-administering Premarin Vaginal cream. Interview with a medication aide (MA) on 10/12/18 at 3:00 pm revealed: -She usually worked as a MA on the evening shift. -She did not know Resident #2 had Premarin Vaginal cream stored in her room. -She recalled the Premarin Vaginal cream was stored on the medication cart one day last week (She was not sure of the date). -Premarin Vaginal Cream was back on the medication cart 10/12/18. Telephone interview with a nurse at Resident #2's primary care physician's office on 10/12/18 at	D 375	See Attached 11/19/18	

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D 375	Continued From page 43 3:15 pm revealed: -The resident's physician was unavailable for interview. -The nurse was not able to find documentation for an order for Resident #2 to self-administer Premarin Vaginal cream. Refer to interview on 10/12/18 at 8:45 am with the Resident Care Coordinator (RCC). Refer to interview on 10/12/18 at 9:25 am with the Executive Director. Refer to interview on 10/12/18 at 1:10 pm with a medication aide/supervisor. 2. Review of Resident #2's physician's order dated 07/23/18 revealed an order for Nizoral shampoo (used to treat scalp irritations) apply to scalp for 5 minutes every other day. There was no documentation on the order for self-administration. Review of Resident #2's record revealed no subsequent physician's order for self-administration of Nizoral shampoo. Observation on 10/11/18 at 11:20 am of medications on hand for administration kept in Resident #2's room revealed: -Resident #2 did not have a roommate. -The resident had a zipper pouch with medications stored inside. -Resident #2 stored the medications in the zipper pouch in a dresser drawer in her bedroom. -A plastic bag labeled for Nizoral shampoo 120 ml dispensed on 07/24/18 with instructions to apply to scalp for 5 minutes every OTHER day was included in the medications.	D 375	See Attached 11/8/18	

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D 375	Continued From page 44 Review of Resident #2's August 2018 and September 2018 MARs revealed: -There was no entry for Nizoral shampoo on the August 2018 MAR and no documentation for administration. -There was an entry for Nizoral shampoo on the September 2018 MAR, scheduled for administration at 8:00 am, and no documentation for administration. Review of Resident #2's October 2018 MAR revealed there was an entry for Nizoral shampoo on the MAR, scheduled for administration at 8:00 am, and documented as administered on 10/01/18, 10/03/18, 10/05/18, 10/06/18, 10/07/18 and 10/08/18. Interview with Resident #2 on 10/11/18 at 11:23 am revealed: -Nizoral shampoo was kept in her room. -She did not wash her hair every day or every other day. -She had her hair washed once a week. -Nizoral shampoo was applied by the hair dresser each week when she had her hair shampooed and fixed. -Staff did not help her with the Nizoral shampoo. -She did not know if her physician ordered the Nizoral shampoo for her to administer herself but she did. Interview on 10/12/18 at 8:45 am with the RCC revealed Resident #2's did not have an order to self-administer Nizoral shampoo documented in her record. Telephone interview with a nurse at Resident #2's primary care physician's office on 10/12/18 at 3:15 pm revealed: -The resident's physician was unavailable for	D 375	see Attached KL Dalton 11/8/18	

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D 375	Continued From page 45 interview. -The nurse was not able to find documentation for an order for Resident #2 to self-administer Nizoral shampoo. Refer to interview on 10/12/18 at 8:45 am with the Resident Care Coordinator (RCC). Refer to interview on 10/12/18 at 9:25 am with the Executive Director. Refer to interview on 10/12/18 at 1:10 pm with a medication aide/supervisor. 3. Review of Resident #2's physician's order dated 08/23/18 revealed an order for Pataday 0.2% eye drops (used to treat allergies) one drop in affected eye(s) once daily. There was no documentation on the order for self-administration. Review of Resident #2's record revealed a subsequent physician's telephone order request for self-administration of Pataday 0.2% eye drops sent on 08/29/18 to the physician but not returned signed. Observation on 10/11/18 at 11:20 am of medications on hand for administration kept in Resident #2's room revealed: -Resident #2 did not have a roommate. -The resident had a zipper pouch with medications stored inside. -Resident #2 stored the medications in the zipper pouch in a dresser drawer in her bedroom. -There was a prescription bottle containing a 2.5 ml bottle of Pataday 0.2% eye drops dispensed on 08/24/18. Review of Resident #2's September 2018 and	D 375	See Attached 11/13/18	

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D 375	Continued From page 46 October 2018 MARs revealed: -There was an entry for Pataday 0.2% eye drops one drop in eye(s) once daily on each MAR, and scheduled for administration at 8:00 am., -There was "bedside/self administer" handwritten on each MAR and no administration documented. Interview with Resident #2 on 10/11/18 at 11:23 am revealed: -She kept the eye drops in her room. -She used the drops for her allergies. -She had used eye drops for seasonal allergies for many years. -She preferred to have the eye drops in her room so that she could administer the drops at her convenience. Interview on 10/12/18 at 8:45 am with the RCC revealed: -Resident #2's had a telephone order requesting self-administration Pataday 0.2% eye drops documented in her record. -She did not realize the telephone order was never signed. Telephone interview with a staff member at Resident #2's eye care provider's office on 10/12/18 at 12:45 pm revealed: -The resident's provider was unavailable for interview. -The staff member could not locate documentation for a request for Resident #2 to self-administer Pataday eye drops and was not aware the resident would need an order to self-administer eye drops. -If the facility refaxed the request, the doctor would authorize the self-administration. Refer to interview on 10/12/18 at 8:45 am with the Resident Care Coordinator (RCC).	D 375	See Attached 11/18/19	

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D 375	Continued From page 47 Refer to interview on 10/12/18 at 9:25 am with the Executive Director. Refer to interview on 10/12/18 at 1:10 pm with a medication aide/supervisor. 4. Review of Resident #2's physician's order dated 08/23/18 revealed an order for Systane Gel 0.4%-0.3% eye drops (used to treat dry eyes) one drop in each eye at bedtime as needed for dryness. There was no documentation on the order for self-administration. Review of Resident #2's record revealed a subsequent physician's telephone order request for self-administration of Systane Gel 0.4%-0.3% eye drops one drop in each eye at bedtime as needed for dryness sent on 08/29/18 to the physician but not returned signed. Observation on 10/11/18 at 11:20 am of medications on hand for administration kept in Resident #2's room revealed: -Resident #2 did not have a roommate. -The resident had a zipper pouch with medications stored inside. -Resident #2 stored the medications in the zipper pouch in a dresser drawer in her bedroom. -There was a prescription bottle containing a 2.5 ml bottle of Systane Gel 0.4%-0.3% eye drops one drop in each eye at bedtime as needed for dryness dispensed on 08/24/18. Review of Resident #2's September 2018 and October 2018 MARs revealed: -There was an entry for Systane Gel 0.4%-0.3% eye drops one drop in each eye at bedtime as needed for dryness. -There was "bedside/self administer" handwritten	D 375	See Attached 11/9/18	

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D 375	Continued From page 48 on the September 2018 MAR and no administration documented. -There was an entry for self-administration on the October 2018 MAR and no administration documented. Interview with Resident #2 on 10/11/18 at 11:23 am revealed: -She kept the Systane Gel 0.4%-0.3% eye drops in her room. -She used the drops at night when her eyes felt dry. -She had used eye drops for dryness in the last week. -She preferred to have the eye drops in her room so that she could administer the drops at her convenience. Interview on 10/12/18 at 8:45 am with the Resident Care Coordinator(RCC) revealed: -Resident #2's had a telephone order requesting self-administration of Systane Gel 0.4%-0.3% eye drops documented in her record. -She did not realize the telephone order was never signed. Telephone interview with a staff member at Resident #2's eye care provider's office on 10/12/18 at 12:45 pm revealed: -The resident's provider was unavailable for interview. -The staff could not locate documentation for a request for Resident #2 to self-administer Systane Gel 0.4%-0.3% eye drops and did not know the resident would need an order to self-administer eye drops. -If the facility refax the request, the provider would authorize the self-administration. Refer to interview on 10/12/18 at 8:45 am with the	D 375	See Attached 11/19/18	

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D 375	Continued From page 49 Resident Care Coordinator (RCC). Refer to interview on 10/12/18 at 9:25 am with the Executive Director. Refer to interview on 10/12/18 at 1:10 pm with a medication aide/supervisor. Interview on 10/12/18 at 8:45 am with the Resident Care Coordinator (RCC) revealed: -She did not know of the facility policy for self-administration of medications. -She did not have a system in place to audit for requirements for a resident to self-administer medications. -She did not know of an assessment for Resident #2 to self-administer medications. -She thought Resident #2 had a physician's order to self-administer the medications she had in her room. Interview on 10/12/18 at 9:25 am with the Executive Director revealed: -She was not familiar with the requirements for a resident to self-administer medications. -She had not had a chance to audit resident records for compliance with self-administration requirements. -The RCC would be responsible to monitor compliance with self-administration requirements. Interview on 10/12/18 at 1:10 pm with a medication aide/supervisor revealed: -Resident #2 had orders to self-administer several of her medications. -Resident #2 had been self-administering some of her medications for more than 1 year. -The resident kept the medications secured in her room and told the staff when she needed refills. -The RCC would be responsible for assuring	D 375	See Attached. KCT WALK BD 11/19/18	

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D 375	Continued From page 50 residents' self-administration medications had current orders for self-administration.	D 375		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident	D 482	See Attached 11/12/18	

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D 482	Continued From page 51 while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process and after alternatives had been tried and documented in the resident's record for 1 of 3 sampled residents (Resident #1) who had half bed rails. The findings are: Review of Resident #1's current FL-2 dated 08/27/18 revealed: -Diagnoses included hypertension, dementia, chronic renal insufficiency, anemia, blindness, cataracts, and peripheral vascular disease. -She was intermittently confused. -She was non-ambulatory. -She was incontinent of bowel and bladder. -She required assistance with bathing, dressing, and feeding. -Functional limitations included sight.	D 482	See Attached Walker 11/19/18	

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D 482	Continued From page 52 Review of Resident #1's Care Plan dated 01/22/18 revealed: -The resident scored 3 (extensive assistance) with toileting, ambulation, bathing, dressing, grooming, and transferring. -The resident had very limited vision. -The resident was noted to have blindness and limited eye-hand coordination. Review of Resident #1's Licensed Health Professional Support (LHPS) dated 07/26/18 revealed: -The resident was evaluated for ambulation using assistive devices and transferring semi-ambulatory or non-ambulatory residents. -"Resident had several falls this quarter with no noted injury". -Staff assist with transfers to and from the wheelchair and with propelling wheelchair due to resident being blind. Review of Resident #1's record revealed: -There was an ordered dated 07/31/18 for a hospital bed with half side rails. -There was a delivery receipt dated 09/12/18 from a contracted durable medical equipment (DME) supply company for an electric hospital bed with side rails. Review of Resident #1's record revealed on 10/05/18 at 10:30 pm, the resident was found on the floor beside her bed. The resident had her arm caught between the side rail and the mattress. Resident was complaining of pain and the resident was transported to the hospital for evaluation. Review of Accident/Incident Reports for Resident #1 revealed on 10/05/18 at 10:30 pm, the	D 482		

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	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 53 resident was found on the floor in the resident's room. Staff obtained vital signs. Resident complained of pain and resident was transported to the hospital for evaluation. The resident's family and provider was notified. Resident returned from the hospital on 10/06/18 with no new orders. Review of the Emergency Department (ED) after visit summary dated 10/05/18 for Resident #1 revealed: -The documented reason for the ED visit was fall, hip pain, and arm pain. -The resident's diagnoses was initial fall encounter and right hip pain. -The resident was to follow up with the residents Primary Care Provider (PCP) as needed. Observation of Resident #1 on 10/11/18 at 6:55 am revealed Resident #1 was resting in the hospital bed with both half rails in the up position. Observation of Resident #1's room on 10/12/18 at 3:00 pm revealed: -The side rails had been removed. -There was a bed alarm on the mattress. Observation of Resident #1 on 10/12/18 at 4:05 pm revealed: -The resident was in her wheelchair in the dayroom. -The resident was leaned forward and leaning to the right. -There was no staff in the dayroom providing supervision for the residents in the dayroom. Interview with Resident #1's roommate on 10/10/18 at 5:19 pm revealed: -The resident was in the AL. -Resident #1's side rails stay up at all times when	D 482	See Attached 11/13/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 54 the resident was in the bed. -The staff kept Resident #1 in the dayroom after breakfast. -Resident #1 was blind and had fallen out of the bed several times. -The side rails seemed to be used for safety, to keep the resident from rolling/falling out of the bed. -On 10/05/18 Resident #1 was unable to free herself after her arm got caught in the bed rail. Interview with a first shift medication aide (MA) on 10/11/18 at 11:15 am revealed: -All of Resident #1's falls occurred in her room. -The resident had many incidents when she rolled/fell out of her bed. -The bed rails were used to "keep her in the bed" and decrease the risk for falls. -She thought the bed rails had been on the bed since last month. -The staff kept the bed rails up at all times when the resident was in the bed. -Resident #1 would not be capable of lowering the bed rails. -Resident #1 would not be able to free herself if she was caught in the bed rails. -She knew Resident #1 had fallen out of bed and had her arm caught in the bed rail on 10/05/18. -The resident's family member knew the bed rails were on the hospital bed. -The hospital bed always stayed in the low position. -All residents in the facility are rounded on every two hours. -There was no restraint policy because the facility did not use restraints. Interview with Resident #1's family member on 10/11/18 at 1:37 pm revealed: -The bed rails were used for safety and to keep	D 482	- See Attached 11/14/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 55 the resident from falling out of the bed. -He requested the bed rails for safety. -She was blind and he did not feel the resident could adjust bed rails as needed. Interview with a second first shift MA on 10/11/18 at 1:55 pm revealed: -Most of the resident's falls were from rolling/falling out of the bed. -The bed rails were used to keep the resident from falling out of the bed. -The bed rails had been on the bed a few weeks. -The resident would not be capable of lowering bed rails as needed. Interview with a first shift personal care aide (PCA) on 10/11/18 at 1:55 pm revealed: -Most falls were caused from the resident falling out of the bed. -The bed rails were used to keep the resident in the bed and decrease falls. -The bed rails had been on the resident's hospital bed for about a year. -The bed rails were kept up at all times when the resident was in the bed. -All hospital beds were kept in the lowest position. Interview with Resident #1's Primary Care Provider on 10/12/18 at 12:10 pm revealed: -She made visits to the facility weekly on Mondays. -She knew Resident #1 was blind. -She knew Resident #1 had fallen on 10/05/18 and was sent to the hospital for evaluation. -She did not know the resident's arm was caught in the bed rails on 10/05/18. -She expected staff to fully inform her anytime a resident had a fall. -She did not think the resident would be capable of lowering the bed rails as needed.	D 482	See Attached 11/19/18	

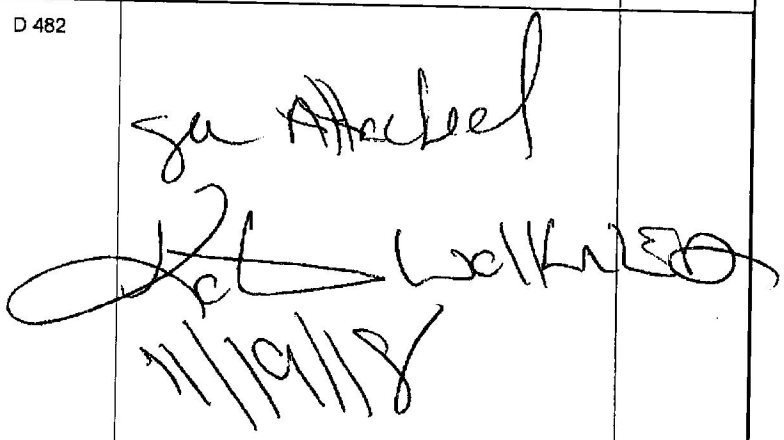
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 56 -The bed rails were used to decrease falls. Interview with a third shift MA on 10/12/18 at 5:00 pm revealed: -She was working on 10/05/18 when Resident #1 got her arm caught between the bed rail and the mattress. -She left the resident the way she found her until EMS arrived. -The resident was complaining of arm pain and she was transferred to the hospital via EMS to be evaluated. -The resident returned on 10/06/18 on her shift with no new orders. -The resident had no fractures or injuries from the incident. -Every resident in the facility was checked on at least every two hours. Interview with the RCC on 10/12/18 at 3:00 pm revealed: -All residents were checked on at least every two hours. -She knew Resident #1 had several falls/incidents and knew Resident #1 had fallen out of bed and her arm was caught in the bed rail on 10/05/18. -She knew the resident was sent to the hospital to be evaluated on 10/05/18. -The facility policy was to keep hospital beds in the lowest position. -No fall mat was ordered for Resident #1. -She knew the facility was required to obtain an order for the hospital bed and bed rails. -She did not know the facility was required to have the family complete a written consent for the bed rails. -She did not know the facility was required to complete an assessment and attempt to decrease falls with the lesser restraint prior to using bed rails.	D 482	See Attached 11/19/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 57 Interview with the Executive Director (ED) on 10/12/18 at 4:30pm revealed: -She was notified on 10/05/18 of Resident #1's incident and informed the resident was sent to the hospital. -The side rails were used for safety and positioning as needed. -She understood the side rails were ordered for safety purposes. -All residents were checked on at least every two hours or as needed. -All hospital beds were kept in the lowest position. -She knew the facility was required to obtain an order for the hospital bed and bed rails. -She did not know the facility was required to have the family complete a written consent for the bed rails. -She did not know the facility was required to complete an assessment and attempt to decrease falls with the lesser restraint prior to using bed rails. -A bed alarm and chair alarm was ordered on 10/11/18. -The bed rails were removed on 10/11/18. -A fall mat had been ordered. Review of the facility's "Restraint Protocol" revealed: -Alternatives must be tried before the use of physical restraints and should be documented. -Some examples of alternatives were physical therapy, devices that assist, frequent monitoring by staff, pain control, family involvement, communication, etc. -If alternatives to physical restraints failed, the least restrictive restraint will be used. -A restraint assessment and care plan will be completed.	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	10/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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 482	Continued From page 58 Based on observation, interviews, and record review Resident #1 was not interviewable. The facility failed to implement an assessment and care planning process and try alternatives prior to using half bed rails as physical restraints for 1 resident who had dementia and was blind and had become entangled in the bed rails after a fall. This failure of the facility was detrimental to the health, safety and well being of these residents and constitutes a Type A2 Violation The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/11/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, NOVEMBER 11, 2018.	D 482	See Attached 11/9/18	
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services that were adequate, appropriate and in compliance with federal and state laws and rules and regulations related to supervision and the use of physical restraints.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 59 1. Based on observations, interviews and record reviews, the facility failed to provide the needed supervision to 1 of 5 residents (#1) who had a history of falls. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observation, interviews, and record review, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process and after alternatives had been tried and documented in the resident's record for 1 of 3 sampled residents (Resident #1) who had half bed rails. [Refer to Tag 0482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A2 Violation)].	D912	See Attached 11/19/18	

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

10A NCAC 13F. 0703(c)(4) Tuberculosis Test, Medical Examination and Immunization

Plan of Correction

- RCC/Designee will contact physician for clarification of FL-2/orders regarding parameters for daily blood pressures and nutritional shake. 10/12/18 and ongoing
- Executive Director/Designee will monitor records to ensure all FL-2's and current orders are clear and accurate. 10/12/18 and ongoing

Monitoring System

- RCC/Designee will review all new FL-2's with current doctor's orders to ensure the orders are clear and accurate including any orders needing parameters. 10/12/18 and ongoing
- Executive Director/Designee will monitor records-(FL-2's and current orders) for accuracy weekly x 4, monthly x 3 and randomly thereafter. 10/31/18 and ongoing

10A NCAC 13F.0901(b) Personal Care and Supervision
G.S. 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- Facility will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the resident. 10/12/18 and ongoing
- Facility will provide additional training with staff to ensure that staff are providing supervision in accordance with each residents' needs. 10/12/18 and ongoing

Monitoring System

- RCC/Executive Director will review each residents care plan and provide training with all SCU staff based on individual needs of the resident. 10/12/18 and ongoing
- RCC/Designee will conduct stand-up meeting 5 days per week with staff to follow up on resident personal care concerns/issues and other medical/physical conditions. 10/12/18 and ongoing.
- Staff trained on resident rights. 10/12/18 and ongoing

See Amended POC Attached

HW

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

10A NCAC 13F. 0902(b) Health Care

Plan of Correction

- SIC/Med Aides will contact physician and document contact based on ordered parameters. 10/12/18 and ongoing

Monitoring System

- RCC will check MAR's/care notes weekly x6 weeks, monthly x3 and then randomly thereafter, to ensure physician is being contacted as ordered. 10/12/18 and ongoing
- Executive Director/Designee will have stand-up meetings 5 day/week to follow up on resident care needs/incidents and other physical/medical conditions to ensure health care referral and follow completed. 10/12/18 and ongoing

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

Plan of Correction

- RCC will ensure ordered supplements are on residents' MAR's. 10/12/18 and ongoing
- Training of SIC/MA to ensure all orders are included on MAR's. 10/12/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor MAR's monthly x 6, then randomly thereafter, to ensure all MAR's reflect current orders. 10/31/18 and ongoing
- Executive Director/Designee will contact physician for all orders that need clarification. 10/31/18 and ongoing

See Amended POC attached

11/29

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service

Plan of Correction

- Training with dietary staff on serving of milk at 2 meals per day. 10/12/18 and ongoing
- Executive Director to ensure when placing food order to have enough milk on hand to serve residents at two meals per day. 10/12/18 and ongoing

Monitoring System

- Executive Director/Designee will observe meals and conduct resident interviews weekly x 6 weeks, monthly x3 and then randomly to ensure milk is being offered at two meals per day. 10/12/18 and ongoing

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

Plan of Correction

- Dietary staff training to ensure snacks are served 3x per day as per posted on the menu. 10/12/18 and ongoing
- Staff training with SCU staff to ensure they assist with serving of residents' snacks 3 x per day. 10/12/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor snacks weekly x4, monthly x 3 and then randomly thereafter. 10/12/18 and ongoing

10A NCAC 13F. 1005(a) Self-Administration of Medications

Plan of Correction

- RCC/Designee will obtain a signed self- administration of Medication order for all medications resident self- administers. 10/31/18 and ongoing
- SIC/Designee will monitor the resident's compliance with self-administering medication by completing the Compliance audit form by the end of each month and placed in the resident record in front to the MAR. 10/31/18 and ongoing
- SIC/Designee will initial each section and sign the form, make a copy and place in the self-administration binder as well. 10/31/18 and ongoing
- SIC/Designee will contact the RCC with any non-compliance issues immediately. 10/31/18 and ongoing

See Amended POC attached
1/4/19

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

- RCC/Designee will contact the family, the physician and the resident whenever the resident is non-compliant with self-administering medications. 10/31/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor resident record/MAR weekly x 6 weeks, monthly x 3 and randomly thereafter. 10/31/18 and ongoing

10A NCAC 13F. 1501(a) Use of. Physical Restraints
G.S. 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- RCC/Designee to audit records to determine the use of restraints. 10/12/18 and ongoing.
- RCC will contact physician and orders obtained to determine alternatives to restraint and/or the least restrictive restraint. 10/12/18 and ongoing.
- Staff trained on residents' rights. 10/12/18 and ongoing

Monitoring System

- Staff trained on physical restraints and alternatives to restraints. 10/12/18 and ongoing
- Executive Director/Designee will conduct random observations and record reviews to determine the use of physical restraints and ensure the proper documentation and procedures are followed, weekly x1 month and then monthly thereafter. 10/12/18 and ongoing.

See Amended POC Attached

Executive Director.

11-19-18
Date

jtkp

Received via Email 11-29-18 MW

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

Revised per phone conversation from E Corporate compliance officer HRP

10A NCAC 13F. 0703(c)(4) Tuberculosis Test, Medical Examination and Immunization

Plan of Correction

- RCC/Designee will contact physician for clarification of FL-2/orders regarding parameters for daily blood pressures and nutritional shake. 11/11/18 and ongoing
- Executive Director/Designee will monitor records to ensure all FL-2's and current orders are clear and accurate. 11/11/18 and ongoing

Monitoring System

- RCC/Designee will review all new FL-2's with current doctor's orders to ensure the orders are clear and accurate including any orders needing parameters. 11/11/18 and ongoing
- Executive Director/Designee will monitor records-(FL-2's and current orders) for accuracy weekly x 4, monthly x 3 and randomly thereafter. 11/11/18 and ongoing

10A NCAC 13F.0901(b) Personal Care and Supervision
G.S. 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- Facility will respond immediately in the case of an accident or incident involving a resident to provide care according to the needs of the resident. 11/11/18 and ongoing
- Facility will provide additional training with staff to ensure that staff are providing supervision in accordance with each residents' needs. 11/11/18 and ongoing

Monitoring System

- RCC/Executive Director will review each residents care plan and provide training with all SCU staff based on individual needs of the resident. 11/11/18 and ongoing
- RCC/Designee will conduct stand-up meeting 5 days per week with staff to follow up on resident personal care concerns/issues and other medical/physical conditions. 11/11/18 and ongoing.
- Staff trained on resident rights. 11/11/18 and ongoing

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

10A NCAC 13F. 0902(b) Health Care

Plan of Correction

- SIC/Med Aides will contact physician and document contact based on ordered parameters. 11/11/18 and ongoing

Monitoring System

- RCC will check MAR's/care notes weekly x6 weeks, monthly x3 and then randomly thereafter, to ensure physician is being contacted as ordered. 11/11/18 and ongoing
- Executive Director/Designee will have stand-up meetings 5 day/week to follow up on resident care needs/incidents and other physical/medical conditions to ensure health care referral and follow completed. 11/11/18 and ongoing

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

Plan of Correction

- RCC will ensure ordered supplements are on residents' MAR's. 11/11/18 and ongoing
- Training of SIC/MA to ensure all orders are included on MAR's. 11/11/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor MAR's monthly x 6, then randomly thereafter, to ensure all MAR's reflect current orders. 11/11/18 and ongoing
- Executive Director/Designee will contact physician for all orders that need clarification. 11/11/18 and ongoing

North Pointe of Archdale
HAL-076-032
Plan of Correction
DHSR Survey

10A NCAC 13F .0904(d)(3)(A) Nutrition and Food Service

Plan of Correction

- Training with dietary staff on serving of milk at 2 meals per day. 11/11/18 and ongoing
- Executive Director to ensure when placing food order to have enough milk on hand to serve residents at two meals per day. 11/11/18 and ongoing

Monitoring System

- Executive Director/Designee will observe meals and conduct resident interviews weekly x 6 weeks, monthly x3 and then randomly to ensure milk is being offered at two meals per day. 11/11/18 and ongoing

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

Plan of Correction

- Dietary staff training to ensure snacks are served 3x per day as per posted on the menu. 11/11/18 and ongoing
- Staff training with SCU staff to ensure they assist with serving of residents' snacks 3 x per day. 11/11/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor snacks weekly x4, monthly x 3 and then randomly thereafter. 11/11/18 and ongoing

10A NCAC 13F. 1005(a) Self-Administration of Medications

Plan of Correction

- RCC/Designee will obtain a signed self- administration of Medication order for all medications resident self- administers. 10/31/18 and ongoing
- SIC/Designee will monitor the resident's compliance with self-administering medication by completing the Compliance audit form by the end of each month and placed in the resident record in front to the MAR. 10/31/18 and ongoing
- SIC/Designee will initial each section and sign the form, make a copy and place in the self-administration binder as well. 10/31/18 and ongoing
- SIC/Designee will contact the RCC with any non-compliance issues immediately. 10/31/18 and ongoing

- RCC/Designee will contact the family, the physician and the resident whenever the resident is non-compliant with self-administering medications. 10/31/18 and ongoing

Monitoring System

- Executive Director/Designee will monitor resident record/MAR weekly x 6 weeks, monthly x 3 and randomly thereafter. 10/31/18 and ongoing

10A NCAC 13F. 1501(a) Use of. Physical Restraints
G.S. 131D-21(2) Declaration of Residents' Rights

Plan of Correction

- RCC/Designee to audit records to determine the use of restraints. 11/11/18 and ongoing.
- RCC will contact physician and orders obtained to determine alternatives to restraint and/or the least restrictive restraint. 11/11/18 and ongoing.
- Staff trained on residents' rights. 11/11/18 and ongoing

Monitoring System

- Staff trained on physical restraints and alternatives to restraints. 11/11/18 and ongoing
- Executive Director/Designee will conduct random observations and record reviews to determine the use of physical restraints and ensure the proper documentation and procedures are followed, weekly x1 month and then monthly thereafter. 11/11/18 and ongoing.

Katina Walker
Executive Director

11/19/18
Date

Peedin, Ray

From: Karen Shaver <Karen.Shaver@myvschome.com>
Sent: Wednesday, November 28, 2018 7:56 AM
To: Peedin, Ray
Subject: [External] SOD we discussed on 11/27/18
Attachments: North Pointe of Archdale--S)D.docx

CAUTION: External email. Do not click links or open attachments unless verified. Send all suspicious email as an attachment to Report Spam.<mailto:report.spam@nc.gov>

Peedin, Ray

From: Karen Shaver <Karen.Shaver@myvschome.com>
Sent: Monday, November 19, 2018 3:44 PM
To: Peedin, Ray
Cc: Meredith Seals
Subject: [External] SOD/Plan of Correction-
Attachments: Scanner_20181119_151240.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Send all suspicious email as an attachment to Report Spam.<mailto:report.spam@nc.gov>

Ray-

Attached is the SOD and the plan of correction for North Pointe of Archdale licensure # HAL-076-032 for survey dated 10/12/18

Should you have any questions please feel free to contact me at 336-707-9420.
Thanks and Happy Thanksgiving.

Sincerely,
Karen Shaver
Victorian Senior Care
Compliance Director